HOLY FAMILY NURSING AND MIDWIFERY TRAINING COLLEGE

BEREKUM

A CLIENT / FAMILY CENTERED MATERNITY CARE STUDY

ON

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BY

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A CLIENT/FAMILY CENTERED MATERNITY CARE STUDY SUBMITTED TO THE NURSING AND MIDWIFERY COUNCIL OF GHANA IN PARTIAL FULFILLMENT FOR THE AWARD OF THE LICENSE TO PRACTICE AS A REGISTTERD MIDWIFE.

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PREFACE

Birth is a dynamic and transforming experience, both on an individual and the societal level, and has the power to profoundly affect the lives of those involved. It is a physiological process characterized by non-intervention, a supportive environment and empowerment of the woman. The client and family centered maternity care study is a study of the care rendered to a pregnant woman and her family. The study starts during pregnancy, continues through labour and ends after a successful puerperium. The study gives the student midwife the opportunity to ensure proper management of pregnancy, labour and puerperium. The client and family centered maternity care study also forms part of the partial fulfilment for the award of a professional certificate in midwifery by the Nursing and Midwifery Council of Ghana by the end of the three-year training as a midwife.

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Not only that but also, I would also like to acknowledge my father Mr. Ativui Believe and my mother Mrs Ativui Rita for their upbringing and teaching me to be upright at all times. Words cannot explain how I appreciate all that you have been doing for me. All I say is a very big thank you and may God richly bless and replenish all you have lost while bringing me up. I am thankful to my sister Mrs Addor Rosemary Ativui, Mr Awotwe Botwey Francis, Asaaseme Felicia and Rev. Francis Kwadwo Fossu for their prayers and support throughout my three years of stay in school. I am also thankful to the authors whose books and literature were used in this study, I am very grateful to them.

INTRODUCTION

Family centered maternity care study is a systematic approach which involves rendering holistic obstetric care to a pregnant client and her family from first day of meeting during

antenatal period through to labour and puerperium. The care study was conducted on Madam Winnifred Mensah, 23-year-old woman who is gravida 2 para 1 alive at the time of the study. She comes from Intotroso in the Ahafo Region.

The interaction with her started on 14th August, 2023during her 7th visit to the facility and she was 37 weeks plus 3 days pregnant then. Although anxious, she was reassured of competent care and was encouraged to share her fears. She had a spontaneous vaginal delivery to a female child on 2nd September, 2023. Care was rendered to her during pregnancy, thus her antenatal visits through to labour and puerperium. Interactions with client ended seven days after delivery.

The study is divided into four (4) sections based on chapters as follows:

Chapter one (1) consists of client's social history, medical, surgical, past obstetrical, present obstetrical, family, menstrual history and habits of daily living.

Chapter two (2) consists of care rendered in the antenatal period. The chapter ends with a care plan which outlines care given based on the nursing process.

Chapter three (3) is narrative of the care given during the first, second and third stages of labour. It ends with a care plan.

Chapter four (4) explains the care provided during puerperium. It consists of daily visits to the client and family. The chapter also explains client's visit to the facility for postnatal care. It also ends with a care plan.

This script also contains literature review, summary and conclusion to the whole study. It contains signatories which makes the work authentic.

LITERATURE REVIEW

PREGNANCY

Fraser & Cooper (2009) Pregnancy is the period when the fertilized ovum embeds in the maternal uterus until it is born thus the state of conception till the delivery of the fetus. The normal duration is 280 days or 40weeks counting from the last day of the menstrual period, she further states that uterine blood flow in pregnancy supplies the myometrium endometrium and placenta, with the latter receiving nearly 90% of the total uterine blood flow near term. It further states that, the anatomical and physiological adaptations occurring throughout pregnancy affect virtually every body system. The timing and intensity of the changes vary between systems but all are designed to support fetal growth and development and prepare the mother for birth and motherhood. The uterus protects and supports the foetus, placenta and amniotic fluid. For most of the 40 weeks of pregnancy, the uterus expands to accommodate the growing foetus and remains relatively quiescent, yet at the time of labour it is able to contract regularly and forcibly to expel the foetus due to its unique properties of contractility and elasticity. She also says, the vagina also increases vascularity which results in the violet colour characteristic of Chadwick's sign. There is increased volume of vaginal

CHAPTER ONE

CLIENTS PARTICULARS

1.0 INTRODUCTION

This chapter deals with the assessment of the client and her family. This involves collection of data from the client and her family. The information was obtained from observation, reviewing, medical and maternal health records. Based on this information the student midwife will be able to give necessary care to the client and her family taking into consideration physical, social, emotional, psychological needs of the client.

1.1 SOCIAL AND PERSONAL HISTORY

Madam Winnifred Mensah Gravida 2 para 1 was born on 20th March 2000 and comes from Intotroso in the Ahafo region. She is 23years old. She weighs 80 kg and she is 152 cm tall. She completed Senior High School (S.H.S) and switched into business without going to the Tertiary. She is dark in complexion and speaks English and Twi. She is a trader and married to Mr. Fred Asubonteng who is also a driver and they have one child who is a male. They are both Christians who attend Presbyterian church of Ghana in Intotroso. Her next of kin is her husband.

1.2 FAMILY HISTORY

According to Madam Winnifred, she is the 3rd born of five children. Her parents are Mr. and Mrs. Mensah. They all come from Intotroso and stay there as well. They are both Christians and are also farmers. According to the client she has both parent alive. There is no known hereditary disease such as sickle cell disease, asthma, mental disease, epilepsy, hypertension, diabetes and heart diseases from both mother and father`s family. Madam Winnifred stated that all her siblings are still alive

There are multiple pregnancies in her family and also there are no congenital abnormalities like hydrocephaly, cleft lip, cleft palate, Down syndrome in her family. The cause of death normally results from natural occurrence.

1.3 MEDICAL HISTORY

Madam Winnifred stated that she has never been hospitalized but stays in the hospital when she is due to deliver she is only treated at the outpatient department she has no chronic disease like hypertension, diabetes, heart disease, Tuberculosis, chronic cough, asthma, mental illness and has no allergies to any food or drug.

1.4 SURGICAL HISTORY

Madam Winnifred stated that she has not had any surgical procedure performed on her neither has she been involved in any road traffic accident which might affect her pelvis. She has not undergone any assisted delivery like caesarian section. She has never received blood transfusion and never donated blood before.

1.5 MENSTRUAL HISTORY

Madam Winnifred verbalized that she had her menarche at the age of 14. She has 28days menstrual cycle which lasted for 5days with moderate flow, and does not experience dysmenorrhoea. She uses sanitary pad during her menses which she changes twice daily. Her last menstrual period was 22nd November 2022. Her estimated date of delivery was calculated and recorded as 29th August 2023. The ultrasound scan was also done and her expected date of delivery was 2ndSeptmber 2023.

1. 6 CLIENT LIFESTYLE AND HOBBIES

Madam Winnifred said she often goes to bed around 9:00pm and usually wakes up around 5:30am in the morning. The first thing she usually does right from bed is to clean her face and brush her teeth. She also does same for her son. She said she brushes her teeth at least once daily with toothbrush and pepsodent. She baths at least once daily. She sweeps her compound and tidy up her room and corridor. She prepares her son for school around 7am. Her husband also goes to the lorry station for passengers since he is into driving. She added that, she likes Banku with okra soup but normally takes porridge as her breakfast. After taking her breakfast she prepares to go to the market to sell her items and comes back around 3:30pm. She prefers doing laundry on weekends.

She said, she empties her bowel at least once daily and takes her bath twice daily. She also makes sure supper is prepared and served around 5:30pm. She stated that, after eating in the evening, she chats with her husband and at times they listen to radio and watch television before she goes to bed.

1.7 PAST OBSTETRIC HISTORY

PREGNANCY

Madam Winnifred gravida 2 para 1(G2 P1A) stated her previous pregnancy got to term before labour started without any gross complication except with minor problems associated with a normal pregnancy. She said she has never had abortion whether spontaneous or induced. She did not experience any danger signs of pregnancy like pregnancy induced hypertension, antepartum haemorrhage, gestational diabetes and anemia among others. She attended antenatal clinic for at

least eight times and received all doses of sulfadoxine pyrimethamine and had 2nd dose of tetanus injection. According to madam Winnifred said her first pregnancy was in the year 2019.

LABOUR

Madam Winnifred said the mode of delivery for her first child was spontaneous vaginal delivery at Gyedu Health Center. She said her first child weighed 3.5kg. Her first child was delivered on 18th march, 2020. She delivered spontaneously per vaginum without any episiotomy given or sustaining perineal tears. She said during the third stage, there were no retained products of conception. She said blood loss after deliveries were not much. And she has never had any post-partum haemorrhage, post-partum psychosis and fever after her deliveries.

PUERPERIUM

According to Madam Winnifred, she did not fall sick during puerperium but experienced pain after delivery and was always in good condition. Her husband helped her in taking care of the child and sometimes she got help from her sister-in law. She has never practiced exclusive breastfeeding in her first delivery and added porridge to the breast milk after the second month since mother-in-law always insists she did so but she breastfed for two years two months. She was educated on the need to practice exclusive breastfeeding and she was glad and very eager to practice it with her current pregnancy. Her first child received all the appropriate immunizations, and did not suffer from any childhood illness. She said, she has not practiced family planning in her life.

1.8 PRESENT OBSTETRIC HISTORY

Madam Winnifred first visited Gyedu Health Center and was diagnosed of being pregnant at 16weeks gestation on the 17th 0f march 2023. She remembered her last menstrual period which was 22nd November2022 and her expected date of delivery was 29th August, 2023 after calculation and the ultrasound scan gave the EDD as 29th August 2023. According to the client's antenatal health records book, her vital signs were checked and recorded, and other investigations and assessment made on her were as follows:

Temperature - 36.4 degree Celsius

Pulse - 82 beat per minute

Respiration - 24 cycle per minute

Blood pressure - 120/80 millimeters of mercury

Height - 162centimeters

Hemoglobin level - 7.1g/dl.

Sickling - negative

Blood group - B

Rhesus factors - positive

Urine for protein - negative

Glucose - negative

HIV - Negative

Hepatitis B - negative

G6PD - negative

VDRL - negative

Physical examination from head to toe revealed no abnormalities like varicosity, oedema and vaginal discharge. On abdominal inspection, there was striae gravidarum present; there was no scars present. Madam Winnifred had no complaints and was healthy.

The client was then educated on nutrition, rest and sleep, and danger signs in pregnancy. Her Symphysio-fundal height measured 13cm and was given the 4th dose of tetanus toxoid. Routine drug was prescribed as follows;

capsule iron III Polymaltose - 1 daily for 30days

Tablet multivite - 200mg daily for 30 days

Madam Winnifred's condition was good and was schedule for the next visit on 14th April 2023. She was a regular antenatal clinic attendant and looked healthy without any danger signs in pregnancy such as anaemia, bleeding per vaginum, severe headache, abdominal pains, swelling and excessive vomiting.

CHAPTER TWO

ANTENATAL CARE

2.0 INTRODUCTION

This chapter talks about client`s antenatal care, first contact with the client, first and second antenatal home visits and subsequent visit to the clinic and nursing care plan for problems identified.

2.1 FIRST CONTACT WITH CLIENT

First contact with the client was at Gyedu Health Center on the 14th August 2023 when client had come for her regular antenatal visit. She was warmly welcomed, offered a seat and reassured. Education was done on personal hygiene of which she made a lot of contributions. Her antenatal book was read through after which Introduction was made about myself as a student of Holy Family Nursing and Midwifery Training college Berekum who came on clinical study and wished to involve her in a study named community health care study. Procedures involved during pregnancy, labour and puerperium was explained to her after which she gladly accepted after rapport was established, she was then showed to the in-charge and permission was seek for her to be used which was agreed and granted. Madam Winnifred was encouraged to empty her bladder. All procedures to be carried out on her were explained to her.

URINE TESTING

Madam Winnifred was given a specimen bottle to take midstream urine, for testing protein and sugar; having explained the procedure to her understanding. A chemically prepared test strip was dipped into the urine sample and the edge of the strip tapped against the side of the urine

specimen bottle. The strip was compared with the reagent bottle and there was no change in colour, indicating negative results for protein and sugar.

Other investigations to be made were explained to her understanding and her vital signs were checked and recorded as;

Temperature - 36.2 degree Celsius

Pulse - 92beats per minutes

Respiration - 19 cycle per minutes

Blood pressure - 137/80 millimeters of mercury

Haemoglobin - 12.0

Weight - 68kg

These findings were recorded in her antenatal record book and the result was communicated to her. She was accompanied to the palpation room and was encouraged and assisted to lie on the couch, privacy was provided, she was told to lie on her side before she lies on her back. Permission was asked from her to examine her. Hands were washed with soap and water and dried with clean towel.

PHYSICAL EXAMINATION

HEAD

The examination started with the head and the scalp being inspected for cleanliness, dandruff, lice, ringworm, alopecia, and scalp infection, and no abnormality was detected. Face was inspected for puffiness, rash, chloasma and no abnormality detected, eyes for pallor of the

conjunctiva and jaundice of the sclera but no abnormality detected. The ears were examined for growth, discharge and pain. Upon conversation with the client, the mouth was examined for cracks, dryness of the lips, inflammation, gum and tongue for pallor, tooth decay, coated tongue and halitosis. She had no cracks on her lips and on other abnormalities detected at these areas examined.

The neck was inspected and palpated for enlarged thyroid gland, enlarged lymph nodes and distended neck veins there was none present.

Each step was explained to her while the examination was ongoing, she was asked to ask questions to allay fears and anxiety.

BREAST EXAMINATION

The breast was inspected for size, shape, nipple abnormalities, condition of the skin, but no abnormality detected. She was asked to put her right hand under her head as one of the breasts was covered. The breast was palpated systematically in a circular manner using the inner aspect of the fingers. The nipple was squeezed gently for fluid (colostrum) with clean cotton wool swab for discharge but no fluid was seen. The procedure was repeated on the other breast and no abnormality detected. She was educated on self-breast examination and was encouraged to do it frequently. And was educated on the need of wearing a well-fitting brazier. Breast feeding history was asked and she had positive desire to practice exclusive breast feeding.

EXTREMITIES

The upper extremities were examined for equality, pallor of the palm and nail beds but were normal. Client had short finger nails with no oedema and any other abnormalities.

The lower extremities were examined for equality, size, neatness of nails, oedema, varicose veins, tenderness of calf muscles and they were without abnormalities.

Her back was examined for deformity of the spine (scoliosis), cost vertebral angle tenderness, sacral region was palpated for oedema and there was no abnormality, the condition of the skin was observed and there was no abnormality detected.

ABDOMINAL EXAMINATION

INSPECTION

On inspection, the shape of the abdomen was ovoid and medium in size. Linear nigra, striae gravidarum were present. There was no fetal movement and no rashes or scar from previous injuries and operation. On general palpation of the abdomen, there were no tenderness or masses.

MEASUREMENT OF THE SYMPHYSIO FUNDAL HEIGHT.

Palms were warmed and the upper border of the symphysis pubis and the uterine fundus was located. The fundal height was measured by putting the zero mark of the tape at the located fundus. It was extended along the contour of the abdomen to the symphysis pubis and measured 31centimeters and the gestational age was 37 weeks plus 3 days.

FUNDAL PALPATION

On palpation, standing at the right side, the client was faced and palms were warmed by rubbing them together and placed on either sides of the fundus. Fingers were curved around top of the fundus to determine what occupied at the upper pole of the uterus. A soft mass indicated fetal buttocks.

LATERAL PALPATION

This is done to determine the fetal back in order to locate the fetal position. The hands were placed on either sides of the uterus at the level of the umbilicus. The uterus was stabilized with one hand and examined with the other hand. The entire area, from the abdominal midline to lateral sides and from the symphysis pubis to the fundus was palpated in a rotatory manner. The smooth curved surface indicated the fetal back, palpated at the mother`s right side and the same procedure was repeated and a rough side indicating the fetal limbs was also palpated.

PELVIC PALPATION

The client`s feet were faced; she was asked to bend her knees slightly in order to relax the abdominal muscle. She was helped to relax by guiding her breathe out slowly. Palms were placed at both sides of the uterus below the umbilicus and the fingers directed towards the symphysis pubis with thumb almost meeting to determine the presenting part. A hard mass was felt indicating the fetal head.

DESCENT OF THE HEAD

By abdominal palpation, descent was assessed in terms of fifths of fetal head palpable above the symphysis pubis. The anterior shoulder was located below the umbilicus; two fingers were placed over it, the symphysis pubis was located and the ulna boarder of the dominant hand was placed just above the symphysis pubis in between the anterior shoulder and the symphysis pubis accommodated the five fingers which indicated descent of $5/5^{th}$ above symphysis pubis.

AUSCULTATION

On auscultation, fetal stethoscope was warmed by rubbing it in the palms. It was placed on the area where the fetal back was located. The ear was placed against the fetoscope and the heart

beat was listened to while comparing it with the maternal pulse. The heart beat was faster than the maternal pulse. When counted for a minute the fetal heart beat was 150beats per minute and it was regular. As soon as the fetoscope was removed, fetal movement was observed. The lie was longitudinal, presentation was cephalic.

VULVA EXAMINATION

Madam Winnifred's permission was sought for vulva inspection and she agreed. A pillow was placed under her head and covered with clean sheet to provide warmth and modesty. The vulva was shaved and clean. Hands were washed and sterile gloves worn. The vulva and perineum was examined for the presence of varicose vein, old episiotomy scars, sores, offensive discharge, ulcers, rashes, warty growth and no abnormality detected. The groin was palpated for the presence of swelling lymph nodes and tenderness but none was detected. The urethra and skene's glands were milked for discharge and bleeding but none was detected. She was asked to bear down while the labia were held open and anterior and posterior vaginal walls were observed for bulging of the walls and also for uterine prolapse. Madam Winnifred was thanked for her cooperation and all findings were communicated to her. Client complained of backache and frequency of micturition. She was reassured and the condition was explained to her that the backache and frequency of micturition are minor disorders of pregnancy and it was caused by the fetal head pressing on the bladder. The relaxation of the supporting ligaments due to the action of the hormone relaxin, which are all normal physiology during pregnancy. She was educated to rest and sleep and also encouraged to assume a comfortable position like lying on her left side when sleeping. She was again encouraged to empty her bladder before going to bed every night. She was encouraged to take in enough fluid and ensure proper personal hygiene. Next visit to the

facility was scheduled with her and she gave directions to her house. The following routine drugs were given;

Tablet multivitamin 200mg daily for 30days

Tablet ferrous sulphate 200mg daily for 30days

Tablet folic acid 5mg daily for 30days.

Client was encouraged to take the drugs as prescribed and was reminded of her next visit to the facility. Madam Winnifred was reminded of danger signs in pregnancy such as severe epigastric pain, bleeding and excessive vomiting. She was asked to report to the facility anytime if she experienced any problem. She was promised a home visit on 19th August, 2023 after exchange of contacts. She was thanked and bid her bye.

2.2 FIRST ANTENATAL HOME VISIT.

On 19th August, 2023, the client was visited in her house as arranged at 4:00pm. The main purpose of the visit was to access Madam Winnifred`s physical environment and also access the physical condition of her house and how she relates with other members of the family. On reaching the house, client was met washing her clothing. She was greeted and she offered a seat and a cup of water as tradition demands, afterwards she asked of my mission. The aim of the visit was explained to her. Introduction was made to her husband and was very happy after explaining the focus antenatal care that would be given to his wife during pregnancy, labour and puerperium.

Madam Winnifred lives a few miles away from the market in Intotroso. Client lived in the husband`s own house with three rooms, of which one room is occupied by their items, the second

room is occupied by the client and her husband and the other one is occupied by client son and mother - in-law. The house was built with cement block and roofed with aluminum sheet. There was only one bathroom and a toilet. They had a kitchen where she keeps her utensils. There were two windows in each room for ventilation. She keeps her refuse in a dustbin without a lid and disposes it daily at the community refuse site which is about 10minutes walk away from their house.

Madam Winnifred was educated to cover her dustbin to prevent flies from settling on the rubbish and uncovered food which could cause infection. Her surroundings were not bushy. The client slept under mosquito net but was still educated on malaria prevention and the effect of malaria on pregnancy since some people do sustain the mosquito bites whiles still doing their house chores before entering their rooms. She uses electricity as her source of light. The house was quite in good condition. She is in good personal relationship with her in-law and her neighbor`s. The client and her family were made aware of hand washing before and after eating and also after visiting the latrine, and there was emphasis on the need to use soap to wash hands under running water and they were encouraged to do so. She was educated on sanitation and was ended by congratulating the client.

She was asked about her preparedness towards labour, she was asked whether her first child was aware of the pregnancy and welcoming a new sibling. The client responded that, she had bought all her things, the items were checked and packed in a bag and placed at a corner in the room which is easy to find. Since the husband was a driver transportation was assured. According to her, she informed her son about the impending and arrival of the baby. She was educated and advised to get someone who would accompany her to the hospital when in labour, and also advised to get people who would donate blood for her. She was asked to keep her antenatal book,

health insurance card and amount of money in her bag (thus birth preparedness and complication readiness). She was thanked for her cooperation and good interaction and was encouraged to continue with good environmental hygiene practices. She complained of frequency micturition and she understood the concept because it was explained to her during our first encounter.

Client was allowed to ask question but she said she had no question. Permission was sought to leave and once again was advised to take her routine drugs as prescribed and reminded on her next antenatal visit. She was thanked for her warm reception and co-operation.

2.3 SECOND ANTENATAL HOME VISIT

The second home visit was made on the 26th August, 2023 the visit was made purposely to check on the health status of Madam Winnifred. She was greeted and enquiry about her health was made to see if there had been improvement in her complaints during the antenatal visit. Her response was that she was doing well and she was asked of her mother in-law and the rest of the family members, but none of them were present at that time. Madam Winifred was in good health but she said she had been experiencing some slight lower abdominal pains and waist pains, and was made to understand that lower abdominal and waist pains in pregnancy at that time was due to the presenting part pressing on the sacral nerves and would resolve after delivery. She was advised to lie on the side with knees and hips bent and placing a pillow between the thighs and another pillow under the abdomen and she was reassured. She was educated on the true signs of labour such as the appearance of "show" and rhythmic regular contractions. She was told to report immediately, if she observed any danger sign such as bleeding per vaginum, severe headache, excessive vomiting, spontaneous rupture of membranes and severe lower abdominal pains. The things she had prepared for labour was brought for inspection again. Client was allowed to ask questions but she had no question. Permission was

sought to leave and once again she was advised to take her drugs as prescribed. She was reminded of her next visit to the clinic; she was thanked for her time and co-operation.

2.4 SUBSEQUENT VISIT TO THE HOSPITAL

On 28th August, Madam Winnifred reported to the facility as scheduled. She was warmly welcomed and a seat offered. Her antenatal book was collected and read through. All the routine procedures were explained to her, and her consent was sought. Her vital signs were checked and recorded as follows;

Temperature	-	36.0degrees Celsius
Pulse	-	87 beats per minute
Respiration	-	20 cycles per minute
Blood pressure	-	120/70 millimeters of mercury

Her weight was 98kg. Urine tested for protein and sugar was negative. Hands were washed and dried with a clean towel and privacy was provided. Client was helped onto the couch after emptying her bladder. The head to toe examination was done and no abnormalities were detected. The abdomen was inspected and it was medium in size with striae gravidarum and linear nigra with no tribal marks but fetal movement was seen. The abdomen was ovoid in shape, on palpation the gestation age was 39 weeks plus 3 days and Symphysio fundal height was 35cm, descent was 5/5 above the pelvic brim. Fetal heart rate was 144 beat per minute on auscultation. The upper and lower limbs were as well inspected with no oedema and varicose veins detected. There was no oedema at the sacral region. All findings were communicated to her

and she was thanked and made comfortable. She complained of constipation and heart burns at 10:30am. She was advised to have enough rest, sleep, drink more fluids and eat fiber rich food such as orange and vegetables. She was advised to maintain her personal hygiene. For heartburns, physiology of heartburns was explained to her, she was encouraged to eat less oily foods and also rest after meals before going to bed and to eat early around 6pm.

She was assured of safe pregnancy, labour and puerperium. She was advised to reduce intake of water in the evening before going to bed. She was asked to prepare herself both physically and psychologically since labour could start any moment.

2.5 THIRD ANTENATAL HOME VISIT.

On the 31st 0f August, 2022, the third home visit was made to client's house to assess her health status. The danger signs of pregnancy which was taught during the previous visit was inquired about, and she was able to remember what was taught. The need for exercise was also re-enforced. She was encouraged to continue taking her routine drugs and report to the facility when labour begun or if she had any health issues. She was also educated on the importance of supervised or hospital delivery as against home delivery. Client complaint of backache. Client was educated on the complications that may arise such as post-partum haemorrhage which could easily be managed when it occurs at the hospital. In the absence of questions, permission was sought to leave and was thanked for her co-operation.

2.6 CARE PLAN DURING ANTENATAL

Problems identified during antenatal period.

1. On 14th of August, 2023, Madam Winnifred complained of Backache.

2. On 19th of August, Madam Winnifred complained of Frequency of micturition.

3. On 26th of August 2023, Madam Winnifred complained of Lower abdominal pain.

4. On 28th of August 2023, Madam Winnifred complained of waist pains.

5. On 28th of August, Madam Winnifred complained of constipation

6. On 31st August, 2023, Madam Winnifred complained of heart burns

SHORT TERM OBJECTIVES

1. Madam Winnifred's backache will subside within 48 hours.
2. Client will be able to cope with frequency of micturition within 24 hours.
3. Client will understand and cope with lower abdominal pain throughout pregnancy.
4. Client waist pain will subside within 48 hours and will be able to cope with it throughout pregnancy.
5. Client backache will reduce within 48 hours and be able to cope with it throughout pregnancy.
6. Client will have normal bowel movement within 48 hours.
7. Client will have reduced episodes of heartburns throughout pregnancy.

LONG TERM OBJECTIVES

Madam Winnifred will go through pregnancy successfully without any complication to mother and fetus.

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES / OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
14/08/23 9:30am	Backache related to increased lordosis as pregnancy advanced.	Client's backache will subside within 48hours as evidenced by client; Verbalizing that backache has reduced.	1. Reassure client of competent care and that the back ache will subside. 2. Educate client on the physiology of backache during late pregnancy 3. Educate her to wear low heeled foot wear. 4. Educate her to reduce prolong standing. 5. Educate client to support her back when sitting.	1. Client was assured of competent care and that the back ache would subside. 2 Physiology of back ache in late pregnancy was explained to client that as pregnancy advance there was increased lordosis. 3. She was educated to wear low heeled foot wear. 4. Client was educated to reduce prolong standing. 5. Client was encouraged to sit straight by using pillow to support the back.	16/08/23 9:30am	Goal achieved as client reported to the midwife that her backache has subsided.	A.R

NURSING CARE PLAN FOR ANTENATAL CONT'D

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVE/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
19/08/23 9:30am	Frequency of micturition in late pregnancy related to the fetal head pressing on the bladder.	Client will cope with frequent micturition within 72 hours as evidenced by client verbalizing that; 1. She is coping with frequency of micturition.	1. Reassure client that she will cope with the increased frequency in micturition. 2. Explain physiology of micturition in the late pregnancy to the client. 3. Encourage client to urinate before sleeping. 4. Tell her to urinate when she has the urge. 5. Encourage client on the use of bedpan in her room.	1. Client was reassured that she would \cope with the increased frequency in micturition. 2. Physiology of micturition in late pregnancy was explained to client that as the head descends into the pelvis, it presses on the bladder. 3. Client was encouraged to urinate before sleeping when she had the urge. 4. She was told to urinate whenever she had the urge. 5. She was encouraged to use bedpan in her room during the night.	22/08/23 9:30am	Goal met as client informed me that she coped well with her situation.	A.R

NURSING CARE PLAN FOR ANTENATAL CONT'D

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTIONS	DATE/ TIME	EVALUATION	SIGN	
26/08/23 4:30pm	Lower abdominal pain related to relaxation of muscles and ligaments by the action of progesterone and relaxin.	Madam Winnifred's pain will reduce within 48 hours as evidence by client verbalizing that, her lower abdominal pain has reduced.	1. Reassure client that her pains will reduce. 2. Encourage client to lie on her left side. 3. Encourage client to place pillows between knees and another pillow under the abdomen. 4. Encourage client to gently apply firm pressure on the painful area. 5. Encourage client to apply warm compress to the lower back. 6. Educate client on the causes of lower abdominal.	1. Client was reassured that her pains would reduce. 2. Client was encouraged to lie on her left side with knee and hips bent. 3. Client was encouraged to place pillows between knees and another pillow under the abdomen. 4. Madam Winnifred was encouraged to gently massage or apply firm pressure on the painful area. 5. Client was encouraged to apply warm compress to the lower back. 6. Client was educated on the causes of lower abdominal during late pregnancy.	28/08/23 10:30am	Goal fully met as the patient verbalize that, the abdominal pain has subsided.	A.R	

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
28/08/23 4:00pm	Waist pain related to physiological changes in late pregnancy (Uterine contraction).	Madam Winnifred's waist pain will be reduced within 48 hours as evidenced by client verbalizing that her waist pain has subside.	1. Reassure client that her condition is a normal physiology and that it will be resolved very soon. 2. Encourage client to have enough rest and sleep. 3.Encourage client to lie on her side with knees and hips bent. 4. Encourage client on minimal work and exercise. 5. Encourage client to wear low heeled shoes and slippers	1. Client was reassured that her condition was a normal physiology and that it would be resolved very soon. 2. Client was encouraged to have enough rest and sleep both day and night. 3. Client was encouraged to lie on her side with her knees and hips bent. 4. Client was encouraged to minimize on strenuous work and exercise. 5. Client was encouraged to wear low heeled shoes and slippers.	30/08/23 5:00pm	Goal met as client informed the midwife that her waist pain has reduced.	A.R

NURSING CARE PLAN FOR ANTENATAL CONT'D

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
28/08/23 7:30am	Constipation related to physiological changes in pregnancy.	Madam Winnifred will have her normal bowel movement within 48hours as evidenced by her; Verbalizing that she has gained her normal bowel movement by eliminating at least,	1. Reassure client that she will have her normal bowel movement. 2. Explain the physiology of constipation to the client. 3. Encourage her to take in more roughage. 4. Educate her on minimal exercise like walking around her house. 5. Encourage client to increase fluid intake (8	1. Client was reassured that she would be able to have her normal bowel movement. 2. The physiology of constipation was explained to her that it was reduced movement of the gut due to pregnancy 3. Madam Winnifred was encouraged to take in more roughage like orange and vegetables like kontomire. 4. She was educated to do minimal	30/08/23 7:30am	Goal met as Madam Mariam reported that she gained her normal bowel movement.	A.R

		twice daily	glasses of fluids).	exercises like walking around her house. 5. Client was encouraged to take 8 glasses of fluid.			

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DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES / OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTIONS	DATE/ TIME	EVALUATION	SIGN
28/08/23 7:30am	Heart burns related to regurgitation of acidic gastric content into the oesophagus.	Madam Winnifred will be relieved of heart burns within 24hours as evidence by client verbalizing absence of heart burns.	1. Reassure client that her heart burns will be relieved. 2. Explain the physiology of heart burns to client 3. Encourage client to prop herself up in bed. 4. Encourage client to lie on left lateral position. 5. Encourage her to sit down for a while after a meal before going to bed. 6. Encourage client to reduce intake of fatty and spicy meals.	1. Client was reassured that her heart burns would be relieved. 2. The cause of heart burns was explained to client 3. Client was encouraged to prop herself up in bed. 4. Client was encouraged to lie on left lateral position. 5. Madam Winnifred was encouraged to sit down for a while after a meal before going to bed. 6. Client was encouraged to reduce the intake of fatty and spicy meals.	29/08/23 4:30pm	Goal fully met as client told the midwife that her heart burns stopped.	A.R

CHAPTER THREE

LABOUR

3.0 INTRODUCTION

This chapter consists of the management of the first stage to fourth stage of labour, problems client encountered, the care given to her and the immediate care of the new born.

3.1 ADMISSION AND MANAGEMENT OF LABOUR

ADMISSION

On the 2nd September 2023 madam Winnifred Mensah reported to the hospital at 12:40pm with the complaints of lower abdominal pains. She was accompanied by her mother in-law to the facility. They were welcomed and were offered seat. Client looked anxious and she was assured that she was in safe hands. She complained of lower abdominal pains and waist pain. She was reassured to allay her anxiety. Her antenatal card was taken and read through. Her expected date of delivery was confirmed. She was made comfortable in bed and all procedures to be carried out were explained to her to gain her consent. Client's labour history was taken and recorded. Client said she ate rice with light soup before coming; she did not take any medication or emptied her bowels before coming. Her vital signs were checked and recorded as follows:

Temperature	----------	36.0 degree Celsius
Pulse	----------	90beats per minutes
Respiration	----------	20 cycles per minutes
Blood Pressure	----------	120/80 millimeters of mercury

A specimen bottle was given to client for the midstream urine collection for urine examination it was screened for protein and glucose. The amount of urine passed was 100mls. A tray containing strips of urine reagent strip was used to test for glucose acetone and protein and the result was negative and the colour of urine was amber, clear and not offensive. Hands were washed with soap under clean running water and dried with clean dry towel. Having explained the procedure and her consent sought, head to toe examination was conducted.

Procedure was explained to the client concerning the head to toe examination. she was well position on the couch. Hands were washed with soap and water and dry with clean dry towel before the procedure. Head to toe examination was conducted thoroughly on client.

Client's abdomen was ovoid in shape and medium in size. The abdomen was assessed striae gravidarum, linear nigra, rashes, scar, masses, tenderness. Fetal movement were present but no scar was found on inspection. Her abdomen was palpated, Symphysio fundal height was 36cm, and gestation age was 40weeks, the lie was longitudinal, presentation was cephalic, and descent was 3/5 palpable abdominally. Contraction was 3 in10 minutes lasting for 32 seconds. On auscultation the heart rate was 139beats per minute with good volume and regular in rhythm. Client was told examination of the vulva will be done and this was to assess the adequacy of the pelvic, presenting part and the state of the cervix and cervical dilatation. The procedure was explained to her and she was given the opportunity to ask questions. A verbal consent was obtained from her. Hands were washed and dried with clean dry towel. A sterile tray was set containing two gallipots, one containing savlon solution, the second gallipot with sterile cotton wool swabs, a pair of sterile gloves and a receiver for used swabs and all were covered with a sterile towel. The legs were separated with knees flexed and thighs apart as instructed. Vulva was inspected for varicosities, oedema, vulva wart, sores, discharge, bleeding and scars from

previous deliveries but no abnormality was detected. The vulva was swabbed with five sterile cotton wool swabs and diluted savlon lotion. The labia majora was separated with two fingers of the left hand and the index finger of the right hand (dominant hand) was inserted into the vagina at the lower end of the opening and the middle finger was added. The vagina was warm and moist, ischial spines were blunt, the sacrum was well curved, and the sacral promontory was not reached. The cervix was soft, thin and four (4) centimeters dilated with membranes intact at 1:00pm. The presenting part was cephalic and well applied to the cervix. A fist was made in-between the ischial tuberosity which accommodated all four knuckles. Madam Winnifred was dried and perineal pad was applied and made comfortable in bed. She was encouraged to lie on her left side. Gloves were removed inside out. Hands were washed with soap under clean running water and dried with a dry clean towel. Client was informed about progress of labour and educated on cervical dilatation which was done with the help of a dilatation board. All findings were recorded on the partograph and communicated to the in charge. The physiology behind the pains was explained to her. She was educated and encouraged on deep breathing exercise and sacral massage during contractions as this would help her to cope better with labour pains. Client was then educated on hygiene during labour such as changing of perineal pad when it fell on the floor or when wet. Emptying her bladder frequently and walking around to facilitate descent and cervical dilatation was mentioned and encouraged her to do so. She was continuously monitored with partograph.

PREPARATION FOR BIRTH

The emergency plan was reviewed. The midwife in-charge was informed to assist when the baby does not breathe and to supervise through -out the procedure and a ward assistant was also asked to assist in the care of the mother. The environment was already clean and privacy was ensured.

The resuscitation area was checked and all equipment's were functioning well, lights were on and emergency light was available for use when needed. The delivery set and emergency drugs were made available, client was asked whether her birth companion should be called in the first stage but she denied. Client was informed that her abdomen would be cleaned for skin to skin care during the second stage. A blood donor was identified and a taxi driver was called and informed in case of any referral. Hands were washed with soap under running water and dried with clean towel.

MANAGEMENT OF FIRST STAGE OF LABOUR

Client was put on partograph on admission when labour was established. Fetal heart rate, contractions and pulse were monitored every 30 minutes and vaginal examination, descent, blood pressure and temperature were done four hourly.

Madam Winnifred's vital signs was checked and were:

Fetal heart rate…...147bpm

Pulse…….86bpm

Contractions were 3 in 10 minutes lasting for 36seconds.

She was encouraged to take light nutritious diet and normal fluids in bits to prevent dehydration and to help her during the second stage of labour. She took a bottle of malt. Madam Winnifred was also encouraged to adopt left lateral position to prevent supine hypotension syndrome.

At 5:00pm, client next vaginal examination was due. Fetal heart rate was 146bpm; uterine contraction was 10 minutes lasting 45seconds.Vaginal examination was repeated and cervical os

was seven (7) centimeters dilated with membranes raptured, liquor was clear, descent was 1/5th and there was no moulding present the amount of urine passed was 100mls which was tested for acetone and glucose and the test was negative. She was informed to urinate whenever she feels the urge. Clients vital signs were checked and recorded as Temperature 36.0 degree Celsius, Pulse 87 beats per minutes, Respiration 20 cycles per minutes, Blood pressure 120/80 millimeters of mercury respectively. All findings were recorded on the partograph and client was informed of progress of labour using the dilatation board, she was informed delivery was imminent and during that period she would have the urge to free her bowel and therefore asked to inform me when she feels for pushing.

At 7:45pm Delivery trolley was set up.

The top shelf

Cord scissors

- Cord clump
- 2 artery forceps
- 2 cot sheet
- Episiotomy set
- 4 drapes
- 2 gallipots (one containing cotton swabs soaked in savlon solution and the other containing gauze)
- **Bottom shelf**
- Measuring jag
- Placenta bowl

- Sucker in a bowl of water
- Vitamin k injection
- 10 units of oxytocin
- Pair of sterile gloves
- Bed pan
- Rubber mackintosh
- Rubber apron
- Perineal pad
- Extra sterile gloves

Client was helped to wash her hands and chest with soap and clean water and dried with clean towel to prepare for skin to skin care and she vomited she was reassessed to wash hands again.

At 8:00pm client shouted, she had the urge to pass stools, vaginal examination was done and cervical dilatation was 10cm dilated, descent was 0/5th, contractions was 4 in 10 minutes lasting 45 seconds, pulse was 88 beat per minute and fetal heart rate was 143bpm, blood pressure was 120/70 the perineum bulged and the anus gaped. The in-charge was called to come and assist the delivery. The first stage lasted for 7hours.

3.3 MANAGEMENT OF SECOND STAGE OF LABOUR

The procedure was explained to client and she was reassured that she was in safe hands and would go through labour and delivery successfully. She was positioned according to her preference that was lithotomy position. She was told that the baby would be delivered onto her abdomen and so she should hold it, skin to skin contact would be maintained for an hour to promote bonding and prevent heat loss which she agreed. Hands were washed with soap and water and dried with clean dry towel. Protective clothing was worn, the vulva was cleaned with

antiseptic solution (savlon) and cervical dilatation was confirmed. Madam Winnifred was draped, encouraged to bear down and to rest in between contractions and was also encourage to empty bladder. Client complained of fatigue at 8:05pm. A pad was placed at the anal orifice to prevent contaminating the baby's face with faeces and to provide clean area for delivery. The index and middle fingers were used to maintain flexion of the head as it came out of the vagina. This was in order to allow the smallest diameter of the fetal head to distend the perineum and prevent intracranial injury and haemorrhage. Madam Winnifred was asked to stop pushing but pant or give small pushes with contraction when the head crowned. This was done to await spontaneous delivery of the head with subsequent contractions to prevent perineal tear. The forehead, face and chin swept the perineum and the head was delivered. The baby's face, eyes, mouth and nose were gently cleaned with a sterile gauze. A finger was used to feel around the baby's neck for cord and there was none. The head was supported and restitution was allowed to occur, then external rotation of the head which indicated that the shoulders were in anterior posterior diameter of the pelvic outlet. The anterior shoulder was delivered by applying gentle downward pressure on the head and during subsequent contractions, baby was moved upwards towards mothers' abdomen to deliver the posterior shoulder and the rest of the body was delivered and baby was placed on the mother's lower abdomen. Time of delivery was exactly 8:30pm and it was a life female baby. The baby was dried thoroughly, wet cloths removed, placed directly on mother's abdomen covered immediately with dry cloth to prevent heat loss and provide warmth as well as bonding.

3.4 IMMEDIATE CARE OF THE BABY

Immediately the baby was delivered onto the mother's abdomen, it cried. The first minute APGAR score was 8/10. Liquor was cleaned off the baby with a dry clean towel to keep baby warm and the wet towel was removed. The cord was first clumped 3 finger away from the baby's abdomen and second clamp 2 finger breaths away from the first clump. The cord was cut with cord scissors in between the forceps covered with gauze to prevent splashing of blood. An identification band was placed on the baby's wrist with the name of mother, sex, date and time of birth.

The baby was shown to the mother for her to identify the sex which was female. The baby was placed on mother's abdomen which head was turned to one side to prevent aspiration to help in skin to skin contact and another dry clean towel was used to cover the baby to keep baby warm. Baby was worn a cap on the head and socks on the hands and feet.

3.5 MANAGEMENT OF THIRD STAGE OF LABOUR

The procedure was explained to client. Immediately the baby was delivered, the uterus was palpated to exclude a second twin, 10 unit of oxytocin was given to mother intramuscularly on the left thigh at exactly 8:31pm to help the uterus contract. The cord was re-clumped closer to the perineum and the hanging end was placed in a receiver. The bladder was checked and it was empty. The placenta was delivered by controlled cord traction, the left hand was placed on the fundus to check for contractions, immediately there was contraction the left hand was removed and placed on the lower abdomen in the suprapubic area with palms facing the abdomen of the mother to stabilize the uterus to prevent inversion of the uterus. The clumped cord was held at the same time with the right hand and a gentle downward and outward traction was applied to the cord following the curve of Carus. Counter pressure was maintained with the left hand at the

suprapubic area whiles applying traction to the cord until the placenta was visible at the vulva. Then both hands were used to receive the placenta at the introitus, twisting it gently to prevent the membranes from tearing. The placenta and membranes were delivered completely at 8:36pm. A quick examination was done for completeness of lobes and membranes, retro placental clots to exclude any retained product of conception before it was placed into the receiver for thorough examination later. The uterus was massaged to maintain contraction and to express blood clots. The genital tract was cleaned and gauze wrapped around the index and middle fingers to examine for bleeding, tears of the vaginal wall, and lacerations of the cervix and perineum which there was no tear. Client was cleaned and a sterile pad was placed on the perineum. Client was congratulated and sent to the lying-in ward made comfortable in bed. Client was encouraged to empty her bladder frequently and to feed baby on demand. Baby was put to breast to initiate breastfeeding. Client's mother-in law was informed about the sex and she was allowed to visit her. Client was told to report any bleeding immediately. All findings were recorded on the partograph. Decontamination of delivery items and bed was done thoroughly.

3.6 EXAMINATION OF THE PLACENTA AND MEMBRANES

The placenta was placed in 0.5% chlorine solution before 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 examined, the lobes fitted together without any gab and edges also forming uniform circle at the maternal surface and this meant 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 center of the placenta with one vein and two

arteries seen in the cord. In all 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. The blood loss was 150 milliliters.

3.7 MANAGEMENT OF FOURTH STAGE OF LABOUR

During the fourth stage of labour, close observation of the mother and baby was made for six hours following the expulsion of the placenta, membranes and the arrest of haemorrhage. During this period mother and baby were assessed for every fifteen minutes for two hours, thirty minutes for one hour and hourly for three hours which was recorded behind the partograph.

The uterus was well contracted and all blood clots were expelled, mother cleaned and made comfortable. Client was very happy for delivering a female baby. At the end of the one hour, the amount of urine passed was 100mls. Symphysio-fundal height was 18cm. Client was served porridge with bread to restore her energy lost. The baby was put to breast to feed and help in the involution of the uterus. Client complained of fatigue and she was encouraged to have enough rest. General examination of the baby was done and nothing abnormal was detected. The baby's breathing and colour was checked every 5 minute, warmth was also checked every 15 minute by feeling the baby's feet and all were normal. Other vital signs and condition of the baby were also checked and recorded as follows:

Temperature	----------	36.3C
Pulse	----------	136 bpm
Respiration	----------	42cpm

APGAR score ---------- 8/10, 9/10

Abnormalities ---------- None

Condition of mother ---------- Satisfactory

After the one-hour examination, the mother was given vitamin A capsule 200,000 International units. Madam Winnifred was encouraged to feed baby on demand and wash hands before and after breastfeeding baby and after changing perineal pad.

3.8 MANAGEMENT OF THE NEWBORN

PREVENTION OF DISEASE

This was done within the first 90 minute to prevent infections such as Ophthalmia Neonatorum a condition which is notifiable, neonatal tetanus and hemorrhagic disease of the new born therefore the following treatments were given at exactly 9:10pm.

The baby's eyes were cleaned with sterile cotton wool swab with normal saline and tetracycline eye drop, two drops were instilled on each eye. The umbilical cord was dressed with six cotton wool swabs and methylated spirit, injection vitamin k1 was given.

3.9 EXAMINATION OF THE NEWBORN

Tray Containing:

- Sterile gallipot with sterile cotton swabs
- Cord ligatures, cord scissors, receiver
- Warm towel
- Tape measure
- Weighing scale
- Plastic apron
- Normal saline
- Good light source

Procedure

- Hands were washed with soap and water
- Procedure was explained to madam Mariam.
- Disposable examination glove was put on
- Baby was examined in a clean, warm environment where parents can watch
- Nearby windows were close to make the room warm
- Baby was placed on the back on a clean warm surface
- Baby was placed on a flat surface and only the part to be examine was expose
- General condition of the baby was checked and recorded that is lethargic, cry, breathing, heart rate, temperature, skin.

General examination:

THE HEAD, FACE: The head and scalp were normal with no caput succedaneum, bulging or sunken fontanelles. The eyes opened spontaneously when the baby was held in an upright position and the conjunctiva was clear and the nose was patent.

MOUTH: The mouth was examined by pressing the angle of the jaw which opened the mouth and the tongue, gum and palate were inspected and there was also no false tooth noticed. The palate was high arched, intact and the uvula centrally placed. There was no cleft palate or cleft lip, tight frenulum or tongue tie.

EARS: 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 40cpm. The space between the nipples was noted and the nipples were in alignment. The abdomen was round with no bleeding from the umbilical cord. The cord was examined and there was one vein and two arteries.

LIMBS AND DIGITS: The length and movement of the limbs were also noted. The digits were counted to be normal and separate to exclude webbing. The feet were examined for any abnormality. The axillae, elbows, groin and popliteal spaces were examined without any abnormality detected.

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

GENITALIA AND ANUS: The genital area was examined and there was the presence of vulva, the majora was parted to examine the vestibule. The baby passed urine and meconium indicating patency of the urethra and the anus respectively.

The baby was weighed and the weight was 3.0kg, head circumference was 33cm, length 50cm and temperature was 36.3oc. Vitamin K 1mg was given at the mid anterior-lateral thigh intramuscularly to prevent bleeding disorders in the newborn.

CORD DRESSING

Six cotton wool with chlorhexidine were used for the procedure.one of the cotton was used to hold the cord clamp.one was used to clean the base of the cord in a circular manner. Another one was used to clean from down to up. A different one was also used to clean from down to top and another one from down to top. The last one was used to clean the cord clamp. In all, there was no abnormality detected. The baby was classified as normal and routine care of the baby was initiated. Gloves were removed and disposed aseptically before washing hands with soap under running water and dried with clean dry towel. The baby's skin was smeared with baby oil and wrapped. All findings were recorded.

CONDITION OF BABY AT BIRTH

Temperature	----------	36.3oc
Apex beat	----------	132bpm
Respiration	----------	42cpm

Other assessments were recorded as follows;

Sex	----------	Female
Head circumference	----------	33cm
Length	----------	50cm
Weight	----------	3.0kg

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

First Minute APGAR score

Appearance	----------	1
Pulse	----------	2
Grimace	----------	1
Activity	---------- ---	2
Respiration	----------	2
Total	------ ---------	8/10

Fifth Minute Apgar score

Appearance	----------	2
Pulse	----------	2
Grimace	----------	1
Activity	----------	2

Respiration	----------	2
Total	----------	9/10

Baby was put to breast to feed and aid in involution and create bonding between mother and baby. The general condition of the baby was satisfactory.

CONDITION OF MOTHER AFTER BIRTH

The mother's first vital signs were as follows:

Temperature	----------	36.5oC
Pulse	----------	78bpm
Respiration	----------	20cpm
Blood pressure	----------	120/70mmHg

The uterus was well contracted and all blood clots were expelled and lochia was rubra. Symphysio fundal height was 18cm. The baby was put to breast to help in the involution of the uterus. She was made comfortable in bed and encouraged to urinate frequently. The condition of the mother was satisfactory.

3.10 SUMMARY OF LABOUR.

Date and time of admission	-	2nd September, 2023 at 12:40pm
Date and time of delivery	-	2nd September, 2023 at 8:30pm
Type of delivery	-	Spontaneous Vaginal Delivery (SVD)

Time of expulsion of placenta and membranes	-	8:36pm
Blood loss	-	approximately150mls.

DURATON OF LABOUR

First stage of labour	-	7hours
Second stage of labour	-	30minutes
Third stage of labour	-	5minutes
Total duration	-	7hours, 35 minutes
Injection oxytocin	-	10 units given on the left thigh after delivery of baby

CONDITION OF THE PLACENTA AND CORD

Cord insertion	-	centrally situated
Cord vessels	-	two arteries and a vein
Placenta and membranes	-	complete
Maternal surface	-	dark red
Fetal surface	-	grayish blue
Condition of placenta	-	healthy and normal

3.11 NURSING CARE PLAN FOR LABOUR

PROBL EM IDENTIFIED

1. On 02/09/2023 Madam Winnifred complained of lower abdominal pains.
2. On 02/09/2023 Madam Winnifred was anxious due to unknown outcome of labour.
3. On 02/09/2023 Madam Winnifred complained of nausea.
4. On 02/09/2023 Madam Winnifred was seen vomiting.
5. On 02/09/2023 Madam Winnifred complained of fatigue.

SHORT TERM OBJECTIVES

1. Client will be able to cope with lower abdominal pains within 7 hours.
2. Client will be relieved of anxiety within an hour.
3. Client will be relieved of nausea within 1 hour.
4. Client will be relieved of vomiting within 1 hour.
5. Client will be relieved from fatigue within 1 hour.

LONG TERM OBJECTIVES

Madam Winnifred will go through labour successfully and deliver a healthy baby without any complications to mother and baby.

NURSING CARE PLAN FOR LABOUR

DATE / TIME	NURSING DIAGNOSIS	NURSING OBJECTIVE	NURSING ORDERS	NURSING INTERVENTIONS	TIME/ DATE	EVALUATION	SIGN
02/09/23 12:40pm	Lower abdominal pains related to painful uterine contractions.	Client will cope with lower abdominal pains within 7 hours as evidence by a. Client verbalizing that she is coping well with the abdominal pains b. Midwife visualizing that client is sleeping in between contractions	1. Reassure client that her lower abdominal pain will subside. 2. Explain the process of labour to the client. 3. Encourage client on deep breathing exercise. 4. Encourage client to empty her bladder frequently.	1. Client was reassured that her lower abdominal pain will subside 2. The stages of labour were explained to the client. 3. Client was educated on deep breathing exercise to reduce pain. 4. Client was encouraged to empty her bladder frequently to aid in decent.	02/2/23 7:30pm	Goals fully met as a. Client verbalized she was able to bear the pain. b. Midwife reported that client slept in between contractions.	A.R

DATE / TIME	NURSING DIAGNOSIS	NURSING OBJECTIVE	NURSING ORDERS	NURSING INTERVENTIONS	TIME/ DATE	EVALUATION	SIGN
02/09/23 12:40pm	Lower abdominal pains related to painful uterine contractions.	Client will cope with lower abdominal pains within 7 hours as evidence by a. Client verbalizing that she is coping well with the abdominal pains b. Midwife visualizing that client is sleeping in between contractions	5. Involve client in diversional therapy e.g. engaging in conversation and encourage ambulation 6. Explain the physiology of pain to the Client	5. Client was engaged in conversation and was encouraged to walk around her bed. 6. The reason for the pain was explained to her as a result of contractions of the uterus to help expel the baby.	02/2/23 7:30pm	Goals fully met as a. Client verbalized she was able to bear the pain. b. Midwife reported that client slept in between contractions.	A.R

NURSING CARE PLAN FOR LABOUR CONT'D

DATE / TIME	NURSING DIAGNOSIS	NURSING OBJECTIVE	NURSING ORDERS	NURSING INTERVENTIONS	TIME/ DATE	EVALUATION	SIGN
2/09/23 12:40pm	. Anxiety related to unknown labour outcome.	Client's anxiety level will be reduced within 1 hour as evidenced by client verbalizing that she is no more anxious	1. Reassure client 2. Explain the stages of labour to the client. 3. Explain every procedure to be carried out to client. 4. Update client with progress of labour.	1. Client was reassured that she was in the hands of competent midwives. 2. The stages of labour Were explained to the client. 3. Every procedure carried on client was explained to her.	2/09/23 1:30pm	. Goals met as client said she was no more anxious.	. A.R

DATE / TIME	NURSING DIAGNOSIS	NURSING OBJECTIVE	NURSING ORDERS	NURSING INTERVENTIONS	TIME/ DATE	EVALUATION	SIGN
	.		4. Client was updated on the progress of Labour 5. Allow her to ask questions and answer her appropriately. 6.Educate client on the effect of anxiety	5. Client was allowed to ask questions and was answered appropriately. 6. Client was educated that anxiety could lead to prolong labour.		.	

DATE / TIME	NURSING DIAGNOSIS	NURSING OBJECTIVE	NURSING ORDERS	NURSING INTERVENTIONS	TIME/ DATE	EVALUATION	SIGN
02/09/23 12:40	Nausea related to the hormonal actions in labour	Madam Winnifred will be relived of nausea within one hour as evidence by client reporting that she is no more nauseated.	1. Reassure client. 2. Educate client on the cause of nausea. 3. Encourage client to chew a piece of chewing stick. 4. Assist client to rinse her mouth with mouth wash. 5. Keep environment clean and free from nauseatin 5. Encourage client to take fluids. 6. Administer IV fluid if vomiting becomes severe g vomiting becomes severe.	1. Client was reassured that nausea would subside. 2. Client was educated on cause of nausea as it was due to hormonal actions in labour 3. Client was encouraged to chew a piece of chewing stick. 4. Client was assisted to rinse her mouth with mouth wash. 5. client was given a bottle of malt 6.normal saline was not administered because vomiting was moderate	02/09/23 1:30pm	. Goal achieved as client reported that her nausea has stopped.	A.R

DATE / TIME	NURSING DIAGNOSIS	NURSING OBJECTIVE	NURSING ORDERS	NURSING INTERVENTIONS	TIME/ DATE	EVALUATION	SIGN
02/09/23 4:30pm	. Potential fluid volume deficit related to vomiting.	Client's vomiting will stop within one hour during labour as evidenced by; a. Client reporting that she is no longer vomiting. b. Midwife witnessing that client has stopped vomiting.	1. Reassure client that the vomiting will be resolved 2. Explain the physiology associated to the vomiting that, it is due to the pregnancy hormones. 3.Encourage client to eat light and dry diet 4.Encourage client to eat in order to gain energy. 5. Encourage client to take fluids	Client was reassured. 2. The physiology of vomiting was explained to her understanding. 3. Client was encouraged to eat porridge and biscuit 4.Client was encouraged to eat to gain energy. 5. Client was served with fluids at 500mls every 1 hours in bits.	02/09/23 1:30pm	. Goals fully met as Madam Winnifred verbalized that the vomiting has stopped. b. Midwife reported that client stopped vomiting	A.R

DATE / TIME	NURSING DIAGNOSIS	NURSING OBJECTIVE	NURSING ORDERS	NURSING INTERVENTIONS	TIME/ DATE	EVALUATION	SIGN
02/09/23 4:30pm	. Potential fluid volume deficit related to vomiting.	Client's vomiting will stop within one hour during labour as evidenced by; a. Client reporting that she is no longer vomiting. b. Midwife witnessing that client has stopped vomiting.	1. Reassure client that the vomiting will be resolved 2. Explain the physiology associated to the vomiting that, it is due to the pregnancy hormones. 3.Encourage client to eat light and dry diet 4.Encourage client to eat in order to gain energy. 5. Encourage client to take fluids	Client was reassured. 2. The physiology of vomiting was explained to her understanding. 3. Client was encouraged to eat porridge and biscuit 4.Client was encouraged to eat to gain energy. 5. Client was served with fluids at 500mls every 1 hours in bits.	02/09/23 1:30pm	. Goals fully met as Madam Winnifred verbalized that the vomiting has stopped. b. Midwife reported that client stopped vomiting	A.R

DATE TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTIONS	DATE / TIME	EVALUATION	SIGN
02/09/23 12:40pm	Fatigue related to stresses of labour	Madam Winnifred will be relieved of Fatigue within 12 hours as evidenced by 1. Client verbalizing that the fatigue has resolved.	1. Reassure client that she will regain her strength. 2. Encourage client to rest in between contractions. 3. Restrict the number of visitors. 4. Serve client with energy drinks. 5. Ensure conducive environment.	1. Client was reassured. 2. Client was encouraged to rest in between contractions. 3. Number of client's visitors was restricted. 4. Client was served with malt. 5. Client was encourage to	02/09/23 1:30pm	Goal achieved as client reported a feeling of wellness.	A.R

bath and lights was turn
off.

NURSING CARE PLAN FOR LABOUR

CHAPTER FOUR

PUERPERIUM

4.0 INTRODUCTION

This chapter consists of the care given to the client and the baby from the day of delivery till six weeks' postnatal period. Care plans drawn for the management of problems encountered during puerperium. During this period, the reproductive organs return to their non-pregnant stage and lactation initiated. Also health education, counselling, assessment, support for infant feeding and immunization service for baby is done.

4.1 DAY OF DELIVERY

Client delivered on 2nd September, 2023 at 8:30pm. Madam Winnifred and her baby were transferred to the lying in ward at 9:20pm. After the one-hour continuous skin to skin. They were closely observed for six hours postpartum. She was made comfortable in bed. Her vital signs were checked and recorded as follows:

Temperature	----------	36.6^{o}C
Pulse	----------	64bpm
Respiration	----------	21cpm
Blood pressure	----------	120/70mmHg

Her vital signs were checked every 15mins for 2 hours, 30 minutes for 1hour and hourly for the last 3 hours. The uterus was checked for involution and the perineum was also checked for bleeding during this time. Symphysio fundal height was 18cm and lochia was small and rubra, Madam Winnifred was encouraged to empty her bladder frequently to prevent

postpartum haemorrhage and also change her perineal pad when soaked with blood to prevent infection. Client was educated on how to massage her uterus by rubbing the palm on the fundus to help in the involution of the uterus and arrest of haemorrhage. She complained of after pains. She was told that the pain was as a result of contraction of the uterus and was encouraged to continue feeding her baby which would aid involution. She was given tablet paracetamol 1g start to control her pain. She was given vitamin A capsule 200,000 international unit. Madam Winnifred was served with malt which was brought to her by her mother-in law. She was also educated to breastfeed exclusively on demand and wash hands before breastfeeding. She breastfed her baby afterwards and her mother-in law was allowed to visit her. She took her bath and had a rest for some time.

4.2 SUBSEQUENT CARE OF THE BABY

The baby was bathed the next morning since the time due for the bath was midnight hours after observation with warm water. Head to toe examination was done and the cord was dressed with six sterile cotton wool swab soaked in spirit but no abnormality was detected. The baby was wrapped in a warm dry sheet to maintain body temperature and she was placed beside her mother to breastfeed. The vital signs were taken and recorded as follows;

Temperature	----------	36.6 degree Celsius
Apex beat	----------	132 beat per minute
Respiration	----------	40 count per minute

All findings were communicated to Madam Winnifred and recorded.

BABY BATHING

REQUIREMENTS

1. Soap
2. Sponge
3. Cream and powder
4. Sterile cotton in a gallipot or wrapped
5. Basin
6. Towels: 1 big towel and 3 small ones
7. Cot sheets 2
8. Apron
9. Gloves
10. A clean baby dress, cap and socks (if available)
11. Mackintosh
12. 2 jugs containing hot and cold water each
13. Two receptacles for used water and dirty linen
14. A receiver for used swab

The procedure was explained to mother and a tray was set. 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. She was undressed and wrapped in a big cot sheet. The eyes were cleaned with

cotton wool swabs soaked in clean water from inner canthus to outer canthus. Her face was cleaned with damp face towel and dried. The baby's neck was supported with one hand using two fingers of the hand to protect the ears and the head was washed with soapy sponge. With the body resting on the elbow and still supporting the nape of the neck, the baby was place at the edge of the bowl to rinse the soap off the head and dried. She 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. She was immersed in a bath of warm water with the head above the water and rinsed thoroughly. The baby was place 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, baby was dressed, wrapped and, given to mother to breastfeed. The waste materials were discarded according to infection prevention protocol. Gloves were removed and disposed of. Hands were washed with soap and water before handling the baby.

CORD DRESSING: After baby was bathed, the cord was dressed with cotton wool swabs soaked in methylated spirit, baby was wrapped in a towel to keep her warm and given to the mother. A tray containing a gallipot with cotton wool swabs soaked in methylated spirit, and a receiver was set. Procedure was explained to the mother. A protective apron was worn, nearby windows were closed and baby was kept on an examination table, still in mother's presence, keeping an eye on her, hands were washed thoroughly with soap and water and dried with a clean towel. Gloves were worn and cord was exposed. Cord was inspected for bleeding but it was not bleeding. A cotton wool swab was used to hold the tip of the forceps; the base of the cord was cleaned with cotton wool swab soaked in methylated spirit. The whole cord, front and back were cleaned with different sterile cotton wool soaked in methylated spirit from the base upwards. The tip of the cord was cleaned with a separate cotton wool swab; cord was then left exposed. The baby was wrapped with clean cot sheet

and given to the mother to breastfeed. Both gloved hands were immersed in 0.5% chlorine solution and it was removed. Hand washing was done with soap and water and dried with a clean towel.

4.3 FIRST DAY POSTNATAL (AT CLINIC DURING DISCHARGE)

3rd September, 2023 was the first day after delivery and Madam Winnifred and her baby looked healthy with no abnormality detected after head to toe examination at 9:30am. An enquiry about her bladder habit was asked, of which she said it was resuming to normal. Her vital signs checked and recorded as follows;

Temperature	----------	36.8^{o}C
Pulse	----------	73bpm
Respiration	----------	21cpm
Blood pressure	----------	110/80mmHg

The uterus was well contracted on palpation. Symphysio fundal height was 16cm. Permission was sought to inspect the perineal pad. The lochia was red (rubra) and the amount was small and not offensive. Mother complained of after pains. She was encouraged to change her perineal pad frequently to prevent ascending infections to the uterus. She was encouraged to practice exclusive breastfeeding on demand and educated on the importance of breast milk to her baby. Permission was sought to re-examine the baby. Hands were washed with soap and water and dried with clean dry towel. On general examination by the midwife in-charge there was nothing abnormal detected? For the baby, the cord was checked for bleeding and discharge and there was none. The mother was given education on how to top and tail the baby as well as normal bathing of the baby. The cord was dressed with six sterile cotton wool swabs soaked in methylated spirit. The baby passed meconium and urine which

was normal, the baby was dressed and put to breast. Madam Winnifred was educated on the effect of hot compress application on baby's head in other to close the fontanels and she was discouraged from doing so. Mother was educated on provision of warmth, prevention of infection and good nutrition. The baby was given first immunization, which was Bacillus Calmette Guerin (BCG) vaccine 0.05ml intradermal at the right upper arm to prevent tuberculosis and Oral Polio Vaccine 0 (OPV0) 2 drops at the back of the tongue to prevent poliomyelitis. The mother was advised not to apply anything at the injection site. Mother was also made aware that there would be a tissue reaction over the injection site and scar formation would take place which indicated that the baby had effectively been immunized against tuberculosis. Madam Winnifred was educated on maintaining temperature by wrapping baby as taught, immunization continuation at child welfare clinic, home care; that is practicing exclusive breastfeeding for six months on demand especially at night, that is either feeding every 2 to 4 hours or 8 to 12 times per a day, recognize and manage common breast problems such as engorgement, cracked nipples, and encouraged to report with mastitis. Client was further advised to keep the cord clean and to avoid using local herbs. She was also advised to complete immunization scheduled and recognizing danger signs like fever, refusal and difficulty in feeding. The mother was asked to report any offensive vaginal discharge. She was also encouraged to have enough rest, perform postnatal exercise and she was informed of her discharge. Routine drugs were prescribed as the protocol of the facility. The dosage and time drugs were to be taken were explained to her. She was assisted to pack her things and encouraged to register the baby at birth and death registry. Client was informed of continuity of care for seven days where she would be visited at home. She was discharged home at 11:30am on the following drugs. Client was told that she would be visited for the first seven days in the morning and in the evening.

Tablet paracetamol 1g daily for 3 days

Tablet folic acid 5mg daily for 14days.

Tablet multivitamin 200mg daily for 14 days

Tablet ferrous Sulphate 200mg once daily for 14 days. Baby's vital signs and weight were checked and recorded as;

Temperature ……. 36.0degrees Celsius

Apex beat …….132 beat per minute

Respiration …….38 cycle per minute

Weight ……. 2.9kilogram

FIRST ANTENATAL HOME VISIT

In the evening, at 4:30pm client was visited as said. Mother's vital signs were checked and recorded as

Temperature …… 36.7 degrees Celsius

Respiration ……. 21 cycles per minute

Pulse ……. 76 beat per minute

Blood pressure …… 120/70 millimeters of mercury

Client was allowed to ask questions, in the absence of none, permission was sought to leave. Client and baby were in good condition. Baby's vital signs in the evening were recorded as

Temperature …… 36.2 degree Celsius

Apex beat ……... 120 beat per minute

Respiration …….. 34 cycle per minute

4.4. SECOND POST NATAL HOME VISIT (SECOND DAY POST NATAL)

Madam Winnifred and her baby were visited on 4th September, 2023 at 7:00am. Both mother and baby looked healthy on arrival to their house. Greetings were exchanged and client was informed of the procedures to be carried out. Hands were washed and dried. The baby was top and tailed, head to toe examination was done and no abnormality was detected. Baby passed meconium and urine during topped and tailed. The Cord was also dressed with six cotton wool swabs and methylated spirit using aseptic technique; it was clean, dry and not offensive. The baby was dressed, wrapped and was given to clients' mother in-law. Madam Winnifred 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 and the Symphysio -fundal height was 14 centimeters. The perineum was clean dry and intact, lochia was small red (rubra) and not offensive. Client complained of perineal pain at 7:20am. She was reassured and educated that it was as a result of tissue trauma during delivery. Her vital signs were checked and recorded as follows;

Temperature	----------	36.7degree Celsius
Pulse	----------	77beats per minute
Respiration	----------	21cycles per minute
Blood pressure	----------	110/80millimeters of mercury

Baby was given to mother to breast feed. Baby was able to suck well.

The baby's vital signs and weight were recorded as follows:

Temperature	----------	36.5degree Celsius

Respiration	----------	40cpm
Apex beat	----------	132bpm
Weight	----------	2.8kg

Madam Winnifred was educated on family planning, danger signs in the newborn such as breathing difficulties, cyanosis, persistent vomiting, fever and weak cry. Client and husband were congratulated and permission was sought to leave and she was informed that she would be visited in the evening.

At 4:30pm, client was visited again. Client, the baby and the family looked healthy on arrival. The family had finished having their supper, client had no complaints. Permission was sought to leave and she was informed of the next home visit being the next day, mother was reminded to top and tail baby. Baby's vital signs was checked and recorded as

Temperature …….36.3 degrees Celsius

Apex beat …….130 beat per minute

Respiration …….40 cycle per minute

Mother's vital signs were checked and recorded as

Temperature ……. 37.0 degrees Celsius

Pulse ……. 80 beat per minute

Respiration ……. 22 cycle per minute

Blood Pressure ……. 110/90 millimeters of mercury

4. THIRD POSTNATAL HOME VISIT (THIRD DAY POST NATAL)

On 5th September, 2023 at 7:30am, Madam Winnifred was visited to assess both baby and mother. On observation, the general condition of the family was good. The procedure to be carried out was explained to her. The Symphysio-fundal height was 12cm. The perineum was inspected and it was clean, dry and intact with small bright red lochia (rubra) and not offensive. Her vital signs were checked and recorded as follows;

Temperature	----------	36.5^{o}C
Pulse	----------	74bpm
Respiration	----------	20cpm
Blood pressure	----------	110/70mmHg

The baby was examined from head to toe. The baby was top and tail. The cord was dressed with methylated spirit and six cotton wool swab and mother was taught how the cord should be dressed but no abnormality was detected. Mother was reminded not to put anything on the cord, such as herbs and cow dawn. The baby passed urine during top and tail but did not pass stool. Baby was given to mother to breastfeed and suckling was good as well as mother position. The breast was also lactating well. The baby's vital signs and weight were checked and recorded as;

Temperature	----------	36.4^{oC}
Apex beat	----------	130bpm
Respiration	----------	43cpm
Weight	----------	2.7kg

Madam Winnifred did not have any complain. Permission was sought to leave and she was informed that she would be visited in the evening. At 4:30pm, client was visited again. Client, the baby and the family looked healthy on arrival. The family had finished having their supper, client had no complaints. Baby was top and tailed. Permission was sought to leave and to visit them the next day. Baby's vital signs were checked and recorded as

Temperature …… 36.7 degree Celsius

Apex beat ……. 128 beat per minute

Respiration …… 41 cycle per minute

Mother's vital signs was checked and recorded as

Temperature ……. 37.0 degrees Celsius

Pulse ……. 76 beat per minute

Respiration …… 21cycle per minute

Blood Pressure ……. 110/70 millimeters of mercury

4.6 FOURTH POSTNATAL HOME VISIT (FOURTH DAY POST NATAL)

The third home visit was on the 6th September 2023 at 7:30am. Client, baby and family were doing well. Her perineal pad was inspected. The flow of lochia was small, pinkish in colour (serosa) and not offensive. Client said perineal pain had stopped when asked. Head to toe examination was conducted and mother complained of backache. The Symphysio fundal height measured 10centimeters.Her vital signs were;

Temperature	----------	36.8^{OC}
Respiration	----------	19cpm

Pulse	----------	80bpm
Blood pressure	----------	110/70mmHg

Mother was told to top and tailed baby under supervision which she did it well. Head to toe examination was done on the baby and baby had heat rashes on the skin. Baby's cord was dressed with six cotton wool swabs and methylated spirit and the cord was dry not offensive. The baby passed urine and stools which was brownish yellow in colour. The baby's vital signs and weight were checked and recorded as follows:

Temperature	----------	36.4 degree Celsius
Apex beat	----------	138beat per minute
Respiration	----------	41 count per minute
Weight	----------	2.6kilogram

Client was thanked for her cooperation and support. She was advised to take her routine drugs. Permission was sought to leave and she was informed that she would be visited the next day.

4.7 FIFTH POSTNATAL HOME VISIT (FIFTH DAY POST NATAL)

Madam Winnifred was visited again on 7th September, 2023 at 7:30am; mother, baby and family looked healthy on arrival. Baby had already been top and tailed so head to toe examination was carried out and the baby was normal. Baby's cord was dressed with six 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 8cm, perineum was clean and intact. Lochia was small, serosa and not offensive. The breast was lactating well. She was reassured and educated on other positions

used in breastfeeding such as lying on her side to breastfeed. Her vital signs were checked and recorded as follows:

Temperature	----------	36.5 degree Celsius
Pulse	----------	78 beat per minute
Respiration	----------	21 count per minute
Blood pressure	----------	110/60mmHg

The baby's vital signs and weight were checked and recorded as follows:

Temperature	----------	36.4 degree Celsius
Apex beat	----------	136 beat per minute
Respiration	----------	40 count per minute
Weight	----------	2.6kilogram

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.

4.8 SIXTH POSTNATAL HOME VISIT (SIXTH DAY POST NATAL)

On 8th September, 2023, Madam Winnifred was visited at 7:30am. Mother and baby looked healthy on arrival. Baby was bathed and head to toe examination was done but no abnormality was detected. The cord was off, the stump was dressed with cotton wool swab and methylated spirit, and it was dry and not offensive. No abnormality was detected. Madam Winifred was also examined from head to toe. The Symphysio Fundal height was 6cm, perineum was clean and lochia was small serosa in colour and not offensive on examination.

Madam Winnifred's vital signs were checked and recorded as follows:

Temperature	----------	36.8^{o}C
Pulse	----------	80bpm
Respiration	----------	20cpm
Blood pressure	----------	120/70mmHg

Baby was given to mother to breastfeed and baby's suckling was good, mother sat up in an upright position. Baby's vital signs recorded as follows:

Temperature	----------	36.6^{o}C
Apex beat	----------	130cpm
Respiration	----------	40cpm
Weight	----------	2.7kg

Mother was encouraged to continue with breastfeeding, expression of breast milk if baby was unable to empty breast. She was also educated on the importance of attending child welfare clinic for growth monitoring and immunization. Permission was sought to leave.

4.9. SEVENTTH POSTNATAL HOME VISIT (SEVENTH DAY POST NATAL)

On 9th September, 2023 at 7:00am, Madam Winnifred was visited mother and baby looked healthy on arrival. The whole family was also in good health. Procedures to be done were explained to her. Head to toe examination was done on the baby and there was no abnormality detected. The mother's Symphysio fundal height was not palpable. The perineal

pad was inspected and the flow was scanty and pinkish in colour and not offensive. Her vital signs were also checked and recorded as follows:

Temperature	----------	36.5^{oc}
Pulse	----------	69bpm
Respiration	----------	18cpm
Blood pressure	----------	120/60 mmHg

The baby was bathed and the umbilical stump was cleaned with cotton wool swab and methylated spirit. The baby looked healthy and active. Head to toe examination was done and no abnormality was detected. The cord stump was clean, dry and not offensive. The baby's vital signs were checked and recorded as follows;

Temperature	----------	36.4^{oc}
Pulse	----------	127bpm
Respiration	----------	35cpm
Weight	----------	2.8 kg

Client was encouraged to continue with the exclusive breast feeding and exercise. Client and her family were thanked for their time and cooperation. Client was informed of termination of care on the seventh day. We interacted for a while and permission was sought to leave. She was however informed of the last home visit being the next day.

4.11. FIRST POST NATAL VISIT TO THE CLINIC

On 10th September, 2023, Madam Winnifred and her baby came to the hospital at 10:00am. They were welcomed and a seat was offered to her. Client and baby were looking healthy and neatly dressed. The purpose of this visit was to assess the physical and psychological well-being of the mother and child. Client was asked how she and family were coping with the newborn, workload, rest and sleep. General observation was made on her gait, mood and behavior towards baby and all were good. Her consent was sought for the procedure to be carried out on her and the baby. She was asked to empty her bladder and a sample of urine was taken to test for glucose and protein and all tested negative. Her vital signs and Haemoglobin level were checked and recorded as below;

Temperature	----------	36.7^{o}C
Pulse	----------	80bpm
Respiration	----------	20cpm
Blood pressure	----------	120/70mmHg
Haemoglobin level	----------	11.8g/dl.

Privacy was provided and Madam Winnifred was helped to undress and lie on the examination bed. Hands were washed with soap under running water and dried with a clean dry towel.

Head to toe examination was done on her. On the head, her hair was neat. The conjunctiva was pink, no discharges from the eyes, nose and ears. There was no abnormality detected in the mouth, and there was absence of enlarged nodes on the neck. Breast was lactating well, no engorgement, sore or cracked nipples were detected. The abdomen was firm, there was no tenderness, no scars, enlarged liver or spleen on examination. The uterus was well contracted.

There was no oedema, varicosities and tenderness in calf muscle. The perineum was intact and there was no offensive vaginal discharge and the lochia was small and the colour was alba. She was thanked for the cooperation and helped to dress up. Her baby was also examined from head to toe and no abnormality was detected. The umbilical stump was inspected and it was healed. The baby was lively and active.

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

Temperature	----------	36.4^{oc}
Apex heart beat	----------	136bpm
Respiration	----------	38cpm
Weight	----------	3.1 kg

Mother was encouraged to ask questions but she said there was none and no complaints were made. Client was educated on exclusive breastfeeding and importance of attending child welfare clinic. All findings were recorded and communicated to mother. She was informed of the six weeks' post-natal visit. Madam Winnifred was thanked and accompanied to the clinic entrance.

TERMINATION OF CARE

Explanation was given to Madam Winnifred on the need to be handed over to the midwife in-charge for continuity of care on 10th September, 2023, at 11:00 am. Explanation was made to her that our program was ending on the 13th September, 2023 but client was reassured of midwife in-charge's competency. Client was accompanied to her house and a seat was offered. Client and her husband were thanked for their cooperation, information provided, they were reminded to register the baby at birth and death registry. And also to complete baby's immunization scheduled and permission was sought to leave.

4.12 SECOND POSTNATAL VISIT TO THE CLINIC

According to the midwife in charge, Madam Winnifred reported on 13th September, 2023 for six weeks' postnatal care. There was no abnormality detected on examination. The client and the baby were fine. Mother's vital signs recorded as follows:

Temperature	----------	36.50^{c}
Pulse	----------	78bpm
Respiration	----------	21cpm
Blood pressure	----------	110/70bpm

The baby was given the due vaccination that was oral polio 1, Penta 1(diphtheria, hepatitis B, tetanus, pertussis and homophiles influenza B), 0.5mls intra muscularly at left lateral thigh, pneumococcal vaccine 0.5mls at right lateral thigh (protection against pneumonia) and rotavirus 1.5mls orally was given (protection against diarrhea) was given. Madam Winnifred was informed of the side effect and encouraged to report to the facility any time she encountered any health related problems.

The baby's vital signs and weight were checked and recorded as follows:

Temperature	----------	36.6^{0c}
Apex beat	----------	135bpm
Respiration	----------	41cpm
Weight	----------	5.6kg

According to the midwife in-charge client was handed over to the community health nurse of the hospital. They went to the facility to meet the community health nurse and were offered a seat on arrival.

Introduction was made. She asked of their mission and explanation was made to her that Madam Winnifred was cared for through antenatal, delivery to six weeks postpartum and it was time to officially hand her over to them for continuity of care. The nurse reassured client that she was in safe hands and their readiness to continue caring for her and her baby. The schedule for child welfare clinic and immunization were explained to her and client had no questions when asked. They were thanked and permission was sought to leave

4.13 CARE PLAN DURING PUERPERIUM

On 3rd September, 2023

1. After pains

On 5th September, 2023

2. Perineal pain

On 9th September, 2023

3. Backache
4. Rashes on baby's skin.

SHORT TERM OBJECTIVES

1. Madam Winnifred after pains will reduce within 48 hours.
2. Client will be relieved of perineal pain within 48 hours
3. Client will be relieved of backache within 24 hours.
4. Baby will be relieved of skin rashes within 5 days.

LONG TERM OBJECTIVES

Madam Winnifred and her baby will have a safe and normal puerperium without any complications.

PUERPERIUM CARE PLAN

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
3/12/23 1:00pm	After pains related to uterine involution.	Client after pains will reduce within 48 hours as evidenced by client verbalizing her pain has reduced.	1. Reassure the client that her pain is a sign of involution of the uterus and it will go with time. 2. Encourage client to empty her bladder frequently. 3. Encourage client to continue breastfeeding 4. Encourage client to lie face down with pillow under abdomen.	1. Client was reassured that the pain was a sign of involution of the uterus and it would go with time. 2. Client was encouraged to empty her bladder frequently. 3. Client was encouraged to continue breastfeeding. 4. Client was encouraged to lie face down with pillow under abdomen.	5/12/23 1:00pm	Goal met as client reported that her pain reduced.	A.R

PUERPERIUM CARE PLAN CONT'D

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
			5. Encourage client to walk around or change position.	5. Client was encouraged to walk around or change position in bed.			
			6. Encourage relatives to support client.	6. Relatives were encouraged to help client with her household chores.			
			7. Serve prescribed analgesic.	7. Tablet paracetamol1gram was served when in pain			

PUERPERIUM CARE PLAN CONT'D

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES / OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUA-TION	SIGN

5/09/23 7:20am	Perineal pain related to tissue trauma during delivery.	Client will cope with perineal pain within 48 hours as evidence by client verbalizing that her pain has subsided.	1. Encourage client to maintain good perineal hygiene. 2. Encourage client to do warm sit bath. 3. Encourage client to breastfeed by lying down or sit on a cushion 4. Educate client to eat more protein, vegetables and fruits. 5. Administer prescribed analgesic.	1. Client was encouraged to maintain good perineal hygiene. 2. Client was encouraged to do warm sit bath. 3. Client was encouraged to breastfeed by lying down or sit on a cushion 4. Client was educated to eat protein, vegetables and fruits example orange and kontomire. 5. Paracetamol 1 gram was served to client.	7/09/23 7:20am	Goal achieved as client told the midwife that her perineal pain subsided.	A.R

PUERPERIUM CARE PLAN CONT'D

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVE/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUA-TION	SIGN
7/09/23 7:00am	Backache related to poor breastfeeding posture	Client will be relieved of backache within 24 hours as evidence by client verbalizing that pain is no more.	1. Reassure client that she will be relived of backache. 2. Educate client on the correct sitting positions used in breastfeeding. 3. Educate client to use other methods of breastfeeding. 4. Educate client on the use of warm compress. 5. Encourage client to support her back with pillows when breast feeding. 6. Educate client to support her breast.	1. Client was reassured that she would be relieved of backache. 2. Client was educated to sit up right with her back supported and support one leg on a chair. 3. Client was educated to lie down when feeding the baby. 4. Client was educated on the use of warm compress at her back. 5. She was encouraged to support her back with pillows when breast feeding. 6.Client was encouraged to wear well-fitting brassier	9/09/23 7:00am	Goal met as client verbalized that her back pain was no more.	A.R

PUERPERIUM CARE PLAN CONT'D

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES / OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
9/08/23 7:00 am	Heat rashes related to poor ventilation	Baby will regain normal skin within 5days as evidence by 1. Mother verbalizing that rashes are no more. 2. Midwife observing that the baby rashes have disappeared.	1. Reassure mother that the rashes will disappear. 2. Educated mother to dress baby well. 3. Advice mother to apply powder to baby's skin. 4. Encourage mother to use baby soaps when bathing baby. 5. Educate mother to wrap baby with light cloths. 6. Encourage client to dry baby's clothes in the sun and open windows for ventilation.	1. Client was reassured that the rashes would disappear. 2. Mother was educated to dress baby with cotton cloths. 3. Mother was advised to apply baby powder to baby's skin. 4. Mother was encouraged to use baby soaps when bathing baby. 5. Mother was educated to wrap baby with light cotton cloths. 6. Client was encouraged to dry baby's clothes in the sun to open windows for ventilation.	10/09/23 7:00am	Goal partially met as mother verbalized that baby's rashes had reduced. 2. Midwife observed that the rashes had reduced on examination.	A.R

SUMMARY AND CONCLUSION

The family care study was performed on Madam Mensah Winnifred and her family. She was gravida2 Para 1. She was 23 years old and a Christian. Madam Winnifred was first met on 14th August, 2023, at Gyedu Health Centre - Gyedu, when she came for her regular antenatal visit to the hospital. She was welcomed and offered a seat. Her antenatal book was checked and realized that she was due for antenatal and she fell within the criteria for the study. Client was 37weeks plus 3 days pregnant and it was her seventh antenatal visit. She was managed through pregnancy, labour and puerperium safely through which all minor disorders were taken care of, using the nursing care plan and goals were met when evaluated. She had a spontaneous vaginal delivery to a life female baby on 2nd September, 2023 and discharged the next day. Client and family were visited for the first seven days after delivery and all problems identified were solved using the Nursing Process. She visited the clinic on her first week and six weeks postnatal. Madam Winnifred was given a focused and comprehensive care throughout her pregnancy, labour and puerperium and she was handed over to the community health nurse at the facility for continuity of care in good condition on 13th September, 2023. Client and her family were much grateful at the end of the study. In conclusion, the family centered maternity care has afforded the student midwife the opportunity to identify the various needs of the individual during pregnancy, labour and puerperium and put the knowledge acquired to practice. This knowledge acquired has given the graduand a better understanding of the care of the client and this will be translated to others in the course of her career as a midwife.

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APPENDIX 1

COMPLETE DIAGNOSTIC INVESTIGATIONS DURING ANTENATAL

DATE	SPECIMEN	INVESTIGATION	NORMAL RANGE	FINDINGS	REMARKS
10/07	Blood	Haemoglobin level	12.0g/dl- 16g/dl	12.4g/dl	Normal
		Sickling	Positive /Negative	Negative	Normal
/2023		Grouping	A, B, AB, O	B	Normal
		Rhesus	Negative/Positive	Positive	Normal
		PMTCT	Negative	Negative	Normal
		Syphilis	Negative	Negative	Normal
	Urine	Protein	Negative	Negative	Normal
		Sugar	negative		

COMPLETE DIAGNOSTIC INVESTIGATIONS DURING ANTENATAL

DATE	SPECIMEN	INVESTIGATION	NORMAL RANGE	FINDINGS	REMARKS
01/06/2023					Normal
	Urine	Protein	Negative	Negative	Normal
		Sugar	Negative	Negative	Normal
10/07/2023					Normal
	Urine	Protein	Negative	Negative	Normal
		Sugar	Negative	Negative	Normal

31/07/2023					Normal
	Urine	Protein	Negative	Negative	Normal
		Sugar	Negative	Negative	Normal

COMPLETE DIAGNOSTIC INVESTIGATIONS DURING ANTENATAL CONTINUE

14/08/2023	Blood	Haemoglobin	12.og/dl-16. og/dl		
	Urine	Protein	Negative	Negative	Normal
		Sugar	Negative	Negative	Normal
28/08/2023	Blood	Haemoglobin level	12.og/dl-16. og/dl	12.6g/dl	Normal
	Urine	Protein	Protein	Negative	Normal

Sugar	Negative	Negative	Normal

APPENDIX II

PHARMACOLOGY OF DRUGS FOR THE MOTHER

NAME OF DRUG	CLASSIFICA - TION	DOSAGE	ROUTE	ACTION AND USES	ACTUAL EFFECT	SIDE EFFECT	SIDE EFFECT EXPERIENCED
Tablet	Vitamin	200 milligram	Oral	Helps in formation of red blood cells and increase	Increase	Gastrointestinal	None

multivitamin	Preparation	once daily		appetite	appetite	disturbance	
Tablet folic acid	Vitamin preparation	5 milligram once daily	Oral	Helps in formation of red blood cells and prevent neural tube defect.	Increase Haemoglobin level	Nausea and vomiting	None
Tablet ferrous Sulphate	Hematinic	200 milligram	Oral	Helps in formation of red blood cells	Increase Haemoglobin level.	Gastrointestinal disturbance	Dark stools

PHARMACOLOGY OF DRUGS FOR THE MOTHER

NAME OF DRUG	**CLASSIFICA-TION**	**DOSAGE**	**ROUTE**	**ACTION AND USES**	**ACTUAL EFFECT**	**SIDE EFFECT**	**SIDE EFFECT EXPERIENCED**

Tablet Sulfadoxine Pyrimethamine	Anti- malaria (prophylaxis)	3 tablets start at 16weeks/ after quickening and other 4 doses 4 weeks interval.	Oral	Treatment and prevention of malaria.	Malaria was prevented	Nausea, itching, weakness, insomnia and headache	Nausea
Tablet paracetamol	Analgesic and antipyretic	100 milligram 3 times daily for 3 days	Oral	Helps to reduce increased body temperature and pain	Pain was reduced	Liver damage	None

PHARMACOLOGY OF DRUGS FOR THE MOTHER CONTINUE

NAME OF	CLASSIFICA-	DOSAGE	ROUTE	ACTION AND USES	ACTUAL	SIDE	SIDE EFFECT

DRUG	TION				EFFECT	EFFECT	EXPERIENCED
Injection oxytocin	Oxytocic drug	10 units	Intramuscular	Stimulate contractions	Client had contractions	Vomiting and pressure	None
Capsule vitamin A	Group A vitamin supplement	200,000 IU once daily	Oral	Growth, development and proper sight	Good eye sight and healthy skin	Vomiting	none

PHARMACOLOGY OF DRUGS FOR BABY

NAME OF DRUG	CLASSIFICATION	DOSAGE	ROUTE	ACTION AND USES	ACTUAL EFFECT	SIDE EFFECT	SIDE EFFECT EXPERIENCED
Vitamin k_1	Coagulant	1ml	Intramuscular	Production of prothrombin to prevent haemorrhage	Prevention of hemorrhagic diseases of the new born	None	None
Tetracycline eye drop	Antibiotic	2 drops	Instillation into the eye	To prevent infection of the eye	Prevention of eye infection	None	None
Oral polio vaccine 0	Antigen	2 drops	Oral	To stimulate the body to produce antibodies against poliomyelitis	Prevention of poliomyelitis in children	There may be diarrhea	None
Bacillus Calmette Guriene	Antigen	0.05	Intradermal	To stimulate the body to produce antibodies	Prevention of tuberculosis	Blister formation at the injection site.	Blister formation

(BCG)				against tuberculosis			

PHARMACOLOGY OF DRUGS FOR BABY CON'T

NAME OF DRUG	CLASSIFICATION	DOSAGE	ROUTE	ACTION AND USES	ACTUAL EFFECT	SIDE EFFECT	SIDE EFFECT EXPERIENCED
Oral polio 1	Antigen	2 drops	Oral	To stimulate the body to produce antibodies against poliomyelitis	Prevention of poliomyelitis in children	There may be diarrhoea	None
Penta 1	Antigen	0.5 mls	Intramuscular	To stimulate the body to produce antibodies against diphtheria, hepatitis B, tetanus, pertussis and haemophilus influenza B	Prevention of diphtheria, hepatitis B, tetanus, pertussis and haemophilus influenza B	Fever	Fever
Pneumococ	Antigen	0.5 mls	Intramuscular	To stimulate the body to produce	Prevention of	None	None

cal 1				antibodies against pneumonia	pneumonia			
Rotarix 1	Antigen	1.5 mls	Intramuscular	To stimulate the body to produce antibodies against Rota virus	Prevention of diarrhea	None	None	

APPENDIX III

ANTENATAL RECORDS

DATE	**TEMPE-RATURE**	**BP (mmHg)**	**Wt. (Kg)**	**URINE: SUGAR AND PROTEIN**	**GESTA-TION**	**FUNDAL HEIGHT (cm)**	**PRESEN-TATION**	**DES-CENT**	**FETAL HEART RATE (bpm)**	**COM-PLAINS**	**TREAT-MENT**	**RE-MARKS**
17/3/23	36.7	100/50	63	Negative/ Negative	16	13	–	–	–	No complains	Tab folic acid. Tab ferrous sulphate Tab multivite	
14/4/23	36.0^{OC}	100/50	65	Negative/ Negative	20+1 weeks	19	_	_	158	No complains	Tab folic acid.	Healthy

												Tab ferrous sulphate. Tab multivite	
12/5/23	36.4 ^{OC}	110/60	66	Negative/ Negative	24+1 weeks	24	_	_	154	No complains	Tab folic acid. Tab ferrous sulphate. Tab multivite	Healthy

ANTENATAL RECORDS CONT'D

DATE	TEMPE-RATURE	BP (mmHg)	Wt Kg	URINE: SUGAR AND PROTEIN	GESTA-TION	FUNDAL HEIGHT (cm)	PRESEN TATION	DES-CENT	FETAL HEART RATE (bpm)	COM-PLAINS	TREATMENT	RE-MARKS
01/06/23	36.1^{OC}	110/50	68	Negative/ Negative	28weeks	25	Cephalic	_	148	_	Tab folic acid. Tab ferrous sulphate. Tab multivite Tab Sulfadoxine Pyrimethamine	Healthy
10/07/23	36.0^{OC}	110/60	66	Negative/ Negative	35+3 weeks	29	Cephalic	_	Positive	_	Tab folic acid. Tab ferrous sulphate. Tab multivite Tab Sulfadoxine Pyrimethamine	Healthy

ANTENATAL RECORDS CONT'D

DATE	TEMPE-RATURE	BP (mmHg)	Wt. (Kg)	URINE: SUGAR AND PROTEIN	GESTA-TION	FUNDAL HEIGHT (cm)	PRESEN-TATION	DES-CENT	FETAL HEART RATE (bpm)	COM-PLAINS	TREATMENT	RE-MARKS
31/07/23	36.7^{OC}	100/50	66	Negative /Negative	35+3 weeks	30	Cephalic	_	141	_	Tab folic acid. Tab ferrous sulphate. Tab multivite Tab Sulfadoxine Pyrimethamine	Healthy
14/08/23	36.5^{OC}	110/60	68	Negative/ Negative	37+3 weeks	31	Cephalic		150	_	Tab folic acid. Tab ferrous sulphate. Tab multivite	Healthy

Tab
Sulfadoxine
Pyrimethamine

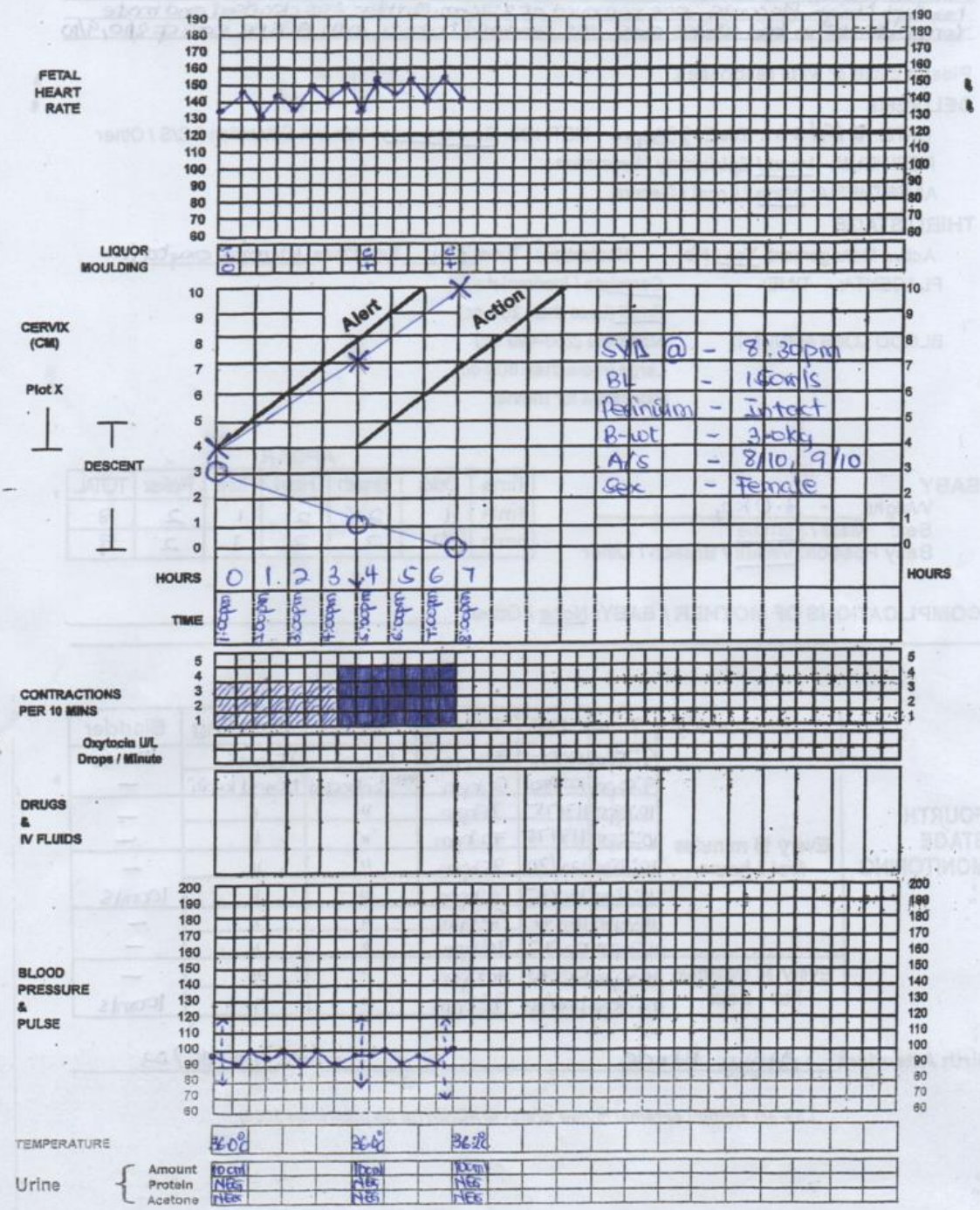
ANTENATAL RECORDS CONT'D

DATE	TEMPERATURE	BP (mmHg)	WT (KG)	URINE: SUGAR AND PROTEIN	GESTATION	FUNDAL HEIGHT (CM)	PRESENTATION	DESCENT	FETAL HEART RATE (bpm)	COMPLAINS	TREATMENT	REMARK
28/08/23	36.2	115/70	69	Negative/ Negative	39+3 weeks	35	Cephalic	_	Positive	Backache Increased frequent micturition	Tab folic acid Tab ferrous sulphate Tab multivite	Healthy

INTERMITENT PREVENTIVE TREATMENT(IPT) FOR MALARIA	1st dose SP 3tabs (directly observed Therapy) 17/03/2023	Gestational age (16 weeks)	2nd dose (1 month) after 1st dose(Directly observed Therapy) 14/04/23	Gestational age in weeks 20+1	3rd dose (1 month) after 2nd dose (directly observed Therapy) 12/03/23	Gestational age in weeks 24+1
	4th dose (1 month) after 3rd dose (directly observed Therapy) 1/06/23	Gestational age 28 weeks	5th week dose (1month) after 4th dose (directly observed Therapy) 10/07/23	Gestational age in weeks 32+3		

WHO Modified Partograph

Registration No. 104/23 Name (Last, First) Mensah, Winnifred Age 23
Date 2/9/23 Parity/Gravida 1 / 2 LMP 22/11/22 EDD 29/8/23 Gestation (wks) 40+1
ROM (Time, Date) / Labour Durable (Hrs) 7hrs 35 Facility/Clinic Name Gyedu Health Centre



LABOR NOTES

On 2nd September 2023 a client G2P1 reported to the facility at 12:40pm accompanied by her mother in-law. client complained of labour pains. On examination, SFH-26cm, FHR-130bpm, Presentation was cephalic. Descent was 3/5. On vaginal examination at 1:40pm, cervix was 4cm dilated with membranes intact. Monitoring was well done. At exactly 8:30, client ~~started~~ delivered an alive female baby which was placed on her abdomen. Baby cried and was wrapped, Cord clamped and cut and sex shown to the mother. 10 units oxytocin was given to mother on her left thigh. Placenta was removed at 8:36pm. Mother was cleansed and made comfortable in bed whiles care was rendered to baby with APGAR score of 8/10, 9/10

Please circle or write responses.

DELIVERY

DATE: 2/9/23 TIME: 8:30pm METHOD: Spontaneous / Vacuum Extraction / C/S / Other

PERINEUM: Intact / Episiotomy / Laceration

ANESTHESIA: None / Local / General

THIRD STAGE

Active Management: Yes / No Medication: Time 8:31 Type/Dose 10 units oxytocin

PLACENTA: TIME: Complete / Incomplete

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

BABY

Weight: 3.0kg

Sex: Male / Female

Baby Position: Vertex / Breech / Other

APGAR

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

COMPLICATIONS OF MOTHER / BABY: None / Other:

FOURTH STAGE MONITORING

Frequency	Time	B/P.	Pulse	Fundus	Bleeding	Bladder
Every 15 minutes first 2 hours	9:35pm	120/70	72bpm	18cm	150mls	100mls
	9:50pm	120/70	80bpm	Well contracted	Normal lochia	—
	10:05pm	118/75	80bpm	〃	〃	—
	10:20pm	118/75	72bpm	〃	〃	—
	10:35pm	124/80	85bpm	〃	〃	—
	10:50pm	120/85	80bpm	〃	〃	100mls
	11:05pm	116/74	92bpm	〃	〃	—
	11:20pm	120/75	76bpm	〃	〃	—
Every 30 minutes For 1 hour	11:50pm	120/70	70bpm	〃	〃	—
	12:20pm	126/75	96bpm	〃	〃	100mls

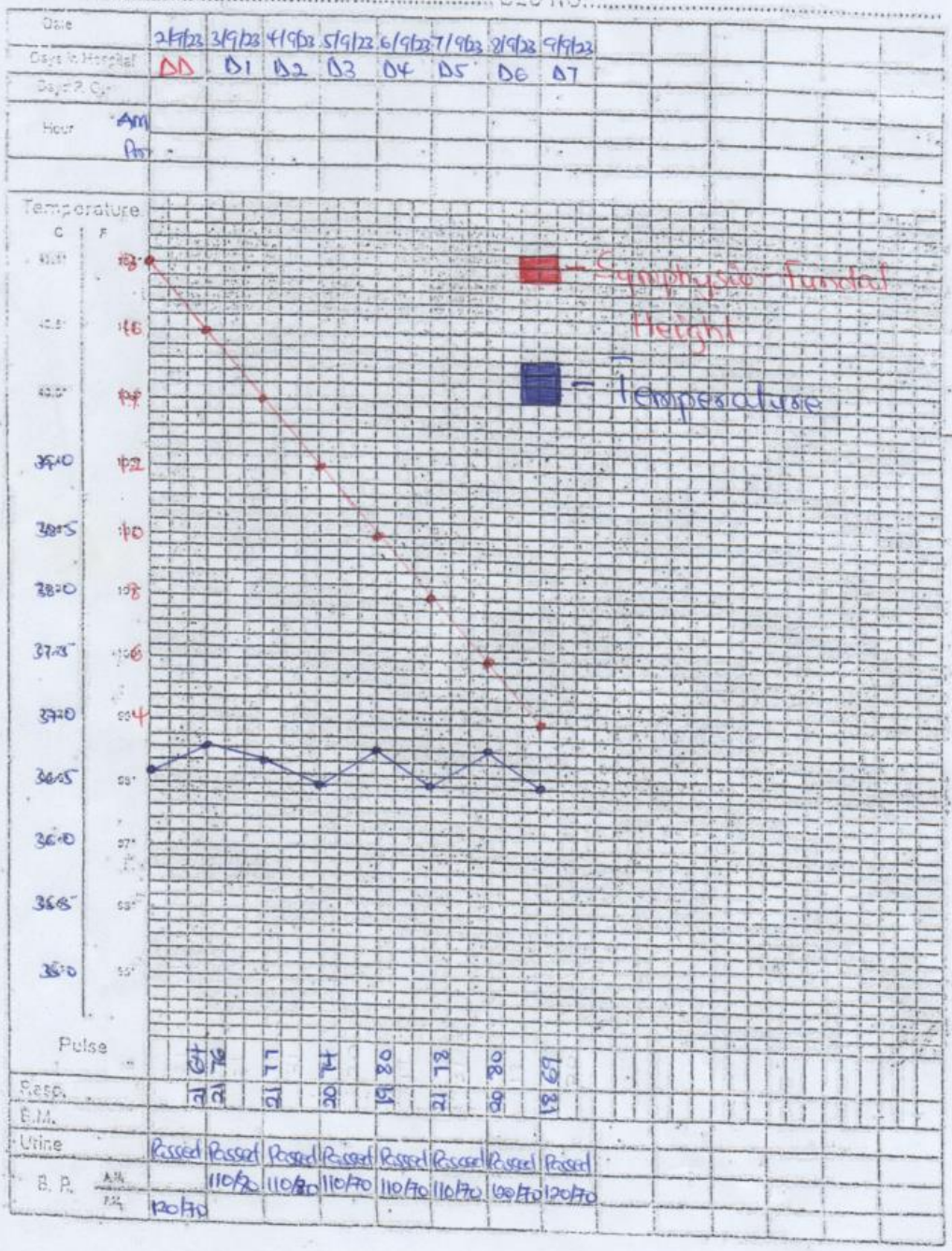
Birth Attendant Ativui. Rhoda Date 02/09/23

MATERNITY CHART

NAME: Mensah Winnifred

AGE: 23years WARD: Lying-In

IP NO.: BED NO.:



NEW BORN EXAMINATION FORM

Name: Baby Winnifred Date of Assessment: 2/9/23. Time: 9:00

Date of Birth: 2/9/23 Time of Birth: 8:30pm Sex: ☐ M ☑ F Age at time of Assessment (days/hrs) _____

Astational Age ☐ 40+1 ☐ Mode of Delivery: ☑ Vaginal Assisted Vaginal C-Section

APGAR: 1min 2 ☐ 5min ☐ 9 Birth Weight: ☐ 3.0 kg ☐ Length: 50 cm Head Circumference: 33 cm

Temperature at time of Assessment: 36.3 °C Urine passed: Yes No Meconium passed: Yes No

Name of Assessor (Midwife/Doctor): _____

1. Respiration
Rate 42cpm
- ☐ 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) _____

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 Winnifred Date of Assessment: 3/09/23 Time: _____

Date of Birth: 2/9/23 Time of Birth: 8:3cpm Sex: ☐ M ☑ F Age at time of Assessment (days/hrs) 1day

Astational Age ☐ 40+1 ☐ Mode of Delivery: ☐ Vaginal Assisted Vaginal C-Section

APGAR: 1min 8 ☐ 5min ☐ 9 Birth Weight: ☐ 3.9 kg ☐ Length: 50 cm Head Circumference: 33 cm

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

Name of Assessor (Midwife/Doctor): _____

1. Respiration
Rate 35
- ☐ 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
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- ☐ Subconjunctival bleed
- ☐ White pupil or cornea
- ☐ Eye discharge
- ☐ Other

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

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

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

16. Clavicle
- ☑ Normal
- ☐ Swelling/Fracture

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

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

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

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 clitoris *
- ☐ 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) _____

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

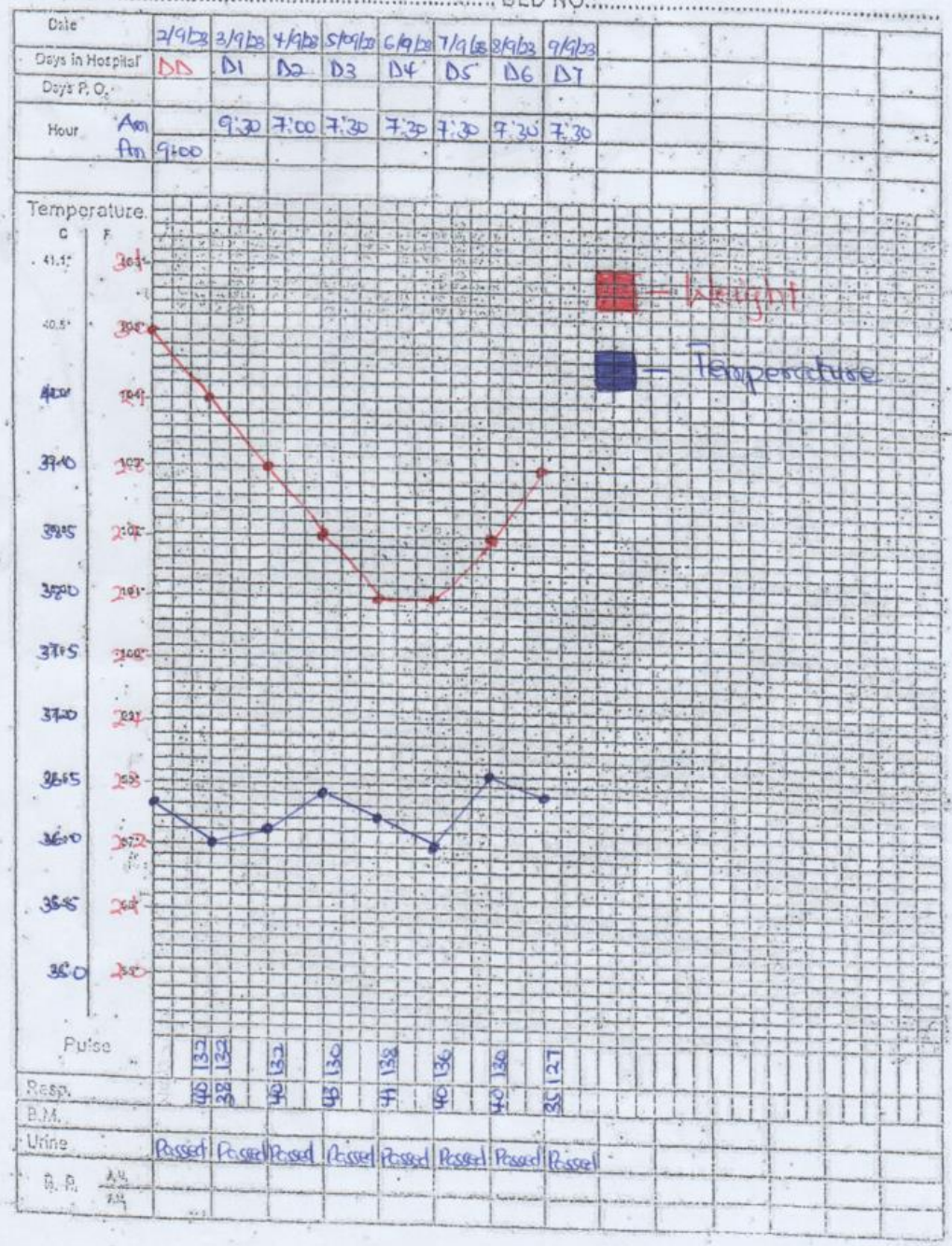
Plan: [ ] Routine Care[ ]Problem. Continue supportive in-patient care [ ] Urgent Referral / Advanced Care[ ] Discharge

TEMPERATURE CHART

NAME: Baby Winnifred

AGE: Neo Born WARD: Lying - in

IP NO.: BED NO.:



NEW BORN CHART

Name: Baby Winifred ..... No: ..... Birth Weight: 3.0kg .....

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

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

Date of Birth: ..... Time: ..... Date of Discharge: 3rd September 2023

Date	2/9/23		3/9/23		4/9/23		5/9/23		6/9/23		7/9/23		8/9/23		9/9/23							
No. of Days	D0		D1		D2		D3		D4		D5		D6		D7							
Weight			2.9kg		2.8kg		2.7kg		2.6kg		2.6kg		2.7kg		2.8kg							
	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM
Temperature		36.3°C	36.0°C		36.1°C	36.3°C	36.4°C	36.7°C	36.2°C		36.0°C		36.6°C		36.4°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
LIMBS
TRUNK
GENETALIA

No abnormalities detected

SIGNATORIES

THE STUDENT MIDWIFE

NAME: ATIVUI RHODA

SIGNATURE: .....

DATE: 7/06/2024

THE MIDWIFE- IN-CHARGE GYEĐU HEALTH CENTER

NAME: MS. ERICA BENEFO

SIGNATURE: .....

DATE: 7/06/2024

THE SUPERVISOR

NAME: MS. MONICA BOAKYE

SIGNATURE.....

DATE.....7/06/2024

THE PRINCIPAL

NAME: MONICA NKRUMAH

SIGNATURE.....

PRINCIPAL
HOLY FAMILY NURSING AND
MIDWIFERY TRAINING COLLEGE
BEREKUM

DATE.....10/06/2024