A FAMILY CENTERED MATERNITY CARE STUDY

WRITTEN ON YEBOAH AUGUSTINA AT

TUOBODOM HEALTH CENTRE

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PREFACE

The client/family centered maternity care is systematic approach used in giving holistic obstetrical care to a pregnant woman and her family from the period of antenatal, labour and puerperium. With the new changes in customer needs and patient charter, it helps the student midwife to acquire the right kind of approaches to care for the pregnant woman. Some of these approaches are, explaining procedure to the client to gain the client's consent, providing privacy and getting the family involved in the care.

The maternity care study helps the student midwife to acquire knowledge which can be used to solve any problem associated with pregnancy, labor and puerperium. The competence of the student midwife is also tested in the practical aspect through the maternity care study which the student uses to identify both short- and long-term problems, set objectives for these problems and give intervention that will help her solve them. The main reason for carrying out this care study is to reduce maternal and infant mortality rate and to promote the health of the baby and mother, including the family. It is in this view that the World Health Organization (WHO) develops the partograph in managing the first stage of labor. Using this tool assists the midwife to identify any complication of labor for prompt intervention. The student midwife during this care study gets the chance to use the partograph to enable her to become competent in using it.

Finally, the client/family centered maternity care is an obligation for every final year student midwife as a requirement by the nursing and midwifery council of Ghana in partial fulfillment towards the award of registered midwifery certificate.

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INTRODUCTION

The family centered maternity care is an academic work which gives the student midwife the opportunity to nurse a client throughout pregnancy, labour and puerperium using the knowledge and skill acquired during the 3-year training programme. The study is based on the use of nursing process as guidelines to identify and help the pregnant woman in solving every problem identified during the period of care. The study was conducted on Madam Augustina Yeboah, a 32 years old gravida 3 Para 2 alive. She hails from Tatale in the Northern Region of Ghana but stays at Domeabra No.2, Techiman Tuobodam, Bono East. We had an encounter on Wednesday 27th october,2021 at Tuobodam Health Centre. 36 weeks gestation and had come for her nine antenatal care visits. Introduction was made as a student midwife who wishes to take care of her throughout the rest of her pregnancy, through delivery and puerperium. She had no health issues when we had the encounter. The interaction ended after client had delivered spontaneously to an alive male child without any complication. Mother and baby had a successful puerperal period and they were handed over to the public health nurse for continuity of care in a healthy state after six weeks of care.

There are four chapters outlined in this script.

Chapter One: Is the collection of the client's social, medical, menstrual, lifestyle and hobbies, past and present obstetrical histories.

Chapter Two: Involves antenatal care which begins from the time of conception till the ninth month when the woman was due for delivery.

Chapter Three: Is about the care given to the client during labour and delivery.

Chapter Four: Talks about the puerperium. At the end of each chapter is a care plan drawn to solve problems encountered by client, summary, conclusion, bibliography and appendix. The client will be called Madam Augustina throughout this project

LITERATURE REVIEW

Pregnancy

Myles (2009) Pregnancy is confirmed when many physiological changes take place in the body and return to its pre-pregnant state during puerperium due to the effect of hormones namely estrogen and progesterone. These hormones are responsible for the major changes that take place during pregnancy. Even though these hormones have their own effects by causing this minor disorders that occur during pregnancy, they are one way or the other an advantage for the mother and the growing foetus since the foetus depends solely on the mother for survival in utero. . Prenatal visit begins soon after the first missed menstrual period to ensure good health of the expectant mother and the fetus. Normal pregnancy last for about 40weeks or 280 days and health care providers refer to early, middle or late pregnancy trimesters. The first trimester last from week 1 through to 13, the second from week 14 through to 26, and the third from week 27 through to 40. A pregnancy is considered to be at term if advances to 38 to 40 weeks. The average duration of pregnancy is 280 days or 40 weeks and this is countered from the last menstrual period. Every pregnancy is a unique experience for that woman and each pregnancy that the woman experiences will be uniquely different.

Perry, (2014) Pregnancy is a period of physical and psychological preparation for birth and parenthood. Prenatal visit begins soon after the first missed menstrual period to ensure good health of the expectant mother and the fetus. Normal pregnancy last for about 40weeks or 280 days and health care providers refer to early, middle or late pregnancy trimesters. The first trimester last from week 1 through to 13, the second from week 14 through to 26, and the third from week 27 through to 40. A pregnancy is considered to be at term if advances to 38 to 40 weeks. Every pregnancy is a unique experience for that woman and each pregnancy that the woman experiences will be uniquely different. This is why it is so important that, the midwife has a knowledge and understanding of the common disorders of pregnancy which include; constipation, fatigue, headache, lower abdominal pain, waist pains, leg cramp, backache, increase vaginal discharge among others in order to advice the woman on strategies that will help her cope with the condition and minimize the effects she experience

Ojo and Briggs, (2006), pregnancy occurs when menstruation ceases for some weeks or months before delivery. Most women experience some minor disorders such as morning sickness, nausea, frequency of micturition, heart burns among others. These conditions may not be life threatening but can be harmful: the women therefore need to be educated on these conditions so that they can understand and cope with their occurrence. In pregnancy progesterone and estrogen increases. These hormones are responsible for the major changes that take place during pregnancy. Even though these hormones have their own effects by causing this minor disorders that occur during pregnancy, they are one way or the other an advantage for the mother and the growing foetus since the foetus depends solely on the mother for survival in utero

Fraser and Cooper (2009), pregnancy is a time of enormous physical and psychological change and adaptation as the woman and her family prepared or expected a new member of the family.

For most women, this is an exciting and happy period of time but may be over shadowed by fear and expectations. Pregnancy is the growth of the uterus and the foetus. The average duration of pregnancy is 280 days or 40 weeks and this is countered from the last menstrual period. Every pregnancy is a unique experience for that woman and each pregnancy that the woman experiences will be uniquely different. This is why it is so important that, the midwife has a knowledge and understanding of the common disorders of pregnancy which include; constipation, fatigue, headache, lower abdominal pain, waist pains, leg cramp, backache, increase vaginal discharge among others in order to advice the woman on strategies that will help her cope with the condition and minimize the effects she experience.

Verrals (1993), pregnancy is the period in which a foetus develops inside a woman's womb or uterus. In the late trimester the uterus pushes on the bladder causing frequent micturition. The hormones progesterone and estrogen are produced in large quantities which exert some action on the various systems of the pregnant woman such as frequency of micturition. During this period, physiological and psychological changes occur due to the effect of estrogen and progesterone which provide nutritive and protective environment for the developing embryo and also prepares the breast for lactation.

Labour

Myles (2009), labour is described as the process by which the fetus, placenta and membranes are expelled through the birth canal. First stage of labour begins with regular rhythmic uterine contractions to the full dilatation of the cervix (10cm) and is managed by the use of a partograph. Partograph is a graphical representation of the progress of labour and salient features of the mother. This helps to improve maternal and neonatal outcome, increases the regularity and quality of observation done on the foetus and mother, serves as early warning system and also helps in decision on augmentation or termination of labour. The first stage lasts for about six to twelve hours and this stage is shorter in multiparous women than in primigravid women. The stage one has active and latent phase and within the latent phase has the transitional phase. The second stage starts from full dilatation of cervical os which is 10cm up to the expulsion of the foetus. The third stage of labour starts from the expulsion of foetus to the separation and expulsion of its membrane and subsequent control of hemorrhage. It usually last within 5-15 minutes after the birth of the baby. The fourth stage of labour is the first six hours vigilant observation of the mother and baby

Fraser and Cooper (2009), Labour is the process by which the foetus, placenta and the membranes are expelled through the birth canal. Normal labour occurs between thirty seven to forty two weeks of gestation. The World Health Organization (1997) defines normal labour to as low risk throughout, spontaneous in onset and presenting with vertex culminating in the mother and infant in good condition after birth. The four stages of labour are described as; stage one is the period of onset of regular uterine contraction to when the cervix is full dilatation of the cervical os and it last 12-14 hours in the primigravida and 6-12 hours in a multiparous woman. The stage one has active and latent phase and within the latent phase has the transitional phase. The second stage starts from

full dilatation of cervical os which is 10cm up to the expulsion of the foetus. The third stage of labour starts from the expulsion of foetus to the separation and expulsion of its membrane and subsequent control of hemorrhage. It usually last within 5-15 minutes after the birth of the baby. The fourth stage of labour is the first six hours' vigilant observation 0f the mother and baby. It also deals with the establishment of lactation and detection of abnormalities and complications in both mother and baby

The National Safe Motherhood Service Protocol (2008), labour begins when there are regular, painful contraction lasting at least 20 seconds (timed by a trained observer), occurring at a frequency of at least two contraction in every 10 minutes and with a cervical dilatation of at least 3 centimeters. The 4 four stages of labour are; first stage, it begins from onset of contraction to full dilatation. In the first stage after 4 cm dilatation a partograph is issued for the monitoring of the labour. The second stage starts from full dilatation to expulsion of foetus. The third stage starts from expulsion of foetus to expulsion of membranes. The fourth stage of labour starts from the expulsion of membranes to the end of puerperium. The WHO partograph has been modified to make it simpler and easier to use the partograph is issued after 4cm dilatation of cervix to monitor the progress of labour and manage the labour.

Konar (2013), Labour as series 0f event that takes place in the genital organs in an effect to expel the whole product of conception out of the womb through the vagina into the outside world. The four stages of labour are first second third and fourth .The labour pain has two component; visceral pain which occurs during the early first stage and the second stage of child birth and somatic which occurs during the late first and second stage. The pain in the first stage is mediated by the T10 to L1 spinal segment and in the second stage is carried by T12 to L1 and S2 and S4spinal segments

Ojo (2006), Labour is the process by which the uterus empties its contents after 28 weeks of pregnancy. It entails the contraction and retraction of uterine muscle fibers, the dilatation of the cervical os and complete expulsion of the fetus, liquor amnii, placenta and membranes. The first stage is the period of onset of regular uterine contraction to when the cervix is full dilatation of the cervical os and it last 12-14 hours in the primigravida and 6-12 hours in a multiparous woman. The first stage has active and latent phase and within the latent phase has the transitional phase. The second stage starts from full dilatation of cervical os which is 10cm up to the expulsion of the foetus the stage last for an hour in primigravida and 5-40 minutes in a multigravida. The third stage of labour entails the expulsion of foetus to the separation and expulsion of its membrane and subsequent control of hemorrhage. It usually last within 5-15 minutes after the birth of the baby. The fourth stage of labour is the six hours after the delivery of the placenta and membranes and close monitoring of the client and baby.

Henderson (2009), states that labour is the period from dilation to expulsion of foetus and its membranes the aims of midwifery care in labour are to achieve a safe labour and birth for mother and baby, and a pleasurable fulfilling experience of child birth for the mother and her partner. labour is called normal if it fulfils the following criteria; spontaneous from onset, painful uterine contraction at regular interval

Puerperium

Myles (2008), states that, following the birth of the baby and the expulsion of the placenta, the mother enters a period of physical and physiological recuperation. Puerperium starts immediately after the delivery of the placenta and membranes and continues for six weeks. Differences between exercise and healthy activist verses rest, relaxation and sleep was strike. Exploring each person's level of activity will encourage advice in relation to appropriate exercise and by association, nutritional intake and rest or relaxation and sleep. Undertaking regular pelvic floor exercise is benefit to the women's long –term health. After birth the uterus involute and there is a heavy discharge called the lochia which originates from the uterine body, cervix and vagina. Depending upon the variation of the colour of the discharge is named as;

Lochia rubra (red) 1-4

Lochia serosa (yellowish or pink or pale brownish) 5-9

Lochia Alba (pale white) 10-15

Fraser and Cooper (2009), puerperium is the period of six weeks after birth which begins as soon as the placenta is expelled. During this period, the reproductive organs return to their non-pregnant state. Puerperium is divided into 3 phases that is; immediate phase – the first 24 hours after delivery of the placenta, early phase- 24hours after delivery of placenta up to 7 days, remote phase 7 days to 6 weeks to 6 months. The general expectation is that by six weeks after birth all the systems in a woman's body will have recovered sufficiently from the effects of the pregnancy and recovered to their non – pregnancy state. immediately after delivery the uterus is firmer and weight about 1000g. There is involution that is the uterus returning to its non-pregnant state, there is discharge from the uterine body, cervix and vagina called the lochia.

Depending upon the variation of the colour of the discharge is named as; Lochia rubra (red) 1-4days Lochia serosa (pink or pale brownish) 5-9 days, Lochia Alba (pale white) 10-15 days

The National Safe Motherhood Service Protocol (2008), the postpartum period is the time from the end of delivery to six weeks after delivery. The post natal, care includes education of the mother on the care of the baby, detection and treatment or referral of any abnormalities for further management. The major causes of death in this period are infection, hypertensive complications, hemorrhage and thromboembolism. The period is arbitrarily divided into; immediate -within 24 hours, early – up to 7 Days and remote – up to 6 weeks. Uterus involute and there is a heavy discharge called the lochia which originates from the uterine body, cervix and vagina. Depending upon the variation of the colour of the discharge is named as; Lochia rubra (red) 1-4days Lochia serosa (pink or pale brownish) 5-9 days

Lochia Alba (pale white) 10-15 days

Ojo and Briggs (2011), states that puerperium lasts for about six weeks after the delivery of the placenta and arrest of haemorrhage. The first ten day of puerperium is term as the lying-in period where close observation of both mother and baby are considered. During this period the abdominal muscles are flaccid and the bruises in the vaginal heals and the genital organs and any other organs which underwent changes during pregnancy return to their pregravid state. Lactation is also established bonding is fostered through the establishment of breastfeeding. The process of readjustment is called involution

Myles (2014), states that puerperium starts immediately after the delivery of the placenta membranes and continues for six weeks. In many culture around the world, 40 days for recuperation is a time- honored practice. The general expectation is that by six weeks after birth

all the systems in a woman's body will have recovered sufficiently from the effects of the pregnancy and recovered to their non – pregnancy state. The pelvic organ revert approximately to the pre pregnant state both anatomically and physiologically. The period is divided into; immediate- within 24 hours, early- up to 7 days, remote- up to 6 weeks uterus involute and there is a heavy discharge called the lochia which originates from the uterine body, cervix and vagina. Depending upon the variation of the colour of the discharge is named as; Lochia rubra (red) 1-4days

Lochia serosa (pink or pale brownish) 5-9 days

Lochia Alba (pale white) 10-15 days

WHY CLIENT WAS CHOSEN

Madam Augustina Yeboah was chosen as a client on 27th October,2021at Tuobodam Health Centre during one of her usual antenatal visit. During education that morning on the topic "personal hygiene", she made some contributions which indicated that Madam Augustina Yeboah had little knowledge on the topic (Personal Hygiene) . The needed information on the topic she required was provided. Introduction was made as a student from Holy Family Nursing and Midwifery Training College Berekum, and was at the hospital for practical experience. Permission was sought from her to be taken as a client for the care study which she accepted. All the necessary particulars were collected. Appointment for home visit was booked, direction to her house was given and phone numbers were exchanged

CHAPTER ONE

CLIENT PARTICULARS

1.0 INTRODUCTION

This chapter gives a preview on the various histories and information about the client, her family and the community in which she lives.

1.1 SOCIAL AND PERSONAL HISTORY

Madam Augustina Yeboah, a 32year old gravida 3 para 2 all alive comes from Tatale in the Northern region of Ghana, but stays at Domeabra No.2 a suburb of Techiman Tuobodam in the Bono east region of Ghana. She is dark in complexion and weighs 84kg and 169cm in height. Her native language is Basaare. She is a Christian who worships at the church of Continuation and she is a baker. Madam Augustina as popularly known is married to Mr. Kwabena Owusu a 40 year old who is a farmer. They have been married for almost 9 years. She had her basic education at Northern Region and the husband also had his education up to the Junior High School. Her source of support through the period of pregnancy is the husband and the family.

1.2 FAMILY HISTORY

Mr. Kofi Nachibo and Madam Akua Yaaba happen to be her parents and it only the mother who is alive. She is the eighth born of her parent's children among ten siblings. The mother speaks Twi and Basaare. Both hail from Northern and now reside at Domeabra. According to Madam Augustina, there is no history of Hypertension, Diabetes Mellitus, Sickle cell disease, Asthma and mental illness in her family. They do not have any history of congenital abnormalities such as cleft lip or palate or heart disease in the family. Death in her family occur naturally.

1.3 MEDICAL HISTORY

According to Madam Augustina, she has no history of medical condition such as hypertension, diabetes, hepatic disorders, kidney problems, pulmonary disorders among others. She has never been admitted to the hospital. Even though she sometimes suffers from certain illnesses, she is treated as an outpatient client whenever she reports to the hospital for treatment. Throughout her life, she has never reacted to any drug or a type of food. She is not on any lifelong medication. She has neither donated blood nor been transfused.

1.4 SURGICAL HISTORY

According to Madam Augustina, she has never received or donated blood. She has not been involved in any road traffic accident which could affect the adequacy of her pelvis. She has never undergone any surgical operation since infancy.

1.5 MENSTRUAL HISTORY

Madam Augustina was 15 years when she had her menarche. Her regular menstrual cycle is 28 days; amount of blood loss is moderate each month and last for 5 days. She uses sanitary pad during the flow and changes it two times daily. She has no history of dysmenorrhea. Last Menstrual Period of which she did not know. Her expected date of delivery by scan was 27th November, 2021.

1.6 CLIENT'S HOBBIES AND LIFESTYLE

Madam Augustina usually goes to bed at 10:00 pm and wakes up at 5: 30 am. Routinely, morning devotion is the first line of action she takes to give glory to Almighty God for his kind gesture and benevolence towards her life. She does few house chores like sweeping, dusting and baths her children. She then starts to prepare breakfast. She serves it for her children to eat after which she prepares them for school. Since Madam Augustina is a Bread Baker, she also prepares for work after taking her bath and making sure everything is in order in the house. She goes to the market

and come home at 3:30pm to prepare supper for the family. All these are done from Monday to Friday. On weekends, she does certain chores such as washing dirty cloths, scrubbing the house and goes to church on Sundays. She prefers playing ludo and watching local movies. She uses toothpaste and tooth brush every morning to clean her teeth. Banku with okro soup and fish is her favorite meal. Client eats three times daily and takes in enough water and empties her bowel twice a day. Together with her family, they watch movies and have some fun until the day fades away. She neither smokes nor drinks alcohol**.**

1.7 PAST OBSTETRICAL HISTORY

Madam Augustina is Gravida 3 Para 2 all alive with no history of spontaneous or induced abortions. The interval between the second pregnancy and the current one was three years. According to the Antenatal records, she never had problem during her pregnancies such as pre-eclampsia, pregnancy induced hypertension, ante partum haemorrhage, anaemia and gestational diabetes. She experienced some minor disorders like leucorrhoea, ptyalism, of which she was managed. Client was a regular attendant at Antenatal session and took three Tetanus doses and she took four doses of Sulphadoxine Pyrimethamine. The mode of her first delivery was spontaneous vaginal delivery with no laceration at the perineum at Tuobodam Health Centre. The outcome of labour was a live healthy male child (first child) with birth weight of 3.1kg and length of 50cm. The second child was also born through spontaneous vaginal delivery at Tuobodam Health Centre. The outcome of labour was a live female child with birth weight of 3.0kg. The interval between their births is three years. The babies cried soon after birth. Postpartum complications such as postpartum haemorrhage, retained placenta were not recorded and client confirmed not experiencing any complications. She stated that she did not suffer any complications after delivery. Madam Augustina exclusively breastfed both children for the first six (6) months and continued with supplementary feeds. Both the first and second child was fully immunized against the

childhood preventable diseases. Much attention was given to her from her beloved husband and family during this period. She has never used any artificial family planning method but uses the natural family planning (calendar method). She attended the postnatal clinic as scheduled.

1.8 PRESENT OBSTETRICAL HISTORY

Madam Augustina reported to the antenatal clinic on 13/04/2021 with the last menstrual period which she had no idea. Upon this the expected date of delivery by scan was 27/11/2021. Serving as baseline for the comparison with the subsequent antenatal recording, the following laboratory investigation and vital signs were recorded on her booking visit; Temperature - 36.8^{0}C, Pulse - 90 bpm, Respiration – 21cpm, Blood Pressure - 90/60mmHg, Weight – 80kg, Height - 169cm

The results of the various laboratory investigations done were as follows

Haemoglobin	13.9 grams per deciliters
Sickling test	Negative
Blood group	O
Rhesus	Positive
Hepatitis B	Non-Reactive
VDRL	Negative
G6PD	Normal
HIV status	Non-Reactive
Urine for protein and sugar	Negative
Gestational weeks	7 weeks
Symphysio fundal height	Not palpable

No abnormality was detected on Madam Augustina after carefully conducting head to toe examination. Clients complains were headache and her inability to sleep especially at night

which was managed. Client complaints has been always addressed during her regular visits to the antenatal and encourage to attend all the subsequent visit at the antenatal clinic her routine care and drugs were given to her. She was served with the following routine drugs.

Tablet ferrous one daily x 30 days

Tablet Folic Acid one daily x 30 days

Tablet Multivitamin one daily x 30 days

CHAPETR TWO

ANTENATAL CARE

2.0 INTRODUCTION

This chapter describes the care given to the client during antenatal period. It also gives information about first contact with client, home visits made and nursing care plan on problems identified.

2.1 FIRST CONTACT WITH THE CLIENT

Madam Augustina was a regular attendant to the antenatal clinic and it was through one of these visits that she was met on the 27th of October, 2021 around 3:00pm at 36weeks gestation and her 9th visit to the clinic. She was warmly welcomed and a seat was offered to her and enquiry about her health and that of her family was made. She said they were all fine and that she was coming for antenatal care. Her antenatal book was collected and glanced through and then introduction was made to her as a student midwife from Holy Family Nursing and Midwifery Training College, Berekum who came to have clinical experience and then wish to use her for my care study. All details of information and procedures involved in the study were explained to her and she gladly agreed and promised to give all the information needed and the maximum cooperation. She was asked to empty her bladder after a specimen bottle was given to her and it was explained to her the need to obtain midstream urine, to check for ketone, protein and sugar.

Urine Testing

Procedure was explained to the woman and her consent was gained. Protective clothing such as mackintosh and gloves were worn. Quantity of the urine was noted, the colour observed, the odour and sediments were noted for. Instructions on the reagent bottle were read, expiry date was checked for and a strip was picked from it and dipped into the urine. The strip was removed immediately and the edge of the strip was tapped against side of the reagent container. The strip was compared

closely with the corresponding colour chart on the bottle. Urine specific gravity and Ph was measured immediately. The findings were communicated to the woman. Items used were discarded according to infection prevention guidelines. Hands were washed and dried. Findings were also recorder and reported to the midwife in-charge. Vital signs were taken and the finding recorded in her antenatal book was as follows; Haemoglobin level – 13.9g/dl, Weight – 84kg, Temperature - 36.5^{0}C, Pulse - 95bpm, Respiration - 20cpm, Blood Pressure - 110/60mmhg

Head to toe examination was explained to her. The necessary equipment for the procedure were gathered and taken to the examination room. Privacy was provided. She was asked to sit on the bed, lie lateral and then assume a supine position. Hands were washed and dried. Under the supervision of the midwife-in-charge, the following examinations were carried out on Madam Augustina.

PHYSICAL EXAMINATION

The examination was started on the client from the head and was supervised by the midwife-in-charge.

Head and Neck: On inspection, the hair was observed to be neatly braided and appeared clean. Her face was also clean and no abnormality was detected. Her eyes were normal in colour and in good condition. The ears were also in proper alignment with the eyes, the nose had patent nares. The mouth was very clean with teeth very clean and in good condition, the lips were nicely kept with a lip balm applied to it, the tongue was kept clean. No abnormality was detected. As the procedure was on going, client was congratulated for having taken good care of herself. The neck was free from lymph nodes and goitre.

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

Extremities; she was asked for tingling and tightness of the finger on making a fist, the hands and fingers were inspected for edema, pallor of palms and nail bed and no abnormality was noted. The legs were inspected for size and equality and palpated for edema, tenderness in the calf muscles varicose veins, size and equality and no abnormality was noted.

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

Abdominal Examination

The procedure and the reason for this examination were explained to the clients understanding. The purpose for the examination is to observe the signs of pregnancy, assess fetal size and growth, auscultate for fetal heart, locate fetal parts and detect any deviation from normal. She was assisted to lie in a dorsal position with the arms on the side to relax the abdominal muscles. Hands were washed with soap and water and dried with a clean towel. Standing on her right hand side the abdomen was exposed. On general palpation of the abdomen there were no tenderness, masses, enlargement of the spleen and liver as well as supra pubic tenderness.

Inspection; the abdomen was inspected for scars, size, shape, striae-gravidarium, linear nigra and foetal movement. Linear nigra was present, the shape was ovoid with no scars, the size was average and there was fetal movement.

Measurement of the Symphysio-fundal height; the upper border of the symphysis pubis was located. For measuring the symphysio-fundal height, the zero mark of the measuring tape was placed from fundus and extended along the contour of the abdomen to the symphyio fundal height. The symphysio-fundal height measured 34cm and the gestational age was 36 weeks.

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

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

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

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

Auscultation; Fetal stethoscope was warmed by rubbing it in the palm. The fetal heart was auscultated by placing fetal stethoscope on the area where the back was located. The ear was placed against the stethoscope, making sure hands were not touching the stethoscope when the fetal heart beat was being counted. Comparing the rate with the maternal pulse and counting how many beats were heard for one minute, it was 140bpm with regular rhythm.

Vulva examination; Permission was sought from Madam Augustina to examine her vulva, which was granted. Hands were washed using aseptic techniques before the procedure. The woman was helped to relax onto the examination bed. She was made to bend her knees and was told to separate her legs gently. With the aid of a direct light, her inner thighs were touched gently before touching any of her genitals in order not to startle her. The labia, clitoris and perineum were inspected. The skin was very smooth and clean and the pubic hair was free of nits and lice. The labia tissue felt soft and consistent on palpation. There was no swelling, redness, marks, rashes, pimples or sores. There were no abnormal discharges. No signs of fistulae were also observed. She was asked to bear down while holding the labia open to watch for any bulging of the anterior or posterior vaginal walls.Madam Augustina was helped to dress up after the examination and all findings were explained to her. She was thanked for her understanding and cooperation. Hands were washed and dried and all findings were recorded in her antenatal book. She complained of backache and she was educated to support her back with pillow when sitting. Permission was sought from Madam Augustina for home visit and it was granted and then directions to her house as well as her contact

numbers were asked for. She was informed on the next antenatal visit which was on the 3rd November, 2021. Routine drugs were served as follows;

Tablet Folic Acid 5 milligrams daily for 7days

Tablet Ferrous Sulphate 200 milligrams daily for 7days

Tablet Multivitamins 200milligrams daily for 7days

Tablet sulphadoxine pyrimethamine fourth dose

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

2.2 FIRST ANTENATAL HOME VISIT

The first home visit to Madam Augustina's house was on the 28th october, 2021 around 3:00pm. The aim of the visit was to assess her home environment and to know how she is prepared toward birth. Greetings were exchanged and seat offered on arrival. She was in the house with her children. The husband was not yet back from work.

PHYSICAL ENVIRONMENT

Madam Augustina lives in a three-bed room house which has bath room, toilet and kitchen built in front of the house. The house is built with blocks and painted green, roofed with aluminum sheet. She lives with her husband and children. Inside her room was a neatly laid bed with a treated mosquito net hanged around it. Things were arranged nicely in her room. The room was well ventilated. There is a well in the house where client fetches water for domestic activities and stores it in a clean large blue barrel with a lid. Electricity is the source of power used in the house. She has a kitchen which is built with wood which was very clean and in a good condition. She gathers rubbish or waste in a container with a cover which she finally disposes every day into the public

refuse dump. She was advised to always cover her dustbin to prevent flies from settling on uncovered food which could bring about diseases. The compound was very nice because it looked very neat and the surrounding was neatly weeded. There was no stagnant water and no choked gutters. She also said that the whole family was ready to accept the new born into the family. She was encouraged to introduce her children to the unborn child to prevent sibling rivalry. She also complained of gastrointestinal reflux and she was educated to sit when performing house hold chores. She was asked to continue with her routine drugs as prescribed. She promised to do as educated. She was encouraged to maintain the neatness in her compound. Before leaving, her layette was checked, she had already packed her bag with items like; sanitary pads, toiletries etc. In this bag included purse with money, insurance card and antenatal book. She was also educated on birth preparedness and complication readiness plan by asking her the person who would accompany her to the hospital to deliver as well as take care of the house during that same period and she replied saying her husband and sister would take that responsibility. The permission to leave was sought and she was promised of another visit.

PSYCHOSOCIAL HISTORY

Client has respect for all manner of people and has a good relationship with neighbour. Client visit friends during her leisure time and also attend all social gathering such as wedding and naming ceremony if only she knows the person.client is a member of a fun club in the community and also a leader in her church.

2.3 SECOND ANTENATAL HOME VISIT

The second home visit was made on 29/10/2021 at around 4:00pm. The visit was made purposely to check on the health status and educate Madam Augustina on birth preparedness and complication readiness plan. Client was doing well except that she complained of lower abdominal

pain. She was therefore encouraged to avoid prolong standing. She was educated on the true signs of labour such as rhythmic regular uterine contractions and show, and was told to give a call and report immediately to the clinic as soon as she sees any danger signs of pregnancy such as severe frontal headache, severe lower abdominal pains, bleeding per vaginum and excessive vomiting. She was thanked for her cooperation and reminded of her next visit to antenatal clinic on 3rd November, 2021. Permission was sought to leave of which she escorted me.

2.4 SUBSEQUENT VISIT TO THE FACILITY

On Wednesday 3rd November, 2021, client came for antenatal care. She was given a seat to sit. The vital signs and weight were checked and recorded as: Weight - 87kg, Temperature – 36.3^0C, Pulse - 93bpm, Respiration - 20cpm, Blood pressure - 120/70mm/Hg

Head to toe examination was conducted which was supervised by the midwife-in-charge. She emptied her bladder and midstream specimen of urine taken and tested negative for protein and sugar. Hands were washed with soap and water and dried with clean towel. Fetal movement was observed, and the abdomen was of medium size and ovoid in shape. On palpation and measurement, the symphysio-fundal height was 36cm and the gestational age was 37weeks 4 days. The descent was 5/5, fetal heart beat was 142bpm. She was assisted to dress up after which hands were washed and dried. All findings were communicated to her and recorded in her antenatal booklet. She was asked about her lower abdominal pain and she said it's now ok, but has frequency in micturation and waist pains so she was told that it was due to the fact that the fetal head was descending into her pelvis. She was advised to avoid prolonged standing and strenuous activities which could aggravate the problem. She was served with routine drugs. She was informed of the next visit to the facility which was 10th November, 2021 and to report before the scheduled date if she encounters any challenge or experience the signs of labour taught.

2.5 CARE PLAN DURING ANTENATAL PERIOD

Problems Identified During Antenatal

Madam Augustina complained of the following;

1. Backache 27/10/2021
2. Gastrointestinal reflux 28/10/2021
3. Lower abdominal pain 29/10/2021
4. Waist pain 3/10/2021
5. Frequent micturition 3/11/2021

Short Term Objectives

1. Client will cope with backache within 24 hours and throughout the pregnancy.
2. Client will be relieved of heartburns within 48hours.
3. Client will cope with lower abdominal pain within 48hours.
4. Client will cope with waist pain within 48hours and throughout pregnancy.
5. Client will cope with frequency of micturition within 48 hours and throughout pregnancy.

Long Term Objectives

Madam Augustina will go through pregnancy, labour and puerperium successfully without any complication to herself and her fetus.

ANTENATAL NURSING CARE PLAN

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES	NURSING ORDERS	NURSING INTERVENTIONS	DATE/ TIME	EVALUATIONS	SIGN
27/10/21 3:00pm	Backache related on pressure on the sacral nerves by the presenting part	Client will cope with backache within 24hours and throughout pregnancy as evidenced by 1.client verbalizing she is coping with backache. 2.Client's husband reported client copes with backache.	1.Reassure client 2. explain the physiology of backache to client. 3. Encourage client to rest her back on a pillow when sitting. 4. Encourage client's family to help her with household chores. 5. Encourage client to sleep on a firm mattress.	1. Client was reassured 2. physiology of backache in late pregnancy was explain to client. 3. Client was encouraged to rest her back on a pillow when sitting. 4. Client's family were encouraged to help with her household chores. 5. Client was encouraged to sleep on a firm mattress.	28/10/21 3:00 pm	Goal fully met as evidenced that client is coping with backache	AU

ANTENATAL NURSING CARE PLAN CONT'D

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
28/10/21 3:00pm	Gastrointestinal reflux related to physiological process of late pregnancy	Madam Augusina will be relieved of heartburns within 24 hours as evidenced by; 1.client verbalizing that she has been relieved of heartburns. 2.Midwife visualizing that; client is adhering to management measure.	1. Educate client to avoid bending over immediately after eating. 2. Client to sit when performing household chores. 3. Educate client to avoid spicy and oily foods. 4. Encourage her to eat small amount of meals at frequent intervals	1. Madam Augustina was educated to avoid bending over immediately after eating. 2. She was educated to sit when performing household chores. 3. Spicy and oily foods was educated to be avoided. 4. Client was encouraged to eat small amount of meals at frequent interval and avoid over eating. 5. Client was educated was educated to avoid going to bed immediately after eating.	29/11/21 3:00pm	Goal fully met as client verbalizing that the heartburns have been reduced.	AU

			5. Educate her to eat early and rest before bed				

ANTENATAL NURSING CARE PLAN CONT'D

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVE	NURSING ORDERS	NURSING INTERVENTIONS	DATE/ TIME	EVALUATION	SIGN
29/10/21 4:00pm	Lower abdominal pains related to pressure exerted by the presenting part.	Client will cope with lower abdominal pain within 48 hours as evidenced by 1. Client verbalizing she is able to cope with pains. 2. client's mother reported that client performs some daily activities like sweeping.	1.Explain to client the cause of lower abdominal pain. 2.Educate client to wear low heel shoes and sandals. 3.Educate client to avoid prolong standing when performing activities. 4.Encourage client to have enough rest during the day and night. 5.Encourage client to adopt a comfortable position when sitting or lying down.	1.Cause of the lower abdominal pain was explained to her. 2.Client was educated to wear low heel shoes and sandals. 3.Client was educated to avoid prolong standing. 4.Client had 4hours rest without interrupted. 5. Client was encouraged to adopt a comfortable position when sitting or lying down.	01/11/21	Goal was fully met as evidenced by client verbalizing that the pain has reduced.	AU

ANTENATAL NURSING CARE PLAN CONT'D

DATE/ TIME	NURSING DIAGNOSIS	NURSING BJECTIVE	NURSING ORDERS	NURSING INTERVENTIONS	DATE/ TIME	EVALUATION	SIGN
3/10/21 9:00 am	Waist pain related to descent of fetal head putting pressure on sacral nerves	Madam Augustina will cope with waist pains within 48hours throughout pregnancy as evidenced by 1.client walking without complaining of backache. 2.Midwife visualizing that client is able to cope with the pain	1.Reassure Madam Augustina 2. Encourage Madam Augustina to have rest and sleep. 3.Teach Madam Augustina good body mechanics 4. Educate Madam Augustina on minimal work and exercise. 5. Give prescribed analgesics.	1.Madam Augustina was reassured pain was temporal. 2.Madam Augustina was to have rest and sleep. 3.Madam Augustina was taught on good body mechanics. 4.Madam Augustina was educated on minimal work and exercise. 5. Prescribed analgesics were served (tab paracetamol 1g tid)	5/11/21 9:00 am	Goal fully met as client said her waist pain has subsided.	AU

ANTENATAL NURSING CARE PLAN CONT'D

DATE/ TIME	NURSING DIAGNOSIS	NURSING BJECTIVE	NURSING ORDERS	NURSING INTERVENTIONS	DATE/ TIME	EVALUATION	SIGN
3/11/21 9:00am	Frequency of micturition related to foetus exerting pressure on bladder in late pregnancy	Client will cope with frequency of micturition within 48hours after delivery as evidence by 1.client verbalizing is coping with frequency of micturition. 2.client's sister confirmed client cope with the micturition.	1. Reassure client. 2. Educate client on the physiology behind the micturition. 3. Place chamber pot at reach of client. 4. Educate Madam Augustina on the use of panty liner. 5. Educate client on urinating in the night before going to bed.	1. Client was reassured that she can cope with situation. 2. Client was educated that the frequency of micturition is due to the descent of the fetal head into the pelvis. 3. Chamber pot was places at reach of client. 4.Madam Augustina was educated on the use of panty liner. 5. Client was educated on the need to pass urine in the night before going to bed.	05/11/20 9:00am	Goal fully met as client understood the physiology behind frequency of micturition and made less complaint.	AU

CHAPTER THREE

LABOUR

3.0 INTRODUCTION

This chapter describes the management of all the four stages of labour of the client and the care plan drawn for problems identified in labour.

3.1 ADMISSION AND MANAGEMENT OF THE FIRST STAGE OF LABOUR

ADMISSION

Madam Augustina reported to the facility on the 9th of November, 2021 at 2:00am accompanied by her mother in law. They were offered seats at the labour ward department after which greetings were exchanged. Her items were collected and general condition was also observed to be good. She was orientated to the ward environment, where the washroom is and where she was going to keep her items. She complained of lower abdominal pain and waist pains. The woman was in an anxious state and she was educated on the various stages of labour and was reassured. Her vital signs were checked and recorded as follows; BP 120/80 mmHg, Respiration 20cpm, Temperature 36.1^0C, Pulse 90bpm.

A general examination was conducted under the supervision of a senior midwife. According to Madam Augustina she had seen ‘show’ prior to her coming. She was accompanied to the labour room and helped onto the delivery bed after emptying her bladder. The volume of her urine was 150mls with protein negative and glucose negative. Pillows were put under her head and upper shoulder. Privacy was provided and her consent was sought. Proper hand washing was performed. Head to toe examination was carried out. There was no pallor observed on the conjunctiva, sclera, palms, tongue, and soles of the feet and no signs of anaemia were present. The feet were also not edematous and were in a good condition. No enlarged veins at the neck.

An abdominal examination was done to check for the position and presentation of the baby which was occipito-posterior and cephalic respectively. The baby was very healthy and descent of the fetal head was $4/5^{th}$. The size, shape and presence of any scars were also checked. There were no scars present. Symphysio-fundal height was 36 centimeters. On auscultation, fetal heart rate was 138 beat per minutes. The contractions were 3 in 10 lasting less than 20 seconds. There was no abdominal tenderness excluding enlargement of the liver and spleen.

Vaginal Examination; the procedure was explained to the client and privacy was provided. The woman was encouraged to empty her bladder. The client was helped to be in the lithotomy position. She was draped. Proper hand washing was done with soap and water and hands were dried with a hand towel. Sterile gloves were worn. Her soiled pad was removed and discarded using the left hand. The woman was asked to bend her knees and separate her legs. The vulva was inspected and there were no scars from previous births. There was no inflammation, varicosities, discoloration and edema. A swab was picked using the right hand and was dipped in disinfectant in an individual gallipot. The swab was dropped from right into left hand and the labia majora, minora and then the vestibule was swabbed using one swab per stroke; and wiping from anterior to posterior. The swabs were disposed off. With the labia minora still separated, the right middle finger was gently inserted into the vagina and was firmly pressed downwards causing the relaxation of the vaginal wall and muscles. The index finger was gently inserted. The vagina was warm and moist , the cervix was soft. There was a cervical effacement. There was no cord prolapse, membranes were still intact. The cervical dilatation was 4cm. The woman was dried and a clean pad was applied. Sterile gloves were removed and hands were washed using soap and water. Hands were dried using a hand towel. The woman was helped to turn over to her side. She was made comfortable in bed. Findings were reported to the woman and she was

encouraged to ask questions and express her concerns. The relatives were informed about the progress of labour. All findings were documented using a partograph.

Preparation for birth

In preparing for birth, two skilled helpers were identified. The first skilled helper was the Midwife-in-charge who was consulted in case of anything and the second skilled helper was a staff nurse who always helps the Midwife-in-charge whenever there was a labour case. The unskilled helper was the client's sister. The physician Assistant was informed that there was a client in labour so in case of any emergency, he will be consulted. Client's sister was also asked to contact the taxi driver to be alert in case there is the need for a referral (advanced care), he would be called. The area for delivery was prepared by assisting client to wash her hands and abdomen to prepare for skin-to-skin care prior to the second stage of labour. Windows and doors were closed, and curtains were drawn when labour was imminent to provide privacy and also to provide warmth. A portable lamp was made available to assess the baby in case of light off. Hands were washed thoroughly with soap and clean water to prevent the spread of infection. The area for ventilation was also prepared and the equipment was checked. A dry, flat and safe space was prepared to receive ventilation if needed. The equipment to help babies breathe were assembled at the area for ventilation. The functions of the equipment were tested especially the ventilation bag and mask. Equipment assembled to prepare for birth included the following; sterile gloves, cot sheets, head covering, scissors, cord clamp, suction device, ventilation bag and mask, stethoscope and clock. Delivery set and emergency drugs were made ready for use**.**

3**.2 MANAGEMENT OF FIRST STAGE OF LABOUR**

Having finished with birth preparation, Madam Augustina was seen anxious since she did not know the outcome of the labour and was seen pushing each time there was contractions. Client

was reassured of normal labour with a healthy baby without any complications after delivery. Client was encouraged to breathe through her mouth when there was contraction and also avoid pushing during contractions since the cervix was not fully dilated and to prevent the cervix from becoming edematous and possible tearing of the perineum. Client was also encouraged to empty her bladder frequently to enhance effective contraction and descent of the foetal head since full bladder could slow down progress of labour. Client was educated not to use her perineal pad when it falls and the importance of changing the pad when soiled and not to be touching the perineal area. The foetal heart rate, contractions and maternal pulse were monitored every thirty (30) minutes but temperature, blood pressure, dilation of the cervix and descent of the foetal head were checked every four (4) hours.

Setting of Trolley

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

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

- Two sterile artery forceps
- One sterile cord scissors
- Sterile drape
- Membrane pierce
- Sterile receiver for placenta
- Sterile Episiotomy Pack containing scissors and suturing forceps

Bottom shelf also contains;

- Drum containing gauze and cotton wool
- Cheatle's forceps in its container

- Bulb syringe in a bowl of water
- Sterile gloves
- Perinea pads
- Cord clamps
- Savlon
- Measuring jug
- An injection tray containing 10unit of oxytocin.
- Identification band
- Examination gloves
- Cot sheet

At 6:00am, Madam Augustina complained of the urge to bear down. Vagina Examination was done again and cervical dilatation was 8cm, contractions were 4 in 10 lasting for 40 seconds, descent 2/5th. The abdomen was also cleaned with savlon to prepare for skin to skin care. On 9th November, 2021 at 8:00am, there was spontaneous rupture of membrane. Fetal heart rate was 146 beat per minutes, contractions were 4 in 10 lasting above 40 seconds, maternal pulse was 96 beats per minutes and blood pressure 120/80mmHg. Vaginal examination was carried out to exclude cord prolapse. On vaginal examination the cervical os was fully dilated and descent 0/5th, temperature 36.6. The midwife in charge confirmed full dilatation. During this time, she was reassured and encouraged to rest in between contraction and 300mls of milo drink was also served. The delivery trolley was set. At 8:00am, she complained of urge to push. The already set delivery trolley was pushed to the delivery bed.

3.3 MANAGEMENT OF THE SECOND STAGE OF LABOUR

Madam Augustina had successfully passed through the first stage. Her cervix was fully dilated at 08:00am. The set trolley was pushed to the delivery bed. Protective clothing such as head gear, goggle, face mask, plastic apron and boots were worn. After hand washing, surgical gloves were put on to complete the sterility of the entire procedure. She was encouraged to assume dorsal position with the knee flexed as agreed earlier. The vulva was swabbed with the sterile cotton and savlon lotion. She was draped with 4 sterile towels; one each on the abdomen, under the buttocks as well as both thighs. Full dilation of the cervix was confirmed by the midwife on duty. A pad was applied to the perineum to prevent faecal content from entering the baby's face. She was reassured and encouraged to bear down with contractions and to rest in between contraction. After crowning, the birth of the head was controlled with the index and middle fingers placed on the fetal head to aid flexion to prevent perineal laceration. With extension, the sinciput, the face, and chin swept the perineum for the head to be born. After the delivery of the head, sterile gauze was used to wipe the eyes from the inner canthus outwards. The face, mouth and nose were also wiped. There was restitution followed by external rotation of the head (internal rotation of the shoulders occurred spontaneously). With both hands on each side of the baby's head, over the ears, a downward gentle pressure was applied towards the mother's perineum to deliver the anterior shoulder. The posterior shoulder was also delivered by upward movement towards the mother's abdomen. The trunk and the rest of the body were also delivered by lateral flexion onto the mother's abdomen at 08:05am.

3.4 IMMEDIATE CARE OF THE BABY

The immediate care of the baby starts from the delivery of the baby's head. The baby's eyes were cleaned from inside out with sterile gauze. The liquor was cleaned from the baby's body and the baby was covered with a warm dry cloth. The baby cried immediately. The first minute Apgar

score was assessed to be 8/10; baby was shown to the mother to identify the sex of the baby. The cord was re-clamped tightly with a cord clamp 2 centimeters away from the baby's abdomen to prevent bleeding. An identification tag was put on the baby's hand. This tag bears the mother's name, sex, date and time of delivery. The fifth minute Apgar score was assessed to be 10/10. The baby was put skin to skin with mother, respiration monitored and breastfeeding initiated.

3.5 MANAGEMENT OF THE THIRD STAGE OF LABOUR

The management of third stage of labour is complete expulsion of the placenta and its membranes from the birth canal until all sources of haemorrhage are arrested. This begins immediately after the expulsion of the baby. Procedure involve in this stage was explained to client's understanding. Permission was sought before continuing with the third stage management. During the active management of the third stage, Madam Augustina's uterus was palpated through the abdomen to exclude the presence of second twin. Oxytocin 10 unit was injected intramuscularly on the upper outer thigh of the client. The cord was re-clamped with an artery forceps closer to the perineum. The left hand was put on the fundus to feel for contraction. As soon as contraction was felt, left hand was repositioned and placed on the suprapubic area with the palm facing the mother's abdomen. The uterus was pushed upward to prevent inversion of the uterus. The right hand held the forceps and the cord. Gentle downward traction was put on the cord and repeated until the placental tissues were visible at the vulva. The placenta was cupped in both hands and gently turned in a twisting motion to deliver the membranes. The act prevented the tearing of the membrane.

The placenta was delivered completely at 8:20am. A quick inspection was made to ensure that the membranes and lobes were intact and it was placed in the receiver. Immediately, the fundus of the uterus was massaged through the abdomen until it was well contracted. Client was taught to be

massaging her uterus from time to time. Blood clot was expelled from the uterus and the blood expelled measured 150mls. She was reassured and permission was asked to conduct examination to exclude any form of trauma to the cervix, vagina and the perineum. There were no cervical, vaginal, or perineal tears. All soiled materials were removed and she was properly cleaned with Dettol solution and made comfortable in a well laid bed. She was encouraged to empty her bladder regularly to ensure good contraction and to report any bleeding. The instruments were placed in a 0.5% chlorine solution for decontamination. She gave thanks to the glorification of the name of the Most High God. Other family members and her husband were also allowed to see Madam Augustina and her baby.

EXAMINATION OF THE PLACENTA

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

3.6 MANAGEMENT OF THE FOURTH STAGE OF LABOUR

The fourth stage of labour begins right after delivery of the placenta, membranes as well as the arrest of bleeding until six hours after the delivery. During the fourth stage, the client and the baby were under close observation for early detection of postpartum complication that arose. Madam Augustina and baby were transferred to the lying-in ward after 1/2hour observation. She was encouraged to continue breast feeding. Mother's vital signs were closely monitored every 15 minutes for 2 hours, every 30 minutes for an hour and every hour for three hours. The uterus was felt for contraction every 15 minutes to make sure it was well contracted. Her vital signs were recorded as follows**;** Temperature 36.^{0}C**,** Pulse 80bpm**,** Respiration 20cpm**,** Blood Pressure 120/60mmhg. Madam Augustina was also educated on how to feel for contraction and also massage her uterus. The symphysio fundal height was measured and recorded as 18cm**.** Mother was advised to report any severe bleeding observed. The lochia was red in colour, moderate flow and had no odour. The client complained of lower abdominal pain which worsened with suckling. The physiology of this was also explained to the client. She took Milo and Bread. Family members were also encouraged to visit Madam Augustina and the new born baby.

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

Prevention of disease (prophylaxis for the baby)

This was done within the first 90 minute to prevent infections such as ophthalmia neonatorium and hemorrhagic disease of the new born therefore the following treatments were given. The baby's eyes were cleaned with sterile cotton wool swab with normal saline from the inner to outer canthus and gentamycin eye drop was instilled. The umbilical cord was dressed with six

cotton wool swabs and methylated spirit. Because Vitamin k_1 is painful it was given after the examination. Hand washing was performed before and after handling of baby.

3.7 EXAMINATION OF THE NEW BORN

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

The head and neck: the head was examined for softness/tension of fontanelles, size and shape, lacerations, caput succedaneum as well as intracranial haemorrhage but no abnormality was detected. Head circumference was measured by encircling the head with a tape measure from the occipital protuberance to the supra-orbital ridges and it measured 34cm. The eyes opened spontaneously when the baby was held in an upright position and the conjunctiva was clear. Eyes were also examined for colour, redness, discharge, placement and conjunctiva for haemorrhage but no abnormality was found. The nose was inspected for size and shape and examined for deviated septum but the septum was normal. The nostrils were inspected for patency and discharges and the mucosa for colour and polyps which were all normal. The mouth was examined by pressing the angle of the jaw which opened the mouth and the tongue, gum and palate were inspected and there was no false tooth noticed. The palate was high arched, intact and the uvula centrally placed. There was no cleft palate or cleft lip, tight frenulum or tongue tie. Suckling, rooting and swallowing reflexes were checked and was present.

The ears were inspected; the upper notch of the pinnae was at the same level with the canthus of the eye. External auditory meatus was patent and the cartilage in the pinnae was checked for it softness. The shape and size was also noted and no abnormality was detected.

Neck**:** The neck was inspected and palpated with no swelling such as congenital goiter, enlarged lymph node, rotation and flexion were good.

Chest and abdomen: The chest was examined, the respiratory movement was regular and the respiratory rate was 41cpm. Breasts were palpated for consistency, masses, and the nipples for position and milk. The space between the nipples was noted and the nipples were in alignment. The abdomen was round with no bleeding from the umbilical cord and no signs of infection. The cord was examined and there was one vein and two arteries. The liver, spleen and bladder were palpated for size, tenderness and masses but no abnormality was detected. Apex beat was present and was recorded as 132bpm.

Extremities: The length, movement and paralysis of the upper limbs were also noted. The digits were counted to be normal and separate to exclude webbing and the palm for the number of palmer creases. The shape and colour of the nail bed were inspected and reflexes (grasping, Moro) checked. Everything was normal. With the lower limbs, the leg and feet were inspected for symmetry, extra digits, webbing, movement, fare foot adduction, clubbed feet, knock-knees, bowed leg, tibia torsion and paralysis but no abnormality was found. The hip had no dislocation and the reflexes (knee jerk/ patella, plantar) were present. The feet were examined for any disability such as talips equinovarus. The axillae, elbow groin and popliteal spaces were examined without any abnormality detected.

Back: The spine was also examined with baby turned to one side. The back was palpated for swelling, dimpling, hairy patches to exclude spinal bifida and for missing vertebrae but no abnormality detected

Genitalia and anus: The urethra meatus was inspected for patency, foreign bodies and discharge. The anus was examined for patency and it was patent. The anus was also palpated for sphincter tone, masses, tenderness but it was normal. The baby passed meconium and urine

Baby's length was measured to be 53centimetres, weight was 2.8kg and temperature was 36.7◦C. In all, there was no abnormality detected. The baby was classified as normal and routine care of the baby continued. Gloves were removed and disposed aseptically before washing hands with soap under running water and dried with clean dry towel. The baby's skin was smeared with baby oil and wrapped. All findings were recorded.

CONDITION OF BABY AT BIRTH

Temperature	36.0^{o} C
Apex beat	132 bpm
Respiration	41 cpm

Other assessments were recorded as follows;

Sex	Male
Head circumference	34cm
Length	53cm
Weight	2.8kg

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

First and Fifth Minute APGAR score

	Appearance	Pulse	Grimace	Activity	Respiration	Total
1st minute	2	2	2	1	1	8/10
5th minute	2	2	2	2	2	10/10

The general condition of the baby was satisfactory.

3.8 CARE PLAN DURING LABOUR

Problems Identified During Labour

9/11/2021

Client complain of:

1. Waist pain
2. Lower abdominal
3. Fatigue
4. Anxiety
5. Potential for infection.

Short Term Objectives

1. Client will cope and relieved with lower abdominal pains within 6 hours and throughout the labour.
2. Client will be relieved of fatigue within 2 hours after labour.
3. Client will cope of waist pain at the end of labour.
4. Client anxiety will resolve within 30 minutes
5. Client will be free from infection throughout labor.

Long Term Objectives

Madam Augustina will go through labour, delivery and puerperium successfully without any complication to her and the baby.

LABOUR CARE PLAN

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
9/11/21 02:00am	Waist pains related to pressure exerted by the presenting part at the sacral region.	Client will cope with waist pain within 6 hours and throughout labour as evidenced by client verbalizing she is coping with the waist pain. 2.Midwife visualizing client adopting coping	1. Reassure client. 2. Educate her on the physiology of the pain. 3. Massage client's sacral region. 4. Educate her to assume a comfortable position but harmless 5. Encourage client to do deep breathing exercise	1. Client was reassured 2. She was educated on the physiology of the pain. 3. Sacral massage was given to the client 4. She was educated to assume a comfortable but harmless position. 5. Client was encouraged to do deep breathing exercise	9/11/21 8:00am	Goal fully met as the midwife observed a relaxed client.	AU

		mechanism like walking.					

DATE/ TIME	**NURSING DIAGNOSIS**	**NURSING OBJECTIVES**	**NURSING ORDERS**	**NURSING INTEVENTION**	**DATE/ TIME**	**EVALUATION**	**SIGN**
9/11/21 2:00am	Lower abdominal pain related to uterine contraction	Client will cope with of lower abdominal pain till the end of labour as evidenced by 1. client verbalizing she coping with abdominal pain. 2.Midwife visualizing client adopting good coping mechanism like walking.	1. Reassure client. 2. Educate her on the physiology of the pain 3.Serve prescribed analgesics (Tablet paracetamol,1g).	1. Client was reassured. 2.Client was educated on the physiology of pain 3.Prescribed analgesic was served (Tablet paracetamol,1g).	9/11/21 9:00am	Goal fully met as midwife observing client go through normal labour successfully.	AU

			4.Encourage client to practice deep breathing exercise 5. Provide diversional therapy.	4. Client was encouraged to practice the deep breathing exercise 5. Client was engaged in a conversation.			

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVE	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN

9/11/21 3:20am	Fatigue related to stress of labour	Client will be relieved of fatigue 2 hours after labour as evidence by 1.Client verbalizing she has been relieved of fatigue. 2.Midwife observing client have a good sleep.	1. Reassure client 2.Encourage client to rest in between labour 3.Encourage client to do deep breathing exercise 4. Serve client a nutritious diet 5. Encourage client to be calm	1. Client was reassured 2. Client was encouraged to rest in between labour 3.Client was encouraging to do deep breathing exercise 4. Client was served with nutritious diet. 5.Client was made to be calm	9/11/21 5: 20am	Goal fully met as midwife observe client relaxed and comfortable	AU

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVE	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
9/11/21 2:00pm	Anxiety related to unknown outcome of labour.	Client anxiety will be relieved by the end of labour as evidenced by 1. client verbalizing that she is no longer anxious. 2.Midwife observing client interrupt with other client.	1. Reassure client 2. Explain every procedure to be carried out to her. 3. Educate her on possible outcome of labour. 4. Encourage client to ask questions 5. Introduce client to competent midwives	1. Client was reassured 2. Every procedure to be carried out was explained to client. 3. Client was educated on possible outcome of labour. 4. Client was encouraged to ask questions.	9/11/20 9:00am	Goal fully met as client was seen relaxed in her bed.	AU

				5. Client was introduced to competent midwives			

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVE	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
9/11/21 3:20pm	Potential for infection related to client's poor hygiene practices.	Client will be free from infection throughout labor as evidenced by; 1. Client showing no signs and symptoms of infection. 2. Midwife visualizing client has no signs of infection such as fever.	1. Educate client on the importance of practicing good personal hygiene. 2. Educate client on how to dispose of used pads. 3. Place sanitary pads at easy reach for client. 4. Encourage client to change soiled pads always and a 5. Encourage client to wash the hands before and after changing soiled pads.	1. Client was educated on the importance of practicing good personal hygiene. 2. Client was educated on how to dispose of used pads. 3. Sanitary pads were placed at easy reach for client. 4. Client was encouraged to change soiled pads frequently. 5. Client was encouraged to wash her hands before and after changing soiled pads.	9/11/21 9:00am	Goal fully met as evidenced by client not showing signs of infections	AU

CHAPTER FOUR

PUERPERIUM

4.0 INTRODUCTION

This chapter provides information about the subsequent care given to the mother and her baby after delivery till six weeks.

4.1 MANAGEMENT OF PUERPERIUM

Both mother and baby were monitored every 15 minutes for 2 hours, 30 minutes for 1 hour and hourly for 3 hours. Madam Augustina and her baby were transferred to the lying-in ward for vigilant observation and they were made comfortable in bed with all observations recorded. Her health was enquired and the pains she complained during her labour had subsided. Madam Augustina was examined from head to toe before she took her bath and no abnormality was found. The lochia was red in colour, moderate in quantity with no bad odour.

Findings from assessment of Madam Augustina were recorded as follows; Temperature 36.6^0C Pulse 80bpm, Respiration 20cpm, Blood Pressure 120/70mmhg, Symphysio fundal height - 17cm, Lochia - Rubra .

Madam Augustina was asked to change her perineal pad when soiled to prevent ascending infection to the uterus and also empty her bladder to help involution of the uterus. She was advised to wash her hands before and after changing pad. She had her bath and kept warm with her baby in bed and encouraged on exclusive breastfeeding on demand. She was also advised to report any abnormal bleeding for prompt action to be taken. Madam Augustina was also educated on simple hand washing before and after touching and feeding the baby and after visiting the toilet. She was

encouraged to take enough rest and sleep especially after breast feeding and put the baby to sleep to restore her energy.

Madam Augustina complained of after pains and painful micturation and was reassured it was temporal and will subside with management. She was served with two tablets of paracetamol to relieve her from the after pains and was encourage to rest.

4.2 SUBSEQUENT CARE OF THE BABY

Six hours after the delivery of the baby, placenta and membranes, the baby was given a warm bath and he passed meconium and urine during his bath. After that the baby was wrapped nicely in a warm towel and his findings from assessment was recorded as follows;

Temperature	36.7^0C
Apex beat	132bpm
Respiration	40cpm
Weight	2.8kg

BABY BATHING

The baby was bathed after six hours observation with warm water and cord dressed.

REQUIREMENTS

1. Soap
2. Sponge
3. Cream/ powder
4. Sterile cotton in a gallipot or wrapped

5. Methylated spirit
6. Basin
7. Towels: 1 big towel and 3 small ones
8. Cot sheets 2
9. Apron
10. Gloves
11. A clean baby dress, cap and socks
12. Mackintosh
13. 2 jugs containing hot and cold water each
14. Two receptacles for used water and dirty linen
15. A receiver for used swab

The procedure was explained to mother and a tray was set. The mother and the support person were made to observe the procedure. A plastic apron was worn and hands were washed with soap, water and dried with a clean towel. The water was mixed and the temperature was tested using the elbow. Sterile gloves were worn and baby was placed on a flat surface. He was undressed and wrapped in a big towel. The eyes were cleaned with cotton wool swabs soaked in sterile water from inner canthus outwards. His face was cleaned with damp face towel and dried. The nape of baby's neck was supported with one hand. His ears were then plugged using two fingers of the hand and the head was washed with soapy sponge. With the body resting on the elbow and still

supporting the nape, the baby was placed at the edge of the bowl to rinse the soap off the head and dried. The baby was exposed; arms and front of trunk were washed paying attention to skin folds. The baby's back was turned with one hand supporting the chest and washed back down to feet paying attention to the skin folds. He was immersed in a bath of warm water with the head above the water and rinsed thoroughly. The baby was placed on a flat surface covered with clean sheet. The baby was dried by using a clean small towel paying attention to the skin folds. The cord was dressed by using sterile cotton wool swabs soaked in methylated spirit. The tip of the cord clamp was held with one sterile cotton wool swab and another was used to clean the base of the cord. The whole cord anteriorly and posteriorly each with a separate swab from the base upwards. The tip of the cord was cleaned with another swab and the cord was left exposed and the swab which was used to hold the cord clamp was used to clean it. The baby was dressed, wrapped and, given to mother to breastfeed. The waste materials were discarded according to infection prevention protocol. Mother was told that the baby will be topped and tailed till cord falls off. Gloves were removed and disposed of. Hands were washed with soap and water before handling the baby. Client was in a good condition after the procedure was carried out.

4.3 FIRST DAY POST DELIVERY AND DISCHARGE

The first day post-partum for Madam Augustina was 9th November, 2021. She took a warm bath in the morning after her perineal pad was inspected for the presence of lochia which was small, no odour and red in colour. The after pain and painful micturation were asked and she said both pains were better now. Her consent was sought for head to toe examination. Everything was normal, breast was lactating well and uterus measured 18cm. Her vital signs were recorded as follows; Temperature 36.4^{0}C, Pulse 74bpm, Respiration 20cpm, Blood Pressure 110/60mmhg

Madam Augustina complained of inadequate sleep during the night as a result of feeding her baby at night. She was encouraged to continue breastfeeding at night since it is important for the growth of her child and also sleep when the baby was asleep especially during the day time. Baby was cleaned with warm water and cord was dressed with cotton wool swab soaked in methylated spirit. Baby was examined from head to toe in the presence of the mother and no abnormality was detected. Baby was reassessed and dressed up neatly and the findings recorded as follows: Temperature 37.00C, Apex beat 138bpm, Respiration 40cpm, Weight 2.8kg, Skin colour Pink, Cord bleeding No, Suckling Yes

All findings were communicated to Madam Augustina. The baby was handed over to her to breast feed. This proved that what was taught during antenatal period was well understood. Madam Augustina took millet porridge with bread as breakfast. She was educated on healthy adequate nutritious diet to help in the production of more breast milk and improve her immunity, and help repair worn out tissues. Madam Augustin was again educated on good personal hygiene, post-natal exercise and the various family planning methods. The essence of the exercise was to help the pelvic organs to return to their original position. She was informed of her discharge. Furthermore, Madam Augustin was encouraged to feed her baby on demand. She was also advised to register the baby at the birth and death registry.

Baby was given BCG and polio “O” vaccine and mother was advised not to apply anything to the site in order to ensure effectiveness of the drugs. She was then asked to come with the baby to take the rest of the immunization at the time scheduled in order to prevent the baby from any of the childhood preventable diseases. Madam Augustin took rice and stew with egg after birth. She was helped to pack her items and also served her routine drugs. She was informed of a visit to her house

for a period of one week starting from the next day and she agreed. After settling her bill with national insurance, she was discharged.

4.4 POST NATAL HOME VISITS

First Post Natal Home Visit.

Madam Augustina was visited in the house after delivery for the first time around 2:20pm on 9th November, 2021. Greetings were exchanged and a seat was offered. The whole family was in good health and her previous complaints had improved, her painful micturation had resolved and after pains was better. Both mother and baby looked healthy on arrival to their house. Client was informed of the procedures to be carried out. Hands were washed and dried with a clean towel. Baby passed meconium and urine. Baby was examined from head to toe. No abnormality detected. Vital signs checked and recorded. The baby was cleaned. The cord was also dressed with cotton wool swabs and methylated spirit using aseptic technique; it was clean, dry and not offensive. The baby was then dressed properly and handed over to the client's sister. Madam Augustina emptied her bladder and head to toe examination was done. The conjunctiva was examined and there was no pallor. The breasts were soft and lactating well. The uterus was well contracted with symphysio fundal height of 17cm. The perineum was clean, dry and intact, lochia was small red (rubra) and not offensive. Her vital signs checked and recorded as follows; Temperature 36.2^{o}C, Pulse 96bpm, Respiration 21cpm, Blood pressure 110/60mmHg, Lochia Rubra, Uterus Contracted, Breast Lactating

Baby was given to mother to breast feed. Baby was able to suck well. The baby was assessed and findings were recorded as follows; Temperature 36.7^{0}C, Pulse 130bpm, Respiration 40cpm, weight 2.7kg, Skin colour Pink, Cord bleeding No, Suckling Yes, Stool color Dark yellowish. Madam Augustina was educated on family planning, danger signs in the newborn such as

breathing difficulties, cyanosis, persistent vomiting and fever. Client and family were congratulated and permission was sought to leave and she was informed of the next home visit the next day during the evening visit

In the evening at 4:00pm, second visit was paid to the client. General health condition of mother and baby was good. Explanation was given to her that she and her baby were going to be examined from head to toe to determine any abnormality for prompt treatment. Client was examined from head to toe and nothing abnormal was detected. Breast was firm and lactating well; lochia was bright red and the flow was small with no offensive odour. Her bowel movement was normal. On palpation, the uterus was well contracted and the symphysio-fundal height was 18 centimeters. Vital signs checked and recorded were ;Temperature 36.4^{o}C, Pulse 96bpm, Respiration 21cpm, Blood pressure 120/70mmHg, Lochia Rubra, Uterus Contracted, Breast – Lactating. The baby was assessed and findings were recorded as follows; Temperature 36.6^{0}C, Pulse 130bpm, Respiration 40cpm, Skin colour Pink, Cord bleeding No, Suckling Yes, Stool colour Dark yellowish

Mother

Vitals	**Morning**	**Evening**
Temperature (o^{c})	36.2	36.4
Pulse (bpm)	96	96
Respiration (cpm)	21	21
Blood pressure (mmHg)	110/60	120/70

Baby

Vital signs	**Morning**	**Evening**
Temperature (o^c)	36.7	36.6
Pulse (bpm)	130	130
Respiration (cpm)	40	40
Weight (kg)	2.7	2.7

Second Postnatal Home Visit.

Madam Augustina was visited on the 10th November, 2021 around 7:34am. She and her baby were in good health. All procedures to be carried out on them were explained to her. Her perineal pad was inspected and lochia flow was small and red in colour without bad odour before she took her bath.Madam Augustina was examined from head to toe and everything was normal, breast was lactating well. The symphysio fundal height was 16cm when measured and findings from assessment were recorded as follows; Temperature 36.4^{o}C, Pulse 72bpm, Respiration 20cpm, Blood pressure 110/60mmHg,

Baby was then cleaned, he passed urine and meconium stool and was also examined from head to toe and nothing was detected. His cord was dressed and was quite dry, no signs of infection were found. The baby was dressed up and findings were recorded as; Temperature 36.8^{o}C, Pulse 138bpm, Respiration 40cpm, Weight 2.7kg, Skin colour Pink, Cord bleeding No, Cord Shrinking, Suckling Yes, Stool colour Dark yellowish. The mother was advised not to apply anything on the cord and encouraged to continue with postnatal exercise and exclusive breast feeding. She was reminded of another visit in the evening.

In the evening at 4:00pm, second visit was paid to the client. General health condition of mother and baby was good. Explanation was given to her that she and her baby were going to be examined from head to toe to determine any abnormality for prompt treatment. Client was examined from head to toe and nothing abnormal was detected. Breast was firm and lactating well; lochia was bright red and the flow was small with no offensive odour. Her bowel movement was normal. On palpation, the uterus was well contracted and the symphysio-fundal height was 17cm and vital signs recorded as Temperature 36.8^{o}C, Pulse 76bpm, and Respiration 18cpm, Blood pressure 110/60mmHg, Baby was then cleaned, he passed urine and meconium stool and was also examined from head to toe and nothing was detected. His cord was dressed and was quite dry, no signs of infection were found. The baby was dressed up and findings were recorded as; Temperature 36.7^{o}C, Pulse 136bpm, Respiration 40cpm, Skin colour Pink, Cord bleeding No, Cord Shrinking, Suckling Yes, Stool colour Dark yellowish

MOTHER

VITALS	MORNING	EVENING
TEMPERATURE(0C)	36.4	36.8
PULSE(bpm)	72	76
RESPIRATION(cpm)	20	18
BLOOD PRESSURE(mmHg)	110/60	110/60

BABY

VITALS	MORNING	EVENING
TEMPERATURE(0C)	36.8	36.7
PULSE(bpm)	138	136
RESPIRATION(cpm)	40	40
WEIGHT(kg)	2.7	2.7

Third Postnatal Home Visit.

Madam Augustina was visited in the house for the third time at 7:30am on the 11th November, 2021 to check up on how they were faring. They were doing well. Perineal pad was inspected. Lochia was small with red colour. She took her bath after everything in the evening. Nothing abnormal was detected during head to toe examination. Symphysio fundal height was 15cm and findings from assessment were recorded as; Temperature 36.0ºC, Pulse 80bpm, Respiration 19cpm, Blood pressure110/60mmHg,

No abnormality was found during head to toe examination. Baby was top and tailed. The cord was dressed with cotton wool with methylated spirit. She was dressed up and findings after assessment were; Temperature 36.6ºC, Apex beat 136bpm, Respiration 42cpm, Weight 2.8kg, Skin colour Pink, Cord bleeding No, Cord Shrinking, Suckling Yes, Stool colour Dark yellowish. All findings were explained to her understanding. She was once again reminded of next visit and was thanked for her cooperation

In the evening at 4:00pm, second visit was paid to the client. General health condition of mother and baby was good. Explanation was given to her that she and her baby were going to be examined

from head to toe to determine any abnormality for prompt treatment. Client was examined from head to toe and nothing abnormal was detected. Breast was firm and lactating well; lochia was bright red and the flow was small with no offensive odour. Her bowel movement was normal. On palpation, the uterus was well contracted and the symphysio-fundal height was 13cm and vital signs recorded as Temperature 36.4^{o}C, Pulse 82bpm, Respiration 20cpm and Blood pressure 100/80mmHg

No abnormality was found during head to toe examination. Baby was top and tailed. The cord was dressed with cotton wool with methylated spirit. She was dressed up and findings after assessment were; Temperature 36.6^{o}C, Apex beat 132bpm, Respiration 42cpm, Skin colour Pink, Cord bleeding No, Cord Shrinking, Suckling Yes, Stool colour Dark yellowish.

Mother

Vitals	**Morning**	**Evening**
Temperature (o^{c})	36.4	36.8
Pulse (bpm)	72	76
Respiration (cpm)	20	18
Blood pressure (mmHg)	110/60	110/60

Baby

Vital signs	Morning	Evening
Temperature (o^c)	36.6	36.6
Pulse (bpm)	138	136
Respiration (cpm)	40	40
Weight (kg)	2.8	2.8

Fourth Postnatal Home Visit.

On 12th November, 2021 around 8:00am, client and family were visited as usual, greetings were exchanged and seat was offered and all family members were in good condition according to the mother. Head to toe examination was carried out and no abnormality was detected. Baby's cord was dressed with cotton wool swabs and methylated spirit, it was dry, not offensive and almost off. Head to toe examination was carried out on mother and no abnormality was detected. The Symphysio fundal height was 14centimeters, perineum was clean and intact. Lochia was small, brownish, contains blood, mucus and leucocytes and not offensive. The breast was lactating well. She also complained of backache, inadequate sleep and skin rashes and she was reassured and educated on other positions used in breastfeeding such as lying on her side to breastfeed and was also educated to support her back when sitting and encourage to sleep more at day time when baby is asleep and avoid too much covering of the baby. Her vital signs were checked and recorded as follows; Temperature 36.3^{o}C, Pulse 82bpm, Respiration 21cpm, Blood pressure 110/60mmHg. The baby's vital signs and weight were checked and recorded as follows: Temperature 36.8^{o}C, Apex beat 128bpm, Respiration 41cpm, Weight 2.9kg, Skin colour Pink, Stamp Healing. Mother was encouraged to ask questions. All findings were communicated to her and the necessary

documentation was done. She was thanked and permission was sought to leave. She was reminded of another visit the next day.

Mother

Vitals	**Morning**	**Evening**
Temperature (o^c)	36.3	36.4
Pulse (bpm)	82	82
Respiration (cpm)	21	20
Blood pressure (mmHg)	110/60	100/80

Baby

Vital signs	**Morning**	**Evening**
Temperature (o^c)	36.8	36.7
Pulse (bpm)	128	132
Respiration (cpm)	41	42
Weight (kg)	2.9	2.9

Fifth Post Natal Home Visit.

The 5th day postnatal visit was on 13th November, 2021 around 8:30am. Everybody in the family was fine and the environment was very clean. Madam Augustina's permission was sought for head

to toe examination after taken her bath, everything was normal and her vital signs were; Temperature 36.2^{o}C, Pulse 76bpm, Respiration 20cpm, Blood pressure 100/60mmHg,

On the fifth day, the symphysio fundal height was 13cm. The breast was lactating well. Examinations were done and everything was normal. Baby's vital signs were: Temperature 36.6^{0}C, Apex beat 136bpm, Respiration 40cpm, Weight 3.0kg and Stamp Healing. Mother was encouraged to continue good personal hygiene as well as that of the baby.

Mother

Vitals	**Morning**
Temperature (o^{c})	36.2
Pulse (bpm)	76
Respiration (cpm)	20
Blood pressure (mmHg)	100/60

Baby

Vital signs	**Morning**
Temperature (o^{c})	36.6
Pulse (bpm)	136
Respiration (cpm)	40
Weight (kg)	3.0

Sixth Post Home Natal.

14th November, 2021 was the sixth home visit to Madam Augustina's house at 9:00am. Client was doing well as well as baby and the entire family**.** Procedures to be done were explained to her. Head to toe examination was done on the baby and there was no abnormality detected. For the mother, Symphysio fundal height was 12cm. The perineal pad was inspected and the flow was scanty and pink in colour and not offensive. Her vital signs were also checked and recorded as follows; Temperature 36.4^{o}C, Pulse 81bpm, Respiration 20cpm, Blood pressure 110/60mmHg, head to toe examination was done and no abnormality was detected. The cord stump was clean, dry and not offensive. The baby was looking active and fine. Madam Augustin was asked to bath baby and clean the umbilical stump with cotton wool swab and methylated spirit under supervision and it was done well. the baby's vital signs were checked and recorded as follows; temperature 36.6^{o}c, apex beat 130bpm, respiration 42cpm, weight 3.1kg. Client was encouraged to continue with the exclusive breast feeding, exercise and the intake of nutritious diet for strong immunity and promotion of lactation. Client and her family were thanked for their time and cooperation and were informed of the last home visit being the next day.

Mother

Vitals	**Morning**
Temperature (o^{c})	36.4
Pulse (bpm)	81
Respiration (cpm)	20

Blood pressure (mmHg)	110/60

Baby

Vital signs	**Morning**
Temperature (o^c)	36.6
Pulse (bpm)	130
Respiration (cpm)	42
Weight (kg)	3.1

Seventh Day Postnatal Home Visit.

On 15th November, 2021 at 9:00am was the last visit to Madam Augustina's house. Client was doing well with baby and the entire family. All procedures to be carried out were explained. Hands were washed and examination from head to toe was done but no abnormality was detected. Lochia was inspected and it was pink in color with no odour. Symphysio fundal height was 11cm. The breast was soft and was lactating very well. Vital signs were checked and recorded and observations as, temperature 36.5^{o}C, pulse 80 bpm, respiration 20 cpm, blood pressure 110/70 mmHg, lochia - serosa, breast is well lactating.

The baby was examined and Madam Augustina's mother was supervised to bath and dress the stump of the cord which was done perfectly. The wound had healed. The baby's vital signs were checked and recorded as temperature 37.0^{o}C, apex heart beat 136 bpm, respiration 42cpm, stool yellow and weight 3.2kg. The baby was dressed and handed over to the mother for breastfeeding. Emphasis was made on her perineal care and the intake of nutritious diets as well as avoiding the

use of hot application on the fontanels. Client was encouraged to continue exclusive breastfeeding for 6 months. It was further explained that, exclusive breastfeeding could serve as a family planning method. Mother was reminded of the postnatal visit to the clinic and its importance. Client was told to report to the hospital when there was any problem as soon as possible and also made her aware that, the day was the last visit to her house, Madam Augustina together with the entire family was thanked for their cooperation. Client was reminded that the day for her first post-natal visit will be on the 17 November,2021. Client and her family also expressed their heartfelt gratitude after which they goodbye me at the gate.

Mother

Vitals	**Morning**
Temperature (o^c)	36.5
Pulse (bpm)	80
Respiration (cpm)	20
Blood pressure (mmHg)	110/70

Baby

Vital signs	**Morning**
Temperature (o^c)	37.0
Pulse (bpm)	136
Respiration (cpm)	42

Weight (kg)	3.2

4.5 FIRST POST NATAL VISIT TO THE CLINIC

Madam Augustina arrived at the clinic with her baby accompanied by her sister on the 16th November, 2021. They were offered a seat and then asked about their health and they were fine including the baby. All procedures to be carried out were explained to Madam Augustina. Her vital signs were checked and recorded as follows: Temperature 36.3ºC, Pulse 78bpm, Respiration 20cpm, and Blood pressure 100/60mmHg. Her midstream urine specimen was collected and tested for protein and sugar but all were absent. Her haemoglobin level measured 12.0g/dl.Madam Augustina's weight was 83kg. She was helped to lie on the couch for a head to toe examination having emptied her bladder. On inspection the hair was well kept, there were no discharges from eye, nose, the conjunctiva was not pale, the sclera had no yellow discoloration and the mouth was clean. The ears were not discharging, neck was palpated for swollen lymph nodes but no abnormality was detected. The breast was examined and no abnormality was found and was lactating well with no engorgement. On abdominal examination, the uterus was not palpable and no enlargement of any abdominal organ. The vulva was inspected and there were no varicose vein, edema and bad odour. The Lochia was pale in colour with scanty flow and odourless. The extremities were free from any edema. All findings were communicated to her. The baby was also examined from head to toe and everything was normal and his vital signs and weight checked were as follows: Temperature 36.6ºC, Apex beat 138bpm, Respiration 42cpm, Weight 3.3kg.

All the information was recorded in the post natal records. The mother was educated on good intake of well-balanced diet since this would improve her health status and also to produce more

breast milk. She was also educated on family planning for her to have an informed choice so that during the six weeks post natal visit she could make a right choice. She was also advised to visit the child welfare clinic for the baby to complete all the immunization scheduled. The baby was circumcised and the mother was educated on how to cater for the wound properly. She was thanked for her cooperation and also all the time spent together. She was very happy and was handed over to the midwife in-charge for continuity of care.

4.6 SECOND POST NATAL VISIT TO THE CLINIC (SIX WEEKS)

According to the midwife in- charge, Madam Augustina reported to the facility at 9:00am on the 22nd December, 2021. She came alone with her baby and they both looked nice and active. Every procedure to be carried out was explained to her. She was asked to empty her bladder and midstream urine was taken and tested for sugar and protein and the result was negative. Her haemoglobin level was 12.2g/dl. Her vital signs were taken which recorded as follows: Temperature 36.3ºC, Pulse 78bpm, Respiration 20cpm, Blood pressure 100/60mmHg,

The baby was also examined from head to toe and everything was normal and his vital signs Temperature 36.6ºC, Respiration 38cpm, Apex beat 134bpm, Weight 3.8kg

Madam Augustina and her baby were sent to the child welfare clinic for immunization as well as family planning unit after which they were handed over to the public health nurse for continuity of care.

4.7 CARE PLAN DURING PUERPERIUM

Problems Identified During Puerperium

Client complained of;

1. After pain 9/11/21
2. Painful micturation 9/11/21

3. Inadequate sleep 12/11/21
4. Backache 12/11/21
5. Skin rashes 12/11/21

Short Term Objectives

1. Madam Augustina's after pains will be relieved within 72 hours
2. Madam Augustina will understand and be relieved of painful micturation within 72 hours after puerperium.
3. Madam Augustina will sleep 1 hour at day time and 3 hours at night within 24 hours
4. Client will be relived of backache will subside within 72 hours
5. Baby will have normal skin integrity within 5 days

Long Term Objectives

Madam Augustina will go through puerperium successfully without any complication to her and the baby.

PUERPERIUM CARE PLAN

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
9/11/21 9:00am	After pains related to uterine involution	Madam Augustina's after pains will be relieved within 72 hours as evidenced by 1.client verbalizing she is no more in pain. 2.client's sister confirming client	1. Reassure client. 2.Explain the physiology to client 3. Encourage client to empty her bladder frequently. 4. Encourage client to continue breastfeeding the baby. 5. Serve prescribed analgesic.	1. Client was reassured. 2.Explain the physiology to client 3. Client was encouraged to empty her bladder frequently. 4. Client was encouraged to continuously feed the baby on demand. 5. Prescribed analgesic was served. {tab paracetamol 1gram tidx3}	12/11/21 9:00am	Goal met as client verbalized that her pain was reduced.	AU

		stop complaining after pain					

PUERPERIUM CARE PLAN CONT'D…

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES	NURSING ORDERS	NURSING INTERVENTIONS	DATE/ TIME	EVALUATION	SIGN

9/11/21 9:30am	Painful micturation related to bruising of urethral canal.	Madam Paulina will understand and be relieved of painful micturation within 72 hours after labour as evidenced by her verbalizing.	1. ReassureMadam Augustina. 2. Explain the cause of the painful micturation to client. 3. Educate her to empty her bladder regularly. 4. Encourage client to change perineal pad when soiled to prevent infection. 5. Educate client on personal hygiene’	1.Madam Augustinawas reassured. 2. The physiology was explained to client. 3. She was educated to empty her bladder regularly. 4. Client was encouraged to change her perineal pad when soiled to prevent infection. 5. Client was educated on bathing twice daily.	12/11/21 9:30 am	Goal met as client said her painful micturition subside.	AU

PUERPERIUM CARE PLAN CONT’D

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES	NURSING ORDERS	NURSING INTERVENTIONS	DATE/ TIME	EVALUATION	SIGN
12/11/21 8:00am	Insomnia related to breast feeding baby at night.	Madam Augustina will sleep 1 hour during the day time and 3 hours at night within 24 hours as evidenced by 1.client verbalizing she can sleep. 2.client's husband reported client sleeps well.	1. Explain the importance of night breast feeding to her. 2. Encourage her to feed the baby on demand. 3. Encourage her to sleep when baby is asleep. 4. Encourage her support person to help her in the household chores. 5. Encourage client to rest enough during the day.	1. Importance of night breast feeding was explained to her. 2. Client was encouraged on the essence of feeding on demand. 3. She was encouraged to sleep when baby was asleep. 4. Her relatives were encouraged to help her in her household chores like washing to enable her to sleep during the day. 5. Client was encouraged to rest enough during the day.	13/11/21 8:00am	Goal met as Madam Augustina said that she slept for 6 hours during the night and 2 hours during the day	AU

PUERPERIUM CARE PLAN CONT'D

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVE	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
12/11/21 8:00am	Backache related to poor posture during breastfeeding.	Client will be cope of backache within 24 hours as evidenced by client verbalizing that pain has subsided. 2.Midwife visualizing client adopting good posture during breastfeeding.	1. Reassure client. 2. Explain the physiology of pain. 3. Give client with a sacral massage 4. Encourage client to sleep on a firm mattress 5. Serve prescribed analgesics	1. Client was reassured. 2. Physiology of pain was explained 3. Client sacrum was massaged 4.Client slept on a firm mattress 5. Prescribed analgesics served.	13/11/21 8:00am	Goal met as client said her pain stoped.	UA

NURSING CARE PLAN DURING PUERPERIUM

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVE	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
12/11/2021 8:00am	Skin rashes related to over clothing of the baby at night.	Baby will have normal skin integrity within 5 days as evidenced by; 1. mother verbalizing that skin rashes have disappeared. 2. Midwife visualizing	1. Educate client not to overdress the baby at night. 2. Educate client not to scratch the rashes to prevent infection. 3. Educate client to change baby's diapers regularly	1. Client was educated not to overdress the baby at night. 2. Client was educated not to scratch the rashes to prevent infection. 3. Client was educated to change baby's diapers regularly.	17/11/21 9:00pm	Goal was fully met as skin rashes subsided, baby had normal skin integrity.	AU

		diminished skin rashes on examination.	4. Educate client to apply barrier cream (e.g. Vaseline and shea butter to the area 5. Educate client to bath baby with mild soap and water always.	4. Client was educated to apply barrier cream (e.g. Vaseline and shea butter) to the area. 5. Client was educated to bath baby with mild soap and water always			

SUMMARY AND CONCLUSION

The study was carried out on Madam Augustina, a 32 years old woman who was Gravida 3 Para 2 all alive. She was met at the Tuobodam Health Centre East on the 27th October,2021 during antenatal session and pregnancy was 36 weeks old. She was in good health when we met.

The cordial relationship that existed among the client, family and staff of the clinic aided to educate them on personal, environmental health, maintenance as well as other health related issues. She had successful antenatal period and entered labour on the 9/11/2021. She was monitored throughout the stages of labour to resolve all her problems by the use of nursing process and she delivered spontaneously of a healthy baby boy on the 9thNovember, 2021. Mother and baby were discharged on the day of delivery in good condition on the 9/11/21.

Mother and baby were visited for seven days after delivery. They were monitored until they were handed over to the community health nurses for continuity of care in good health. Our interaction ended after six weeks of care.

In conclusion, the care has helped the student midwife to gain knowledge and experience. It is an effective means of monitoring pregnancy, labour, delivery and puerperium. This helps to promote a good relationship between the student midwife, the client and the family.

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APPENDIX I

COMPLETE DIAGNOSTIC INVESTIGATIONS

DATE	SPECIMEN	INVESTIGATION	NORMAL RANGE	FINDINGS	REMARKS
13/04/21	Blood	Haemoglobin level	11.4g/dl-16g/dl	13.9g/dl	Normal
		Sickling	Negative	Negative	Normal
		Grouping	A,B,AB,O	O	Normal
		Rhesus factor	Positive/negative	Positive	Normal
	Urine	Protein	Negative	Negative	Normal
		Sugar	Negative	Negative	Normal
11/05/21	Blood	Haemoglobin level	11.4g/dl-16g/dl	13.3g/dl	Normal
	Urine	Protein	Negative	Negative	Normal
		Sugar	Negative	Negative	Normal
11/06/21	Blood	Haemoglobin level	11.4g/dl-16g/dl	12.6g/dl	Normal

	Urine	Protein Sugar	Negative Negative	Negative negative	Normal Normal
12/07/21	Blood Urine	Haemoglobin level Protein Sugar	11.4g/dl-16g/dl Negative Negative	13.3g/dl Negative negative	Normal Normal Normal
22/7/21	Blood Urine	Haemoglobin level Protein Sugar	11.4g/dl-16g/dl Negative Negative	11.8g/dl Negative Negative	Normal Normal Normal

COMPLETE DIAGNOSTIC INVESTIGATIONS CONTINUES

DATE	SPECIMEN	INVESTIGATION	NORMAL RANGE	FINDINGS	REMARKS
13/8/21	Blood	Haemoglobin level	11.4g/dl-16gdl	12.6g/dl	Normal
	Urine	Protein	Negative	Negative	Normal
		Sugar	Negative	Negative	Normal
13/9/21	Blood	Haemoglobin level	11.4g/dl-16g/dl	12.6g/dl	Normal
	Urine	Protein	Negative	Negative	Normal
		Sugar	Negative	Negative	Normal

LABOUR

DATE	SPECIMEN	INVESTIGATION	NORMAL RANGE	FINDINGS	REMARKS
9/11/21	Blood	Haemoglobin level	11.4g/dl-16g/dl	12.5g/dl	Normal
	Urine	Protein	Negative	Negative	Normal
		Sugar	Negative	Negative	Normal

APPENDIX II

PHARMACOLOGY OF DRUGS FOR THE MOTHER

DATE	NAME OF DRUG	CLASSIFICA-TION	DOSAGE	ROUTE	ACTION AND USES	ACTUAL EFFECTS	SIDE EFFECTS	SIDE EFFECT EXPERIENCED
13/10/21	Tablet Multivite	Vitamin preparation	200 milligram Once daily	Oral	Increases appetite, helps in the formation of red blood cells	Increased appetite	Gastrointestinal disturbance	None
13/10/21	Tablet Ferrous Sulphate	Iron supplement	200 milligram Once daily	Oral	Helps in the formation of haemoglobin	Haemoglobin increased	Gastrointestinal disturbance and blood stool	Dark stool
13/10/21	Tablet Folic Acid	Vitamin preparation	5 milligram Once daily	Oral	Proper formation and function of red blood cell	Haemoglobin level increased	Nausea and vomiting	None
13/10/21	Paracetamol	Analgesics	1gram 3 times daily x 3days	Oral	Helps the relieve of pain	Pain was relieved	Prolong use cause damage to the liver	None

13/10/21	Sulfadoxine Pyriminetha-mine	Anti-malaria	3 tablet start after quickening or 16 repeated at 4weeks interval till delivery	Oral	Prevention of malaria.	Prevention of malaria in pregnancy.	Nausea, itching, headache	None

DATE	**NAME OF DRUG**	**CLASSIFICA -TION**	**DOSAGE**	**ROUTE**	**ACTION AND USES**	**ACTUAL EFFECTS**	**SIDE EFFECTS**	**SIDE EFFECT EXPERIENCED**
9/11/21	Injection oxytocin	Oxytocic drug	10 units	Intramus cular	Stimulation of uterine contraction	Uterine contraction was effective	Vomiting, rise in blood pressure	None
10/11/21	Capsule vitamin A	Vitamin A supplement	200,000 units	Oral	Growth , Development and proper eye sight	Normal vision	Diarrhoea and vomiting	None

PHARMACOLOGY OF DRUG FOR THE BABY

DATE	NAME OF DRUG	CLASSIFICATION	DOSAGE	ROUTE	ACTION AND USES	ACTUAL EFFECTS	SIDE EFFECT
9/11/21	Vitamin k	Group K vitamin	1 mg	intramuscular	Production of prothrombin to aid in clothing	No bleeding	None
9/11/21	Gentamycin eye drops	Antibiotics	2 drops	Instillation	To prevent infection	Infection of eye was prevented	None
9/11/21	Oral polio vaccine	Antigen	2 drops	Orally	Production of antibodies to prevent poliomyelitis	Under observation	There may be diarrhoea
9/12/20	Injection Bacillus Calmette Guerin	Antigen	0.5 milligram	Intradermal	Production of antibodies to prevent tuberculosis	Under observation	Blister formation and slight fever

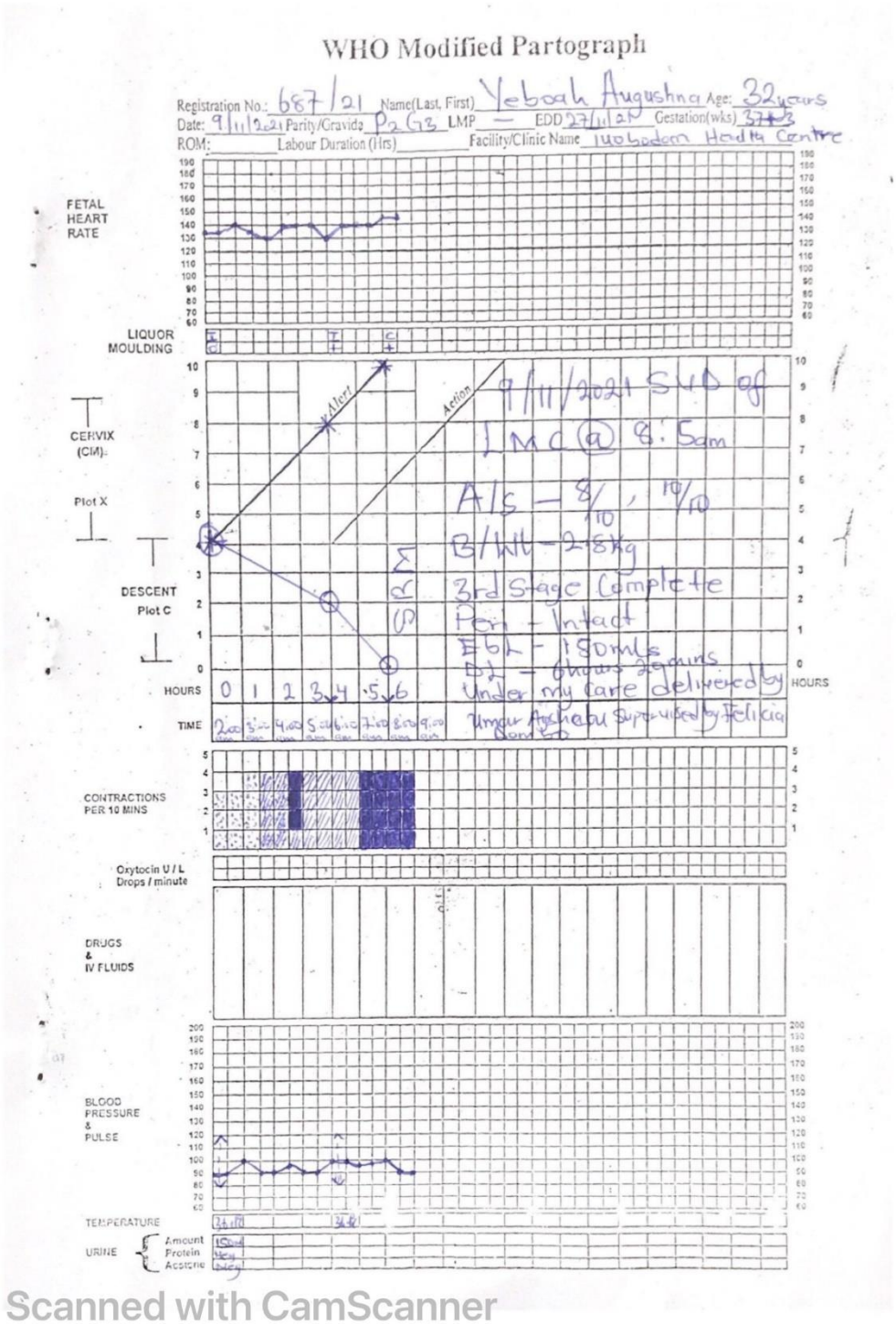
PHARMACOLOGY OF DRUG FOR BABY

DATE	NAME OF DRUG	CLASSIFICATION	DOSAGE	ROUTE	ACTION AND USES	ACTUAL EFFECTS	SIDE EFFECT
22/12/21	Diphtheria pertussis tetanus	Antigen	0.5ml	Intramuscular	Immunity against Diptheria pertussis tetanus	Under observation	Fever
22/12/21	Haemophilus influenza Hepatitis B	Antigen	0.5mls	Intramuscular	Immunity against Haemophilus influenza Hepatitis B	Under observation	Fever
22/12/21	Polio Vaccine (OPV)	Vaccine	2 drops	Oral	Given immunity against poliomyelitis	Under observation	Diarrhoea and fever may occur
22/12/21	Rotavirus	Antigen	1.5mls	Oral	Immunity against Rotavirus	Under observation	Vomiting

APPENDIX III

ANTENATAL RECORDS

DATE	BLOOD PRESSURE (MMHG)	URINE FOR SUGAR AND PROTEIN	PRESENTATION AND POSITION	FETAL HEART RATE	GESTATIONAL AGE	FUNDAL HEIGHT	DESCENT	WEIGHT	HAEMOGLOBIN LEVEL(G/DL)
13/04/21	100/60	Negative	-	-	7weeks^{+3}	-	-	80kg	13.9g/dl
11/05/21	120/80	Negative	-	-	11weeks^{+3}	-	-	77kg	12.0g/dl
11/06/21	110/70	Negative	-	-	15weeks^{+5}	-	-	83kg	12.6g/dl
12/07/21	110/70	Negative	-	132	20weeks^{+2}	18cm	-	72kg	13.1g/dl
22/07/21	100/60	Negative	Cephalic	168	22weeks	24cm	-	80kg	12.8g/dl
13/08/21	110/60	Negative	Cephalic	155	24weeks^{+6}	25cm	-	82kg	12.6g/dl
13/09/21	110/60	Negative	Cephalic	126	29weeks^{+2}	28cm	-	83kg	12.6g/dl
13/10/21	110/70	Negative	Cephalic	142	33weeks^{+4}	32cm	-	84kg	12.6g/dl



LABOR NOTES Admitted at the facility at 2:00am with Complains of labour pains, labour progressed well, Client had a Spontaneous Vaginal delivery to a live male child with a birth weight of 2.8kg, Head Circumference = 34cm, Length of baby = 53, third stage actively managed and completed delivered by CCT, Estimated blood loss = 150mls, Baby's APGAR score for 1 minute and 5 minute are 8/10, 10/10 respectively. Mother and baby looks active and healthy

Please circle or write responses.

DELIVERY

DATE: 9/11/2021 TIME: 8:5am METHOD: (Spontaneous) / Vacuum Extraction / C/S / Other

PERINEUM: (Intact) / Episiotomy / Laceration

ANESTHESIA: (None) / Local / General

THIRD STAGE

Active Management: Yes / No Medication: Time 8:6am Type/Dose Oxytocin (10unit)

PLACENTA: TIME: 8:20am (Complete) / Incomplete

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

BABY

Weight: 2.8kg

Sex: (Male) / Female

Baby Position: (Vertex) / Breech / Other

APGAR

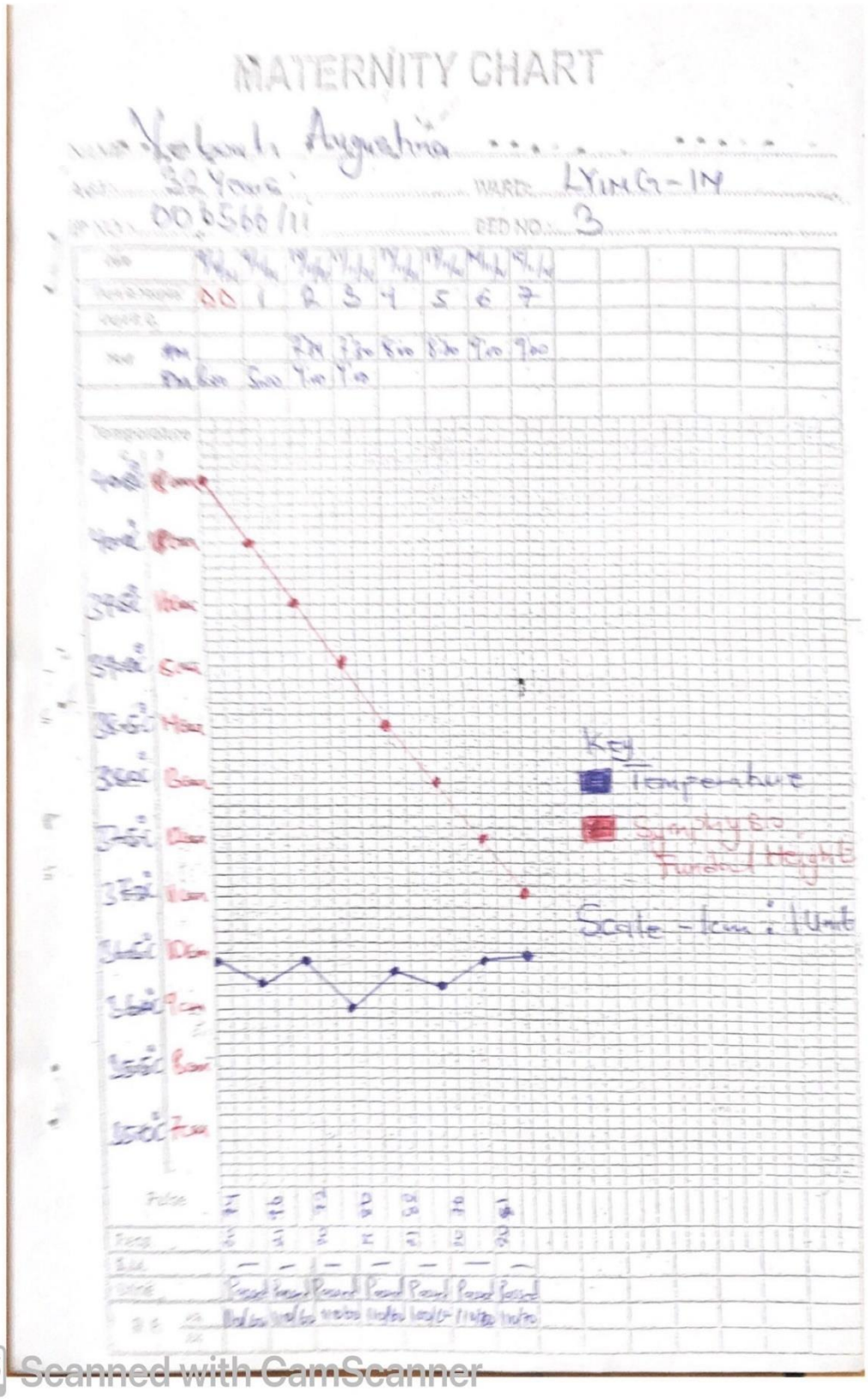
Time	Color	Breath	Heart	Tone	Reflex	TOTAL
1min	2	2	2	1	1	8/10
5min	2	2	2	2	2	10/10

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

FOURTH STAGE MONITORING

Frequency	Time	B/P.	Pulse	Fundus	Bleeding	Bladder
Every 15 minutes first 2 hours	8:30am	120/60	80	18	firm	120mls
	8:45am	116/75	80	firm	moderate	
	9:00am	125/80	82	firm	moderate	empty
	9:15am	111/71	73	firm	moderate	
	9:30am	116/68	80	firm	moderate	
	9:45am	100/71	75	firm	moderate	empty
	10:00am	112/71	83	firm	moderate	
	10:15am	128/71	77	firm	moderate	100mls
Every 30 minutes For 1 hour	10:45am	100/60	78	firm	moderate	empty
	11:15am	110/70	80	firm	moderate	

Birth Attendant Umar Ayishetu (student Midwife) Date 9/11/2021



NEW BORN EXAMINATION FORM

Name: Baby Yeboah Date of Assessment: 9/11/2021 Time:
Date of Birth: 9/11/2021 Time of Birth: 8:5am Sex: ☑ M ☐ F Age at time of Assessment (days/hrs) 1hou
Astational Age ☐ ☐ Mode of Delivery: ☑ Vaginal Assisted Vaginal C-Section
APGAR: 1min 8/10 ☐ 5min ☐ 10/10 Birth Weight: ☐ 2.8kg ☐ Length: 53 cm Head Circumference: 34 cm
Temperature at time of Assessment: 36.7 °C Urine passed: Yes No Meconium passed: Yes N
Name of Assessor (Midwife/Doctor): Umar Ayishetu

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

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

3. Tone
☑ Normal
☐ Floppy *
☐ Increased *

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

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

6. Cry
☑ Normal
☐ Shrill *
☐ Absent *

7. Suck
☑ Good
☐ Weak
☐ Absent

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

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

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

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

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

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

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

16. Clavicle
☑ Normal
☐ Swelling/Fracture

17. Chest
☑ Normal (Shape/movement)
☐ Abnormal_____

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

19. Femoral pulse
☑ Present
☐ Not palpable*

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

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

22. Limbs
☑ Normal
☐ Abnormal_____

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

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

24. Anus
☑ Patent
☐ Imperforate*

25. Resuscitation provided
☑ One
☐ Suction/stimulation
☐ Bag and mask
☐ Endotracheal Tube
☐ Ventilator/CPAP

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

***May indicate severe disease that requires urgent referral**
Diagnoses (if known) Spontaneous Vaginal delivery

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

NEW BORN EXAMINATION FORM

Name: Baby Yeboah Date of Assessment: 9/11/2021 Time:

Date of Birth: 9/11/2021 Time of Birth: 8:5am Sex: ☑ M ☐ F Age at time of Assessment (days/hrs)

Astational Age ☐ ☐ Mode of Delivery: ☑ Vaginal Assisted Vaginal C-Section

APGAR: 1min 8/10 ☐ 5min ☐ 10/10 Birth Weight: ☐ 2.8kg ☐ Length: 53 cm Head Circumference: 34 cm

Temperature at time of Assessment: 36.8 °C Urine passed: Yes No Meconium passed: Yes No

Name of Assessor (Midwife/Doctor): Umar Ayisheta

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

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

3. Tone
- ☑ Normal
- ☐ Floppy *
- ☐ Increased *

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

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

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

7. Suck
- ☑ Good
- ☐ Weak
- ☐ Absent

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

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

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

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

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

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

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

16. Clavicle
- ☑ Normal
- ☐ Swelling/Fracture

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

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

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

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

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

22. Limbs
- ☑ Normal
- ☐ Abnormal

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

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

24. Anus
- ☑ Patent
- ☐ Imperforate*

25. Resuscitation provided
- ☑ One
- ☐ Suction/stimulation
- ☐ Bag and mask
- ☐ Endotracheal Tube
- ☐ Ventilator/CPAP

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

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

Diagnoses (if known) Spontaneous Vaginal delivery

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

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

TEMPERATURE CHART

NAME: Baby Yebbah

AGE: One week. WARD: LYING-IN

IP NO.: 4281/21 BED NO.: 3

Date	9/11/2021	9/11/2021	10/11/2021	11/11/2021	12/11/2021	13/11/2021	14/11/2021	15/11/2021
Days in Hospital	DD	1	2	3	4	5	6	7
Days P.O.								
Hour AM			7:34	7:30	8:00	8:30	9:00	9:00
Hour PM	2:00	5:00	4:00	4:00				

Temperature

C	F	Baby's Weight
40·5		3·2kg
40·0°C		3·1kg
39·5°C		3·0kg
39·0°C		2·9kg
38·5°C		2·8kg
38·0°C		2·7kg
37·5°C		2·6kg
37·0°C		2·5kg
36·5°C		2·4kg
36·0°C		2·3kg
35·5°C		2·2kg
35·0°C		2·1kg

KEY
TEMPERATURE
BABY'S WEIGHT
SCALE - 1cm : 1unit

Pulse		138	138	130	136	128	136	130
Resp.		40	40	40	42	41	40	42
B.M.		Passed	Passed	Passed	Passed	Passed	Passed	Passed
Urine		Passed	Passed	Passed	Passed	Passed	Passed	Passed
B.P.	AM	—	—	—	—	—	—	—
	PM	—	—	—	—	—	—	—

NEW BORN CHART

Name: Baby Yeboah ..... No: 4281/21 ..... Birth Weight: 2.8kg

Sex: Male ..... Mother's No: 006566/11 ..... Length: 53cm

Nature of Delivery: Spontaneous Vaginal Delivery ..... Diagnosis: Term Baby

Date of Birth: 9/11/2021 ..... Time: 8:5am ..... Date of Discharge: 9/11/2021

Date	9/11/2021		9/11/2021		10/11/21		11/11/2021		12/11/2021		13/11/2021		14/11/2021		15/11/2021							
No. of Days	DD		1		2		3		4		5		6		7							
Weight	2.8kg		2.7kg		2.7kg		2.8kg		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
Temperature		37.0°C		36.6°C	36.8°C	36.7°C	36.6°C	36.6°C	36.8°C		36.6°C		36.6°C		37.0°C							
Stools		passed		passed	passed	passed	passed	passed	passed		passed		passed		passed							
Urine		passed		passed	passed	passed	passed	passed	passed		passed		passed		passed							
Remarks	Head Neck Trunk Limbs Genitalia — NAD																					

SIGNATORIES

THE STUDENT MIDWIFE

NAME: UMAR AYISHETU

SIGNATURE: .....

DATE: 4/10/2022

THE MIDWIFE IN CHARGE

NAME: MS. FELICIA DOMBO

SIGNATURE: ~~.....~~ (for)

DATE: 05/10/2022

THE SUPERVISOR

NAME: MS. CELESTINE AHIAWORNU

SIGNATURE: ~~.....~~ (for)

DATE: 04/09/2022

THE PRINCIPAL

NAME: MONICA NKRUMAH

SIGNATURE: ~~.....~~ (for)

DATE: 20th September, 2022

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

STAMP.....

SIGNATORIES

THE STUDENT MIDWIFE

NAME: UMAR AYISHETU

SIGNATURE: …….

DATE: …….

THE MIDWIFE IN CHARGE

NAME: MS. FELICIA DOMBO

SIGNATURE: ……

DATE: …….

THE SUPERVISOR

NAME: MS. CELESTINE AHIAWORNU

SIGNATURE: …….

DATE: …….

THE PRINCIPAL

NAME: MONICA NKRUMAH

SIGNATURE: …….

DATE……

STAMP……..……