HOLY FAMILY NURSING AND MIDWIFERY TRAINING COLLEGE, BEREKUM

A CLIENT /FAMILY CENTERED MATERNITY CARE STUDY

ON

MADAM DEBORAH OKYERE

BY

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AT

KENYASI HEALTH CENTRE

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

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PREFACE

Client and family Centered Maternity care is a standardized approach of rendering care to an anticipating mother and her family through pregnancy, labour and puerperium. The aim of this study is to help know the client better to be able to respect her cultural and religious beliefs, traditions and values. This care is based on a thoughtful understanding of the client as a unique person with specific problems or needs that must be addressed. Basically include the physical, emotional and psychological aspect of nursing to the expectant mother and her family. The study makes it possible for the student midwife to put into practice the knowledge and skills she has acquired during her training.

The family centered maternity care study is an academic work which gives the student midwife the opportunity to nurse a client throughout pregnancy, labor and puerperium using the knowledge and skills acquired during the three-year training program.

The study helps the midwife to use new trends in midwifery like the opportunity to use partograph in monitoring client during labour. This partograph is a tool developed by World Health Organization (WHO), which when used correctly helps curb the menace of maternal death in the country. The active management of third stage of labour also introduced to limit the occurrences of postpartum haemorrhage. Additionally, it helps the midwife to put into practice the safe motherhood initiative which has been adopted in order to improve quality of health through antenatal care, labour and postnatal care.

A client centered maternity care helps to foster a good interpersonal relationship between clients and the student midwife and also strengthen the trust that exists between them.

The care study is a partial fulfillment of the requirement by the Nurses and Midwives Council of Ghana in awarding a Midwifery Certificate to the graduate at the end of the program to enable one to practice as a midwife in Ghana or any other country in the world.

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INTRODUCTION

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

The care study started from pregnancy, labour and puerperium and during this period the clients physical, psychological, spiritual and social changes were considered with. The framework of her family and community. The care study was carried on Madam Deborah Okyere a 24years old expectant mother, gravida 2 Para 1(G2P1). She was 37weeks + 2 days when she was met at Kenyasi Health Centre at the antenatal unit for review and she was selected for the care study since she qualified for the criteria, thus she has given birth to one child per vaginal without any complication and carried the pregnancies to term. She was first met on the 1st of December, 2022 at the antenatal unit when she came for antenatal review and that was the day the care study started.

Madam Deborah's problems identified during pregnancy, labour, puerperium and her environment were managed. The condition from the beginning till the end of the interaction was satisfactory. Madam Deborah had a successful pregnancy, delivered spontaneously on the 13th December 2022 to a live female baby. Puerperium was also successful and client and baby were handed over to the midwife in-charge of kenyasi Health Centre in good condition for continuity of care.

The four chapters outlined in the script, includes Chapter one, which talks about assessment of client histories in order to gain knowledge about the client, Chapter two talks about the antenatal care given to the client, chapter three talks about labour and chapter four talks about puerperium. The care and management rendered at each stage has been outlined, and a care plan was drawn at the end of pregnancy, labour and puerperium to identify and solve problems of the client and also

to prevent complication from occurring. Summary, conclusion, bibliography, appendices, and signatories are also included.

LITERATURE REVIEW

PREGNANCY

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

Marshall & Raynor (2014) Pregnancy starts from the time conception is confirmed until the beginning of labour and also the midwife facilitates woman-centered care by providing her with accessible and relevant information to help her make an informed choice throughout pregnancy. This book went on further to say that the aim of antenatal care is to monitor the progress of pregnancy optimize maternal and fetal health. To achieve this, the midwife critically evaluates the physical, psychological and sociological effects of pregnancy on the woman and her family. The key principles of antenatal care by the midwife are, providing a holistic approach to the woman' care that meets her individual needs, recognizing complications of pregnancy and appropriately referring women to the obstetric team or relevant health professionals or other organizations, facilitating the woman and her family in preparing to meet the demands of birth, and making a birth plan, offering parenthood education within a planned programmed or on an individual basis.

Marie Elizabeth (2013) defines pregnancy as when the woman's egg and a man's sperm cell unit to form zygote. The duration of pregnancy has been calculated by the clinicians in terms of 10 lunar months or 9 months and 7 days or 280 days or 40 weeks, calculated from the first day of the last menstrual period. This is called menstrual or gestational age. It is divided into 3 trimesters, a period of three months in each trimester. The first trimester begins from the fertilization of the ovum to 12 weeks of gestation. The second trimester begins from the 13th week to the 24th week of pregnancy. The third trimester starts from the 25th week to the 40th week. General check-up is

done at interval of 4 weeks up to 28 weeks; at interval of two weeks up to 36 weeks and thereafter weekly till the expected date of delivery. Ideally this should be more flexible depending on the need, and the convenience of the patient.

King (2014) pregnancy is a time of profound anatomic and physiologic changes in a woman's body. Maternal physiologic systems make adaptations needed to support the developing foetus and at the same time, maintain maternal homeostasis. Pregnancy last approximately two hundred and sixty-six days (266) or thirty-eight weeks (38) from ovulation. The antenatal period is into trimesters, first trimester is considered to be weeks 1 to 12 (12weeks) because organogenesis is completed at the end of twelve weeks and the risk of spontaneous abortion is significantly reduced at time. Historically, the second trimester was considered to be weeks 13 to 28 weeks was limit of viability. The third trimester extend from 29 to 40 weeks. The term 'post-date' or post term is typically used to describe a pregnancy beyond forty weeks (40).

Weller (2014) defines pregnancy as being with child, the condition from conception to the expulsion of the fetus. During this period, a lot of physiological and psychological changes take place in the woman. This affects the entire system as a result of hormonal influence, some women suffer minor disorders like vomiting, heart burns, constipation, waist pains, nausea, ptyalism (excessive salivation), food craving and others which most of these changes go away after delivery. Also, if these are not treated early, they can lead to severe complications which could be life threatening, therefore, it is important for the pregnant woman to attend antenatal clinics as soon as she realizes she is pregnant, for supervision, observations, investigations, and examinations for early detection and treatment of any deviation from normal. During this period, the expectant mother needs special education, encouragement and care, in order to cope with these minor disorders. These educations are given at the antenatal clinics by the attending midwife. Antenatal

care is a special care to promote a healthy mother and foetus. Focus antenatal is a special care given to a pregnant woman by the attending midwife and an obstetrician, during pregnancy to ensure that, maternal and foetal health are normal. The aim of focus antenatal is to detect early and treat any abnormalities, prevent complications, promote health and educate mothers on complication readiness.

Ojo and Briggs (2011) states that when pregnancy occurs, menstruation ceases for some weeks or months after delivery. Most women experience some minor disorders such as morning sickness, nausea, frequency of micturition, heart burns among others. Such conditions may not be life threating but can be harmful: the women therefore need to be educated on these conditions so that they can understand and cope with their occurrence. Antenatal care is the advice, supervision and attention a pregnant woman receives to ensure good health as well as early detection and treatment of complications which may affect the woman or her baby.

LABOUR

According to Marshall & Raynor (2014) labour purely in the physical sense, may be described as the process by which the foetus, placenta and membranes are expelled through the birth canal. However WHO as cited by Marshall & Raynor (2014) defines normal labour as one that is low risk throughout spontaneous in onset with the foetus presenting by vertex, ultiminating in the mother and infant being in good condition following birth.

Konar (2013) defined labour as series of events that takes place in the genital organs in an effort to expel the viable products of conception out of the womb through the vagina in the outer world.

The onset of labour is determined by a complex interaction of maternal and foetal hormones and is not fully understood. It would appear to be multifactorial in origin, being a combination of hormonal and mechanical factors. Levels of maternal oestrogen rise sharply during the last weeks of pregnancy, resulting in changes that overcome the inhibiting effects of progesterone. High levels of oestrogens causes uterine muscle fibres to display oxytoxic receptors and form gap junctions with each other. Oestrogen also stimulates the placenta to release prostaglandins that induce a production of enzymes that will digest collagen in the cervix, helping it to soften.

Also Verrals (2014) describes the onset of labour as the occurrence of regular painful contractions that promote dilatation of the cervix. Contractions that occur at regular intervals with increasing frequency, duration, and intensity are hallmark of labour.

There are three stages of labour that has being established; the first, second third and fourth stages.

The first stage of labour starts with cervical dilatation which begins with regular rhythmic uterine contractions until the cervix is fully dilated. During this stage enquiry is to be made about the onset of labour pains or leakage of liquor if any through general and obstetrical examinations including vaginal examination are to be carried out and recorded. Records of antenatal visits, investigation reports and any specific treatment given if available are to be reviewed. There is an assessment of progress of labour and partograph recording.

The second stage of labour begins with the expulsion of the foetus from the birth canal, it starts when the cervix is fully dilated and the woman has the urge to expel the foetus.it ends when the foetus is born.

The third stage of labour is the complete expulsion of the placenta and its membranes as well as the arrest of haemorrhage.

The fourth stage of labour is 6 hours after the delivery of the placenta and membranes and the arrest of haemorrhage.

PUERPERIUM

Konar (2013) puerperium as the period following childbirth during which the body tissues, specially the pelvic organs revert back approximately to the pre-pregnant state both anatomically and physiologically.

Marshall &Raynor (2014) says puerperium starts immediately after birth of the placenta and membranes and continues for 6weeks.

Verrals (2014) defines puerperium as when there is a delivery of the placenta and membranes, and when the woman begins the physiologic transition to the non-pregnant state lasting for 6 weeks.

By the 6 weeks most women have completed the last of the physiologic transitions; uterine involution is complete, lochia has ceased and laceration is well established. Konar (2013) defines involution as the process whereby the genital organs revert back approximately to the state as they were before pregnancy. The woman is termed as puerperal.

During this stage there are many physiological changes that takes place. In the postnatal period all the mother‟s body systems have to adjust from the pregnant state back to the prepregnant state. Mothers go through a transitional period and the period of physiological adjustment and recovery following birth is closely related to the overall health status of the mother.

Among the physiological changes Konar (2013) says the uterus becomes firm erect with alternate hardening softening. The uterus measures about 20×12×7.5 centimetres (length, breadth, and thickness) and weighs about 1000grams. At the end of six weeks, its measurement is almost similar to that of the non-pregnant state and weighs 60 grams.

The cervix contracts slowly, the external os admits two fingers for a few days but by the end of the first week, narrows down to admit the tip of finger only. The contour of the cervix takes a longer time to regain (6 weeks) and the external os never reverts back to the nulliparous state.

In the muscles there is marked hypertrophy and hyperplasia of muscle fibres during pregnancy, during puerperium, the number of muscle fibres is not decreased but there is substantial reduction of the myometrial cell size. Withdrawal of the steroid hormones, oestrogen and progesterone, may lead to increase in the activity of the uterine collagnase and the release of proteolytic enzyme autolysis of the protoplasm occurs by the proteolytic enzyme with liberation of peptones which enter the blood stream.

The changes of the blood vessels are pronounced at the placental site. The arteries are constricted by contraction of its wall and thickening of the intima followed by thrombosis. During the first week the arteries undergo thrombosis, hyalinisation and fibroidend arteries and the veins are obliterated by thrombosis. New blood vessels grow inside the thrombi.

Konar (2013) further explains that the distensible vagina, noticed soon after birth takes a long time (4-8 weeks) to involute. It regains its tone but never to the vaginal state. The mucosa remains delicate for the first few weeks and submucous venous congestion persists even longer. The rugae partially reappear at the third week but never the same degree as in the pre-pregnant state. The intriotus remains permanently larger than the vaginal state. Hymen is lacerated and is represented by nodular tags- carunculae myrtiformes.

Broad ligaments and round ligaments requires considerable time to recover from stretching and relaxation.

Pelvic floor and pelvic fascia take a long time to involute from the stretching effect during parturition.

The lochia that is the vaginal discharge for the first fortnight during puerperium originates from the uterine body, cervix and vagina. It has got a particular fishy smell. Its reaction is alkaline tending to become acid towards the end, the colour depend upon the variation ,, Lochia rubra (red) 1-4 days.

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

Lochia alba (pale white) 10-15 days.

The amount whether scanty or absent signifies infection or lochiometra indicates infection. Also the persistence of red blood colour beyond the normal limit signifies subinvolution.

The urinary tract that is the bladder mucosa becomes oedematous and hyperaemic and often shows evidence of submucous extravasations of blood. The bladder capacity is increased. The bladder may be over distended without the desire to pass urine. The common urinary problems are

1. Over distension
2. Incomplete emptying
3. Presence of residual urine.

With all definitions and changes it can be deduced that puerperium is the period from birth to 6 weeks of delivery.

WHY CLIENT WAS CHOSEN

Madam Deborah was seen at kenyasi Health Centre as a client on one of her usual antenatal visits to the clinic. On our first contact, Madam Deborah was seen talking to a friend on how she sees sleeping under a treated mosquito net makes her feels uncomfortable because of the heat and makes her feel restricted sleeping under a treated net because of the frequency of micturition she was having difficulties during the night so an approach was made, education was made on the importance and benefit of sleeping under the net to both the baby and herself since frequent malaria in pregnancy can cause miscarried and that frequency of micturition is a normal physiology which will only be reduced on its own. She was advice to either reposition her bed to where the fan is in her home or get a standing fan for herself. Upon going through her antenatal booklet, she was qualified to be used for the care study, thus a multiparous woman of G2P1 with no complication in her previous pregnancy, labour, and puerperium and also in her 37^{th} week of gestation.

Introduction of self was made as a student midwife from Holy Family Nursing and Midwifery Training College, Berekum, who is on clinical practice and the interest to select her for a study, of which She agreed and said she was glad.

Since she accepted and therefore fit into the criteria for selection of the study, education and explanation of the care was given to her, routine procedures were carried out, and the midwife in-charge after her assessment approved of client to be used. Direction to her house was given and home visit appointment was booked.

CHAPTER ONE

ASSESSMENT OF CLIENT/FAMILY

1.0 INTRODUCTION

This chapter entails information about the client, her family and community. Her information was collected through her history taking and through physical examination, organized and documented and was obtained through both subjective and objective data. It gives an account of the assessment on the client, Madam Okyere Deborah her family and the community in which she lived.

1.1 PERSONAL AND SOCIAL HISTORY

Madam Deborah is a 24-year-old lady who comes from kenyasi number 2 in the Ahafo Region of Ghana. She stays near the fire service office. She is dark in complexion, she is 153cm tall and weighs 59kg. She speaks Akuapim twi. She has been in a relationship with Mr Antwi Micheal for 5 years but has been married for 2 years now. She is blessed with a son called Douglas Okyere. Madam Deborah had her education up to primary three and is currently a house wife. Madam Deborah is a Christian and worships at Global blessing church and she is very religious so she does not smoke or take in alcohol. Her next of kin is Mr. Antwi Micheal. Mr. Antwi Micheal, her husband is a 28 years old man, a native of Kenyasi number 2, who had his formal education up to Junior High level and he is an Akan. He is also a Christian and worship with Apostlic Church of Ghana and a business man as his occupation. His hobbies are watching football and listening to music whiles his wife like sleeping, watching tv and listening to music as her hobby. Madam Deborah and her family patronize health care services from kenyasi Health Center in the Ahafo region of Ghana.

1.2 CLIENT'S LIFESTLE AND HOBBIES

Madam Deborah wakes up around 5:30am and does her devotion. She cleans the compound after her devotion and brushes her teeth. After that she prepares breakfast and takes her son to school. She comes back to bath and then she rests till noon and prepares lunch. She waits for the son to come back from school at 2pm and goes to the market to buy foodstuffs to prepare for supper. She usually prepares supper around 4pm and eats around 6pm. She rests after eating which she uses this time to watch news on television. She bathes after watching news and makes sure the son does his homework and study. She listens to music and sleeps at 9:30pm. She usually does her household duties as a wife. Bathing and bowel movement is at least twice daily and empty's the bladder four to five times in her current state. She eats three square meals a day. In the morning she usually eats porridge and bread, in the afternoon plantain and egg stew as lunch, and in the evening she takes banku with soup and meat. Her favorite food is plantain and egg stew. She likes spicy and sugary foods and sometimes takes in soft drinks but does not use tobacco/cigarette smoking, cola nut chewing, alcohol or coffee consumption.

1.3 FAMILY'S MEDICAL AND SOCIAL-ECONOMIC HISTORY

Madam Deborah said there are no hereditary diseases like sickle cell disease, diabetes, hypertension, heart disease, epilepsy, HIV infection, asthma or mental illness in her family. She has no history of twin pregnancies, no congenital abnormality and no psychiatric/mental disorders in the family. Her parents are Madam Alice Okyereh and Mr lawrance Okereh who are both late. She has four siblings thus, 3 females and a male of which she is the second child among them and they are all hustlers. Death occur naturally in their family.

1.4 MEDICAL HISTORY

Madam Deborah said she has not been on admission at the hospital before but receives medical treatment on out-patient basis, whenever she is ill. According to her, she has no existing condition like hypertension, sickle cell, heart disease, diabetes, asthma, glucose 6 phosphate dehydrogenase (G6PD) defect, mental illness, TB, respiratory disease, heart disease, epilepsy, HIV infection, alcohol and smoking, syphilis, respiratory disease, birth defects, mental health disorder and multiple pregnancies. She has no known allergies to food or any drugs and not on any medications. She has never been transfused nor donated any blood. She has not received any treatment like surgeries, traditional/spiritual healing/camp, psychiatric.

1.5 SURGICAL HISTORY

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

1.6 MENSTRUAL HISTORY

Madam Deborah had her menarche at the age of fifteen (15). Her menstrual cycle is 28 days lasting usually for 7 days and for the first 3 days it is a heavy flow which is very redish in colour but the last 4 days is a normal flow which is dark red in colour with no dysmenorrhea. She uses sanitary pads during her menstrual period. She gave her last menstrual period as 8th March 2022. (08/03/2022.) as documented in her antenatal card. Base on this her estimated date for delivery (EDD) was calculated as 15th December 2022.

1.7 PAST OBSTERTRIC HISTORY

PREGNANCY

Madam Deborah has had two pregnancies and alive male child as then(G2P1). She has no history of abortion, being spontaneous or induce. With her first pregnancy, she was pregnant in the year 2017 with a single feotus. During her first pregnancy she attended antenatal clinic session for her first child. She carried her pregnancy to term without any complication like ante-partum hemorrhage, urinary tract infection, malaria or anemia in pregnancy except some minor disorders of pregnancy like heart burns, frequency of micturition, lower abdominal pains, leg cramps, nausea and vomiting of which she reported to the hospital and they were explained to her as normal physiological changes in pregnancy which would resolve as pregnancy progresses. She also had no pregnancy induced diseases like hypertension and diabetes. Her first child was five years before she got pregnant again. She had two doses of tetanus toxoid and five dose of sulfadoxine pyrimethamine for her last pregnancy and 3rd doses of tetanus toxoid and five dose of sulfadoxine pyrimethamine for her current pregnancy.

LABOUR

At term she had a spontaneous vaginal delivery to her son at Esther maternity home on 5th January 2017. Labour did not last for long and it was without any complications such as postpartum hemorrhage. She said placenta and membranes were fully expelled shortly after she was given an injection on the thigh. Blood loss was minimal. The baby's weight was 2.8kg respectively and the baby had no abnormalities and her condition after birth was good.

PUERPERIUM

Client said her puerperium was without any complications such as post-partum hemorrhage or infection. She practiced exclusive breastfeeding for 6 months and continued with complementary feeds like wean mix, other foods taken by the family and weaned her babies after 2 years. Her baby received care and all immunizations during her post-natal visits to the postnatal clinic and child welfare clinic. Both mother and baby did not suffer any ailment during puerperium. She received support from her husband and her elder sister during puerperium. Husband used male condom as their family planning method.

1.8 PRESENT OBSTETRICAL HISTORY

Madam Deborah G2P1 reported to the kenyasi Health center antenatal clinic for registration on the 04/05/22 with 8 weeks gestational age. Her last menstrual period was on 08/03/22 and her expected date of delivery was calculated as 15/12/2022. According to her scan it was still the same 15/12/2022. Detailed information about her personal, menstrual, obstetrical, lactation, medical, surgical, family and contraceptive histories were taken. Her weight was 59 kilograms and height was 153cm. Head to toe examination done with no abnormality detected. Based line vital signs was checked and recorded as follows.

- Temperature - 36. 4 ˚C
- Pulse - 82 bpm
- Respiration - 22 cpm
- Blood pressure - 100/60 mmHg
- Urine test showed negative for both protein and sugar.

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

- Haemoglobin level - 12.9g/dl
- Blood group - A
- Rhesus factor - Positive
- HIV status - Negative
- Hepatitis B - Negative
- G6PD - No defect
- Sickling - Negative

- Stool (cyst, protozoa, ova) - No abnormality detected
- Syphilis (VDRL) - Non reactive

Symphysio-fundal height couldn't be detected because uterus was not palpable. Client received her 3rd dose of tetanol diphtheria immunization on her first visit {04/05/2022}. Client lodged no complains. She was served with routine drugs as below;

- Capules Iron III polymaltose 1daily for 30 days

Client made her next appointment on 01/06/22.

On 01/06/22 at 12 weeks gestation, and her third appointment was 28/6/2022 at 16 weeks of gestation. She has also received education on nutrition, rest, sleep, exercise, danger signs of pregnancy as per her card and the importance of regular antenatal visits.

She made complains like lower abdominal pain and passing of watery stools and was manage.

Client had visited the ANC 8 times before she was met. Madam Deborah was a healthy pregnant woman on the first day of contact (01/12/2022).

CHAPTER TWO

ANTENATAL CARE

2.0 INTRODUCTION

This chapter talks about the antenatal care given to madam Deborah during her pregnancy period. It includes first contact with the client, first antenatal home visit, subsequent visits to the clinic by client, subsequent home visit as well as the nursing care plan drew for problems identified.

2.1 FIRST CONTACT WITH THE CLIENT.

The first contact with Madam Deborah was at 8:00am on Thursday 1st December, 2022. The client was a regular attendant of Kenyasi health center. Madam Deborah was 37weeks 2days pregnant, and this was her nineth visit. She was warmly welcomed and offered a seat. She was educated on the importance of attending antenatal clinic on time and also educated her to reduce her work load in that state of pregnancy.

Her antenatal booklet was collected and read to note the previous recordings. The midwife in charge was already informed about a quest to find a client who met the criteria to be used for the client and family centered maternity care study and the midwife in-charge explained and sought consent from the client, the client was found to have met the criteria. Madam Deborah was assisted through the routine laboratory investigation after vital signs were checked and recorded. Her haemoglobin level was 12.2g/dl and her HIV screening result was negative.

Her vital signs and weight were checked and recorded as:

- Temperature - 36.4 degree Celsius
- Pulse - 82 beats per minute

- Respiration - 21 cycles per minute
- Blood Pressure - 100/60millimeters of mercury

  Other investigations includes,

  - Symphysio-fundal height - 36cm
  - Haemoglobin - 12.2grams per deciliter
  - Weight - 65.5Kilograms

After all these procedures, she was asked to empty her bladder and specimen bottle was given to her to collect mid-stream specimen of urine to test for urine protein and glucose.

Urine Testing: Protective clothing like apron and gloves were worn. The quantity, colour, odour, smell and sediments were noted. A chemically prepared strip was picked and dipped into the urine sample. The strip was immediately removed and the edge of the strip taped against side of the urine container to prevent spilling of urine onto the clothes. After one (1) minute, the stick was compared with the corresponding colour on the container. There was no change in color of the strip indicating a negative result when compared closely with the corresponding color chart on the container.

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

The procedure involved in physical examination was explained to her and she consented. Privacy was provided by closing doors and nearby windows and curtains drawn and hand washing was done.

HEAD TO TOE EXAMINATION

Madam Deborah was assisted to sit on the bed, lie on her right side and then assume a supine position after client has been assisted to undressed, examination was started.

Head and Neck: on examination from the head there were no scars on the scalp. The hair was check for brittleness, dandruffs, lice, infection and also distribution of hair but that moment her hair was combed and styled nicely and neatly. Few educations were done and she was congratulated. The face was also examined for the presence of edema, chloasma and rashes but no abnormalities were detected and the skin looked smoothed and facial colour was well distributed. Her eyes were examined and there was no pallor, jaundice and discharges from it. The nose was examined with no discharges, the mouth was examined with no dental carries, and tooth decay, halitosis during conversation, no cracks or sores were found on the lips, the gum and tongue were inspected for pallor and they were normal. Her ears were examined with no pain and discharges from it. Her neck had no enlarged thyroid gland, palpable lymph nodes or distended veins.

Breast Examination: Client was informed on examining the breast and she consented. On breast examination both breasts were present, the shape and size were normal, the areolar was very dark in colour, and the skin of the breast were smooth with the nipple well projected. The breast nearer was covered and the other one farther was exposed to be examined. The client was asked to put the hand of the part to be examined under her head and with the left hand supporting the breast, the right hand was used to palpate the breast systematically in a circular manner using the inner aspect of the fingers for masses, enlarged axillary lymph nodes but no abnormality was detected. The nipple was also squeezed gently with cotton wool and expressed fluid was examined for it colour and it was clear with no foul smell and same procedure was performed on the other breast. While doing the breast examination she was told to be observant, since she would have to repeat what was done at home to detect abnormalities of the breast after every menstruation. She was made comfortable and covered up. Findings were explained to client.

Upper Extremities: after client was informed about the continuation of examination, Client was ask if she had tingling and tightness in an attempt to make a fist, and she answered negative. Her upper extremities were examined for equality, extra digit, presence of edema, nail beds for pallor and there was no abnormalities. Her nails had also been cut and kept clean.

The Client was informed about the next step and client was assisted into a left lateral position.

Lower Extremities: Madam Deborah was asked to lie on her back again for examination of the lower extremities. There was no pain found in the calf, her toe nails were short and clean, there was no varicose vein, extra digit or edema on the lower extremities. The legs was checked for equalities and nail bed for pallor. She was congratulated for a neat and healthy body.

Back: her back was examined for any abnormalities of the spine and sacral region for edema and for varicose veins of which no abnormality was detected. The skin was in good condition and costovertebral angle tenderness was absent.

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

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

Measuring of symphysio-fundal height: the zero end of the measuring tape was placed on the fundus of the uterus and the tape extended to the upper boarder of the symphysis pubis and the symphysio-fundal height measured 36cm and gestational age of 37weeks 2 days.

Fundal palpation: hands were warmed by rubbing them together to avoid inducing contractions. Standing on the right side of the client, both hands were placed just below the xiphisternum and down the abdomen until the upper part of the fundus were felt. The fundus was occupied by a soft round mass indicating the buttocks.

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

Pelvic palpation: Upon facing the client's lower limbs and placing the palms of both hands on either side of the lower abdomen below the umbilicus pointing downwards and inwards, the head was palpated in the lower pole of the uterus. On palpation the lie was longitudinal, presentation was cephalic and the position was right occipito-anterior.

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

Auscultation; The fetal heart was auscultated by warming and placing fetal stethoscope (fetoscope) on the area where the back was located; the ear was placed against the fetoscope, making sure hands were not touching the fetoscope and the fetal heart beat was counted. Comparing the rate with the maternal pulse and counting how many beats were heard for one minute, it was 147bpm with regular rhythm.

Vulva Examination; Permission was sought to inspect her vulva after hand washing was done .Client's vulva was inspected after the examination light was turned towards the genital area for clear view. The vulva was well shaved and clean. The perineum, labia and clitoris were inspected and it was clean, they had no abnormalities such as swollen tissue, rashes, warts or blisters and

there was no indication of female genital mutilation, and no abnormal discharges found. Hands were washed and dried. Findings were communicated to her and she was congratulated for her co-operation. She was thanked and was helped to turn to her left side before getting off the bed and to do so any time she rises from bed. She was assisted to dress up. Madam Deborah was offered a seat and was asked if she had any complains, of which she gave the discomfort of urinating frequently especially at night. Explanation was made to her that it was one of the physiological changes that occur in later part of pregnancy as a result of the descending fetal head exerting pressure on the bladder She was told to drink more water in the day but less during the night as this might help reduce the frequency of urination at night. She was encouraged to continue maintaining personal hygiene and also to have enough rest and sleep. She was told to get all her items needed for delivery ready and well packed this was done after being educated on the signs of labour. Finally education on the need to attend antenatal on time was reinforced. Signs of labour were explain to her as she was in her late weeks. She was served with her routine drugs as below;

- Cap lron III Polymaltose 1 daily x 7days
- Tab Folic Acid 5mg 1 daily x 7days
- Tab Ferrous sulphate 1 daily x 7days

We discussed home visitations and she gave directions to her house after which contacts were exchanged and she was seen off. The date for her next appointment (6th December, 2022) was given to her.

HOME VISITS

2.2 FIRST ANTENATAL HOME VISIT

The first home visit to madam Deborah was on the 2nd December, 2022, by foot according to directions given. Upon arrival at the vicinity, it was identified that Madam Deborah lives in a U-shape house near fire service office. The visit was purposefully to access client, house, assess community in which she lived, make more investigations about her family background and check if she was prepared for her birth. She was living with the husband's family so it was a family house. After a warm welcome and exchange of pleasantries and seat was offered by client. She called her mother, husband and her son and an introduction was made to them as a student midwife from Holy Family Nursing and Midwifery Training College Berekum who had come to the community for a care study and she has agreed to be chosen. After that she then offered me a sachet of water. During the conversations, the following observations were made; it was observed that the room was a single room partitioned with a yellow and green long curtain and was well kept and the chairs and table arranged neatly in the room, the floor was well cemented, they have a wooden bed with an insecticide treated net hanging loosely over it. She was encouraged to sleep in it with the family (husband and son) every day. The room had adequate lighting and ventilation. Their clothes were nicely folded into their various bags. She was congratulated and asked to keep it up. In other to inspect her washroom, client was asked of a place to urinate of which she showed, and it was observe that the place was neat, after inspecting the washroom, a quick glance through the house was made and the house portrayed a tidy environment.

The house is built with cement and made up of seven single rooms, fourteen windows and a pouch in front with a wooden trap door on each room and has good ventilation system. She uses her pouch

as a kitchen where she cooks and the pouch was neatly kept and her utensil was well arranged in a cabinet. There is a toilet and bath in the house which is shared with the people living in the house. Their source of light is electricity and pipe borne water is their source of water and they keep their refuse in a waste bin and dispose of it into a Zoom lion waste collector container. Client was asked about who has being cleaning the bath house and the toilet and was told it was cleaned twice a week by her husband's sisters. She was advised on the use of antiseptic solution in and on the toilet seat before using, since she was at risk of urinary tract infection, and also to wash her hands with soap under running water after visiting the toilet. She was asked about her preparations towards delivery and her layette was inspected, everything on the delivery list was intact and was neatly arranged and she had a blood donor (her sister). She was encouraged to arrange with her husband's brother since he had a car and could transport her to the hospital when labour sets in. She had also prepared an amount of money and added it to her suit case. Her support person was her husband's brother. Client had her husband's number which she can call when needed.

Education was given to her on the signs of true labour which were, painful regular and rhythmic uterine contractions which will be felt as tightening discomfort or actual pain, a blood-stained mucoid discharge from the vagina, there may be rupture of membranes. She was encouraged to visit the health center immediately she experienced any of these signs and take her drugs as prescribed. Enquiries about her frequency of micturition was made, of which she said it has reduced. Client was further asked if she had any problem and she said she has been experiencing backache. Explanation was made to her that it was one of the physiological changes that occur in the later part of pregnancy. It was further explained to her that, it could be due to the weight of the pregnant uterus and product of conception or relaxation of muscles and ligament by progesterone and relaxin hormones.

Education to lie in a left lateral position, support herself with pillow when sitting or standing and to apply warm compress to the back. Madam Deborah understood and promise to adhere to the education as she did when she had the discomfort from the frequent micturition. Later during our interactions her husband called on phone and he was informed. The phone was provided and an introduction was made again to him, he was very happy for the presence being there to educate the wife on certain things. Client's husband was encouraged to support client in the performance of household chores and taking care of their active son. The family were encouraged to continue eating nutritious diet and to always drink clean and safe water. Client's son then said what he learnt in school on that day. Afterwards permission was sought to leave the house and to visit again some other time. She was reminded of her next visit to the health center.

2.3 HOME ENVIRONMENT

PHYSICAL

Client's house is located near fire service office at kenyasi. It is built with cement blocks, which is plastered and painted and roofed with aluminium roofing sheets. It contains seven rooms with fourteen windows and a pounch in front with a wooden trap door on each room and has good ventilation system. She uses her pouch as a kitchen where she cooks and the pouch was neatly kept and her utensil was well arranged in a cabinet. Madam Deborah mentioned that, she and her family are occupying one room. There is a bathroom and a toilet which is built with cement blocks and is semi-detached from the house which she shares with other family members in the house. The floor of the bathroom is cemented. Their source of water is from a pipe borne in the house and electricity is their source of electricity. She mentioned that refuse was dumped in a waste bin and dispose of it into a Zoom lion waste collector container. It was observed that the surroundings were neat.

PSYCHOSOCIAL

Madam Deborah lives with her family and her husband's family. She relates well with her them and her neighbours, Client said whenever there is a problem concerning the house, a sitting is organized for them to bring in their views on how to solve the issue. Disputes are being settled in the family to ensure there is peace and harmony. Madam Deborah attend funerals, weddings and other ceremonies when the need arises with her husband. An introduction was made to the family members as a student midwife who will be taking care of her through pregnancy, labour and puerperium.

2.4 SECOND ANTENATAL HOME VISIT

Madam Deborah was visited at home on 4th December 2022 at 9:00 am. Her husband's brother was not around but her son and grandmother were around. Madam Deborah was greeted and a seat was offered. Client was asked of her health and that of the family, of which she confirmed they were doing well. The aim of the visit was to inquire about her health and to assess if client had adhered to the education given to her. During the interaction with her, Madam Deborah said the backache has resolved since she adhered to my counsel given to her and she was feeling fatigue. Education to practice exclusive breast feeding after birth was done. Madam Deborah complained of fatigue but explanation was given that it was one of the physiological changes that occur in the later part of pregnancy. It was further explained that, it was due to the weight of product of conception and inadequate rest. Madam Deborah was encouraged to take have adequate rest during the day and avoid strenuous activities. Madam Deborah said her husband would accompany her to the clinic if labour commences. Educations on the signs of true labour were reinforced and she was encouraged to report as soon as she notices any of the signs. Permission was sought to leave and she was told to call when labour begins or if any problem occurs.

At 7:30am, on 6th December 2022, client was asked how she was coping with the fatigue and she said she was doing well.

2.4 SECOND ANTENATAL VISIT TO THE CLINIC

Madam Deborah next antenatal visit was on the 6th December 2022. She arrived very early and was welcomed and her health and that of her family was asked of which she responded they were all doing well. She was neatly dressed with a cheerful face and she was asked of how she was coping with the fatigue, which she said, she was coping with it. She was then taken through the routine care, urine sample was taken to test for the presence of protein and glucose of which was tested negative. Her vital signs/weight was checked and recorded as;

Blood pressure - 110/70 millimeters of mercury

Temperature - 36.6 degree Celsius

Pulse - 82 beat per minute

Respiration - 22 cycles per minute

Weight - 73 kilograms

Permission was sought to examine her. Having urinated earlier, privacy was provided and she was helped onto the bed on her left side. Hands were washed with soap and water and dried. On physical examination from head to toe, no abnormality was detected. Hands was rubbed together to make them warm and abdominal examination were performed with the following findings, the abdomen was spherical and little fetal movements detected. The linea nigra running through the midline of the abdomen and the symphysio fundal height was measured to be 36cm. On fundal palpation an irregular soft mass was felt which indicated that the fetal buttocks of the upper pole of the uterus.

On lateral palpation the right side of the abdomen revealed a smooth curved mass indicating the back of the fetus. On pelvic palpation a smooth hard mass was felt indicating fetal head at the lower pole of the uterus. It was therefore concluded that, the presentation was cephalic and position was right occipito-anterior with the descent of 5/5th.

On auscultation the fetal heart rate was 131 beats per minute with regular rhythm.

Client was assisted to get up from the bed and a seat was offered to her. Hands were washed and dried. Findings were documented and communicated to her. She was asked of any complaints or questions and she said she was having heart burns. It was explained to her that it was the action of progesterone on the smooth muscle causing relaxation of the gastric sphincter leading to reflux of gastric contents. Client was encourage to eat less spicy and oily foods, sit up for a period of time after eating and also lie on her side and lie down with many pillows to raise her up. In the absence of further questions she was encouraged to continue with her routing drugs.

The next home visit was scheduled on 13th December 2022, and then she was escorted out of the facility.

2.5 SUBSEQUENT VISIT TO THE CLINIC

Madam Deborah visited the clinic on the 13th December 2022 around 7:00am with complaints of mild lower abdominal pain. She was welcomed and a seat was offered, enquiries of her health and that of her family was made. She went through the normal routine procedures. Her weight was 67kg.The following observations were also made and recorded:

Temperature - 36.4^0c

Pulse - 82bpm

Respiration - 21cpm

Blood pressure - 100/60mmHg

Client was asked to empty her bladder and a sample of her midstream urine tested for protein and glucose were negative. Physical examination from head to toe was done and nothing abnormal was detected. Under the supervision of the in-charge. Abdominal examination was done. The abdomen looked globular. Fetal movements were noticed.

On palpation, the fundal height was 37cm with 38+6 days gestation. The lie was longitudinal, presentation was cephalic and position was right occipito - anterior with a descent of 5/5th above the pelvic brim.

On auscultation, the fetal heart rate was 130bpm with regular rhythm and good volume. Client was thanked and helped off the examination bed and then assisted to dress up and a seat was given to her. All findings were communicated to her and documented in her maternal health record booklet. She complained of lower abdominal pain. She was also educated to take a warm bath at night and to take her mind off the fetal movement. She was also educated to sleep in a position (left/lateral) that would be comfortable but harmless to her and the fetus.

2.6 NURSING CARE PLAN ON ANTENATAL

1. On 1/12/22 Frequency of micturition.

2. On 2/12/22 Backache.

3. On 4/12/22 fatigue.

4. On 6/12/22 heart burns.

5. On 13/12/22 lower abdominal pain

Short Term Objectives

1. Client will cope with frequency of micturition within 24 hours.

2.Client's backache will subside within 48 hours.

3. Client's heart burns will resolve within 48hours.

4. Client's fatigue will resolve within 48hours.

5. Client's can cope with lower abdominal pain within 7hours

LONG TERM OBJECTIVE

Client will be healthy throughout pregnancy without any complication

NURSING CARE PLAN FOR ANTENATAL

DATE / TIME	NURSING DIAGNOSIS	NURSING OBJECTIVE /OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTIONS	DATE/ TIME	EVALUATION	SIGN
1/12/22 at 7:30am	Frequent micturation related to pregnancy.	Client will feel comfortable within 24 hours by understanding and coping with as evidenced by Client	1. Reassure client that her condition can be managed. 2. Educate client on the cause of frequent micturition. 3. Educate client to use to use panty liners if she can afford.	1. Client was assured that her condition will be resolved after birth. 2. Client was educated on the causes of frequent micturition. 3. Client was educated to use panty liners if she can afford.	2/12/22 at 7:30am	Goal was fully met as client reported that she can cope with frequency of micturition.	C.S.K

		verbalizing that she can cope with the condition.	4. Educate client to use tissues to wipe vulva after urinating. 5. Encourage client to keep a clean covered chamber pot at bedside.	4. Client was educated to use tissues to wipe the vulva after urinating. 5. Client was educated to keep a clean covered chamber pot at bedside.			

DATE / TIME	NURSING DIAGNOSIS	NURSING OBJECTIVE /OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTIONS	DATE/ TIME	EVALUATION	SIGN
2/12/22 at 10:30am	Backache related to the relaxation of muscle and ligament by hormone progesterone and relaxin.	Madam Deborah's pain will reduce within 24 hours as evidenced by; 1.Client verbalizing that the pain has reduce. 2.Client scoring lower mark on comparative pain assessment scale.	1. Reassure client that the pain will reduce. 2. Educate client on the cause of backache. 3. Encourage client to support herself with pillows beneath the knees and abdomen.	1.Client was reassured pain will reduce 2. Client was educated on the cause of low back pain and she understood 3. Client was encouraged to support herself with pillows beneath the knees and abdomen.	4/12/22 at 10:00am	Goal was fully met as Client informed me that pain has reduced.	C.S.K

			4. Encourage client to lie in a left lateral position. 5. Encourage client to apply warm compress at the lower back.	4. Client was encouraged to lie in a left lateral position. 5. Client was encouraged to apply warm compress at the lower back.			

NURSING CARE PLAN FOR ANTENATAL

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES/ OUTCOME CRITERIAL	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
4/12/22 at 9:00am	Fatigue related to stress from under taking household chores	Client's fatigue will resolve within 48hours as evidence by Madam Deborah verbalizing that she is feeling rested.	1. Reassure Madam Deborah that she will be resolve of fatigue. 2. Encourage her husband's sister to assist in household chores.	1. Madam Deborah was reassured that she will be resolved of her fatigue. 2. Client's husband's sister was encouraged to assisted in household chores.	6/12/22 at 9:00am	Goal was fully met as client informed the midwife that her fatigue had resolved.	C.S.K

			3. Educate client to have rest and sleep in between activities. 4. Encourage client to reduce household activities. 5. Encourage client to adopt more comfortable position when like left lateral when sleeping	3. Client was educated to have rest and sleep in between activities 4.Client was encouraged to reduce household activities 5. Client was encouraged to adopt more comfortable position like left lateral when sleeping.			

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES/OUTCOME CRITERIAL	NURSING ORDERS	NURSING INTERVENTION	DATE/TIME	EVALUATION	SIGN
6/12/22 at 9:00am	Heartburns related to reflux of stomach contents.	Client's heart burns will resolve within 48hours as evidenced by client verbalizing that the heartburns has resolved.	1.Reassure client of quality care. 2. Educate client on physiology of heart burns. 3. Educate client to reduce the intake of fatty and spicy foods.	1.Client was reassured of quality care to be rendered 2. Client was educated on physiology of heart burns. 3. Client was educated to reduce the intake of fatty and spicy foods	8/12/22 at 8:00am	Goal fully met as client verbalizing those heartburns had resolved.	C.S.K

			4. Encourage her to use more pillows when sleeping. 5. Encourage client have early supper 6. Encourage her to sit up at least 2-3 hours after eating	4. Client was encouraged to used more pillows when sleeping. 5. Client was encouraged to have early supper 6. Client was encouraged to sit up at least 2-3hours after eating.			

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVE/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTIONS	DATE/ TIME	EVALUATION	SIGN
13/12/22 at 8:00am	Lower abdominal pain related to fetus exerting pressure on the lower pole of the uterus.	Client will be able to cope with lower abdominal pain within 7 hours as evidenced by client verbalizing that she can cope with lower abdominal pain	1. Reassure client that this physiological disorder will reduce soon after delivery. 2. Educate client on the causes the lower abdominal pain. 3. Encourage client to reduce chores. 4. Encourage client to exercise like walking and mildly massage the affected part.	1. Client was reassured that the lower abdominal pain will reduce after delivery. 2. Client was educated on the causes of lower abdominal pain. 3. Client was encouraged to reduce chores. 4. Client was encouraged to exercise and mildly massage the affected part.	13/12/22 at 3:30pm	Goal was fully met as client reported that she could cope with lower abdominal pain.	C.S.K

			5. Encourage client to have enough rest and sleep.	5. Client was encouraged to have enough rest and sleep.			

CHAPTER THREE

LABOUR

3.0 INTRODUCTION

This chapter describes the management of labour in four stages thus; first, second, third and fourth stages and immediate care of the newborn, subsequent care, examination of the newborn and care plan for the management of the problems encountered during this period.

3.1 ADMISSION AND MANAGEMENT OF FIRST LABOUR

During morning shift on the 13th of December 2022, Madam Deborah arrived at the labour ward at 9:30am, accompanied by her husband's sister and her grandmother, after her grandmother called on phone to give information about her granddaughter experiencing lower abdominal pain and waist pain. Grandmother and husband's sister were asked to relax outside. Assessment was done to rule out the urge to push before client was taken through the admission process. History of labour was taken from client and she said labour started around 8:20am, show was noticed at home and the contractions became frequent. Madam Deborah said she had not seen any trickling of water or blood but could feel increased fetal movements. Enquires were made to know if she took any medications or herbs since the pain started but she answered no. She had her last meal and bowel movement in the morning at around 7:00am of the that day. Client was reassured of competent care to be rendered after which she was made comfortable in bed and privacy maintained. Client layette was arranged by her bedside and she was encouraged to empty her bowel and bladder when she had the urge into a bed pan provided. Client was asking questions about the duration and outcome of labour. Madam Deborah was reassured of competent care to be given as well as education on procedures to be

performed and the stages of labour. She was also reassured that she will not be left alone but the husband's sister as well as myself will be readily available for her.

Her vital signs were checked and recorded as follows;

Temperature - 36.7 ^{0}C

Pulse - 104bpm

Respiration - 22cpm

Blood Pressure - 100/70mmHg

Privacy was provided and explanation was given on procedure for physical examination from head to toe. Consent was sought from client and she agreed. Madam Deborah was asked to empty her bladder and take a midstream urine to test for protein and acetone which when tested was negative for protein and glucose. Client passed 150mls of straw colored urine. Client was assisted to undress and cover herself with a piece of cloth and assisted onto the examination bed. Hands were washed with soap and water, dried and warmed. The head to toe examination was done under the supervision of the midwife in-charge. The hair, sclera, conjunctiva, nose, mouth, ears, neck were without any abnormality. The face was a bit tensed because of the painful contractions. The breast was firm on the chest with no engorgement or inversion of the nipple and the arms were proportionate in length, the nails were also short and clean. On her lower extremities, there was no varicose vein found on the legs. There was no pallor, edema nor jaundice. The hands were warmed again by rubbing them together.

Inspection: on abdominal inspection, the abdomen was globular in shape, there was linea nigra on the abdomen and no straie gravidanum or previous scar was observed.

Measuring of the symphysio-fundal height: Symphysio - fundal height was 37 centimeters with gestation of 38 weeks +6days.

On fundal palpation: the fundus was palpated and a soft mass was identified as the fetal buttocks.

Lateral palpation: this was done to find the back and limbs of the fetus which revealed a smooth fetal back to be at the right side of the abdomen and limbs on the left side as it felt rough.

On pelvic palpation; the lie was longitudinal, position was right occipito-anterior, and presentation was cephalic.

Descent was determined by locating the anterior shoulder 2.5 cm below the umbilicus and symphysis pubis which admitted four fingers. Descent was four-fifth ($4/5^{th}$) palpated above the pelvic brim.

On auscultation; the fetoscope was rubbed on the palm to warm it before placing it on the abdomen to listen to the fetal heart beat for a full minute which read as 140 beats per minute with regular rhythm and good volume.

The uterine contractions was timed for 10minutes and it recorded 2 in 10 minutes lasting 25 seconds approximately.

Vaginal examination

Permission was asked to perform vaginal examination of which she agreed. Procedure for vagina examination was explained to her in order to promote comfort and seek her co-operation. A sterile tray was set containing two gallipots, one containing savlon antiseptic

solution, the other gallipot with sterile cotton wool swabs, a pair of surgical gloves and a receiver for used swabs and all was covered with a sterile towel.

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

Client was then helped into a lithotomy position with her knees flexed and thighs apart. Examination gloves was worn and soiled pad removed and discarded with the left hand. A pair of surgical gloves were worn. The vulva was well shaved though soiled with the blood-stained mucous (show). It had no abnormalities. A sterile cotton wool swab was picked with the right hand dipped into the gallipot containing savlon solution. The swab was dropped from the right hand into the left hand and used to swab the labia majora and the minora using a swab for each. With the left hand parting the minora, the last swab in the right hand was used to clean the vestibule from anterior to posterior. Client was informed that, the middle finger followed by the index finger will be put into her vagina to assess the condition of the vagina and cervix and that she will feel a bit uncomfortable. With the labia minora still separated, the right middle finger was inserted into the vagina gently but firmly pressing downward whilst the index finger was added into the vagina in order to relax the vagina wall and muscles.

On vaginal examination, the vagina was warm and moist, the sacrum was well curved, the ischial spines were blunt, the sacral promontory was not reached and cervix was thin, soft, elastic and cervical os was 4cm dilated at 9:30am. The presenting part was well applied to the cervix with intact membranes. Moulding was not present. The pubic arch was wide, and the rectum was empty. On withdrawal of the fingers, observation was made on the examining fingers and they were clear and not offensive. The vulva was cleaned and a clean perineal pad was applied. Client was made comfortable with the help of the midwife-in-charge. All instruments used were decontaminated in 0.5% chlorine solution. Hands were washed and dried after the gloves were discarded.

PREPARATION FOR BIRTH

In preparing for birth, helpers were identified including the skilled and unskilled personnel. The midwife in-charge was identified as the skilled personnel and the client's grandmother was identified as the unskilled personnel. The doctor on call was notified about the client's admission. Client's brother had donated blood at the blood bank when an enquiry was made. Emergency boxes (like PPH and Eclampsia) with their appropriate items were available. The delivery room had been already cleaned. Client was encouraged to wash hands and she was informed that the windows will be shut and fans will also be put off to provide a warm environment for the baby when it is time for delivery, of which she agreed.

Room was well lighted and ventilated. Madam Deborah was also educated that the baby would be delivered onto her abdomen on a sterile towel and she will have to support the baby. She was also informed that her abdomen will be cleaned for skin to skin care with the baby. The resuscitation box had all the items needed such as a stethoscope, scissors, cord clamp, sucker, self -inflating bag and mask of different sizes. The self-inflating bag was tested to see whether it was functioning, also the radiant bulb was switched on to provide warmth to the cot. Other items like cot sheets was also made available. Referral centers and their numbers as well as ambulance and its driver were all checked to be available. Delivery items were also made available.

Madam Deborah was encouraged to assume any position favorable but not harmful to her. She was encouraged to possibly assume a left lateral position to increase placental perfusion and prevent supine hypotension. She was encouraged to ambulate to aid in the descent of the fetal head. A bed pan was provided for her and was encouraged to urinate when she feels the urge to further aid in descent of the fetal head. Client was encouraged to take in water or any sweetened fluid to prevent dehydration.

Madam Deborah was reminded of the deep breathing exercises so as to conserve energy for the second stage. Sacral region was massaged during contractions to relieve her from pain.

Madam Deborah was continuously and closely monitored on the partograph throughout the first stage of labour, maternal and fetal conditions were recorded and labour progressed well. Client was monitored on the partograph as follows; fetal heart rate, uterine contractions and maternal pulse were checked every thirty (30) minutes. The cervical dilation, descent, membranes, moulding, blood pressure and temperature were checked every four (4) hours. Urine test for protein and acetone was done every four (4) hours. Client was reassured again of competent care to be rendered and all procedures were explained before their performance. All findings were communicated to her. At 9:30am fetal heart rate was 140bpm, contractions were 2 in 10 lasting 25 seconds and maternal pulse was 140bpm.

At 10:00am fetal heart rate was 138bpm, contractions were 2 in 10 lasting for 36 seconds and maternal pulse was 76bpm.At 10:30am Fetal heart rate was 136bpm, contractions 3 in 10 lasting 35seconds and maternal pulse was 79bpm. At 11:00am fetal heart rate was 132bpm, contractions were 3 in 10 lasting 36 seconds and maternal pulse was 74bpm. She was assisted to lie on her left side and breathe through her mouth since she was complaining of severe waist pain. She was reassured that she will soon have her baby and all discomforts will be resolved and a sacral massage was given to reduce the pain. She was encouraged to assume a favourable position not harmful to the fetus and the physiology of uterine contraction was explained to her. At 11:30am fetal heart rate was 133bpm, contractions were 4 in 10 lasting 37 seconds, maternal pulse was 80bpm. At 12:00pm fetal heart rate was 136bpm contractions were 4 in 10 lasting 38 seconds, maternal pulse was 76bpm. At 12:30pm fetal heart rate was 138bpm, contraction 3 in 10 lasting 42 seconds and maternal pulse was 78bpm. The progress of labour was documented and then communicated to client. Client was sweating a lot and was cleaned with a wet towel. She was also given iced water to calm herself. Temperature was checked and

recorded as 36.7˚C and blood pressure was 110/90mmHg, urine was taken to test for protein and acetone and they all showed negative and the amount as 100mls and head descent was 2/5th Client was due for vaginal examination. It was observed that client had removed pad onto bed. She was quickly told not to do that since she could be infected. She was encouraged to wash her hands and discard pad if fallen or soiled.

Vagina examination revealed cervical os 8cm dilated. Progress of labour was communicated to her and she was reassured.

Delivery trolley was set paying attention to sterility. It contained the following items;

Top shelf

- A sterile bowl for savlon solution
- A delivery pack containing;

  Two sterile towels

  Two artery forceps

  Two dissecting forceps

- An episiotomy pack containing;

  Episiotomy scissors

  Needle holder

  Dissecting forceps

- Receiver for placenta
- Sterile gauze swabs and cotton wool swabs in a gallipot
- Clean sucker.

Bottom shelf

- Pre-packed sterile gloves
- Warm towels and blanket
- Jug to measure blood loss
- Perineal pads,
- Syringes and needles
- Cord clamp
- Baby identification band
- Antiseptic lotion
- Fetoscope
- Drainage bag and catheter
- A drug tray containing injection Oxytocin, Lidocaine, water for injection, injection vitamin K, and Tetracycline eye drop
- Two clean cot sheets.

Oxygen source and suctioning machine were all in good working condition.

At 12:00pm fetal heart rate was 136bpm, contractions were 4 in 10 lasting 38 seconds, head and maternal pulse was 76bpm.

At 12:30pm fetal heart rate was 138bpm, contractions were 3 in 10 lasting 42 seconds and maternal pulse was 78bpm. At 1:00pm membranes ruptured spontaneously with clear liquor. Vaginal examination was done to exclude cord prolapse and there was none, cervix was 9cm dilated with moulding (+), fetal heart rate 139bpm, contractions were 3 in 10 lasting 43 seconds and maternal pulse was 74bpm. At 1:30pm fetal heart rate was 142bpm, contractions were 3 in 10 lasting 45 seconds and maternal pulse 76bpm. At 1:59pm fetal heart rate was 136bpm, contractions were 4 in 10 lasting 48 seconds and maternal pulse was 80bpm. Client complained

of bearing down, so vaginal examination was repeated and the cervical os was 10cm dilated, head decent was 0/5th. The client was encouraged to breathe through her mouth. The perineum was quickly examined, the vulva and anus were gaping, perineum was bulging and a trickle of blood was evident. Progress of labour was communicated to the midwife in-charge and the client that the cervix was fully dilated. All findings were explained to her and recorded on the partograph sheet. The midwife in charge confirmed full dilation of the cervix.

3.2 MANAGEMENT OF THE SECOND STAGE OF LABOUR

Client was positioned in the second stage room at 2:03pm. She was asked which position she preferred and she responded that she wanted to lie in a dorsal position. She was helped on to the delivery bed and asked to lie on her side.

A sterile trolley was pushed near the delivery bed at the right side of her. Client was reassured to allay her anxiety. Protective clothing was worn (mackintosh apron, safety boots, goggles, and nose mask). Hands were washed and dried and a pair of sterile gloves were put on.

Client was draped and dilatation of cervical os was confirmed. A perineal pad was applied to the anus to prevent faecal matter from contaminating the delivery field hence infecting the baby and FH was checked with each contractions. Client was encouraged to bear down with contractions and rest in between. The fingers of the left hand were placed on the advancing head to aid the smallest diameter of the head distends the perineum. When the head crowned, she was asked to stop pushing and pant and the fingers were spread equally over the vertex to restrain any sudden expulsive effect. She was asked to take a deliberate breath to aid pushing. The head was delivered by extension, by allowing the sinciput, the face and chin to glide slowly over the perineum to be delivered. The baby's eyes were cleaned with sterile cotton wool swabs from the inner canthus to the outer canthus to prevent infection using one swab for each eye. The mouth and nose were also wiped gently with sterile gauze. Neck was felt for cord but there

was none. Restitution took place followed by external rotation of head allowing the shoulders to lie in the anterior-posterior diameter of the pelvic outlet, the hands were placed on the sides of the baby's head over the ears and with gentle downward traction the anterior shoulder was delivered towards the mothers' anus followed by upward traction toward the mother's abdomen to deliver the posterior shoulder. The rest of the body was delivered through lateral flexion along the curve of carus onto the mother's abdomen. At exactly 2:10pm an alive female infant was delivered and she cried loudly. The client was congratulated for her effort and co-operation. Baby was wiped, placed on mothers' abdomen for skin-to-skin contact and covered. Her husband's sister and grandmother were informed of her successfully delivery.

IMMEDIATE CARE OF THE BABY AT BIRTH

Immediately the head was delivered, sterile gauze was used to clean the baby's face, mouth and nose. The eyes were cleaned with sterile cotton wool from inside out. The baby was delivered onto the mother's abdomen. The baby cried immediately after delivery and she was congratulated. The baby was wiped with a clean cloth paying attention to the skin folds. Wet linen was changed. The baby was shown to the mother for confirmation of sex which she identified as female and the baby was put to breast to initiate breastfeeding whiles on the mother's abdomen for skin-to-skin care.

A brunette and baby's socks was put on as well as cloth for warmth. The cord was clamped 3cm from the baby's abdomen, and 2cm from the first clamp with artery forceps and was cut in between the two forceps with a sterile scissors covered with sterile gauze to prevent splash of blood. This was done to separate the baby from the mother. The first and fifth-minute Apgar score was 9/10 and 10/10 respectively. An identification band with the name of the mother, sex, date and time was placed at the baby's wrist. Client was congratulated.

APGAR SCORE		FIRST MINUTE	FIFTH MINUTE
Appearance	-	1	2
Pulse/heart rate	-	2	2
Grimace/reflex	-	2	2
Activity/muscle tone	-	2	2
Respiration	-	2	2

3.3 MANAGEMENT OF THE THIRD STAGE OF LABOUR

The third stage of labour starts after delivery of the baby and ends with complete expulsion of the placenta, its membranes and control of bleeding. This stage was actively managed. The procedure was explained to her. The presence of undiagnosed second twin was checked and there was none. Ten (10) unit of oxytocin was injected intramuscularly at the thigh to aid contraction of the uterus and separation of the placenta by the midwife in-charge. Controlled cord traction was the method used in delivering of the placenta in order to prevent having retained placenta or products of conception. The cord was reclamped with an artery forceps closer to the perineum and the tip end placed in a receiver in between the thighs. The left hand was placed on the fundus and as soon as there was contraction, the left palm was placed just above the symphysis pubis to support the uterus, with the palm facing the fundus of the uterus. This was done to prevent inversion of the uterus. With the right hand, the clamped cord was held. When the uterus was contracted, a very gentle pull was applied on the cord in a downward motion. The downward pulling was continued until the placenta was visible in the vulva. The two hands were used to receive the placenta and it was gently twisted to tease out the membranes completely at 2:15pm(5minutes). The placenta was placed in the receiver and inspection was quickly made to be sure that the membranes and lobes were intact. The uterus

was massaged to stimulate contraction and expel clots. Gauze was wrapped around the first and second fingers of both hands to inspect the vulva, vaginal walls and the cervix as well as the perineum which were all intact. Blood loss per vaginum was about 120mls. Client was cleaned nicely and perineal pad was applied over the vulva and she was made comfortable in bed to rest at the labour ward. She was encouraged to urinate frequently whenever she had the urge so that the uterus could contract well and help in involution of the uterus and to prevent postpartum hemorrhage. All items used was decontaminated in 0.5% chlorine solution and hands was dipped into the chlorine solution to make it less infectious before removing gloves and discarded appropriately.

EXAMINATION OF THE PLACENTA AND MEMBRANES

Protective clothing was worn and a thorough inspection of the placenta and membranes was done in order to ensure no part of it have been retained during its delivery after it had been sent to the sluice room. The placenta was put in 0.5% chlorine solution to make it less infectious and it was held by the cord allowing the membranes to hang loosely downwards. The cord was of normal size and the cut edge was cleaned with cotton wool which revealed two arteries and one vein. It was surrounded by Wharton's jelly. The cord insertion was central, it had no false or true knots. The fetal surface was shinny and smooth with its color being bluish grey. The branches of the cord vessels were seen radiating on its' surface The placenta was placed on a flat surface with the maternal surface facing upward. Through inspection, the color was dark red and the cotyledons were intact. There were no infarcts or extra lobes on the maternal surface. It was then disposed of appropriately.

The working surface was wiped with 0.5% chlorine solution and decontaminated the delivery instruments in 0.5% chlorine solution for 10 minutes, washed with soap and water, rinsed, allowed to air dry and packed to the central sterilization supply department (CSSD) for

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

3.4 MANAGEMENT OF THE FOURTH STAGE OF LABOUR

The fourth stage of labour refers to the first six (6) hours after the delivery of all products of conception. During this period, the baby and mother were closely monitored to detect any complication that may arise and be managed accordingly.

Mother

At 2:20pm madam Deborah was assisted and sent to the lying-in-ward to an already prepared warm bed after one-hour uninterrupted skin to skin care at the labour ward. Her vital signs and condition of the uterus were checked every 15 minutes for the first one hour. Client's immediate post - delivery vital signs were checked and recorded as follows;

Temperature - 36.4^0c

Pulse - 84bpm

Respiration - 20cpm

Blood Pressure - 120/70 mmHg

The uterus was palpated and it was well contracted and symphysio-fundal height was 16 centimeters. She was encouraged to urinate frequently as this will aid contraction of the uterus and involution. Her perineum was observed and the pad for amount of lochia which was bright red, moderate and not offensive. Madam Deborah was encouraged to change her pad frequently when soaked and to wash her hands before and after changing pad and before handling baby. For the first six hours she was given porridge with bread after which she continued

breastfeeding. She was also encouraged to massage her uterus, change pad and to void if she has the urge.

Baby

Prevention of diseases of the new born

This was done after one (1) hour uninterrupted skin to skin care. The procedure to be carried out on the baby was explained to the mother. Hands were washed and dried with a clean towel. The baby was put on a clean, warm and flat surface in the presence of mother. Chloramphenicol eye drop was instilled on the inner canthus of the eye with the hand pressing on the cheek. Cord was inspected for bleeding but it was fresh and in good condition without any bleeding. The umbilical cord was cleaned with sterile cotton wool swabs soak in methylated spirit and kept dry. Vitamin K1 was given also as a prophylaxis for prevention of hemorrhagic disease of the newborn after examination of the newborn due to the pain it causes.

SUMMARY OF LABOUR

Date and time of delivery - 13th December 2022 at 2:10pm

Type of Delivery - Spontaneous Vaginal Delivery

Time injection oxytocin was given - 2:11pm

Time of Expulsion of Placenta and membranes - 2::15pm

Drugs given - Injection Oxytocin 10 units

DURATION OF LABOUR

1st Stage	-	6 hours, 35minutes
2nd Stage	-	15minutes
3rd Stage	-	5 minutes
Total time	-	6 hours, 55minutes

CONDITION OF MOTHER

Condition of mother	-	Stable
Perineum	-	Intact
Fundal Height	-	16cm
Blood Pressure	-	120/70mmHg
Pulse Rate	-	84bpm
Respiration rate	-	20 cpm
Temperature	-	36.4ºC
Blood lost	-	120ml

CONDITION OF BABY

Heart rate	-	148bpm
Respiration	-	48cpm

General condition of baby - Satisfactory

Sex of Baby - Female

Baby's Weight - 2.9kg

Congenital Abnormalities - None detected.

Baby's Full Length - 46cm

Head circumference - 32cm

Meconium - Passed

Urine - Passed

PROBLEMS IDENTIFIED

3.5 NURSING CARE PLAN DURING LABOUR

- Anxiety
- Lower abdominal pain
- Waist pain
- Excessive sweating
- Risk of infection

SHORT TERM OBJECTIVES

- Client will be allaying of anxiety within 30 minutes
- Client will cope with lower abdominal pain till she delivers
- Client will cope with waist pain within 2 hours.
- Client will remain well hydrated and comfortable within 2 hours and at the end of labour
- Client will show no signs of infection within 24 hours.

LONG TERM OBJECTIVE

Client will go through labour successfully with healthy baby without complication to both mother and baby.

NURSING CARE PLAN DURING LABOUR TABLE

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES /OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTIONS	DATE /TIME	EVALUATION	SIGN
13/12/22 at 9:30am	Anxiety related to unknown outcome of labour.	Madam Deborah will be allayed from anxiety within 30 minutes as evidenced by 1. Madam Deborah verbalizing she is no longer anxious. 2. She has a cheerful facial expression.	1. Reassure client of competent care to be rendered in the management of the condition. 2 Encourage her to voice out all her needs and fears. 3. Provide answers to questions accordingly and appropriately.	1. Madam Deborah was reassured of competent care to be rendered in the management of the condition. 2. Madam Deborah was encouraged to voice out all her needs and fears 3.Client was provided with answers to question accordingly and appropriately.	13/12/22 at 10:00am	Goal was fully met as client's anxiety was allayed and she had a relaxed facial expression.	C.S.K

			4. Involve client in her care 5. Keep Madam Deborah informed of the progress of labour. .	4. Madam Deborah was involved in her care. 5. Madam Deborah was informed of the progress of labour.			

NURSING CARE PLAN ON LABOUR

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES/OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTIONS	DATE/ TIME	EVALUATION	SIGN
13/12/22 at 9:30am	Lower abdominal pain related to painful uterine action	Madam Deborah will cope with lower abdominal pain till she deliver as evidenced by Madam Deborah verbalizing that she can cope with pain	1. Reassure Madam Deborah that she will be relieved after delivery. 2. Explain physiology of the lower abdominal pain to Madam Deborah.	1. Madam Deborah was reassured that will be relieved after delivery. 2. Physiology of lower abdominal pain was explained to the Madam Deborah.	13/12/22 at 2:20pm	Goal full met as Madam Deborah coped with the lower abdominal pain and cooperated during labour	C.S.K

		2. She was Cooperating during labour	3. Encourage Madam Deborah to adopt comfortable position and ambulate. 4. Communicate progress of labour to Madam Deborah. 5. Encourage Madam Deborah to do deep breathing exercise during contractions.	3. Madam Deborah was encouraged to adopted comfortable position and ambulated. 4. Progress of labour was communicated to client. 5. Madam Deborah was encouraged to do deep breathing exercise during contractions.			

			6. Provide diversional therapy by conversing with client.	6. Diversional therapy was provided to client by conversing with her.			

NURSING CARE PLAN ON LABOUR

DATE / TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTIONS	DATE / TIME	EVALUATION	SIGN
13/12/22 at 11:00am	Waist pain related to pressure on pelvic muscles.	Madam Deborah will cope with waist pain within 2 hours as evidenced by client verbalizing that she is coping with waist pain and performing deep breathing exercise during uterine contractions.	1. Reassure Madam Deborah that she will be relieved after delivery. 2. Explain physiology of waist pain to Madam Deborah. 3. Massage sacral region during contraction to relieve pain.	1. Madam Deborah was reassured that she will be relieved after delivery 2.The physiology of waist pain was explained to the Madam Deborah 3.Sacral region was massaged during contractions to relieve her pain	13/12/22 at 1:00pm	Goal was fully met as client coped with waist pain and performed deep breath exercise till, she delivered.	C.S.K

			4. Encourage client to adopt comfortable position and ambulate (left lateral). 5. Communicate progress of labour to client. 6. Provide diversional therapy by conversing with client.	4. Madam Deborah was encouraged to adopt a comfortable position and ambulate (left lateral) 5. The progress of labour was communicated to client 6. Diversional therapy was provided to client by conversing with her			

NURSING CARE PLAN ON LABOUR

DATE / TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTIONS	DATE / TIME	EVALUATION	SIGN
13/12/22 at 12:30pm	Impaired comfort related to excessive sweating.	Madam Deborah will remain comfortable (within 2 hour) and throughout labour as evidenced by midwife observing that Madam Deborah	1. Reassure client of competent care to promote comfort. 2. Explain the cause of the sweating. 3. Serve Madam Deborah cold water to drink at frequent interval. 4. Give ice cubes to client to sip	1. Client was reassured of competent care to promote comfort. 2.The cause of the sweating was explained to the client 3. Madam Deborah took cold water frequently 4. Ice cube was given to the Madam Deborah to sip	13/12/22 at 2:30pm	Goal fully met as client was observed to be comfortable and felt relaxed.	C.S.K

		feels comfortable and not sweating excessively.	5. Mop the face and body of client with wet towel. 6. Improve ventilation by open windows and putting on fans.	5. Madam Deborah's face and body was mopped with wet towel. 6. Windows was opened and fan put on			

NURSING CARE PLAN FOR LABOUR

DATE / TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTIONS	DATE / TIME	EVALUATION	SIGN
13/12/22 at 12:40pm	Potential risk for infection related to mishandling of perineal pad	Madam Deborah will be free from infection within 24 hours as evidenced by; 1. Madam Deborah verbalizing that	1. Reassure Madam Deborah that she will be free from infections. 2. Encourage client to wash her hands before and after touching perineal pad. 3. Educate Madam Deborah on the need to change perineal pad whenever soaked to prevent infections.	1. Madam Deborah was reassured that she will be free from infections. 2. Client was encouraged to wash her hands before and after touching perineal pad. 3. Madam Deborah was educated to change her soaked perineal pad to prevent infections.	13/12/22 at 1:40pm	Goal fully met as Madam Deborah verbalized that she does not feel sick.	C.S.K

		she does not feel sick 2. The midwife observing that she shows no signs of infection.	4. Educate Madam Deborah to discard pad if fallen. 5. Teach Madam Deborah how to fix pad properly.	4. Madam Deborah was educated to discard fallen perineal pad. 5. Madam Deborah was taught to fixed pad properly.			

CHAPTER FOUR

PUERPERIUM

4.0 INTRODUCTION

This chapter gives details of subsequent care given to the mother and her baby during the first six weeks of delivery. Health education and home visits were given from the first to seventh day.

MANAGEMENT OF FIRST STAGE OF LABOUR

4.1 Day of delivery

Madam Deborah delivered on 13th December 2022 at 2:15pm to an alive female baby. Client and her baby were transferred to the lying-in ward after an hour of close observation when their conditions were satisfactory. Her immediate post-delivery vital signs at 2:20pm recorded as follows;

Mother's Vital Signs

Temperature - 36.4^0C

Pulse - 84bpm

Respiration - 20cpm

Blood Pressure - 120/70 mmHg

On palpation the uterus was well contracted and the symphysio-fundal height measured 16 cm just below the umbilicus. The lochia was red in color and flow was moderate. On examination,

no abnormality was detected. She was encouraged to change her sanitary pad when wet to avoid the risk of infection and for comfort. She was encouraged to report any excessive bleeding and also to urinate frequently to enable the uterus to contract firmly. Emphasis was placed on fluid and adequate diet to help replace worn out tissues and promote growth by encouraging husband and other family members to provide adequate water and food like protein (meat, egg, beans, milk etc.), fruit (orange, apple, banana etc.) and vegetable (kontomire etc.). At 4:00pm, client complained that when her baby suckles she experiences pain. Madam Deborah was reassured and it was explained to her that suckling will help in the involution of the uterus so she should continuously breastfeed the baby. Madam Deborah was served with 1gm of paracetamol. And baby was put to breast and she suckled effectively. She was advised on breastfeeding problems such as cracked nipples, engorgement and mastitis, and to report if problem persisted. The need for hand washing before and after breastfeeding, after visiting the toilet and changing perineal pad were stressed. She was educated on how to massage the uterus by rubbing the palm on the fundus to help in the contraction of the uterus. She was also advised on rest and sleep. Her support person was encouraged to help in the care of the baby to ensure good rest of the client. Her husband's sister brought her banku and ground nut soup.

Examination of the newborn

At 3:15pm baby was put on a clean warm and flat surface. Baby was then exposed systematically as it was examined from head to toe in the presence of the mother. Its color was pink on observation and she appeared active. The head was examined for shape and size, widened sutures, bulging or depressed fontanels, any edematous swelling, (caput succedaneum) no abnormalities were found.

A tape measure was used to encircle its head starting from the occipital protuberance to the supraorbital ridges to measure the head circumference and it was 32centimeters.

The Ears were examined for size, shape, and patency, softness of the cartilage, alignment and discharges.

The Eyeballs were examined for presence and color, pallor, jaundice and deformities.

The Nose was examined for shape, size, patency, deviated septum and discharges.

The Buccal Cavity was inspected for false teeth, tongue tie, color of tongue and gum, cleft palate using the little finger to feel for palate for any sub mucous cleft, the neck for nodules, rigidity and congenital goiter but no abnormality was detected.

The Chest, Respiratory Movement was normal, nipples were in alignment without discharges, and breast had no mass.

The Upper Extremities were inspected for equality, number of palmer creases clubbed fingers, extra or loss digits. Baby's ability to perform Moro and grasp reflexes was also checked and was present.

The Abdomen was examined for shape, size, with no bleeding from the umbilical site and abnormalities such as omphalocele, gastroschisis were absent.

The Lower Extremities were inspected for equality, clubbed feet, extra/loss digits, none was detected. Congenital hip dislocation was also checked using the Ortolani's test and there was no dislocation since a 'clunk' sound was not heard. With baby lying on one side, its back was examined for abnormalities like spinal bifida, meningocele, oedema which were absent. **The Genitalia** were inspected with the labia majora covering the minora and the urethral orifice was patent as it passed urine. The anus was also examined and it was patent as baby passed meconium. Baby was weighed and it was 2.9 kilograms and length was 46 centimeters. Vitamin K (1mg) was injected intramuscularly at the thigh of the baby to prevent hemorrhagic diseases of the baby. The baby was monitored for cord bleeding and there was none. Gloves

were removed and disposed aseptically before washing and drying hands. All the findings were communicated to the parents and recorded afterwards. The baby was then dressed nicely in a warm sheet and given to the mother for breastfeeding while observing suckling reflex. Client was educated on the importance of exclusive breast feeding for the first six months of birth.

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

Temperature 36.6degrees Celsius

Heart rate 148bpm

Respiration 48cpm

Baby's condition was satisfactory.

SUBSEQUENT CARE OF THE BABY

Baby bath and cord dressing

After 16hours of delivery, permission was sought from mother to bath the baby of which she consented. Hand was wash with soap and water and dried with towel. Brief examination was done and no abnormality was detected. The baby passed meconium and urine which was normal. The cord was inspected for bleeding and discharge but there was none. Baby's vital signs was checked and recorded as,

Baby's Vital Signs

Temperature - 36.5 ℃

Apex beat - 146bpm

Respiration - 38cpm

Weight - 2.9kg.

REQUIREMENT NEEDED FOR BABY BATH

Top Shelf

1. Sterile cotton swab
2. Sterile water in a galipot
3. Sterile galipot

Bottom shelf

1. Soap
2. Sponge
3. Cream / powder / oil
4. Basin
5. Towels: 1 big towel and 3 small ones
6. Cot sheet 2

. 7. Apron

8. Gloves

9. A clean baby dress, cap and socks

10. Mackintosh

11. 2 jugs containing hot and cold water each

12. Two receptacles for used water and dirty linen

13. A receiver for used swab

14. Chloexidine gel

15. Sterile cotton in a gallipot or wrapped.

A plastic apron was put on. Hands were washed with soap and water and dried with clean towel. Both cold water and hot water were mixed together and the temperature of the water was checked using the elbow. Gloves were worn and the baby was put on a protected flat surface and was undressed. Baby was then wrapped with a cot sheet with the head exposed for it to be bathed.

The Eyes were cleaned with clean cotton wool swabs soaked in clean water from inner canthus to outer canthus and the face cleaned with damp face towel and dried. The nape of the baby's neck was supported with one hand.

The Head was supported and the baby's ears plugged with two fingers. The head was then washed with soapy sponge. Baby was then lifted off flat surface, supporting the nape of the neck and the body resting in the elbow, to the edge of the basin and soap rinsed off baby's hair and dry. Baby was then put on protected flat surface and exposed.

The Arms And Front Of Trunk were washed paying attention to the skin folds. The back of the baby was turned with one arm supporting the chest and with a hand holding the distal arm of the baby.

The Back was washed down to the feet, paying attention to the skin folds. Baby was supported firmly and immersed in warm water, with head above water and rinsed thoroughly. She was then placed on the flat surface covered by a big bath towel. A small towel was used to dry the baby, paying attention to skin folds. Baby oil, as well as, powder was applied on the baby. The

baby was wrapped with clean dry cot sheet after which the cord was exposed. The gloves were removed, hands were washed with soap and water and a sterile gloves worn.

The Cord was inspected for bleeding but there was none. Six sterile cotton wool swabs were used to dress the cord. The tip of the cord was held with sterile cotton wool swab soaked in chloexidine gel, then swabbed 5cm away from the base and after that the base of the cord was cleaned with separate cotton wool swabs soaked in methylated spirit. The whole cord was cleaned from the base upwards and lastly the tip was also cleaned with separate cotton wool swab soaked in methylated spirit. The cord was left exposed to air dry. Baby was dressed after diaper was put on. The baby was wrapped with clean dry cot sheet to maintain her temperature and given to her mother. Findings were communicated to the mother and she was thanked for her co-operation and she was accompanied to the bedside. The working surface and the instruments were decontaminated with 0.5% chlorine solution for 10 minutes; it was then washed. The gloves were removed and hands washed and dried and the procedure was documented

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

4.2 FIRST DAY POST DELIVERY (AT HOSPITAL)

On 14th December 2022, was the first day after delivery and Madam Deborah and her baby were very healthy with cheerful looking face when they woke up around 6:30am. All procedures to be carried out on both mother and baby were explained. Perineal pad was inspected and blood flow was small and red in color (rubra) without odour, and enquiries about her bladder habit was asked, of which she said it was resuming to normal. She brushed her teeth, emptied her bowel and had warm bath. Madam Deborah was served with porridge and bread as her breakfast. She complained of lower abdominal pain and sleepless in the night which she said was due to breastfeeding of the baby at night therefore did not have enough

sleep at night. She was encouraged on good and enough breastfeeding during the day and to ensure the atmosphere is calm at night this will enable the baby to sleep at night so that she can also rest. She was also educated to sleep in the afternoon when the baby too is asleep, she was reassured and encouraged to sleep when baby sleep. It was explained to client the important of feed baby at regular intervals. She was made comfortable in bed. Her vital signs were checked and recorded as follows;

Madam Deborah's assessment was recorded as follows;

Temperature	36.3^{o}c
Pulse	80bpm
Respiration	22cpm
Blood Pressure	118/91mmHg
Lochia	Rubra
Fundal Height	15cm
Condition of the uterus	contracted
Breast	Lactating

Madam Deborah's symphysio- fundal height was 15 centimeters above the symphysis pubis. Her lochia was red (rubra) in color when checked and amount was minimal and not offensive after permission was sought to inspect it. Madam Deborah was then assisted to perform kedel exercise to strengthen the perineal muscles. She was served with tea and bread by the mother as breakfast.

The baby was also examined with permission from the mother after hand washing with soap and water and dried with towel. On examination, there was no abnormality detected. The baby passed meconium and urine which was normal. The cord was inspected for bleeding and discharge but there was none. Vital signs of the baby were checked and recorded. The baby was bathed and the cord was dressed with cotton swabs and chloexidine gel and given to mother to breastfeed. On observation, mother positioned baby well and baby also had a good suckling and swallowing reflex. The baby's assessment was recorded as follows;

Temperature	36.6^{o}c
Apex beat	146bpm
Respiration	38cpm
Skin color	Pink
Cord condition	Clean dry
Cord bleeding	None
Suckling	Good
Weight	2.8kg
Stool color	Meconium

All findings were communicated to mother. Later in the day around 8:30am, the baby was given the immunization against tuberculosis with bacilli calmatte Guerin (BCG) by the community health nurse from the Reproductive and Child welfare Clinic but polio '0' (OPV0) which prevents the baby against poliomyelitis was not given since it was a day after delivery. The BCG was given intradermal on the right upper arm of which the mother was informed that it will form a blister and scar later and she was advised not to apply anything to the site in other

to ensure effectiveness of the vaccine and 2 drops of Polio '0' vaccine (OPV0) was given at the back of the tongue. Client was told to come with the baby to take the rest of the immunization at the time scheduled in order to protect the baby from any of the childhood preventable diseases like Measles, Tetanus, and Diphtheria and among others.

Preparation for discharge

She was told that, she would be discharged that day. She was educated on healthy adequate nutritious diet like fish, ground nut, and green leafy vegetables to help in the production of more breast milk and improve her immunity as well. This could help repair worn out tissues. She was also educated on personal hygiene, the various family planning method available and post-natal exercises. The essence of the exercise was explained to her that it would help the pelvic organs to strengthen the pelvic muscles and gaining her shape back. Furthermore, she was educated on demand feeding and exclusive breast feeding.

Madam Deborah was educated to breastfeed whenever the baby demands it. She was health insured therefore her medicines were collected for her from the pharmacy with health insurance card and some money paid for other billings. Routine drugs were served as prescribed. Madam Deborah was reminded of her counsel and was informed of her discharge. Madam Deborah's drugs were given to her and the dosage and time for taking the drug were explained to her again as follows:

Capsule Amoxicillin - 500 milligram tab for 7 days

Tablet Metronidazole - 400 milligrams tab for 7 days

Tablet Paracetamol - 1gram tab for 5 days

She was educated on when the fontanelles will close naturally and therefore no hot water should be applied with the intention of helping it to close earlier.

She was helped to pack her belongings and was educated on intended post-natal visits for a period of one week which was explained to her that she would be visited at home for seven days for continuity of care. Madam Deborah was educated on and how to manage some common breast problem such as cracked nipple and breast engorgement. She was also encouraged not to apply anything on the cord aside the use of chloexidine gel. She was encouraged to register the baby at the birth registry and informed of continuity of care. Madam Deborah was then discharged at 10:00am and went home with her husband's brother car accompanied by myself.

POST NATAL VISITS

4.3 FIRST POSTNATAL HOME VISIT

On 14th December 2022 at 4:50pm, client and family were visited as promised. Madam Deborah was at home with her grandmother and son. Greetings were exchanged on arrival. Enquiry about the baby and her health was made of which she responded they were all fine. Madam Deborah's interrupted sleep which she complained during first day post-delivery when asked. Madam Deborah said she was able to sleep better than previous night. Permission was sought to do the examination of which she agreed. After hand washing, symphysio-fundal height was measured. The reading was 15 centimeters above the symphysis pubis. The perineal pad was checked and the color of the lochia was bright red and not offensive. Client's vital sign checked and recorded as follows;

(EVENING)

Temperature	36.9^{o}c
Pulse	79bpm
Respiration	20cpm

Blood pressure	100/70mmHg
Lochia	Rubra
Condition of the uterus	Contracted
Breast	Lactating

She was asked whether she has any problem and she responded no. Head to toe examination was done on the baby and there was no abnormality. Baby's assessment was as following,

Temperature	36.6 ^{o}c
Apex beat	145bpm
Respiration	45cpm
Skin color	pink
Cord condition	dry and clean
Cord bleeding	None
Suckling	Good
Stool color	meconium

4.4 SECOND POSTNATAL HOME VISIT

On the 15th December 2022 at 7:50am, another visit was made to Madam Deborah. The main aim of the visit was to know if the mother and baby were in good health. Madam Deborah was examined, her breast was lactating well and her uterus was well contracted, her symphysio-fundal height was 14cm. Perineal pad was inspected and lochia was bright red in color (rubra),

the flow was moderate and not offensive. She was congratulated after the examination. Madam Deborah's assessment was recorded as follows;

The reading was 14 centimeters above the symphysis pubis. The perineal pad was checked and the color of the lochia was bright red and not offensive. Client's vital sign checked and recorded as follows;

(MORNING)

Temperature	$36.4^{o}c$
Pulse	81bpm
Respiration	20cpm
Blood pressure	110/80mmHg
Lochia	Rubra
Fundal height	14cm
Condition of the uterus	Contracted
Breast	Lactating

She was asked whether she had any problem or complains and she responded no. Head to toe examination was done on the baby but there was no abnormality found. The baby was assessed and recorded as follows;

Temperature	$36.6^{0}c$
Apex beat	130bpm
Respiration	48cpm

Skin color	Pink
Cord condition	Dry and clean
Cord bleeding	None
Suckling	Good
Weight	2.7kg
Stool color	Meconium

The baby was top and tail and dressed nicely with cap and socks and wrapped loosely in a warm sheet and made comfortable in bed. Madam Deborah was asked if she has any complains and she said her breast was heavy, she was encouraged to breastfeed baby more frequently. At 5:30 pm in the evening, client and family was visited again. Madam Deborah was assisted to position and fix baby well to the breast while breastfeeding. Madam Deborah was again educated to breastfeed baby frequently and also make sure one breast is completely empty before giving the other one to the baby. Madam Deborah was also educated on the need to apply cold compresses on the breast and the need to put on a well-fitting brassiere to help relieve the engorgement. Madam Deborah was educated to continue to express as often as necessary milk to make her comfortable until engorgement stops and findings were recorded.

(EVENING)

Temperature	36.7^{o}c
Pulse	70bpm
Respiration	18cpm
Blood pressure	110/70mmHg

Lochia	Rubra
Condition of the uterus	Contracted
Breast	Lactating

The baby's vital sign was checked and recorded after which cord was dressed. Permission was then sought to leave and she was informed of the next visit.

Temperature	36.7^{o}c
Apex beat	132bpn
Respiration	46cpm
Skin color	Pink
Cord condition	Clean dry
Cord bleeding	None
Suckling	Good
Stool color	Greenish brown

4.5 THIRD POSTNATAL HOME VISIT

On the 16th December 2022 at 7:30am a visit was paid to Madam Deborah and her family, they were all in good health but client looked moody. She was encouraged to share her problems and to be happy for what God has done for her and her family. Madam Deborah was examined from head to toe and the uterus was well contracted. The symphysio-fundal height was 13cm. The perineal pad was inspected for lochia and the color was bright red (rubra), the flow was moderate with no odour. The breast was also lactating well. Madam Deborah said the baby can now hold the breast and breastfeeding well. Client's assessment was recorded as follows,

(MORNING)

Temperature	36.5^{o}c
Pulse	82bpm
Respiration	20cpm
Blood pressure	110/60mmHg
Lochia	Rubra
Fundal height	13cm
Condition of the uterus	Contracted
Breast	Lactating

The baby was topped and tailed in the present of the mother while singing a lullaby to her and cord dressed for the second time and it looked dry. Baby passed greenish brown stool and urinated during bathing. The baby was assessed and recorded as follows;

Temperature	36.8^{o}c
Apex beat	130bpm
Respiration	48cpm
Weight	2.6kg
Skin color	pink
Cord condition	clean and dry
Cord bleeding	None

Suckling	present
Stool color	Greenish brown

In the evening at 6:40pm mother and baby were visited. Madam Deborah was assessed and recorded and baby was top and tailed and cord was dressed. Vital signs of baby were checked and recorded. Client complained that elder child has been angry and has refused to eat since they were discharge home. It was explained to her that, the elder child feels neglected and she was encouraged to care for him and to allow him to play with baby under her supervision to avoid sibling rivalry. She was informed her about the change of visit to daily bases. Permission was then sought to leave and it was granted.

(EVENING)

Temperature	36.8^{o}c
Pulse	82bpm
Respiration	20cpm
Blood pressure	110/80mmHg
Lochia	Rubra
Condition of the uterus	contracted
Breast	Lactating

Baby's vital signs were as follows;

Temperature	36.8^{o}c
Apex beat	142bpm

Respiration	48cpm
Skin colour	Pink
Condition of the cord	Shrinking
Cord bleeding	None
Suckling	Good
Stool colour	Yellowish

4 .6 FOURTH POSTNATAL HOME VISIT

On 17th December 2022, Madam Deborah and family were visited at 7:15am. The aim of the visit was to access how they were fairing. All the family members were around on arrival, they were all in good health when asked and their environment was clean. Madam Deborah verbalized that the pains she felt in her breast had subsided greatly and they also felt lighter when asked. Head to toe examination was done and was detected that the engorged breast has resolved and there was no abnormality detected on Madam Deborah. Her perineal pad was inspected for lochia and the flow was moderate, pink in color (serosa) and not offensive. Symphysio-fundal height was measured and it was 12cm and recorded as follows;

Temperature	36.2^{o}c
Pulse	80bpm
Respiration	20cpm
Blood pressure	110/90mmHg
Lochia	Rubra
Fundal height	12cm

Condition of the uterus	contracted
Breast	Lactating

Client complained of perineal pain, she was educated on the cause of it and was reassured. Madam Deborah's mother was assisted to top and tail the baby and after that she was taught how to use chloexidine gel in dressing the cord. The baby passed yellowish stool and urinated during the procedure. She wrapped the baby loosely in a sheet and made her comfortable in bed. Baby's vital signs and other observations were recorded as follows;

Observation	Morning
Temperature	$36.6^{o}c$
Apex beat	132bpm
Respiration	40cpm
Cord	Shrinking
Cord bleeding	None
Suckling	present
Weight	2.6kg
Stool colour	Yellowish

Client said that the elderly child is happy and now play with the baby. After that she was asked if there were any complains and she responded negative. She was informed of the next home visit and permission was asked to leave. They expressed their gratitude for the visit and was accompanied outside the house.

4.7 FIFTH POST NATAL HOME VISIT

On the 18th December, 2022 at 7:00 am, she was visited once again. On arrival, Madam Deborah was brushing her teeth. The rest of the family members were asked how they were doing and they responded they were fine by God's grace. Hot water was already available for bathing but she requested that, she would like to perform some pelvic exercises before bathing. The symphysio-fundal height was 11centimeters. The perineal pad was examined and the color was pink (serosa) without any offensive odour and no abnormalities detected at the perineum. Madam Deborah's assessment was recorded as follows;

Temperature	36.5^{o}c
Pulse	83bpm
Respiration	23cpm
Blood pressure	120/80mmHg
Lochia	Serosa
Fundal height	11cm
Condition of the uterus	Contracted
Breast	Lactating

Madam Deborah topped and tailed her baby under supervision. Baby's cord was dressed with chloexidine gel and it looked dried and about to slough off, and baby was dressed nicely and wrapped in white cloth and made comfortable in bed. Madam Deborah said the baby has already passed yellowish brown stool and urinated. Baby was assessed and the observations were recorded as follows;

Temperature	36.7^{o}c
Apex beat	134bpm
Respiration	48cpm
Skin color	pink
Cord	Dried and about to slough off
Cord Bleeding	None
Suckling	present
Weight	2.7kg
Stool color	Yellowish brown

Madam Deborah's grandmother was encouraged to assist client in the care of the baby and was educated not to apply anything on the stump to prevent infection but should always leave it clean and dry.

Permission was asked to leave.

4.8 SIXTH POSTNATAL HOME VISIT

Madam Deborah was visited again on 19th December 2022 at 7:30am. Everybody in the house was in good health. Madam Deborah was seen happy and was smiling all around as she has adequate support and love from her relatives and friends as well. Every procedure to be carried on was explain to her. The symphysio- fundal height was 10cm. The perineal pad was examined and the color was pink (serosa) without any offensive odour. Head to toe examination was carried out without any abnormalities detected.

Temperature	36.6^{o}c
Pulse	70bpm
Respiration	20cpm
Blood pressure	110/60mmHg
Lochia	Serosa
Fundal height	10cm
Condition of the uterus	Contracted
Breast	Lactation

The baby's cord was off, she was bathed and the stump dressed with chloexidine gel. Yellowish-brown stool and urine were passed during bathing. The baby's weight was 2.8kilogram. She was wrapped loosely in a warm baby sheet. Baby's assessment was recorded as follow;

Temperature	36.8^{o}c
Apex beat	128bpm
Respiration	40cpm
Skin color	pink
Cord	Off
Cord bleeding	Absent
Suckling	Present

Weight	2.8kg
Stool color	Yellowish brown

She reported of no complains. They were informed about the next day to be the first postnatal visit to the hospital and the last post-natal home visit to them. They were not really happy about the last visit announcement, but they were assured of meeting again at the postnatal clinic. They were bid goodbye.

4.9 SEVENTH POST NATAL HOME VISIT

The last post-natal home visit was on the 20th December, 2022at 6:26pm. On arrival, Madam Deborah had her daughter on her laps while singing lullaby. Greetings were then exchanged and routine examinations started after permission was soughed.

Madam Deborah's symphysio- fundal height was 9cm. Her perineal pad was inspected and the lochia was pink (serosa) and not offensive with the flow reduced in amount. Madam Deborah's assessment was recorded as follows:

Temperature	36.4°c
Pulse	72bpm
Respiration	20cpm
Blood pressure	110/70mmHg
Lochia	Serosa
Fundal height	9cm
Condition of the uterus	Contracted
Breast	Lactation

Hot water was available for bathing the baby. The baby was bathed and the stump dressed with chloexidine gel. Yellowish brown stool and urine had been passed before bathing. She was wrapped loosely in a warm baby sheet. Baby's assessment was recorded as follows;

Temperature	36.6^{o}c
Apex beat	136bpm
Respiration	52cpm
Skin color	Pink
Cord	Healing
Cord bleeding	No
Suckling	Present
Weight	2.9kg
Stool color	Yellowish brown

Madam Deborah said she took fufu and light soup as super. Interaction went on for a while in which she was asked of any complains and she complained of engorged breast. She was encouraged to continue feeding the baby on demand and also to fix baby properly onto the breast when feeding her. By so doing, her breast will not be engorged and her nipple will not develop sore. Madam Deborah's husband was encouraged to help her to take warm baths and also on the need to massage the breast. They were then discharged from home visits. The family was thanked for their understanding and cooperation. Emphasis of that visit being the last was made again. They also expressed their gratitude.

4.10 FIRST POST-NATAL VISIT TO THE CLINIC

On 21st December, 2022, Madam Deborah and her baby visited to the clinic around 8:00am. They were warmly welcomed and a seat was offered to them. Madam Deborah was looking cheerful and neatly dressed. The baby was also looking very active, nice and healthy. Her permission to check her vital signs and weight and was recorded as below;

Mother's Vital Signs

Temperature - 36.2 degrees Celsius

Pulse - 74beats per minute

Respiration - 19 cycles per minute

Blood pressure - 110/80 millimeters of mercury

Weight - 62 kilogram

Baby's Vital Sign

Temperature - 36.6 degrees Celsius

Pulse - 132 beat per minutes

Respiration - 42 cycles per minutes

Weight - 3.0 kilogram

Since it was her first postnatal clinic visit, there was the need to send her to the Laboratory for further investigations. Madam Deborah was therefore given a specimen bottle for urine to be sent to the Laboratory for urine analysis to be performed. She was educated on the need and procedure to provide midstream urine for the examination. A sample of blood was also taken

from Madam Deborah with her consent to be sent to the laboratory for haemoglobin to be tested. The samples were then sent to the laboratory. The results were as follow

Haemoglobin	11.6 g/dl
Urine protein	Negative
Glucose	Negative

The results were explained to her and she expressed signs of joy upon hearing that all results were normal and smiled also.

Madam Deborah was sent to the palpation room where privacy was provided by drawing the curtains and closing doors and windows. She was helped to assume a comfortable position with which she chose to lie laterally on her left 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, hair was neat and well styled. The conjunctiva was pink and there was no discharged from the eyes, nose and ears. No abnormality was found in the mouth and neck as the mouth buccal cavity looked pink with normal odor and neck was free from any palpable masses and free from distensions of blood vessels as well. On the breast, it was lactating well but engorgement was detected. On examining the abdomen, no abnormality such as sub involution, tenderness, enlargement of liver and spleen was detected. The symphysio-fundal height was 8cm.

With the lower extremities, certain condition such as edema was looked out for. It was detected that she showed no abnormality of that sort.

The perineum was intact and there was no offensive vaginal discharge and the lochia was white in color. All findings were communicated to her after the procedure. She was then thanked for her co-operation and helped to dress up.

Head to toe examination was also performed on the baby to look out for abnormalities. On the head, the anterior and posterior fontanelles was palpated for pulsation and it was present and normal. A few skin rashes on the baby's forehead which looks like heat rash. Madam Deborah was reassured that its normal for babies to develop skin rashes as their skin is sensitive to a different environment and encouraged to dress the baby according to the weather, she should ensure baby wears clean and dry cotton clothing, wash her hands before and after handling the baby and ensure diapers are changed frequently. There were no discharges from the eye and nose. The skin was nice, very pink and with no rashes. The chest movement was normal as well as the extremities. The umbilical cord was healed. Findings were communicated to the mother and she was congratulated for taking good care of the child and herself. She was educated on various family planning methods, when to resume sex, the need to feed the baby exclusively for 6 months especially in the night. She was also encouraged to register the baby at the birth registry. She was again educated on the need to attend child welfare clinic in order to monitor the growth of her baby, early detection of infection or disease and the need to complete all the immunization. She was encouraged to continue practicing of exclusive breastfeeding and the pelvic floor muscle exercise. Both mother and baby were in good health and documentation was done on all findings.

She was reminded of the six weeks' post-natal visit to the clinic. She was thanked for cooperation. Madam Deborah and family was handed over to the Public Health Nurses at the Reproductive and Child Health Unit for continuity of care. Madam Deborah was sad of what was said but she was promised to be checked on from time to time through phone calls and was seen off.

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4.11SECOND POST-NATAL VISIT TO THE CLINIC

According to the midwife in charge, on the 24th January, 2023 at 8:20am madam Deborah came to the clinic for six weeks visit. They were warmly welcome and they all looked very healthy. General examination was conducted from head to toe as well as vital signs after her permission was sought.

Her vital signs and weight were checked and recorded as follows:

Temperature	36.8ºc
Pulse	75bpm
Respiration	20cpm
Blood Pressure	110/60mmHg
Weight	60kg

Madam Deborah was given a urine sample container to provide some urine to be sent to the Laboratory for urine analysis to be performed. She was educated on the need and procedure to provide midstream urine for the examination. A sample of blood was also taken from Madam Deborah with her consent to be sent to the Laboratory to be tested for haemoglobin level. The samples were then sent to the Laboratory. The results from the Laboratory were as follows;

Haemoglobin-	12.2 g/dl
Urine protein	Negative
Glucose	Negative

The results were explained to her and she expressed her joy upon hearing the results.

Madam Deborah was sent to the palpation area where privacy was provided by drawing the curtains and windows. She was helped to assume a comfortable position 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, hair was neat and well styled. The conjunctiva was pink and there was no discharge from the eyes, nose and ear. No abnormality was found on the mouth and neck. On the breast, no abnormalities such as sore nipple, engorgement, cracked nipple and mastitis were detected and the breasts were lactating well. On examining the abdomen, no abnormality such as sub involution, tenderness, enlargement of liver and spleen was detected. No scars were found and uterus was not palpable.

With the lower extremities, certain condition such as edema was looked out for. It was detected that she showed no abnormality.

She was asked if she has resumed menstruation but she said no. she was educated on the need to start a family planning method to prevent unwanted pregnancy.

Her baby was also examined from the head to toe to look out for abnormalities. On the head, the anterior fontanelle was palpated for pulsation and it was normal. The posterior fontanelle had closed. There were no discharges from the eyes and nose. The skin was smooth with no rashes. The chest and upper extremities were normal. The umbilical stump was inspected and it had healed and was off. The lower extremities were normal. Weight of baby was 5.0kg

The baby`s vital signs and weight were as follows:

Temperature	36.7ºC
Respiration	38cpm
Apex heart beat	132bpm

Madam Deborah and her baby were handed over to the child welfare clinic and family planning unit for the six weeks' immunization against diphtheria pertussis, tetanus, haemophilus influenza type B and hepatitis B.(pentavalent).

She was encouraged to ask questions but she asked none and made no complaints either. She was reminded on exclusive breastfeeding, rest and sleep, exercise and nutritious diet, which would help in lactation. Madam Deborah and her children were able to cope with their new sibling. She was finally handed over to the public health nurse for continuity of care but she was asked to report to the facility any time she encountered any health-related problem.

She was thanked for her co-operation and understanding during our interaction and was bid farewell.

4.12 NURSING CARE PLAN DURING PUERPERIUM

PROBLEMS IDENTIFIED

- On 13/12/22 Afterpain
- On 14/12/22 Insufficient sleep
- On 16/12/22 risk for mood changes
- On 17/12/22 perineal pain
- On 20/12/22 Skin rashes

SHORT TERM OBJECTIVE

- Client's after pain will reduce within 48hours.
- Client will be able to sleep for 2hours daily and 6hours in the night within 24hours
- Client will express joy and happiness within 24hours.
- Client's perineal pain will reduce within 48hours
- Baby would be relieved of skin rashes within 72hours

LONG TERM OBJECTIVES

Client and baby will go through puerperium successfully without any complications

CARE PLAN DUIRING PUERPERIUM

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
14/12/22 at 6:30am	Afterpain related to involution of the uterus.	Client's after pain will reduced within the next 48hours as evidenced by client verbalizing the pain has reduced.	1. Reassure client that the pain is temporary. 2. Explain the cause of the pain to allay anxiety. 3. Encourage client to apply warm compress at her lower abdomen. 4. Encourage client to continue breastfeeding. 5. Serve prescribed analgesics.	1. Client was reassured that pain is temporary. 2. The cause of the pain was explained to the client to allay anxiety. 3. Client was encouraged to apply warm compress on the lower abdomen. 4. Client was encouraged to continue with breastfeeding. 5. Client was served prescribed analgesics.	16/12/22 at 6:30am	Goal was fully met as client reported that the pain had reduced.	C.S.K

NURSING CARE PLAN DURING PUERPERUIM

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
14/12/22 at 6:30am	Insufficient sleep related to caring for baby at night.	Client will have at normal sleeping pattern of 6-8 hours during the night and 2 hours during the day within 24 hours as evidenced by client verbalizing that she can sleep at night.	1. Reassure client that baby's demand is important so she should be assisted. 2. Encourage client to sleep when baby sleeps. 3. Educate client and family to reduce the number of visitors. 4. Teach client how to breastfeed in a lying down position.	1. Client was reassured that baby's demand is important so she will be assisted. 2. Client was encouraged to sleep when baby sleeps. 3. Client and family was educated to reduce the number of visitors. 4. Client was taught how to breastfeed in a lying down position.	15/12/22 at 6:30am	Goal fully met as client reported she had slept 6hours at night and 2 hours during the day.	C.S.K

			5. Educate client to feed baby adequately before going to bed	5. Client was educate to feed baby adequately before going to bed.			

NURSING CARE PLAN DURING PUERPERIUM

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
16/12/22 at 7:30am	Risk for mood changes (postpartum blues) related to hormonal action in the body	Client will express joy and happiness within 24 hours as evidenced by: 1. Client verbalizing that she feels very happy and loved. 2. Relatives observing that client expresses joyful facial expression.	1. Reassure client of competent care in management of the condition. 2. Encourage client to engage in recreational activities such as listening to music and lessen stress 3. Educate client's partner and relatives to take part in the care of the newborn such as changing his	1. Client was assured of competent care in the management of the condition. 2. client was encouraged to engage in recreational activities such as listening to music and lessen stress. 3. Education was given to client's partner and relatives to take maximum part in the	17/12/22 at 7:30am	Goal was fully met as she was seen happy and smiling all over.	C.S.K

			diapers when soiled and caring for the older sibling. 4. Assist the client to rethink about the image of motherhood. 5. Listen to the client and provide encouragement	care of the client, the baby and the older sibling 4. Client was assist to rethink about the image of motherhood. 5. Client was listened to and the words of encouragement was provided for her			

DATE/ TIME	NURSING DIAGNOSIS	OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
17/12/22 at 7:15am	Perineal pain related to tissue trauma during delivery	Client perineal pain will relieve within 72 hours as evidence by the client verbalizing that the pain has relieved	1. Reassure client that pain would subside. 2. Encourage client to maintain good perineal hygiene 3.Encourage client to do warm sit bath 4.Encourage client to breastfeed the baby by lying down or sitting on a cushion 5. Administer prescribed analgesics	1. Client was reassured that the pain would subside. 2. Client was encourage to maintain good personal hygiene 3.Client was encourage to do warm sit bath 4.Client was encourage to breastfeed the baby by lying down or sitting on a cushion 5. Prescribed analgesics was administer.	20/12/22 at 7:15am	Goal fully met as client reported that the pain has resolved.	C.S.K

NURSING CARE PLAN DURING PUERPERUIM

DATE/ TIME	NURSING DIAGNOSIS	OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
20/12/212 at 8:00am	Skin rash related to warm environment.	Baby will be relieved of skin rashes within 72 hours as evidence by 1. Mother verbalizing that rashes are no more 2.Midwife observing that rash has disappear.	1. Explain the physiology of rash to mother(milia). 2.Educate mother to dress baby with cotton cloths. 3.Encourage mother to use baby soaps when bathing baby. 4.Encourage mother to wash hands. 5.Encourage mother to apply baby powder .	1.Physiology of rash was explained to mother. 2.Mother was educated to dress baby with cotton cloths. 3.Mother used baby soaps when bathing baby. 4. Client washed hands before and after handling baby. 5.Mother applied baby powder to baby's skin.	23/12/22 at 8:30am	Goal met as Client said baby"s rashes had reduced.	C.S.K

SUMMARY AND CONCLUSION

Madam Deborah a 24-year-old Gravida two Para one (G2P1) was the client used for the Family Centered Maternity care study conducted at Kenyasi Health centre in the Ahafo region. She made her first antenatal visit on 4th May, 2022 in her early pregnancy. She was met 1st December, 2022 during her usual antenatal clinic visit with gestation of 37 weeks +2 days and was given individualized care both at the clinic and home visits. Minor problems identified were managed using the nursing process. Client finally had a spontaneous vaginal birth to a live healthy female child on the 13rd December, 2022 at 2:10pm with no complication to both mother and baby.

Client and baby were cared for during puerperium, through continuous home visits for a week. On 20th December, 2022 thus the first postnatal clinic visit, they were handed over to the Public Health Nurses at the Reproductive and Child Health Unit for continuity of care.

In conclusion, this care study is an opportunity to put into practice all the theoretical knowledge acquired in classroom with the help of the clinical in-charge.

It has helped me to conduct a very good delivery.

It has also helped me to build a trustworthy relationship with the client and the family.

It has helped me to know how to care for a client in their own environment.

It has helped me to know how to help client make decision on their own and solve problem

BIBLIOGRAPHY

1.Ojo, O. A., & Briggs, E. B. (2011), *A Textbook for Midwives in the Tropics.* London, United Kingdom: Taylor & Francis Ltd.

2.Marie E. (2013) *Textbooks for midwives (2nd Edition).* New Delhi: CBS Publisher & Distribution.

3.Wellner, F.B (2014) *Midwifery for Nursing* (4th Ed), Australia

4.King, L.(2014), T., Brucker M. C., Fahey O.J., Gegor L.C. & Varney H. *Varney`s Midwifery* (15th edition.). New Delhi: Jones and Bartlett India Pvt. Limited.

5.Konar, H., (2013). *D. C. Dutta's Textbook of Obstetrics. Kolkata*: New Central Book Press Limited.

6.Marshall, J, & Raynor, M (2014): *Myles Text Book for Midwives* (16th edition), London, Churchill Livingstone Elsevier Ltd.

7.Verrals, S., (2014). *Anatomy and Physiology Applied to Obstetrics,* (3rd edition) Singapore

APENDIX I

COMPLETE DIAGNOSTIC MEASURES

ANTENATAL CARE

DATE	SPECIMEN	INVESTIGATION	NORMAL RANGE	FINDINGS	REMARKS
4/05/22	Blood	Haemoglobin level	11.4g/dl-16g/dl	12.9g/dl	Normal
		Sickling	Negative	Negative	
					Normal
		Rhesus factor	Positive/Negative	positive	
					Normal
		HIV/AIDS	Negative	Negative	
					Normal
		Grouping	A, B, AB, O	A	
					Normal
		Hepatitis	Negative	Negative	
					Normal
		Stool	Negative	Negative	
					Normal
		VDRL	Negative	Negative	
					Normal
		G6PD	Negative	Negative	
					Normal
	Urine	Protein	Negative	Negative	Normal

		Glucose	Negative	Negative	Normal
1/06/22	Urine	Protein Glucose	Negative Negative	Negative Negative	Normal Normal

DATE	SPECIMEN	INVESTIGATION	NORMAL RANGE	FINDINGS	REMARKS
28/06/22	Urine	Protein	Negative	Negative	Normal
		Glucose	Negative	Negative	Normal
22/9/22	Urine	Protein	Negative	Negative	Normal
		Glucose	Negative	Negative	Normal
15/11/22	Blood	Haemoglobin level	11.4g/dl-16g/dl	12.4g/dl	Normal
	Urine	Protein	Negative	Negative	Normal
		Glucose	Negative	Negative	
1/12/22	Urine	Protein	Negative	Negative	Normal
		Glucose	Negative	Negative	Normal

LABOUR

DATE	SPECIMEN	INVESTIGATION	NORMAL RANGE	FINDINGS	REMARKS
13/12/22	Blood	Haemoglobin level	11.4g/dl-16g/dl	12.4g/dl	Normal
	Urine	Protein	Negative	Negative	Normal
		Glucose	Negative	Negative	Normal

PUERPERIUM

DATE	SPECIMEN	INVESTIGATION	NORMAL RANGE	FINDINGS	REMARKS
20/12/22	Blood	Haemoglobin level	11.4g/dl-16g/dl	11.6g/dl	Normal
	Urine	Protein	Negative	Negative	Normal
		Glucose	Negative	Negative	Normal

APPENDIX II

PHARMACOLOGY OF DRUGS FOR THE MOTHER

NAME OF DRUG	CLASSIFICATION	DOSAGE	ROUTE	ACTION AND USES	ACTUAL EFFECT	SIDE EFFECTS	SIDE EFFECT EXPERIENCE
Tablet Sulphadoxine Pyrimethamine	Anti-Malaria	3 tablets start at 23weeks 6days/ after quickening and repeated at 4 weeks' interval till delivery	Oral	Prevention of malaria	Malaria was prevented in pregnancy	Nausea, itching, headache	None
Injection oxytocin	uterotonic	10 units	Intramuscular	Intramuscular	Uterine contraction was effective	Vomiting, rise in blood pressure	None

Tablet Ferrous Sulphate	Haematonic	10 milligram Once daily	Oral	Helps in the formation of hemoglobin	Hemoglobin increased	Gastrointestinal disturbance and blood stool	Dark Stool
Tab multivitamin	Vitamin preparation	200 milligram for 30days	Oral	Formation of red blood cells	Increase appetite	Gastrointestinal disturbance	None
NAME OF DRUG	**CLASSIFICATION**	**DOSAGE**	**ROUTE**	**ACTION AND USES**	**ACTUAL EFFECT**	**SIDE EFFECTS**	**SIDE EFFECT EXPERIENCE**
Tablet Folic Acid	Vitamin Preparation	5milligram Once daily	Oral	Proper formation and function of red blood cell	Hemoglobin level increased	Nausea and vomiting	None
Paracetamol	Analgesic	1000 milligram 3 times daily.	Oral	Help the relieve of pain	Pain was relieved	Prolong use causes damage to the liver.	None

Tetanus Diphtheria	Anti-Tetanus	0.5 milligram	Intramuscular	Protect mother and fetus against tetanus infection	Client was protected from tetanus infection	Mild fever and malaise	None

PHARMACOLOGY OF DRUGS FOR THE BABY

NAME OF DRUG	CLASSIFICATION	DOSAGE	ROUTE	ACTION AND USES	ACTUAL EFFECT	SIDE EFFECT	SIDE EFFECT EXPERIENCE
Vitamin K	Coagulant	0.5 milligram	Intramuscularly	Production of prothrombin	No bleeding	None	None
Chloraphenicol	Antibodies	2 drops	Instillation	To prevent infection	Infection of the eye was prevented	None	None
Oral polio vaccinse	Antigen	2 drops	Orally	Production of antibodies to prevent poliomyelitis	Poliomyelitis. Under observation	There may be diarrhea	None
Injection Bacillus Calmette Guerin	Antigen	0.5 milligrams	Intradermal	Production of antibodies to prevent tuberculosis	Tuberculosis. Under observation	Blister formation and slight fever	None

Pneumococcal 1	Antigen	0.5 ml	Intramuscular right thigh	Vaccinates neonate against pneumonia	Under observation	Redness at the sight of injection and fever.	None observed
Pentavalent 1 (5 in 1)	Antigen	0.5 ml	Intramuscular left thigh	Vaccinates neonate against diphtheria, pertussis (whooping cough), tetanus, hepatitis B, homophiles influenza B	Under observation	Low grade fever	None observed
Rotarix 1	Antigen	1.5 ml	Oral	Prevention of gastroenteritis	Under observation	None	None

APPENDIX III

ANTENATAL RECORDS

DATE	WEIGHT (KG)	BLOOD PRESSURE (MMHG)	URINE FOR SUGAR AND PROTEIN	GESTA-TIONAL AGE IN WEEKS	FUNDAL HEIGHT (CM)	PRESEN-TATION AND POSITION	DESCENT	FETAL HEART RATE BEAT PER MINUTE	COM-PLAINTS	TREATMENT	REMA-RKS
04/05/22	59	100/60	Negative Negative	8	-	-	-	Positive	No complain	Cap iron III polymaltose Tetanol Diphtheria injection	Healthy

01/06/22	59	110/70	Negative Negative	12	-	-	-	Positive	Lower abdomen	Cap iron III polymaltose	Healthy
28/06/22	60	111/60	Negative Negative	16	14	breech	-	Positive	Passing watering stools	Cap iron III Polymaltose 1st dose Sulphadoxine pyrimethamine	Healthy
22/09/22	63	110/70	Negative	28+2	27	breech	-	Positive	Headache	Cap iron III Polymaltose	Healthy

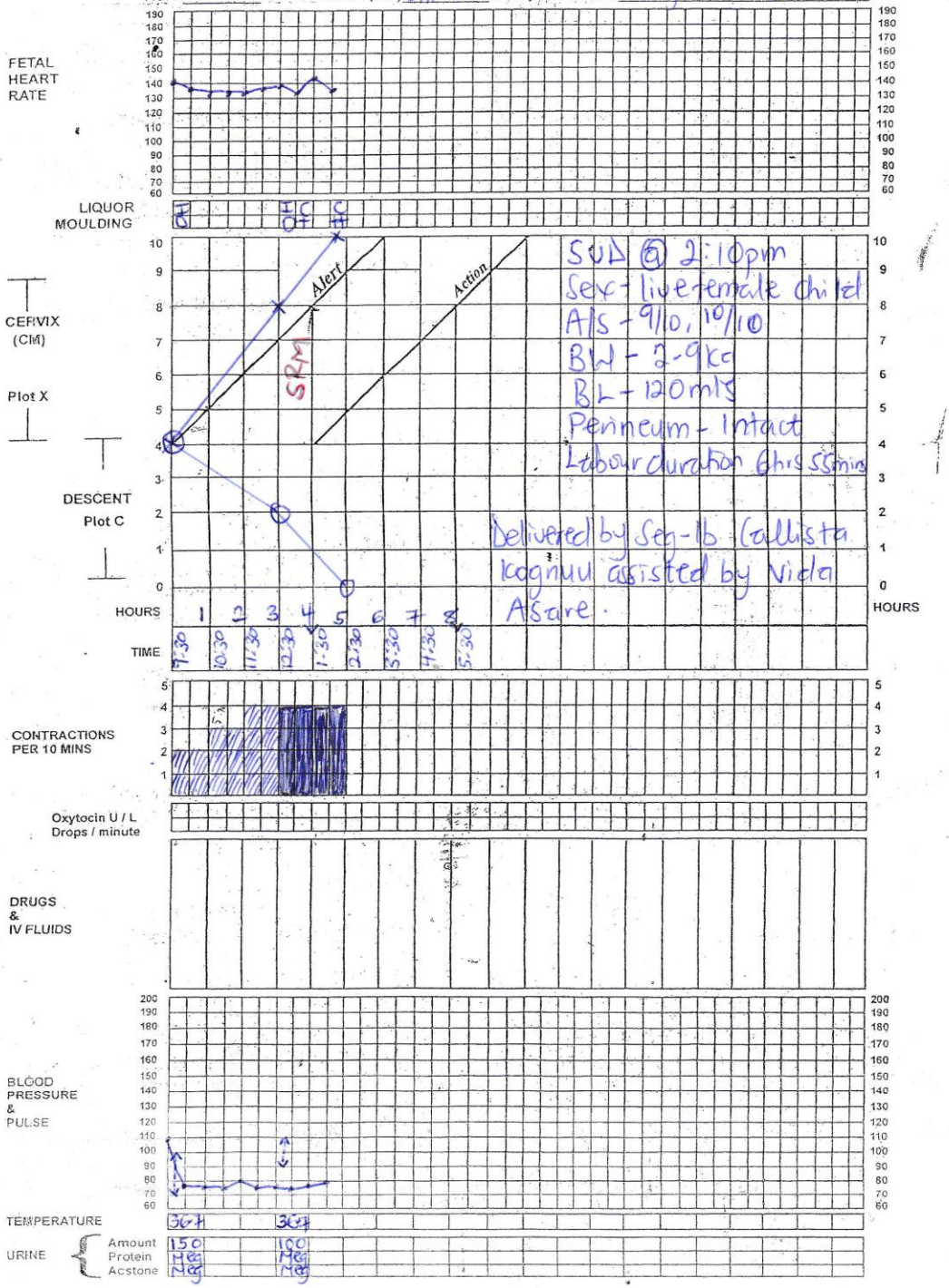
			Negative							2nd Sulphadoxine pyrimethamine	
15/11/22	65	100/60	Negative Negative	36	35	cephalic	-	Positive	No Complain	Cap iron III Polymaltose 3rd Sulphadoxine pyrimethamine	Healthy
1/12/22	65.5	100/60	Negative	37+2	36	cephalic	-	Positive	Frequency micturation	Cap III polymaltose	Good

			Negative							4th Sulphadoxine pyrimethamine	
6/12/22	66	110/70	Negative Negative	38	36	cephalic	-	Positive	Heart Burns	Cap iron III Polymaltose 5th Sulphadoxine pyrimethamine	Healthy

13/12/22	67	100/60	Negative Negative	38+6	37	cephalic	-	Positive	Low abdominal pains	Cap III polymaltose	Good

WHO Modified Partograph

Registration No. KHC/6805/21 Name(Last, First) Okiere Deborah Age: 24years
Date: 13/12/22 Parity/Gravida 1/2 LMP 5/3/22 EDD 15/12/22 Gestation(wks) 38weeks 6days
ROM: Labour Duration (Hrs) 6hrs 55min Facility/Clinic Name Kenyatta Health center



LABOR NOTES

Madam Obyere Deborah delivered an alive female child thru
SVD at 2:10pm without any complications. APGAR score was 9/10, 10/
respectively. Oxytocin 10units was given and placenta was delive
at 2:15pm with complete and intact membranes. Blood loss was
Baby's birth weight was 2.9kg, Head Circumference - 32cm, Chest
46cm, Temperature 36.3°C, Heart rate - 148bpm and respiration -
Both mother and baby sent to lying-in ward in a good co
and close monitoring still continues.

Please circle or write responses

DELIVERY

DATE: 13/12/22 TIME: 2:10pm METHOD: (Spontaneous) / Vacuum Extraction / C/S / Other

PERINEUM: (Intact) / Episiotomy / Laceration

ANESTHESIA: (None) / Local / General

THIRD STAGE

Active Management: (Yes) / No Medication Time 2:11pm Type/Dose Oxytocin 10units

PLACENTA: TIME: 2:15pm (Complete) / Incomplete

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

BABY

Weight: 2.9kg

Sex: Male / (Female)

Baby Position: (Vertex) / Breech / Other

APGAR

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

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

FOURTH STAGE MONITORING

Frequency	Time	B/P.	Pulse	Fundus	Bleeding	Bladder
Every 15 minutes first 2 hours	2:20pm	120/70	84bpm	16cm Well contracted	150mls	150mls
	2:35pm	110/60	86bpm	Well contracted	No active bleeding	Voided
	2:50pm	110/80	83bpm	✓	✓	Nill
	3:05pm	100/70	78bpm	✓	✓	Nill
	3:20pm	120/60	80bpm	✓	No active bleeding	Nill
	3:35pm	120/80	77bpm	Well contracted	✓	Voided
	3:50pm	110/70	81bpm	✓	✓	Nill
	4:05pm	110/60	83bpm	✓	✓	Nill
Every 30 minutes For 1 hour	4:35pm	110/60	82bpm	✓	No active bleeding	Nill
	5:05pm	120/60	81bpm	Well contracted	No active bleeding	Voided

Birth Attendant: Sec-1b Callista Kognuu assisted by Vida Asare Date: 13/12/22

MATERNITY CHART

NAME: Deborah Okyere

AGE: 24 years WARD: Lying-in

P NO.: KHCM6305/21 BED NO.: 4

Date	13/06/22	14/06/22	15/06/22	16/06/22	17/06/22	18/06/22	19/06/22	20/06/22	21/06/22
Days in Hospital	D0	D1	D2	D3	D4	D5	D6	D7	D8
Days P. O.									
Hour AM		6:30	7:50	7:30	7:15	7:00	7:30		8:00
Hour PM	2:20	4:50	5:30	6:40				6:26	
Temperature									
Pulse	84	80	81	82	80	83	70	72	74
Resp.	20	20	20	20	20	20	20	20	19
B.M.	Passed	Passed	Passed	Passed	Passed	Passed	Passed	Passed	Passed
Urine	Passed	Passed	Passed	Passed	Passed	Passed	Passed	Passed	Passed
B. P. AM		118/70	110/80	110/60	110/90	120/80	110/60		110/80
B. P. PM	120/70	100/70	110/70	110/80				110/70	

Temp SFH

41.1° 16 cm
40.0 15 cm
39.5 12.5 cm
39.0 10 cm
38.5 8.5 cm
38.0 6 cm
37.5 4.5 cm
37.0 2.5 cm
36.5 0 cm
36.0 cm
35.5 cm
35.0 cm

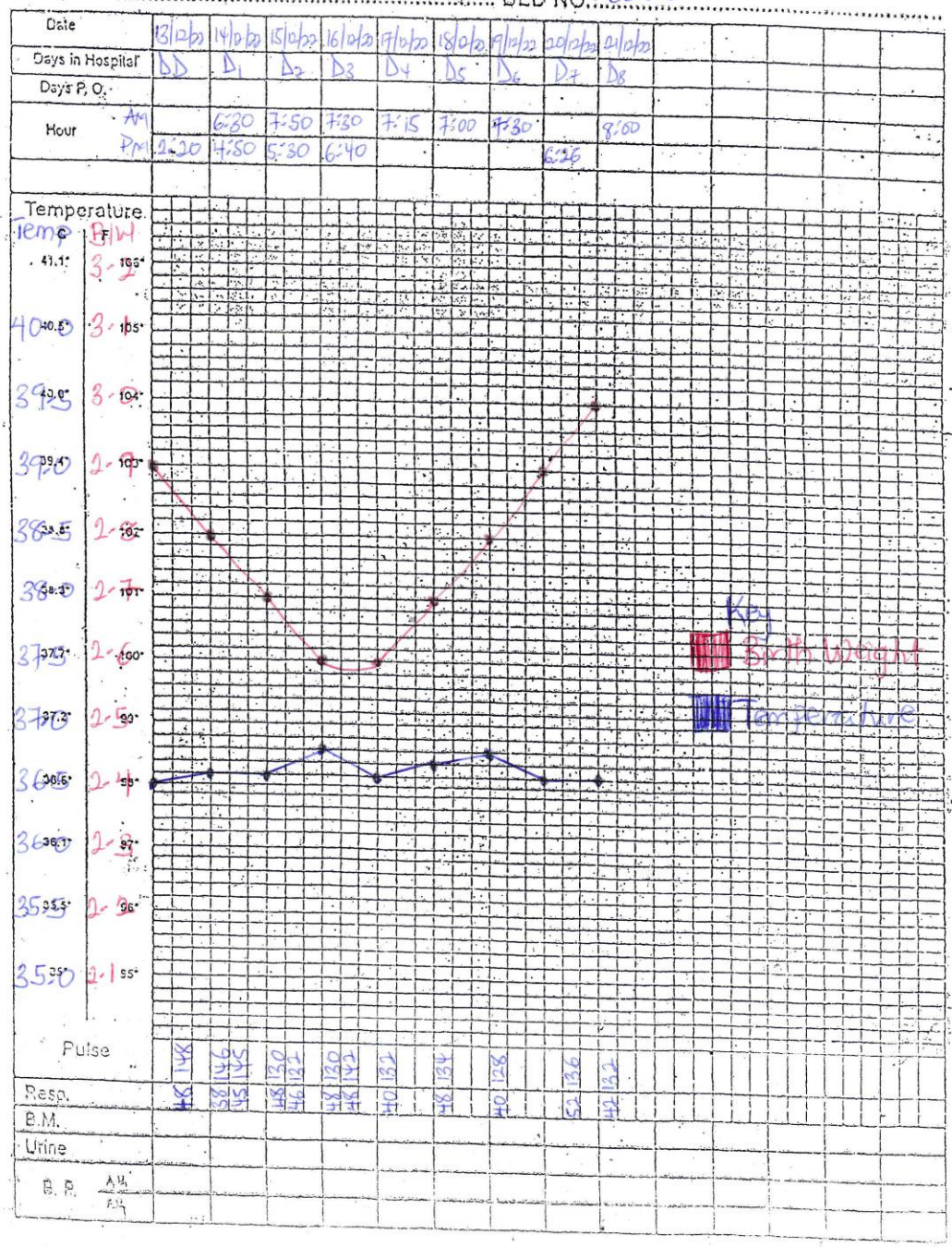
Key
Symphysio fundal height
Temperature

TEMPERATURE CHART

NAME: Baby Abena Okyere

AGE: New WARD: Lying - in

IP NO.: BED NO.: Cot 6



NEW BORN EXAMINATION FORM

Name: Baby Abena Okyere Date of Assessment: 14/12/22 Time: 6:30am
Date of Birth: 13/12/22 Time of Birth: 2:10pm Sex: ☐ M ☑ F Age at time of Assessment (days/hrs) _____
Astational Age ☐ 38weeks ☑ Mode of Delivery: ☑ Vaginal Assisted Vaginal C-Section
APGAR: 1min 9/10 ☐ 5min ☐ 9/10 Birth Weight: ☐ 2.9 kg ☐ Length: 46 cm Head Circumference: 32 cm
Temperature at time of Assessment: 36-6 °C Urine passed: Yes No Meconium passed: Yes No
Name of Assessor (Midwife/Doctor): Seg-lb Callista Kognuu

1. Respiration
Rate 38
☐ 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: 146
☑ 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) Term baby

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

NEW BORN EXAMINATION FORM

Name: Baby Abena Akyere Date of Assessment: 13/12/22 Time: 3:15pm
Date of Birth: 13/12/22 Time of Birth: 2:10pm Sex: ☐ M ☑ F Age at time of Assessment (days/hrs) 1 hour
Astational Age ☐ 38 weeks ☐ Mode of Delivery: ☑ Vaginal Assisted Vaginal C-Section
APGAR: 1min 9/10 ☐ 5min ☐ 10/10 Birth Weight: ☐ 2.9 kg ☐ Length: 46 cm Head Circumference: 32 cm
Temperature at time of Assessment: 36.6 °C Urine passed: Yes No Meconium passed: Yes No
Name of Assessor (Midwife/Doctor): Seg-Ib Callista Kognuu

1. Respiration
Rate 48
☐ 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 *
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5. Cord
☑ Normal
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7. Suck
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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: 148
☑ 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) Term baby

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

NEW BORN CHART

Name: Baby Abena Ocyere ..... No: ..... Birth Weight: 2.9kg .....

Sex: Female ..... Mother's No: KHC/6305/21 ..... Length: 46 .....

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

Date of Birth: 13/12/2022 ..... Time: 2:10pm ..... Date of Discharge: 14/12/2022 .....

Date	13/12/2022		14/12/2022		15/12/2022		16/12/2022		17/12/2022		18/12/2022		19/12/2022		20/12/2022		21/12/2022					
No. of Days	DD		D_1		D_2		D_3		D_4		D_5		D_6		D_7		D_8					
Weight	2.9kg		2.8kg		2.7kg		2.6kg		2.6kg		2.7kg		2.8kg		2.9kg		3.0kg					
	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM
Temperature		36.5°C	36.6°C	36.6°C	36.6°C	36.7°C	36.8°C	36.8°C	36.6°C		36.7°C		36.8°C			36.6°C	36.6°C					
Stools		Passed	Passed	Passed	Passed	Passed	Passed	Passed	Passed		Passed		Passed			Passed	Passed					
Urine		Passed	Passed	Passed	Passed	Passed	Passed	Passed	Passed		Passed		Passed			Passed	Passed					
Remarks	Head Neck Trunk Limbs Genitalia → No abnormalities detected.																					

SIGNATORIES

THE STUDENT

NAME: SEG-IB CALLISTA KOGNUU

SIGNATURE.....

DATE: 7th July. 2023

THE MIDWIFE IN-CHARGE (KENYASI HEALTH CENTER)

NAME: KASSIM RUBAMA

SIGNATURE:.....

DATE: 14/07/2023

THE SUPERVISOR

NAME: MARTHA KYEREMAA

SIGNATURE:.....

DATE: 14/07/2023

THE PRINCIPAL

NAME: MONICA NKRUMAH

SIGNATURE:.....

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

DATE: 14/07/2023