HOLY FAMILY NURSING AND MIDWIFERY TRAINING COLLEGE, BEREKUM

A CLIENT /FAMILY CENTERED MATERNITY CARE STUDY ON MADAM AGYEIWAA REGINA

BY

ALBERTHA NYARKO

4122190012

SUBMITTED TO THE NURSING AND MIDWIFERY COUNCIL OF GHANA IN PARTIAL FULFILMENT TOWARD THE AWARDS OF LICENSE TO PRACTICE AS A REGISTERED MIDWIFE.

AUGUST, 2022

TABLE OF CONTENTS

PREFACE

Client and family centered maternity care is a systematic approach of carrying out holistic and individualized care to both the expectant mother and her family during the period of pregnancy, labour and puerperium. The study is carried out by a student midwife based on a thoughtful understanding of the client as a unique individual with specific problem and needs and to assist her solve them. The client and family are assured of confidentiality.

The aim of the family centered maternity care study is to obtain the best possible healthy outcome for the client and her family members. The study also offers the student midwife the maximum opportunity to use the knowledge acquired in the classroom t assess herself.

The care study is an academic project which gives the student midwife the chance to choose a client and manage her from period of pregnancy to ten days early puerperium. The student midwife uses the nursing process which involves assessment, diagnose, planning, intervention and evaluation to adequately care for the client.

The care study forms part of the academic exercise and also in partial fulfillment of course requirement by the nursing and midwifery council to enable the student midwife obtains a certificate in midwifery.

ACKNOWLEDGEMENT

I wish to express my sincere gratitude to God Almighty for granting me the knowledge, wisdom, understanding and strength to reach this far.

My sincere gratitude goes to my client Madam Regina Agyeiwaa and her family for their cooperation and information which helped me a lot in the writing of this care study.

My sincere appreciation goes to the midwife in charge Abena Boahemaa, ward in charge Amoako Atta Sabina and staffs of Tanoso health center for their encouragement, help, suggestions and supervision during the writing of this script.

I am also grateful to the entire tutors of Nursing and Midwifery Training College, Berekum especially my supervisors Ms. Ernestina Mensah and Ms Diana Owusu- Serwaa for their precious time, energy and corrections during the period of care and marking of the care study. Not forgetting the principal of the school for admitting and giving me the opportunity to be trained as a midwife.

Again, I wish to acknowledge the authors and publishers whose various books were used as references.

Lastly, my heartfelt gratitude goes to my mother, father, friends and siblings for their support both spiritually and financially.

INTRODUCTION

The client and family centered maternity care study refers to all the midwifery care rendered to the expectant mother and her family throughout pregnancy, labour and puerperium. It entails every aspect of the woman's social, physical, spiritual and psychological well-being.

The care is considered within the framework of the family and the community with the aim of preparing the pregnant woman to face labour, puerperium and to initiate lactation and subsequent care of the baby.

This particular care study is about Madam Regina 4th of November 2021 at Tanoso health center (Bono region), after familiarity was built between myself and Madam Regina at the antenatal clinic. It was her fourth antenatal visit and her gestational age was also 36 weeks. After a comprehensive introduction of myself to her, she was informed about my idea of using her for my family centered maternity care study which she happily agreed. She was thanked for her cooperation and accepting my request.

Madam Regina was cared for, during the antenatal periods. Visitation to her home was made to know her family, her surroundings and the community in which she lives. The client and her entire family were included in the care. The condition from the beginning till the end of the interaction was good and satisfactory. Madam Regina had a successful pregnancy, delivered spontaneously on 23rd November, 2021 to an alive baby boy. She had a successful puerperium and was in good health. She was then handed over to the midwife in-charge at Health Center for continuity of care on the 4th December, 2021.

She was taken as my client with the aim of educating her and the family on minor disorders in pregnancy, birth preparedness and complication readiness plan, signs of labour, assisting her in managing minor disorders and also manage her during first, second, third and fourth stages of labour, puerperium and withstanding subsequent care of the baby.

This care study is in four chapters;

The Chapter One reveals client's particulars such as social, family, obstetric, medical and surgical histories. Chapter Two talks about the antenatal care rendered to Madam Regina throughout her pregnancy.

Chapter Three is concerned about management of Madam Regina during labour.

Chapter Four is also concerned about management of Madam Regina during puerperium. The chapter two, three and four has care plan attached to each. The source of information obtained is from the client herself, her family, antenatal record book and other relevant text books.

LITERATURE REVIEW

PREGNANCY

(Tiran, 2008) said pregnancy is a state of conception to the delivery of the fetus. The normal duration is 280 days (40 weeks or 9 month and 7 days) counted from the last normal menstrual period to delivery, or 265days from conception to delivery. He said that during this period, certain physiological and psychological changes occur in the body as a result of hormonal influence that is estrogen and progesterone. These hormones help to prepare the breast during pregnancy and also help to sustain the pregnancy to therm. They are responsible for the disorders like morning sickness, constipation, heartburns and frequency of micturition which needs to be managed well. She therefore needs to be supervised, educated and given advice so that she will be able to cooperate with all the changes that will occur. Pregnancy has three divisions which are first trimester, second trimester and third trimester. The first trimester is from the first day of the last menstrual period to the (12^{th}) weeks of pregnancy. The second trimester starts from the twelve weeks to the twenty fourth weeks and third trimester starts from the twenty fourth weeks to the fortieth week of gestation. The supervision and care given to the pregnant woman is known as focus antenatal care.

Myles (2014) describes pregnancy as a unique experience for every woman and each pregnancy the woman experiences will be new and uniquely different, nausea and vomiting, constipation, heartburns, headache, leg cram are minor disorders of pregnancy. Changes in the urinary system during pregnancy occurs as a result of enlarging uterus affecting all the parts of the urinary tract at various times with the hormones of pregnancy having an even greater influence than mechanical effects. Progesterone relaxes the walls

of the ureters, and allows dilatation and kinking. In some women this can result in stasis of urine resulting in marked infection.

OJO (2006) said, the patient is the first person to suspect pregnancy. Her suspition is often based on the fact that she has missed her period. The amenorrhea occurs because of following implantation of the fertilized ovum, the increase secretion of oestrogen and progesterone by the ovary converts the endometrium into the decidua of pregnancy, and menstruation ceases. He further mentioned that, morning sickness, continuous enlargement of the breast, fetal movement, painless uterine contractions are some of the signs and symptoms that occur at different stages of pregnancy.

Fraser& Cooper (2009) states that every pregnancy is a unique experience for that woman and each pregnancy the woman experience will be uniquely different. This is why it is so important that, the midwife has a knowledge and understanding of the common disorders of pregnancy which include; constipation, headache, leg cramp back ache and others in order to advise the woman on strategies that that will help her to cope with her condition and minimize the effects she experiences.

King (2014) states that, the prenatal period covers the time from the first day of the last menstrual period to the start of true labour, which marks the beginning of the intrapartum period. Prenatal period is divided into trimesters, the first trimester is 1to 12 weeks because organogenesis is completed at the end of twelve weeks (12) and the risk for spontaneous abortion is significantly reduced at this time. Second trimester is 13 to 28 weeks, third trimester extends from weeks 28 to 40. The term ‘post- date’ is typically used to describe a pregnancy beyond forty weeks (40).

Verrals (1992) pregnancy is a state of conception to the delivery of the fetus. The normal duration is 280 days (40 weeks or 9 month and 7 days) counted from the last normal menstrual period to delivery, or 265days from conception to delivery. The weeks are grouped into three trimesters namely first trimester (week 1- week 12). During the first trimester the body undergoes many changes. Hormonal changes affect almost every organ system in the body. These changes can trigger symptoms like stopping of menstrual period, and other signs include; heartburns, mood swings headache, frequent muturation, morning sickness, tender, swollen breast and etc. Second trimester (week 13-week28) as the body changes to make room the growing fetus, the pregnant woman may have backache, stretch marks darkening of the areola, numbness and tingling sensation and etc. Third trimester (week 29-week 40) In the third trimester, some of the discomfort in the second trimester may continue and the cervix undergoes a slight growth and becomes softer as pregnancy advances.

LABOUR

According to O.A.OJO and E. BRIGGS (O.A & E.B, 2006), labour is the process by which the uterus empties its contents after the 28^{th} weeks of pregnancy. It entails the contraction and retraction of the uterine muscle fibres, the dilatation of the cervical os and the expulsion of the baby, liquor amni, placenta and membranes. It further explains that, the causes of onset of labour are unknown but many theories have offered few of these and are stated as:

1. Overstretching and over distension of the uterus at term.
2. Placental efficiency is diminished toward term, resulting in reductions in the level of estrogen and progesterone.

3. The uterus becomes sensitive to the effect of oxytocin produced by the posterior pituitary glands.
4. There is an increase contractibility of uterus towards term. The Braxton Hicks' contractions increase in amplitude and may bring about the onset of labour.

5. The onset of labour has also been associated with hyperpyrexia, cyanosis and emotional upset.

Labour, according to Frazer and Cooper, (Cooper F. a., 2009) is a process by which the fetus, placenta and membranes are expelled through the birth canal and that labour is divided into four stages; The First Stage of labour is the period of onset of regular uterine contraction till full dilation of the cervical os and it last 12 – 14 hours in the primigravida woman and 6-12 hours in the multiparous woman. The Second Stage of labour is from the full dilation of the cervical os which is 10 centimetres up to complete expulsion of the fetus. The Third Stage of labour also starts from the separation and expulsion of the placenta and membranes and subsequent control of haemorrhage. It usually last within 5-15minutes after the birth of the infant. The Fourth Stage of labour is the firsK2t six hours vigilant observation of the mother and baby. It also deals with the establishment of lactation and detection of abnormalities and any complication in both mother and baby for prompt management.

Konar (2013) states that, labour is the process by which the fetus, placenta and membranes are expelled through the birth canal. The events of labour are divided into four stages: First stage starts from the onset of true labour pains and ends with full dilation of the cervix. It is in other words the 'cervical stage' of labour. Its average

duration is twelve hours (12) in primigravida and (6) in multiparae. Second stage starts from dilation of the cervix (not from the rupture of membranes) and ends with expulsion of the fetus from the birth canal. It mostly last up to 30 minutes in multiparous and 60 minutes in nulliparous women. Third stage begins after delivery after delivery of the fetus and ends with the expulsion of the placenta and membranes. Its average duration is about 15 minutes in both primigravida and multipara. Fourth is the stage of observation for at least one (1) hour after expulsion of product of conception. During this period, general condition of the patient and the behavior of the uterus are to be carefully monitored.

Marshall& Raynor (2014) stated that labour in the physical sense as the process by which the fetus, placenta and membranes are expel through the birth canal. Normal labour occurs between 37 to 40 weeks of gestation. Labour begins when there are regular, painful contractions and with cervical dilatation. Signs and symptoms of labour are painful regular contractions, show, progressive dilation of the cervix, and sometimes ruptured membranes. First stage of labour begins with cervical dilatation which begins with rhythmic contractions until the cervix is fully dilated. This stage is in two phases, the latent phase is 0 - 3cm and the active phase starting from 4cm – 10cm when the cervix is fully dilated with both phases lasting from 8- 12hours. Second stage of labour begins with the expulsion of the foetus from the birth canal. It begins when the cervix is fully dilated and the woman feels the urge to expel the foetus. It is however complete when the baby is born. This last from 30 minutes to 1 hour. The third stage is the separation and the expulsion of the placenta and its membranes as well as arrest of haemorrhage. From the above, it can be deduced that labour is a physiological

phenomenon which can be managed by the midwife with the use of partograph, aseptic delivery process and active management of third stage of labour (control cord traction).

Myles (2014) describes labour as the process by which the fetus, placenta and membranes are expelled through the birth canal. It also explained that the first stage of labour can be divide into 3 stages namely;

- The latent phase which is prior to the active phase of first stage of labour and may last for 6-8hours in primigravida when the cervix dilates from 1cm to 3cm and to cervical canal shortens from 3cm long to less than 0.5cm long.
- The active phase which is the time the cervix undergoes more rapid dilations. This begins when the cervix is 4cm dilated and the presence of rhythmic contractions, is completed when the cervix is fully dilated (10cm).
- The transitional phase which is the stage of labour when the cervix is from around 8cm dilated until it is fully dilated or the until the expulsive contractions of second stage are felt by the woman. There is often a brief lull in the intensity of uterine activity at this time.

PUERPERIUM

Frazer and Cooper, (D.M & M.A, 2003), states that, puerperium starts immediately after delivery of the placenta and membranes and continues to six weeks during which the uterus and other organs which were affected during pregnancy return to their non-pregnant state. Frazer and Cooper further describe puerperium as the education given to mothers on how to care for their babies, good nutrition determination and detection of any abnormality for further treatment and also introduce her to family planning.

Ojo and Briggs, (O.A & E.B, 2006), said puerperium is a period of six weeks postpartum in which the uterus, the genital organs and any other organs which underwent changes during pregnancy return to their pre-gravid state. According to them, this process or readjustment is called involution and that during that period lactation is also established. From the various points of view of the above authors, it maybe deduced that, puerperium is a period of 6weeks which begins as soon as the placenta is expelled. At this stage all the organs and other structures that under gone changes during pregnancy return to their non-pregnant state. The management which the mother and baby required during puerperium is based on three principles;

1. Promoting physical and psychological well-being of mother and baby.
2. Encouraging good infant feeding and maternal to child relationship.
3. Supporting and strengthening the mother's confidence to enable her to fulfill her mothering role within her family and cultural status. During this period, organs of reproduction return to their non-pregnant state, lactation is established, and mother recovers from the stress of pregnancy and labour.

Myles (2014) stated that puerperium starts immediately after delivery of the placenta and membranes and continues for six weeks after which all the systems in the woman's body will recover from the effects of pregnancy and return to their non -pregnant state. Myles strikes the difference between exercise and healthy activity verses rest, relaxation and sleep. Exploring each person's level activity will encourage advice in relation to appropriate exercise and by association, nutritional intake and rest or relaxation and sleep. Undertaking regular pelvic floor exercise is of benefit to the woman's long-term health. Myles mentioned that, regardless of whether women are breastfeeding, they may

experience tightening, and enlargement of their breast towards the 3rd or 4th day. Hormonal influences encourage the breast to produce milk. For women who are breastfeeding the general advice is to feed the baby and avoid excessive handling of the breast. Simple analgesics may be required to reduce the discomfort.

According to Denise Tiran (2008), puerperium is the period after childbirth when the uterus and the other organs return to their non –pregnant state which is termed as involution. Puerperium is (6) weeks after birth. The puerperal woman is managed socially, mentally, and psychologically in the care of the baby and herself including the family. The new born takes the first immunization to prevent childhood diseases.

National Safe motherhood Protocol, (2008), describes puerperium as the period from end of labour, delivery of placenta and arrest of hemorrhage to six weeks after delivery. It further says that, the purpose of post-natal care is to maintain the physical and psychological wellbeing of the mother and child. It includes education to maintain the mother on the care of the child, detection and treatment or referral of any abnormality for further management. The essential postnatal care includes; comprehensive screening to detect complication in both mother and baby, treatment of complication in mother and baby, assessment and support for the infant feeding, malaria and anemia prevention, health education and counselling, family planning counselling and services, immunization services for mother and baby. From the above definition, it can be deduced that, puerperium is the management of the mother and baby to exclude puerperal sepsis, other complication and establishment of lactation.

WHY I CHOSE MY CLIENT

Madam Regina G2 P1 reported to the antenatal clinic on 4th November 2021 client complained of frequency of micturition and she was explained to her that her previous pregnancy was not like that. Client was advised that every pregnancy was different and that she should not worry. The physiology of micturition was explained to her that due to the growing uterus exerting pressure on the bladder. And she was encourage to put chamber pot in reach of her bed and she was educated to take less water in the evening to so that it not disturb her sleeping . Opportunity was taken for introduction as a student midwife from Holy Family Nursing and Midwifery Training College, Berekum on community midwifery practical. Permission was sought from her if she could be used for the study. She agreed and was told to share her problems. The midwife in-charge was informed and permission was granted. After going through the normal antenatal process, she gave the direction to her house, her phone number was taken and she was promised of a visit. Appreciation was express.

CHAPTER ONE

ASSESSMENT OF CLIENT / FAMILY

1.0 INTRODUCTION

This chapter gives the preview on various information about the client social, family, medical, surgical, menstrual, past and present obstetrical histories as client lifestyle, hobbies and her community in whole.

1.1 PERSONAL AND SOCIAL HISTORY

Madam Regina Agyeiwaa gravida 2 para 1 alive is a 29year old lady who comes from Tanoso in Bono Region and stays at Susanso in Tano North. Madam Regina house is near the Susanso Ahenfie. She is dark in complexion, weighs 75 kilograms and 165 centimeters in height at booking. Madam Regina is a catering. She is a Christian and fellowships at Apostolic church at Tanoso. Madam Regina is a senior high school graduate. Client speaks and understand Twi and English. Client next of kin is her sister Serwaa Rita

1.2 FAMILY HISTORY

Madam Regina is first born to Mr. Osei Akoto and Madam Martha Abrafi. Her father is a palm wine tapper and her mother is a business woman. Among the five children, there are four females and one male. No known histories of any chronic or hereditary diseases such as cancer, diabetes mellitus, epilepsy, hypertension, sickle cell disease,mental illness in the family. She has twins in her family but no congenital abnormality such as extra digits, clept palate, clept lip,spinal bifida in the family.

1.3 MENSTRUAL HISTORY

Madam Regina had her menarche at the age of fifteen (15) years which lasts for seven (7 days with normal flow. Madam Regina does not take any medication during her period normally uses two (2) pads a day during her menses to promote personal hygiene. She has never experienced dysmenorrhea in her life. Her last menstrual period was 20th February, 2021 and her expected date was 27th December, 2021.

1.4 SURGICAL HISTORY

Madam Regina, has never undergone any surgical procedure and has never been involved in road traffic accident which could have affected her pelvis .She also added that she has neither donated nor received blood transfusion.

1.5 MEDICAL HISTORY

According to Madam Regina she has no known medical history of conditions such as anemia, heart disease, respiratory disorders, epilepsy, hypertension

1.6 LIFESTYLE AND HOBBIES

Madam Regina normally wakes up around 5:00am, she prays and brushes her teeth with toothbrush and toothpaste after which she sweeps her room and compound. She added that she does not sweep the compound always because it is swept in turns. She then goes to throw her rubbish away at the dump site which is 6 minutes' walk away from her house . And her husband help her with fetching of water which is 4 minutes' walk away from their house, bath their first son which is 2years of age and dress him. By 7: 00am she has done her house chores and prepare their breakfast after that she takes her bath

.client takes her porridge with bread in the morning, rice with tomato sauce in the after afternoon and banku with soup or hot pepper with fried fish in the evening. She added that, since orders are not effective, she goes to the market place to sell her cabbage , she closes around 4.30pm . She then go home to prepare their evening meal which mainly banku with okro soup since that is her favorite. Client said during her leisure time, she rests on her bed or watch television. Client urinates frequently when she takes in enough fluid and empties her bowel at least once a day.

1.7 PAST OBSTETRIC HISTORY

Pregnancy; Madam Regina gravida 2 para 1 alive and healthy went through all her pregnancy successfully without any complications. she had her first pregnancy in the year 2018. She said she took the two doses of Tetanus` diphtheria injection as well as K23 doses of Sulphadoxine Pyrimethamine (SP)) in her first pregnancy. She delivered her child at term. She said during her pregnancy, she only experienced some minor disorders such as backache, waist-pains, nausea and vomiting of which she reported to the clinic and they we're explained to her as a normal physiological change in pregnancy which would resolve as pregnancy progressed. She has never suffered any pregnancy induced conditions such as pregnancy induces hypertension, pre eclampsia and gestational diabetes. She visited the antenatal clinic for at least 4 times during her pregnancy. According to client the interval between the first child and the current pregnancy is 2 years.

Labour: According to Madam Regina, her previous delivery took place at health center by spontaneous vaginal delivery. Client first child was delivered at Tanoso health center

who was a male and weighed 3.2kg at birth per records.The duration of labour for the first born did not exceed 12 hours. Client said the placenta was delivered few minutes after the baby was born, and the child was in good health after delivery. There was no complication such as postpartum haemorrhage and breastfeeding was initiated at birth. Abnormalities such as cleft palate,cleft lip,extra digit were not detected at birth . Amount of blood loss was 200m|s in her previous delivery.

Puerperium; Madam Regina went through puerperium successfully without any complications such puerperal infection and sepsis. She started breastfeeding her child after delivery. Her child looked healthy and normal. Her child was fully immunized against the childhood preventable diseases. She did not practice exclusive breastfeeding for six months and weaned after 1year 6months. Client also stated that her family supported her in taking care of the baby and some of the household chores. She uses the natural family planning method thus lactational amenorrhea method. She said her child was fully immunized against vaccine preventable disease according to schedules. She did not experience problems like puerperal sepsis and etc.

1.8 PRESENT OBSTETRIC HISTORY

Madam Regina G2P1alive first visited the clinic on the on 14th June, 2021, she was 16weeks+1day of gestation and symphysio-fundal height was 12cm. Client last menstrual period was on the 20th February, 2021 and her expected date delivery was calculated as 27th November, 2021. Ultrasound scan gave her on 28th November, 2021. Her vital signs and laboratory investigations on that day were as follows;

Temperature	36.8 degree celsius
Pulse	80 bpm
Respiration	23cpm
Blood pressure	100\70mmHg
Weight	79 kg
Height	165cm
Lab Investigations	
Haemoglobin	12.2g\dl
Sickling	Negative
Blood Group	O
Rhesus factor	Positive
Urine for pregnancy test	Negative
Hepatitis B	Negative
VDRL	Non-Reactive
Protein in urine	Negative
Glucose in urine	Negative
G6PD	Negative
Urine albumin	Negative
Antibody screening for HIV	Non-Reactive
Stool test	Negative

On head to toe examination, there was no abnormalities detected. Education on danger signs was given. She was educated on the need to attend Antenatal Clinic regularly. She was put on the following drugs.

Tab Ferrous sulphate	200mg-1dly×30 days
Tab Folic acid	5mg 1dly×30 days
Tab Multivitamin	200mg 1dly×30 days

CHAPTER TWO

ANTENATAL CARE

2.0 INTRODUCTION

This involves the care rendered to Madam Regina during pregnancy .This includes first contact with client, first antenatal home visit, physical environment, pyschosocial assessment, subsequent home visit ,subsequent visit to the clinic and nursing care plans drawn to solve problems encountered by the client during this period.

2.1 FIRST CONTACT WITH CLIENT

Client was met for the first time on the 4th November, 2021 at 10:00am, when she was thirty-six (36) week gestation and was attending her fourth antenatal visit at Tanoso health center. Madam Regina complained of frequency of micturition and the physiology of frequency of micturition was explained to her during pregnancy uterus stretches to compress on bladder so little urine that will enter bladder she will feel to urinate. She was educated that after she finished urinating she should cleaned her vulva with tissue. Self-introduction was made to Madam Regina as a student midwife from Holy Family Nursing and Midwifery Training College Berekum who has been stationed there for seven weeks clinical to write care study and would use her as client. Her antenatal booklet was taken and her previous antenatal records. Client was encouraged to ask question when necessary and also thanked for her cooperation. Client vital signs were checked below;

Temperature	36.2 degree celsius
Pulse	83bpm
Respiration	22cpm
Blood pressure	100\70mmHg
Weight	76kilogram
Height	165 centimeters
Haemoglobin level	12.6g\dL

Urine Testing

Client was directed to the washroom to give sample of her urine specimen bottle for urine testing for the presence of protein and glucose by the use of a urine reagent strip. Protective clothing like apron and gloves were worn. The quantity, colour, odour,smell and sediment were noted. Urine strip was picked and dipped into the urine sample. The strip was immediately removed and the edge of the strip tapped against side of urine container to prevent spilling of urine onto the clothes. After one (1) minute, the stick was compared with colours on the container. There was no change in colour of the strip indicating negative result for both protein and glucose.This procedure was aimed at detecting and ruling out any abnormalities and to provide sharp intervention where necessary.

GENERAL PHYSICAL EXAMINATION

A tray was set containing the following items;

1. A sterile gallipot with sterile cotton wool swabs with a lid.
2. A receiver for used cotton wool swabs.
3. A tape measure
4. A fetal stethoscope
5. A watch with a second land
6. Client's folder with a blue pen

A couch was screened for privacy, she was assisted to change her dressing and wear examination gown after having emptied her bladder. Permission was sought for head to toe examination to be carried out and she granted. Madam Regina was assisted unto the couch of lateral position. Hands were washed with soap under running water and dried with clean dry towel. She positioned herself dorsally for physical examination under the supervision of the clinical coordinator.

Head and Neck Examination,

On examination of the head and neck, the hair was nicely and neatly braided without dandruff. The face was not puffy, pink conjunctiva with no discharge from both eyes and was in aligned with ears. Teeth was cleaned without any calculus, dental carries and peri dental diseases and no offensive odour of the mouth. No cracked lips, and the lips were also dried. The neck was also palpated for lymph nodes, and distended neck vein but nothing was found.

Breast Examination,

On breast examination , before the breast was palpated, the breast were exposed to check for size, shape, signs of pregnancy, dimpling and nipple retraction and condition of her skin. The breast was palpated systematically in a circular manner using the inner aspect of the fingers and client was reminded of self-examination. There was no lymph nodes and no discharge from the nipple when squeezed. The same was done to other breast and no abnormality was found. Breastfeeding history was asked and her desire to breastfeed was positive as her previous child and was negative.

Extremities

The upper extremities both left and right upper limbs showed equal size and length. No oedema of the hands and the finger nails were well trimmed short and neat with no extra digit.

Lower extremities no varicose veins on legs was found llegs was examined for size, and equality and palpated for oedema, tenderness in the calf.

Back

The back was examined and palpated for spinal or vertebra abnormalities and there was none,sacral region were inspect for signs of oedema or rash on her buttocks.

ABDOMINAL EXAMINATION,

Inspection

The abdomen was inspected for medium in size and ovoid in shape. Linear nigra was present and scars and striae gravidarum were absent.

Symphysio fundal measurement,

The zero end of the tape measure was placed on the fundus of the uterus and was extended to the upper border of the symphysis pubis and the symphysio fundal height was obtained as 34 centimeters.

Fundal palpation

Palms were rubbed together to prevent induced contractions, standing at the right-hand side of the woman and facing the head, fundus was palpated with both hands and fingers curved around the fundus and the buttocks of the foetus were felt occupying the upper pole of the uterus. The fundus was at the xiphisternum.

Lateral Palpation

On lateral palpation; one hand was used to stabilize one side of the uterus and the other hand was moved gently in a circular manner at the right side of the abdomen and the foetal limbs were palpated which were rough. This was repeated at the left side of the abdomen and the foetal back was felt. Foetal position was left occipitoanterior

Pelvic Palpation

On pelvic palpation; upon facing the lower limbs of the client at her right-hand side, both hands were placed closely together and pointing downwards and inwards below the umbilicus, the presentation was cephalic and the lie was longitudinal.

Descent

The anterior shoulder was first located using two fingers. The upper border of the symphysis pubis was also located. Five fingers were admitted between the anterior shoulder and the upper border of the symphysis pubis indicating decent of $5/5^{th}$ above the pelvic brim.

Auscultation

Fetal stethoscope was warmed by rubbing it in the palm and placed on the right side of the abdomen where the back was located. Fetal heart rate was listened and counted for one full minute

while comparing it to the maternal pulse which was 132 beats per minute.

Vulva Examination

Permission was sought from client and she agreed. There was no rash, giving critical attention to the groins, there was no offensive discharge, old scars, vulva warts and varicosity. She was asked to stretch her legs and lie to relax, while gloves were removed and placed them into the kidney dish. She was thanked for her cooperation and hands washing was done, she was asked to sit up before getting off the couch. She was assisted

to redress. Details of the examination were made known to her and findings was also communicated to her. Findings were recorded in her Maternal Record Book; she was given the platform to asked question and if she has any complains. Client complains of constipation, waist pain, and client reply of no question. She was educated to take more fruits, vegetables, whole grain and to put pillow on her back when sleeping. Education was given on birth preparedness and complication readiness as well as the need for family planning after delivery. Her medications given were as follows;

Tablet multivitamin	200mg 30days,
Tablet Folic Acid	5mg daily for 30 days,
Tablet Ferrous Sulphate	200mg daily for 30days

. After conversation, she was asked the direction to her house and reminded of her next visit to the clinic on the 18th November and wished her well and bid her goodbye.

2.2 FIRST ANTENATAL HOME VISIT

The first visit to Madam Regina home was on 7th November, 2021. It was Sunday at her residence around 4:00pm after informing her of a visit to the house. The goal of the visit was to observe the environment where she lives and make assessment of her home situations to avoid health threatening conditions and to provide continuous care after delivery. It was really a warm welcome to the house by the family, after exchanging greetings, an introduction was made to her mother. She was asked of the general condition of the family and she responded, they are doing well. She was further asked of if she has complains and she complained of constipation, and waist pain And

physiology of waist was explained to her that it is due to relaxation of muscle in the sacral region. She was asked whether she is taking her routine drugs as prescribed and responded yes and she was encouraged to continue the medication and if she is having any problem about her health she should report to the clinic.

PHYSICAL ENVIRONMENT

The house was built with cement bricks and roofed with aluminium sheets. Client occupies a big room with her child and husband. The room has two windows were well arranged for proper ventilation and she was congratulated and asked to keep it up Again she was asked whether she she sleeps under insecticide treated net and she said yes She was again educated on the importance of sleeping under an insecticide net. The kitchen was well kept, her bathroom were kept clean, but the toilet were outside the house which is public toilet. The source of water is good, the source light is electricity. The house was neatly kept with good drainage system. She was thanked and permission to leave was sought. She was informed about the next visit to the clinic.

PSYCHOSOCIAL

Madam Regina and her family have cordial relationship with each other. Madam Regina has a warm and friendly relationship with the tenants other family members staying around the house and neighbors. Her friends most at times visit her and she also visit them at her leisure time. Madam Regina introduced me to her neighbors. She has respect for humans and likes to makes new friends. Madam Regina attend to social gathering likes funerals and wedding ceremony at all times.

2.3 SECOND ANTENATAL HOME VISIT

The second visit to Madam Regina's house was on the 14th November, 2021 which was Sunday at 5:00pm. She was met at almost done with preparation of her food. She was greeted, warm welcome was given and seat offered. The aim was to inquire about her general condition and client complained of lower abdominal pain. The physiology of lower abdominal pain was explained to her that stretching of round ligament due to fetal movement and client was encouraged to wear low heel fitting shoes. Client was asked to bring her things she will send to hospital for inspection if everything is well packed. Some of the items included delivery pads, six cot sheets, six old sheet, two toilet rolls, two carbonic soap, one antiseptic solution, two rubber mackintosh for delivery, baby socks, cap, and baby dress. Client was educated on danger signs and birth preparedness and complication readiness. Madam Regina vital sign was checked and recorded as

Temperature	36.1 degree celsius
Pulse	81bpm
Respiration	21cpm
Blood pressure	110\70mmHg
Smphysio fundal height	35cm
Fetal heart rate	139bpm

Client and relatives were thanked for nice reception for their time and permission was sought for departure.

2.4 SUBSEQUENT VISIT TO THE CLINIC

Madam Regina visited the clinic on 18th November, 2021 at 9:00am. Client complains of backache and the physiology of backache was explained to her that it was caused by increased release of relaxin which causes ligament laxity. She was asked of her previous complain during home visit and she said she could now cope with the lower abdominal pain, waist pain, constipation, and frequent micturition. Routine examination was conducted and recorded as;

Temperature	36.8 degree celsius
Pulse	79bpm
Respiration	21cm
Blood pressure	100\70mmHg
Weight	70kg
Symphyio fundal height	36cm
Fetal heart rate	134bpm

All procedures be carried out on her to gain her cooperation and sought her consent. She was asked to empty her bladder. Provision of privacy was done by screening the bed and then helped her to undress and assisted her onto the couch. Thoroughly hand washing was done and cleaned with clean hand towel and started with the head to toe examination under the supervision of midwife in-charge. Her general appearance was good and no abnormality was detected.

Abdominal examination was carried out. On inspection, the abdomen was globular, striae gravidarum and linear nigra were present with no scar. On palpation, the symphsio-fundal height was 36cm with gestational age of 38weeks. On lateral palpation, fetal back was at right side and lie was longitudinal, presentation was cephalic with head descent 5\5th .

2.5 CARE PLANS DURING ANTENATAL PERIOD

Problems Identified During Antenatal

Madam Regina complained of the following;

1. On 4th November, 2021	frequency of micturition
2. On 7th November, 2021	Constipation
3 On 7th November, 2021	Waist pain
4. On 17th November, 2021	Lower abdominal pain
5. On 18th November, 2021	Backache

Short Term Objectives

1. Client will be able to cope with frequency of micturition 24 hours after delivery.
2. Client will pass stool once within 48 hours.
3. Client's waist pain will be reduced and cope with throughout pregnancy within 24 hours.
4. Client's lower abdominal pain will be reduced and cope with throughout pregnancy within 24 hours.
5. Client backache will be reduced and cope with throughout pregnancy.

Long Term Objectives.

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

CARE PLAN DURING ANTENATAL

DATE/ TIME	NURSING DIAGNOSIS	NURSUNG OBJECTIVES/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTIONS	DATE/ TIME	EVALUATION	SIGN
04/11/21 10:00am	Frequency of micturition related to growing uterus exerting pressure on the bladder.	Client will be able to cope with frequent micturition 24 hours after delivery as evidence by by client verbalizing that frequent micturition as reduced. 2. Midwife observing that client micturition has subside.	1. Reassure client that frequent micturition will subside because is normal physiology . 2. Educate client on the physiology of micturition. 3. Encourage client on the use of panty liners. 4. Encourage client on kegel exercise to thighten the muscle. 5. Encourage client to keep chamber pot reach of her bed.	1.Client was reassured on her condition. 2. Client was told it was due growing fetus exerting preesure on the bladder . 3. Client used panty liners. 4. Client understood on how to do kegel exercise thighten her muscle. 5. Chamber pot was placed in reach of client	05/11/21 10:00am	Goal fully met as client verbalized that she been relieved of frequency of micturition. Midwife observing that client micturition has reduced.	AN

DATE/TIME	NURSING DIAGNOSIS	OBJECTIVES/OUTCOME CRITERIA	NURSING ORDERS	INTERVENTION	DATE/ TIME	EVALUATION	SIGN
7/11/21 4:00pm	Constipation related to activity of progesterone causing decreased peristalsis and relaxation of the smooth muscles of the large intestine during pregnancy.	Client will pass stool more than one within 48 hours as evidenced by Client verbalizing that she was able to pass stool more than one in 48 hours.	1.Reassure client that constipation will be relieved. 2. Explain the physiology behind constipation to client due to relaxation of smooth muscle of large intestine. 3. Educate her to take in foods rich in fiber. 4. Encourage her to take in more water . 5. Encourage client to eat more fruits everyday. 6. Educate the client to do exercise.	1 Client was reassured that her. 2.Explanation of physiology of constipation was given to client. 3.Client took food rich in fiber like fruits and vegetables. 4.Client drinks more water everyday. 5.Client eats more fruits everyday. 6.Client understood the health benefits of exercises and engaged herself in exercises.(walking)	8/11/21 4:00pm	Goal fully met as Client verbalizing that she passed stool once within 48 hours and is relieved from discomfort of constipation.	

CARE PLAN DURING ANTENATAL

DATE/ TIME	NURSING DIAGNOSIS	OBJECTIVES/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTIONS	DATE/ TIME	EVALUATION	SIGN
7/11/21 4:00pm	Waist pain related to relaxation of pelvic ligament.	Client's waist pain will be reduced within 48 hours as evidenced by: 1.Client verbalized that her waist pains has resolved. 2.Midwife observing client perform daily activities without complains of waist pains.	1. Reassure client that waist pain will be subside. 2. Encourage client to have enough rest. 3. Educate client to seat in between activities. 4. Educate client to manage work activities and moderate exercises. 5. Educate client on the physiology of waist pain	1. Client was reassured. 2. Client had enough rest during the day. 3. Client understood and sat down in between activities 4. Client was educated to manage works and moderate exercises 5. Client was educated on the physiology of waist pain due to descent of fetal head putting pressure on sacral nerves.	8/11/21 7:30pm	Goal fully met as evidenced by client verbalized that waist pain has reduced . Midwife observing that client waist has no waist pain.	A N

CARE PLAN DURING ANTENATAL

DATE/ TIME	NURSING DIAGNOSIS	OBJECTIVES/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTIONS	DATE/ TIME	EVALUATION	SIGN
14/11/21 7:40pm	Lower abdominal pains related to descent of the fetal head in late pregnancy.	1.Client's lower abdominal pain will be reduced and cope with throughout pregnancy within 24 hours as verbalizing by client the pain has subsided 2. Midwife observing that client can cope with lower abdominal	1. Reassure client that abdominal pain will subside. 2. Explain the physiology of lower abdominal pains to client. 3. Encourage client to reduce household activities. 4. Encourage client to wear low heel shoes. 5. Encourage client husband to help her with household chores.	1. Client was reassured that pain will be relieved with time after delivery. 2. The cause of lower abdominal pains was explained to client that pain was due to stretching of ligament during fetal movement. 3. Client reduced household activities. 4. Client wore low heeled shoes throughout pregnancy. 5. Client's husband helped client with household chores like sweeping and washing.	14/11/21 9:40pm	Goal fully met as evidenced by client verbalizing that her lower abdominal pains has reduced after intervention was given. Midwife observing that client pain has subside with cheerful facial expression,	A N

CARE PLAN DURING ANTENATAL

DATE/ TIME	**NURSING DIAGNOSIS**	**OBJECTIVES/ OUTCOME CRITERIA**	**NURSING ORDERS**	**NURSING INTERVENTIONS**	**DATE/ TIME**	**EVALUATION**	**SIGN**
18/11/21 **9:**00am	Backache related to physiological adjustment of growing uterus causing change in posture	Client backache will be reduced and cope with throughout pregnancy as within 4 hours evidence by 1.client verbalizing that backache has reduced 2. Midwife observing that backache has subsided.	1. Reassure client to allay anxiety 2. Explain the physiology of backache in late pregnancy to client 3. Encourage client to sit down in between activities 4. Encourage client to rest her back on a pillow when sitting 5. Encourage client family to help her with house hold chores 6. Encourage client to sleep on a firm mattress.	1. Client was reassured that backache will be relieved. 2. Explanation of physiology of backache in late pregnancy was given to client. 3. Client sat down in between activities. 4. Client rested her backache on a pillow when sitting. 5. Client family helped with her house chores. 6. Client slept on firm mattress	**19**/11/21 **7:**00pm	Goal fully met as evidenced by client verbalizing that she has been relieved of backache . Midwife observing that client backache is subside	A N

CHAPTER THREE

INTRAPATAL CARE

3.0 INTRODUCTION

This chapter describes the management of labour, immediate care of the newborn, examination of the newborn and care plan drawn for the management of the problems encountered during labour and delivery.

3.1 ADMISSION AND MANAGEMENT OF FIRST STAGE OF LABOUR

On Tuesday 23rd November, 2021, Madam Regina reported to the facility Tanoso health center, at around 5:40am with mother complaining of lower abdominal pains and she was assured that it is due to the pressure of descent of the fetal head pressing on the sacral nerves and it will resolve soon after delivery. They were welcome and offer a seat while glancing through her ANC book and with help of midwife in-charge and her expected date of delivery was 27th November. Her hemoglobin was 12.6g\dl and she was 38weeks+ 5days.Madam Regina complain of waist pains and noticed blood stained mucus at around 3:50am. Even her facial expression during interaction shows that she was in pains inquiries about her last meal was made and she said is eats rice with tomato stew at 5:20pm . Madam Regina's mother was reassured that everything was going to be alright. She was sent to the examination room and assisted to change her clothing. Procedures going to be done were explained to her and permission was sought to carry on. She was asked to empty her bladder which was tested for sugar, albumin and acetone amount 150mls but was all negative. She was assisted to lie on the couch and a quick

examination from head to toe and no abnormality was detected but during the examination, her face looked anxious. Abdominal examination was then conducted. On inspection, abdomen looked globular in shape with no scar and fetal movement was noticed. Linear nigra and striae gravidarum were also present.

On palpation at 5:50am, the symphysio -fundal height measured 37cm. Fundal palpation revealed the buttock in upper pole , lateral palpation revealed back of the fetus at the right side of abdomen and limbs at left side. The lie was longitudinal, presentation was cephalic and the position left occipito anterior. Descent was 4\5th above the pelvic brim. On auscultation , fetal heart rate was 138bpm with regular and rhythmic volume. Uterine contractions were checked and recorded as 2 in 10 minutes lasting for 31 seconds.

The procedure was explained to her that she was going to be examined vaginally. She put put in lithotomy position with knees flexed and thigh separated. A tray was set up for vaginal examination. Hands were washed with soap under running water and dry with clean towel and sterlie gloves were worn on both hands. The vulva swabbed with 5 sterlie cotton wool swabs soaked in salvon, swabbing the majora first, then minora and vestibule.

Inspection of the vulva for oedema, warts, scar varicosities was done and no abnormalities were detected. The vulva was shaved neatly. The vagina examined and it was warm and moist with no offensive discharge, cervix was soft and thin and there was evidenced of show. Cervical dilatation was 4cm, cervix had effaced and was soft and thin with membrane intact and there was no moulding. The sacral promontory was not

reached and ischial spine were blunt. Sub-pubic angle accommodated two fingers in the arch.

She was cleaned and applied clean perinea pad at the vulva. Gloves were remove and disposed off and hands were with soap under running water and dry with clean towel. Client bed was shown to her , findings was communicated to her and progress of labour and how far cervix had dilated to her and documented findings on the partograph sheet. She was encourage to micturate frequently to helps in descent of fetal head.Madam Regina advised not to bearing down prematurely to prevent cervical tear and oedematous cervix . Her vital signs checked and recorded as follows,

Temperature	36.6 degree celsius
Pulse	80bpm
Respiration	20cpm
Blood pressure	110\60mmHg
Hemoglobin	12.5g\dl

3.2 MANAGEMENT OF THE FIRST STAGE OF LABOUR

Uterine contraction, maternal pulse and fetal heart rate were checked half hourly and urinalysis, temperature was checked every two hourly and vaginal examination, blood pressure were done four hourly and recorded o the partograph.

At 6:20am, fetal heart rate was 130bpm with good volume and rhythm. Uterine contraction was 2 in 10 minutes lasting for 32 seconds, maternal pulse was 80bpm.

At 6:50am fetal heart rate 134bpm and uterine contraction was 2in10 minute lasting for 33 seconds and maternal pulse 84bpm. Client looked anxious because of severe pains and worried about unknown outcome of labour and so client was reassured to allay anxiety.

At 7:20am fetal heart rate was 132bpm and uterine contraction was 3in 10 minutes lasting for 35seconds and maternal pulse 82bpm.

At 7:50am fetal heart rate was 140bpm and uterine contraction was 3 in 10 minutes lasting for 36seconds and maternal pulse 78bpm.

At 8:20am fetal rate was 136bpm and uterine contraction was 3in 10 minutes lasting for 38 seconds and maternal pulse was 80bpm.

At 8:50am fetal heart rate was 138bpm and uterine contraction was 4 in 10 minutes lasting for 38 seconds, maternal pulse 82bpm.

At 9:20am fetal heart rate was 138bpm with good volume and uterine contraction was 4 in 10 minutes lasting for 39 seconds and maternal pulse was 86bpm

At 9:50am maternal temperature 36.2degree celsius, pulse 86bpm, blood pressure 110\60mmHg, urine passed measured 120m\s and protein and acetone were tested and negative for both. Fetal heart rate was 140bpm with good volume and regular rhythm. Uterine contraction was 4 in 10 lasting for 41 seconds, examination was was done , cervical dilation was 8cm, head descent was done abdominally and read 2\5th above pelvic brim. Membranes were intact and there was no moulding.

At 10:20am maternal pulse was 76bpm , uterine contraction 4 in 10 minutes lasting 42 seconds. Fetal heart rate was 134bpm .

At 10:50am fetal heart rate was 135bpm with good rhythm and contraction was 4 in 10 lasting for 44 seconds and maternal pulse 82bpm. Madam Regina was sweating profusely so her face towel was soaked in water and used it in cleaning her body. The window opened and switched on the fans to ventilate the room adequately.

At 11:20am ,fetal heart rate was 140bpm and uterine contraction was 4 in 10 minutes lasting for 46 seconds and maternal pulse was 88bpm. She complained of fatigue and was encourage to calm down to prevent maternal exhaustion during contractions and diversional therapy employed by engaging her in conversation.

At 11:50am uterine contractions became stronger and expulsive in nature counting 4 in 10 lasting for 48 seconds. Fetal heart rate was 130bpm with good volume and rhythm, maternal pulse was 90bpm. Membranes ruptured spontaneously and was clear, vaginal examination was done to rule out cord prolapsed, confirm full dilatation of the cervix and it was 10cm dilated. Head was $0\backslash 5^{th}$ on pelvic examination, there was moulding (++) and there was no caput formation. The progress of labour was communicated to to midwife in charge and she confirmed findings with another vaginal examination. Perineum was bulging and anus was gaping.

PREPARATION FOR BIRTH

A helper was indentified both skilled (ward in charge) and the non- skilled (mother) to assist in the delivery when needed. Emergency plan was also reviewed which includes, calling of referral center and calling of taxi driver to help in transportation of client to referral center, an obstetrician and pediatrician when need arise. Client was reminded that she will be assisted to wash her hands and chest when second stage is eminent to prepare

for skin to skin care to prevent infections to baby. The room was well lighted and portable lamp was also in place when lights out. Preparation of the area for ventilation and checking of equipment was also done by prepare a dry, flat and safe space for receiving the baby for ventilation when needed and equipment to help in resuscitation were checked for their functioning . The items include the suction device, ventilation bag and mask, stethoscope, scissors, timer, head covering, cloths and gloves. Delivery set and emergency drugs were readily available when checked. Her vital signs and other observation were checked and recorded as,

Temperature	36.7 degree celsuis
Pulse	82bpm
Respiration	22cpm
Blood pressure	110\70mmHg
Fetal heart rate	138bpm
Descent	3\5th
Contraction	2 in 10 minutes seconds

SETTING OF TROLLEY

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

Top shelf

- Delivery pack containing; four clean towels
- Two artery forceps
- Two dissecting forceps
- Two gallipots with cotton swabs and gauze respectively
- One cord scissors
- Receiver
- Episiotomy scissors

Lower shelf

- Bed pan
- A receiver for placenta
- Container with syringes and needles
- Fetoscope
- A syringe containing oxytocin drug in a covered container
- Antiseptic lotion. Example Savlon
- Extra perineal pad
- Sterile gloves
- Small cap containing water and bulb syringe
- Cord clamp
- Two cot sheets

  .Lidocaine

3.3 MANAGEMENT OF SECOND STAGE OF LABOUR

She was positioned in a lithotomy position as client opted for this position. A gown, mackintosh apron, mask and boots were warned. After that, hands were washed with soap under running water and dried. Sterile gloves were warned. Fetal heart rate and maternal pulse was checked and recorded after each contraction. Vaginal examination was done to confirm full dilation of the cervix, perineum, pubis and inner thighs of the client were swabbed with gauze soaked in savlon solution and client was draped with a clean towel. A clean perineal pad was applied over the anus to prevent fecal matter from contaminating the delivery field. Client complained of inadequate food intake and was served with malt. Her perineum was shiny and over stretched, so she was instructed to place buttocks down to prevent tears. Flexion was maintained by placing fingers of the right hand on the advancing head in order to allow the smallest diameter to distend the perineum. Decent of the fetal head continued till crowned. As soon as the baby's head crowned, she was asked to breathe through her mouth and give only small pushes with contraction to prevent rapid expulsion of the fetal head which could result in perineal tears and intra cranial injury. The sinciput, face and chin swept the perineum and the head was delivered by extension. The mouth and nose were gently cleaned with sterile gauze. The eyes were wiped with sterile cotton wool swab from the inside out as well as the face. The neck was quickly felt for cord around neck. The mother was reminded that the baby will be delivered on to her abdomen whiles waiting for restitution and external rotation of the fetal head. This was accompanied by internal rotation of the shoulders. The anterior shoulder was delivered by pressing the head down gently and the posterior shoulder swept the perineum to be delivered. The rest of the body was delivered by

lateral flexion onto the mother's abdomen at 12: 00noon, baby cried immediately after birth, baby was dried with the sterile cot sheet on the mother's abdomen for one hour and covered with a sterile cot sheet to prevent heat loss, provide warmth and to promote bonding.

3.4 IMMEDIATE CARE OF THE BABY

This commenced as soon as the head of the baby was delivered. The eyes were cleaned with a sterile swab from within outwards the neck was felt for cord around was absent. Baby was delivered unto mother abdomen. The baby was dried thoroughly to keep the baby warm and stimulate breathing.The umbilical cord was clamped about 2 centimeters away from the baby's abdomen and again, clamped 3centimeters away from the first clamp with an artery forceps. The cord was cut in between the two clamps by covering the scissors with gauze to prevent splashing of blood. The baby was shown to the mother to confirm the sex of the baby and she said is a male. This was done 3 minutes after delivery of the baby. The baby was dried and head covered with cap and place on the mother's abdomen to initiate skin to skin and covered baby and mother with a warm cot sheet to maintain warmth. The baby's APGAR score assessed at the first and fifth minutes were 8/10 and 9/10 respectively. An identification band with mothers name, sex of the baby, date and time of delivery was put around baby's wrist. The baby was breathing quietly and easily.

APGAR SCORE

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

3.5 MANAGEMENT OF THIRD STAGE OF LABOUR

Madam Regina was informed and procedure was explained to her. Client still in the lithotomy position, the cord clamped and cut end of the cord was placed in a receiver in between the thighs near the perineum to receive the placenta, membranes and blood loss. A gentle palpation of the uterus was done, and the in charge was asked to confirm, to rule out undiagnosed twin. There was no other fetus, so 10unit of oxytocin were given intramuscularly on the thigh of the mother by the midwife in-charge to aid in contraction of the uterus and expulsion of the placenta. Cord was re-clamped closer to the perineum and the cord with artery forceps were held with the dominant hand. The non-dominant hand was place on the fundus to check for contraction. With contractions, the hand was repositioned just above the symphysis pubis with the palm facing the woman's umbilicus. The uterus was pushed in an upward direction to serve as counter traction to prevent inversion of the uterus. The cord and forceps were also held firmly at the same time with downward traction, the process was repeated until the placenta became visible at the

vulva. The placenta was cupped by both hands and twisted to remove pressure on the fragile membranes. The placenta and membranes were delivered completely at 12:03pm. Quick examination of the placenta was done to make sure there are no retained products. The placenta was placed in a receiver for thorough examination to be done. The perineum was cleaned and gauze was used to wrap two fingers of each hand to inspect the vagina and cervix but no tear or laceration was detected. The uterus was massaged to expel clot. Client was taught how to massage the uterus and was asked to feel for immediately. She was educated to massage the uterus by herself and report any change immediately. Client was clean off the liquor and blood with a clean pad after examination. A new perineal pad was applied at the vulva and she was made comfortable in bed. She was asked to cross her legs to keep the perineal pad in position.

3.6 EXAMINATION OF PLACENTA AND MEMBRANES

The placenta was sent to the sluice room and it was immersed in 0.5% chlorine solution for examination. The cord was situated at middle of the placenta with two arteries and a big vein in the cord with no knot. The cord with membranes hanging and membranes were examined for completeness and it was intact. The placenta was then laid on the flat surface for further examination. The amnion was peeled from the chorion up to the umbilical cord and fully viewed, the lobes fitted together without any gab, this indicated that there were no missing lobes and edges also forming uniform circle at maternal surface, there was no infarcts on the maternal surface, there was also no blood vessels radiating into the membranes which indicated absence of succenturiate lobe. The cord was situated at the center of placenta .The fetal surface was intact with no abnormality. Blood clots from the maternal surface were added to the blood loss. Blood loss 200m\s.

After the examination the instruments were immersed in 0.5% chlorine solution for 10 minutes. The instruments were removed, washed, rinse, dried and made ready for sterilization. She was asked to urinate when she had the urge for the uterus to contract and was told that if she should feel any change, she should not hesitate to report.

3.7 PREVENTION OF DISEASES

Cord was dressed with Methylated Spirit and client was to observe the cord for redness and discharge from the cord. Injection 1mg of vitamin K was given intramuscularly to prevent bleeding disorder. Chloramphenicol eye drop on each eye to prevent infection. Hands were washed under running water with soap and cleaned with a clean towel. Mother was educated to wash hands before and after breastfeeding baby. She was further explained to breastfeed on demand.

3.8 MANAGEMENT OF THE FOURTH STAGE OF LABOUR

During this period mother and baby was observed. Client was asked of the complains during labour and she said all the complains has resolved.

Examination of the New Born

Procedure was explained to my client, gloves were worn.The head was examined first, for bulging and fontanels, size, shape, laceration and caput succedaneum but none was present. Head circumference was measured and it was 33cm using the tape measure from occipital protuberance to supra orbital ridges and its length was 50cm. Mouth

was inspected for any false teeth, tongue tie, cleft palate etc. Nostrils was checked for any deviations. The neck for congenital goiter and lymph node. Chest was inspected for size,

shape and chest wall movement with respiration and respiration rate was 42 cycles per minutes and the apex heart beat was 140 beat per minute. Breast were palpated for masses and nipple for extra nipple but was normal. Examination of both upper and lower extremities was done and normal. Examination of both upper and lower extremities was examine for oedema, fracture for hand and legs and no abnormality was detected. Abdomen was inspected for shape and size. Baby's back was examined for swelling, spinal bifida or missing vertebrae but none was noticed. Skin was pink and no abnormality found. Anus and rectum were inspected for potency and the scrotum was also examined if testes is well descended and no abnormality was found. Baby's weight was recorded as 3.0kg. And vital signs were recorded as,

Temperature	36.5degree celsius
Apex heart rate	136bpm
Respiration	42cpm

Hand washing was done and findings was communicated to mother. Baby was wrapped in a warm cot sheet and was placed beside her for breastfeeding.

Management of Mother

Madam Regina and her baby were transferred into the lying –in room, made comfortable and also congratulated for her corporation. Uterus was felt for contractions symphysio fundal height 15 centimeter. The total blood loss after fourth stage 200mls. Lochia was red in colour (rubra), moderate in quantity and had no smell, urine passed was 90 mls and her vital signs together with bleeding were monitored every 15minutes for 2 hours, 30

minutes for 1hour till the end of the 6 hours. The baby condition was checked alongside with monitoring of the mother. There was no bleeding from the cord and no other abnormality was detected. Client was educated on frequency of micturition and changing of perineal pads when soaked, how to fix baby to breast, the importance of exclusive breastfeeding for the first six months and feeding on demand was stresssed. Client was seen fatiqued due to stress of labour. Client mother was allowed to see her and she was served with beverage and bread.The first post-delivery vital signs were checked and recorded as follows; and the rest were recorded on partograph.

Temperature	36.8 degree celsius
Pulse	78bpm
Respiration	22cpm
Blood pressure	110\80mmHg

SUMMARY OF LABOUR

Client was admitted to the ward with her mother complaints of waist pain and lower abdominal pain and when assessed labour started and was monitor. Labour progressed normally and spontaneous vaginal delivery of live male child at 12:00noon. Active management of Third stage of labour was done. Perineum was intact and blood loss was small (200mls). Condition of the baby was very good as well as mother. The placenta and its membranes were intact. Duration of labour lasted for six (6) hours.

CONDITION OF THE MOTHER

Fundal height	17cm
Uterus	Contracted
Lochia	Red (rubra)
Urine output	100mls

Condition of Baby At Birth

General examination of the baby was done and no abnormalities detected . The baby had pink skin colour, umbilical cord was not bleeding. The baby was classified as normal and routine care given. Baby passed urine and meconium within some few minutes after birth.

The baby's vital signs were as follows,

Temperature	36.5 degree celsius
Apex heart rate	136bpm
Respiration	41cpm
APGAR in first minute	8\10
APGAR in fifth minute	9\10
Sex	male
Head circumference	33cm
Full length	50cm
Abnormality	None
Condition of baby	Very good

APGAR SCORE

Apgar score at first minute 8/10, Apgar score at fifth minute 9/10 and Baby condition was satisfactory.

Duration of Labour

1st Stage	5 hours 35 minutes,
2nd Stage	45minute
3rd Stage	10 minutes.
The total duration of labour	6hours 30 minutes

Record of Mother

Date of Delivery	23rd November, 2021
Time of delivery	12:00pm
Mode of delivery	Spontaneous vaginal delivery
Perineum	Intact

3.9 NURSING CARE PLAN ON LABOUR

Problems Identified

1. Lower abdominal pains
2. Waist pain
3. Anxiety
4. Fatigue
5. Inadequate food intake

Short Term Objectives

1. Client will be relieved of abdominal pains within 24 hours
2. Client will be relieved of waist pain within 3 hours.
3. Client will be relieved of anxiety by the end of labour
4. Client will be relieved of fatigue within 1hours.
5. Client will eat half of her meal served.

Long Term Objectives

Client will deliver a healthy and an alive baby without complications to mother and the baby during labour and puerperium.

NURSING CARE PLAN ON LABOUR

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES	NURSING ORDERS	NURSING INTERVENTIONS	DATE/ TIME	EVALUA -TION	SIGN
23/11/21 5:40am	Lower abdominal pains related to cervical dilatation	Client will be relieved of lower abdominal pains within 1 hour as evidence by 1. Client practicing comfort measures. 2. Midwife visualizing that client is coping with lower abdominal pain. Client.	1. Reassure client that she will be relieved of lower abdominal pains . 2. Educate client on the process of labour. 3. Massage sacral region during contraction to relief pain. 4. Encourage client to rest in between contraction. 5. Communicate progress of labour to client.	1.Client was reassured that she will be relieved of fatigue. 2. Client understood the progress of labour. 3. Sacral region of client was massage during each contraction to relief her of pain. 4. Client was encourage to rest in between contraction. 5.The progress of labour was communicated to client.	23/11/21 6:40am	Goal met as client informed midwife she was relived of her tiredness. Midwife observing that client is less tired.	NA

NURSING CARE PLAN ON LABOUR

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES	NURSING ORDERS	NURSING INTERVENTIONS	DATE/ TIME	EVALUATION	SIGN
23/11/21 5:40am	Waist related to descent of fetal head.	Client will be relieved of waist pains within 3 hours. 2. Midwife observing that client waist pains is subside.	1. Reassure Client that waist pain is normal. 2. Explain the physiology of waist pains. 3.Give client sacral massage. 4. Engage client in conversation. 5. Encourage client to do deep breathing exercise.	1. Client was reassured that waist pain she will be relieved of waist pains. 2. The physiology of waist pain was explained to her that it is due descent of fetal head. 3.Client was given sacral massage. 4.Midwife interact with client. 5.Client was encouraged to do deep breathing exercise.	23/11/21 8:40am	Goal fully met as client said her waist is subside. Midwife observing that client is no more in pains..	NA

CARE PLAN FOR LABOUR CONT'

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES	NURSING ORDERS	NURSING INTERVENTIONS	DATE/ TIME	EVALUATION	SIGN
23/11/21 6:50am	Anxiety related to the unknown outcome of labour	Client will be allay anxiety within 1 hour as evidenced by client verbalizing that she can eat meal served 2. Midwife observing that client is relieved of anxiety .	1. Reassure Client that anxiety is temporary. 2. Orient client to delivery room to allay fear and anxiety. 3. Encourage client to ask questions and briefly and simply. 4. Explain every procedure to client. 5.Be with client throughout labour.	1. Client reassured was that everything will be fine. 2. Client was oriented toward environment. 3. Client was allowed to ask questions. 4. All procedures was explained to the client. 5. Midwives were with client throughout labour.	23/11/21 7:50am	Goal met as client told midwife that she is no more anxious. Midwife observing that her anxiety is relieved.	NA

NURSING CARE PLAN ON LABOUR CONT'

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES	NURSING ORDERS	NURSING INTERVENTIONS	DATE/ TIME	EVALUA-TION	SIGN
23/11/21 11:20am	Fatigue related to stresses in labour	Client will be relieved of fatigue within 1hour as evidenced by client verbalizing she is relieved of fatigue. 1. As midwife observing that client fatigue has subsided	1. Reassure Client she will be relieved of fatigue. 2.Encourage client remain calm to prevent maternal exhaustion. 3.Encourage deep breathing exercise. 4.Encourage client to rest in between contraction 5.Serve client with cool drink.	1. Client was reassured that she will be relieved of fatigue. 2.Client was encourage to remain calm to prevent further maternal exhaustion. 3. Client was encourage to continue deep breathing exercise. 4. Client was encourage to rest in between contraction. 5.Client was served with cool drink	23/11/21 12:20pm	Goal met as client said her fatigue is subsided. Midwife observing client fatigue is relieve.	NA

NURSING CARE PLAN ON LABOUR CONT'

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES	NURSING ORDERS	NURSING INTERVENTIONS	DATE/ TIME	EVALUATION	SIGN
23/11/21 11:20am	Inadequate food intake related to stress of labour	Client will eat half of her meal served within 2hours as evidenced by client verbalizing she can eat meal served.	1. Reassure client was reassured that everything will be fine 2. Plan meal with client 3.Explain the process of labour to client. 4.Serve client with beverage. 5.Involve client in planning meal.	1. Client was reassured. 2.Meal was plan client. 3.Process of labour was explained to client. 4 Client was served with beverage. 5. Client was involved in meal planning.	23/11/21 1:20pm		NA

CHAPTER FOUR

POSTNATAL CARE

4.0 INTRODUCTION

This chapter talks about the management of puerperium thus the care rendered to both mother and baby after delivery. It also throws more on the subsequent care of baby, preparation towards discharge, subsequent post-delivery assessment, home visits, postnatal review and

4.1 DAY OF DELIVERY

Madam Regina and Baby were made comfortable in bed. Vital signs of client were checked and recorded as follows;

Temperature	36.8degree celsius
Pulse	78bpm
Respiration	22cpm
Blood pressure	110\80mmHg

On examination, breast were firm and the nipples were prominent. Palpation of the uterus 15cm above the symphysis pubis, lochia was heavy in amount, red in colour and with no clots. She was advised to change her perineal pads frequently when soiled and to report any abnormal vaginal bleeding. Client was encouraged to empty the bladder frequently since full bladder interferes with contractions of the uterus with subsequent bleeding. Client relatives were also allowed to visit mother and baby. Client relatives

were asked to bring her any food of her choice. She was educated on fixing baby for breastfeeding. Baby was examined from head to toes for any sign of injury. Vital signs were checked and recorded as follows,

Temperature	36.5 degree celsius
Apex heart rate	140bpm
Respiration	40cpm
Weight	3.0kg

4.2 SUBSEQUENT CARE OF THE BABY

Baby was monitored continuously and condition of baby was good throughout. Baby was bathed six (6) hours after delivery. Immediately after baby bath, cord was checked for bleeding dressed. Baby was dressed and wrapped in warm cot sheet to keep baby warm to prevent hypothermia. Baby temperature was maintained by wrapped baby well and also the temperature was assessed. Client was advised not put anything such as cow dung, herbs, or ointment on the cord. The breathing rate was also checked and was in normal range.

Mother was educated on frequent breastfeeding as many as possible a day and also exclusive breastfeeding, proper hand and washing also on the essential care of the new born such as cord care. Then mother was encouraged to report any danger sign such as irregular breathing rate, jaundice, fever, report immediately to the nearest health facility.

FIRST BATH OF THE BABY

At 7 am the next day baby was given the first bath, Madam Regina was informed about the need for the baby to be bathed, and she agreed gladly.

Requirements;

1. Top Shelf
2. Methylated spirit in sterile gallipot
3. Baby's diapers
4. Sterile cotton wool swabs and gauze in galipot
5. Sterile gloves
6. Sterile water in gallipot
7. Baby's oil
8. Baby sponge and soap in soap-dish
9. Baby's towel
10. Bottom shelf
11. Mackintosh apron
12. Receptacle for used water
13. A bowl for mixing water
14. Kidney dish for used gauze and swab
15. A bowl containing hot and cold water respectively
16. Disposable gloves

All needed items and baby bath trolley were made ready. Water was mixed and temperature was tested with the elbow. Hands were washed and sterile gloves worn. Baby was placed on a protected flat surface, and covered with a single sheet. Sterile cotton was dipped in sterile water and used to clean the baby's eyes from the inner canthus outward and disposed into a receiver. Face was cleaned with a wet towel. Nape of neck was supported by the palm and the ears were plugged with the thumb and middle finger. Baby's head was washed in a circular motion with soapy sponge after which it was rinsed out and dried with a towel. Body was bathed, paying particular attention to the skin folds, rinsed and dried with a towel. Vaseline was applied all over the body of the baby to provide warmth. Gloves were removed, hands washed and dried.

Cord Dressing;

Baby's cord was inspected for bleeding and there was no bleeding. Six sterile cottons were used to dress the cord using methylated spirit. One was used to hold the clamp and two were used to swab the base of the cord. The whole cord was swabbed anteriorly and posteriorly with a separate swab each from the bottom upwards, the tip of the cord was then cleaned with the remaining cotton and left opened to heal by dry gangrene. Baby was wrapped nicely to maintain warmth. Mother was asked to fix the baby to breast by ensuring that she sit in a good position to attached baby well to breast feed. Mother was educated that baby should be breastfeed on demand.

DAY OF DISCHARGE

In the morning on the 24th November, 2021 Madam Regina and her family around 7:00am to find out how they were doing. After exchanging pleasantries, permission was sought to examine her and the baby . Hands were washed with soap under running water .Vital signs of client and baby were checked and recorded at 7:30am as follows,

Temperature 36.2^0C

Pulse 79bpm,

Respiration 22cpm

Blood pressure 120/80mmHg.

Client was examined from head to toe and no abnormally found. Client was discharged on 24th November,2021. On examination breast were firm and nipples prominent. There was colostrum in the breast. Uterus was firm and well contracted. Symphysio-fundal height was 15cm above the symphysis pubis. Client complained of after pains and was encouraged to breast feed on demand as it helps involution of uterus and advised to continue the postnatal exercises to strengthen the pelvic floor muscles about ten to twenty minutes everyday. She also complained of backache and was encouraged to sleep on firm mattress and apply a gentle massage over when positioning and attachment. Her vulva was inspected, lochia was reddish brown in colour (Rubra), and flow was small and not offensive. She was also advised to always keep the perineum clean and change pads to prevent infection. Baby was re-examined, and observations were recorded at 10am as;

MORNING

Temperature	36.6 degree celsius
Apex heart rate	142bpm
Respiration	42cpm
Weight	2.9kg

Drugs	Dosage	Route of administration
BCG	0.05mls	left upper arm
OPV O	2drops	orally

Baby was immunized to protect him against tuberculosis and poliomyelitis respectively. Client was advised not to apply anything at the injection site but to count time the immunization at the child welfare clinic when the child is six weeks old in order to protect her against the childhood diseases like yellow fever, pertussis among others. Client was later informed of discharge. She was helped to pack her belongings and the following drugs were prescribed for the mother.

Tablet Folic Acid	5mg dly × 14days,
Tablet Ferrous Sulphate	200mg bd × 14days,
Tablet Vitamin B Complex	200mg tds × 14days
and Tablet Paracetamol	1000mg bd × 5days

Drugs and dosages were explained to her and the need to take the drugs was stressed. Her NHIS card used to settle her bills. Client was educated to avoid applying hot water on the baby's fontanelles and sutures. She was recommended to continue using treated mosquito net and maintained good personal hygiene, she was encouraged to have rest and sleep and was reminded of a visit to her house to continue the care for seven days. The family were bidden farewell.

POSTNATAL HOME VISITS

4.3 SECOND DAY OF DELIVERY(FIRST HOME VIST)

In the evening first visit was made to Madam Regina on the 24th November, 2021 at her mother's house at 4:30pm to find out how they are doing. Both mother and baby looked healthy on arrival. Family was much pleased with the visit. In trying to find out her previous complain, client said her after pain and backache has subsided. Explanation was given to her and permission was sought to examined mother and the baby . Hands were washed with soap under water both were assessed from head to toe to detect any abnormality for early treatment, she was asked to empty her bladder. The fundus was measured and it was 14cm, lochia was red (rubra) and not offensive. Client complained of breast milk is not coming and was encouraged to massage the breast excess breast milk and relatives were asked to involve her in breastfeeding. Observations were recorded at 4:30pm as follows,

EVENING

Temperature	36.6 degree celsius
Pulse	89bpm

Respiration	22cpm
Blood pressure	110/80mmHg
Symphysio fundal height	14cm
Uterus	well contracted
Breast	lactating

Permission was sought to top and tail the baby in front of mother for her to observe and it was granted. Baby was examined thoroughly from head to toe, cord was dry and not offensive. The cord was also dressed with cotton wool soaked in methylated spirit, it was cleaned and kept dry and there was no bad odour. According to client, baby passed meconium about three times and passed urine as well. Observation was recorded at 4:30pm as follows,

EVENING

Temperature	36.7 degree celsius
Apex heart rate	140 beat per minute
Respiration	42 cycle per minute

Permission was sought to leave and she was reminded that she would be visited the next day.

4.4 THIRD DAY POST DELIVERY (2ND POSTNATAL HOME VISIT)

On 25th November, 2021, the second visit was made to Madam Regina house around 8:00am in the morning, she was asked if she has complaints and she complained of breast engorgement and loss of appetite and was encourage apply hot compress on the breast. Permission was sought to examine both mother and baby. The head to toe examination was done on her and no abnormality was found. Her perineum was clean, the lochia was found to flow minimal, the colour was red (rubra) and without bad odour. The symphysio fundal height was 13centimeters. She complained of inadequate sleep and was encouraged to have warm bath before going to bed and also limit number of visitors with the baby. Her vital signs were checked and recorded as follows,

MORNING

Temperature	36.3 degree celsius
Pulse	79 beat per minute
Respiration	20 cpm
Blood pressure	110\60mmHg
Uterus	Contracted
Breast	lactating and heavy

EVENING 5pm,

Temperature	36.5 degree celsius
Pulse	79 bpm
Respiration	21cpm
Blood pressure	100\60mmHg

SFH 11cm

Breast Lactating

The baby was topped and tailed general examination was carried out and no abnormality was found. The cord was neatly dressed and was clean and dry with no abnormalities was detected. The baby had passed stools. Observations were recorded at 8am as follows,

Temperature 36.8 degree celsius

Apex heart rate 142bpm

Respiration 56cpm

Weight 2.8kg

EVENING

Temperature 36.8 degree celsuis

Apex heart rate 140bpm

Respiration 42cpm

Weight 2.8kg

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

4.5 FOURTH DAY POST DELIVERY (3RD POSTNATAL HOME VISIT)

On 26th November, 2021 the third home visit was made to Madam Regina's house at 8:00am, she was greeted. Mother and baby were doing well. She was asked about her

sleep and she said she could now sleep for more than 8hours in a day. Permission was sought to inspect client's perineal pad and it was pink, moderate in flow without any offensive smell. Her breasts were lactating well. Symphysio fundal height was 12centimeters. Her vital signs were checked and recorded as follows;

Morning;

Temperature	36.0^0C,
Pulse	78bpm,
Respiration	18cpm
BP	100\70mmHg
At 4pm	
Temperature	36.2
pulse	70bpm
Respiration	16cpm
Blood pressure	109|68mmHg
Symphysio fundal height	12 centimeters.
Breast	lactating
Uterus	well contracting

General examination was carried out and no abnormality was present. The baby also passed stool and urine. The cord was neatly dressed and it was detaching. Observations were recorded as follows; Morning

Temperature	37.0^0c,
Apex heart beat	134bpm
Weight	2.7kg
Respiration	51cpm
At 4:00pm	
Temperature	36.8 degree celsuis
Apex heart rate	135bpm
Weight	2.7kg.
Respiration	46cpm

4.6 FIFTH DAY POST DELIVERY (4TH POSTNATAL HOME VISIT)

The fourth home visit was made to Madam Regina 's house at 4:00pm on 27th November, 2021. Lochia was pink (serosa) with scanty flow without odour on inspection. Head to toe examination was done and everything was normal. Symphysio fundal height was 11centimeters, her vital signs were checked and recorded as follows;

Temperature	36.5^0c
Pulse	74bpm,
Respiration	19cpm,
BP	100/60mmHg.

During the examination, it was realized that the cord had fallen off and baby was bathed. Madam Regina confirmed that it fell off during the night. The stump was then dressed and the area was cleaned and dried. The baby passed urine and stool which was yellow in colour. Observations were recorded as follows;

Temperature 36.8^0c,

Apex heart rate 120bpm,

Respiration 51cpm

Weight 2.7kg.

Client was asked if she has any complained client said she find it difficult to sleep at night and education was given to her on personal hygiene and the need for her to rest during day time.

4.7 SIXTH DAY POST DELIVERY (FIFTH POSTNATAL HOME VISIT)

The fifth postnatal home visit was on 28th November, 2021 at 4:00pm. Greetings were exchanged with client and her family after which a seat was offered in client's room. Mother and baby were both in a healthy condition when it was inquired. After the head to toe examination, no abnormality was found. Inspection of the lochia was done and the colour was pink (serosa) without any bad odour and flow was scanty. Symphysio fundal height 10 centimeters. Client's vital signs were checked and recorded as follows:

Temperature 36.5^0c,

Pulse 72bpm

Respiration 19cpm

BP 100/60mmHg.

Baby was bathed, head to toe examination was done and no abnormalities were found on the baby. Stump of cord was then dressed and the area was cleaned and dried. Findings were taken and recorded as follows;

Temperature	36.5^0c
Apex heart beat	125bpm,
Respiration	40cpm,
Weight	2.8kg .

Madam Regina was was educated to breastfeed the on demand . Permission was sought to leave.

4.8 SEVENTH DAY DELIVERY (SIXTH DAY POSTNATAL HOME VISIT)

The sixth day postnatal home visit was done on 29th November, 2021 at 5:00pm . Greetings were exchanged with client and her family and mother said the baby crying has minimized and now sleeps a lot. On head to toe examination, no abnormalities were detected. Her breast was lactating well. Inspection of the lochia was done and the colour was pink(serosa) normal flow without any bad odour. Madam Regina said the baby had pass stool that evening before arrival. Symphysio fundal height 9cm.

Client vital signs were checked and recorded as follows:

Temperature	36.5
Pulse	79bpm
Respiration	20cpm
Blood pressure	110|70mmHg
Breast	Lactating

Baby was already bathed, head to examination was done and no abnormality was found on the baby. The stump was then dressed and the area was clean and dry. Baby vital signs and weight were taken and recorded as follows:

Temperature	36.7degree celsuis
Apex heart beat	142bpm
Respiration	44cpm
Weight	2.9kg

Education was given to her on importance of ensuring good personal hygiene and need to feed the baby frequently on demand. Client said she appreciated a lot and she was thanked for her cooperation. Permission was sought to leave.

4.9 EIGHT DAY POSTNATAL (SEVENTH POSTNATAL HOME VISIT)

The seventh day postnatal home visit was done on 30th November, 2021 at 7:20pm . Greetings were exchanged with client and family and a seat was offered in client room. Mother and baby were both in a healthy condition. On head to toe examination , no abnormalities were detected. Her breast was lactating well. Symphysio fundal height was 6 centimeters.Inspection of the lochia was done and the colour was pink (serosa) normal flow without any bad odour. Madam Regina said baby pass stool in the afternoon before arrival.

Client vital signs were checked and recorded as follow:

Temperature	36.6 degree celsius
Pulse	80bpm
Respiration	21cpm
Blood pressure	120|70mmHg

Baby was already bathed , head to examination was done and no abnormality was found on baby. The stump was then dressed and the area was clean dry.

Baby vital signs and weight were taken and recorded as follows:

Temperature	36.6degree celsius
Apex heart beat	135bpm
Respiration	40cpm
Weight	3.0kg

Client was educated on the danger signs in baby like and the need to seek early care. She said she appreciated that a lot,and she was thanked for her cooperation, she was reminded that tomorrow will be her first visit to the clinic and last visit to her house. Permission was sought to leave.

4.10 FIRST DAY POST NATAL VISIT TO THE CLINIC (8th DAY POST DELIVERY)

On 1st December, 2021 at 7:30am, Madam Regina and her baby came to the facility. A seat was offered to her. Client and baby were healthy. Procedure to be carried out was explained to her and she consented. Madam Regina was asked to empty her bladder before the head to toe examination. Midstream urine was taken and checked for protein and sugar and all tested negative. Head to toe examination was done and everything was within the normal range. Lochia was checked and the flow was scanty, the colour was brownish (serosa) with no odour. Privacy was provided and she was assisted to lie on the

couch for the head to toe examination. Hands were washed with soap under running water and dried with a clean towel. Head to toe examination was done on her. On the head, hair was neat, the conjunctiva was pink, no discharges from the eyes, nose and ears. There was no abnormality detected in the mouth. Breast was lactating well, no engorgement, sore or cracked nipples were absent. The abdomen was palpated and there was no tenderness, the uterus 5cm. Observations were checked and recorded as follows;

Temperature	36.2degree celsius
Pulse	74bpm
Respiration	19cpm
Blood pressure	100\50mmHg
Weight	74kg
Haemoglobin	11.6g\dL

She was thanked for the cooperation and helped to dress up.

Head to toe examination was done on baby and no abnormality was found. Umbilical stumped was dressed, cleaned and dried, baby's weight was 3.1kg. She was also educated on the importance of the child welfare clinic. Mother was reminded that she will be handed over to the midwife in-charge for continuity of care and was educated to consult them in case of any problem. Baby's vital signs was checked and recorded as follows;

Temperature	36.6 degree celsius
Apex heart rate	122bpm
Respiration	44cpm

TERMINATION OF CARE

On 1st December, 2021 at 11:00am, explanation was made to her that the program was ending that day, but client was reassured of midwife in charge competency . She was educated on the family planning, immunization of the baby till five years old. Client and mother were thanked for their corporation, information was provided to her, that the midwife would be taking care of her from now onwards. Client was also encouraged to register her child at the birth and death registry and she was educated exclusive breastfeeding for six months.Client was again encouraged to report the facility first any time herself or the baby isn't feeling well and also have rest to regain her strength. Client was accompanied to her house and a seat was offered. Client and her family was thanked for their cooperation Permission was sought to leave.

CIRCUMCISION OF THE BABY

After examination of the baby,Madam Regina was informed that the circumcision is about to be done and asked if she wanted to observe but replied in the negative . The baby was prepared and circumcised by the midwife in_charge. Gel was applied to the area circumcised area wrapped with gauze after which baby was clothed and given to the mother to breastfeed.

Education was then given to wash hands with soap under running water before handling baby and to always keep the wound dry to prevent infection and report any signs of bleeding, swelling or discharge.

Client was reminded of her second postnatal visit to the clinic. Baby was registered at Birth and Death Registry. Madam Regina and her family were thanked for their cooperation and for helping me to achieve my aim.

4.11 SECOND POSTNATAL VISIT TO THE CLINIC (SIX WEEKS POST DEELLIVERY)

Madam Regina visited the clinic with the baby on 3rd January 2021, she was welcomed to the clinic by the midwife in charge. Both mother and baby were in healthy condition and had no complaints. Physical examination was done and no abnormality was found, breast was lactating well, uterus was also well involuted and menstruation had not commenced and vital signs was checked and recorded as follows,

Temperature	36.1 degree celsius
Pulse	67 bpm
Respiration	18cpm
Blood pressure	110\70 mmHg
Weight	81 kilogram

Baby's general condition was good, head to toe examination was done and baby's posterior fontanelle was closed and vital signs were checked and recorded as follows,

Temperature	36.3 degree celsuis
Apex heart rate	134 beat per minute
Respiration	44 cycle per minute
Weight	3.9 kilogram

Baby was given immunization against polio, diphtheria, pertussis, tetanus, haemophilus influenza type B, hepatitis B given to children at six weeks. The extra vaccines namely pneumococcal and rotavirus for protection against pneumonia and diarrhoea respectively was also reminded to be given,

Vaccine	Dosage	Route of administration
Polio1	2 drops	Oral
Rotavirus	1.0milimeters	Oral
Penta	0.5milimeters	intramuscularly on right thigh

they were handed over to the child welfare clinic, family planning unit to ensure continuity of care and were educated to consult them in case of any problem. Client was congratulated, according to the midwife in charge.

On 1st December, 2021, client was handed over to the child welfare clinic for continuity of care, she was encouraged to always send the baby for the monthly CWC schedule for the baby to be fully immunized against the six-childhood killer disease. Client was congratulated and permission was sought to leave according to midwife in charge.

Problem Identified

1. After pains
2. Backache
3. Breast engorgement.
4. Inadequate sleep
5. Loss of appetite

Short Term Objectives

1. Client will be relieved of after pains within 24 hours
2. Client will be relieved of backache within 48 hours.
3. Client will be relieved of breast engorgement within 24 hours.
4. Client will be able to sleep for 4hours within 72hours
5. Client will be able to eat half of her meal served.

Long Term Objective

Client will go through puerperium successfully without any complication to both mother and baby.

4.12 CARE PLAN DURING PUERPERIUM

DATE/ TIME	NURSING DIAGNOSIS	OBJECTIVE/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
24/11/21 4:00pm	After pains related to involution of the uterus.	Client will be relieved of after pains within 24 hours as evidenced by client verbalizing that she is no more in pains. 2. As midwife observing that client after pain as reduced	1. Reassure client that after pain is normal. 2. Encourage client to void frequently. 3. Encourage client to breastfeed frequently and on demand. 4. Explain the physiology of the pain to client. 5. Give client paracetamol 1g to reduce pain .	1. Client was reassured. 2. Client was encouraged to void frequently. 3. Client was encouraged to breastfeed frequently and on demand. 4. The physiology of after pain was explained to client that during breastfeeding her uterus shrinks back to its normal shape and size 5. Client was given paracetamol 1g daily before breastfeeding.	25/11/21 4:00pm	Goal fully met as client said that she was relieved of pain.	NA

CARE PLAN DURING PUERPERIUM CONT'

DATE/ TIME	NURSING DIAGNOSIS	OBJECTIVE/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUA-TION	SIGN
24/11/21 4:00pm	Backache related to position and attachment of baby to breast.	Client will be relieved of backache within 48hours as evidence by; client verbalizing that she has been relieved of back pain. 2. As midwife observed that client is relieved from backache	1. Reassure client 2. Explain the physiology of pains. 3. Encourage client to apply warms pack at the back. 4. Apply gentle massage over the back. 5. Encourage client to sleep on to sleep on firm mattress 6. Encourage client to position and attached baby to breast	1. Client was reassured 2.The physiology of backache was explained to client that due to changes of muscloskeletal system that persist after delivery due pregnancy hormone loosen . 3.Client was encouraged to apply warm water bottle pack at the back. 4.Client was encouraged to gently massage her back. 5.Client was encouraged to sleep on a firm mattress. 6. Client was encouraged to position and attachment baby to breast	26/11/21 4:00pm	Goal met as client reported that she has been relieved of backache. Midwife observing that client backache is subside.	**NA**

CARE PLAN DURING PUERPERIUM CONT'

DATE/ TIME	NURSING DIAGNOSIS	OBJECTIVE/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUA-TION	SIGN
25/11/21 9:00am	Breast engorgement related to inadequate emptying of the breast	Client will be relieved of breast engorgement within 24 hours as evidenced by client verbalizing that the pain has reduced. 2. Midwife verbalization that client breast is subside.	1. Reassure client that breast engorgement will be relieved. 2. Explain the physiology of breast engorgement to client. 3. Teach client to express excess breast milk. 4. Ask client to apply warm and compress alternatively. 5. Encourage client to continue breastfeeding on demand.	1. Client was reassured. 2. Physiology of breast engorgement was explained to client that excess accumulation of breast milk if the baby is not able to suck well. 3. Client was taught to express breast milk 4. Client applied warm and cold compress on her breast alternatively. 5. Client was encouraged to continue breastfeeding baby on demand.	26/11/21 9:00am	Goal fully met as client informed the midwife that her pain was no more and breast engorgement has subsided. Midwife that client breastfeed her with no pain.	**NA**

CARE PLAN DURING PUERPERIUM CONT'

DATE/ TIME	NURSING DIAGNOSIS	OBJECTIVES/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
27/11/21 4:00pm	Inadequate sleep related to night breast feeding.	Client will be able to sleep for within 72hours evidenced by client verbalizing that she is able to sleep.	1.Encourage client to have periodic rest during the day when baby is asleep. 2.Educate client to breast feed baby to his satisfaction. 3.Encourage her relative to help her with the household chores. 4.Encourage client to have a warm bath in the evening before bed. 5.Encourage client to limit the number of visitors.	1. Client was encouraged to have a periodic rest when baby was asleep. 2. Client was educated to breast feed baby to his satisfaction. 3. Client's relatives were encouraged to help her with the household chores. 4. She was encouraged to have a warm bath before bed. 5.Client was encouraged to limit the number of visitors	30/11/21 4:00pm	Goal fully met as client verbalized that she had adequate sleep.	**NA**

CARE PLAN DURING PUERPERIUM CONT'

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
25/11/21 9:00am	Loss of appetite related to stresses after labour.	Client will be able to eat her meal served in a frequent interval.	1.Reassure client that she resumed her eating pattern. 2.Educate client on the need to take adequate diet 3.Involve client in planning of meal. 4.Serve client with food in an attractive manner. 5.Administer vitamin supplement to prevent anaemia .	1. Client was reassured. 2.Client was educated on the need to take adequate diet. 3.Client was involved in the planning of meal. 4.Client food was served attractively. 5.Vitamin supplement was administered.	25/11/21 9:00am	Goal fully met as client said that she ate half meal served.	**NA**

SUMMARY AND CONCLUSION

This client and family centered care study was carried out on Madam Regina, a 29year old gravida 2 para 1 all alive, who comes from Tanoso (Bono region). The care given during antenatal, labour and puerperium was successful without any complication.

She attended her first antenatal Clinic on 4th June, 2021 the first meeting was on 4th November, 2021, when she was 36weeks, gestation at Tanoso Health Center. Friendship was established, effective was rendered to client throughout pregnancy, labour and puerperium. She attended the clinic till delivery as expected. Education on good nutrition, personal hygiene, and exclusive breastfeeding was given to her She had spontaneous vaginal delivery to a live male child on 23rd November,2021. She encountered some minor problems during pregnancy, labour and puerperium, with laboratory investigations, examinations and nursing care plan, her identified problems during pregnancy, labour and puerperium were solved without any complication to herself and the family.

She had an intensive puerperal care and was handed over to a Public Health nurse for continuity of care. There were proper documentations of all the activities and procedures carried out on her for proper reference.

This study has helped me gain more experience in situation where classroom acquired knowledge has demonstrated on client and the family. It has expanded the knowledge, skills and potentials to render better and quality care to any pregnant woman.

BIBLIOGRAPHY

Fraser, D.M, and Cooper, M.A (2009) *Myles Textbook for Midwives*, (15thEd). New Delhi: Churchill Livingstone, London.

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

King LTMC (2014) *Varneys Midwifery* (5th Edition) New Delhi: Jones and Bartleft India pot, Ltd.

Myles. (2014). *Myles Textbook for Midwives Edition 15.* Edinburgh London; Churchill Livingstone Elsevier limited.

Marshall, J. & Raynor, M. (2014). *Textbook for Midwive*s (6th edition). London: Churchill Livingstone Elsevier Ltd.

Ojo, O.A (2006): *A textbook for Midwives in the topics* (1st Ed), Edward Arnold Betford Square.

Tiran, D. (2008). *Baillier's Midwives Dictionary.* (11th) london, newyork: elsevier limited.

Verrals, S, (1997) *Anatomy and physiology Applied to Obstetrics*, (3rd ed) Churchill Livingstone, London.

APPENDIX I

COMPLETE DIAGNOSTIC INVESTIGATION

DATE	SPECIMEN	INVESTIGA-TION	NORMAL VALUE	FINDING	REMARKS
14/06/21	Urine	Sugar	Negative	Negative	Normal
		protein	Negative	Negative	Normal
	Blood	Haemoglobin level	12.2g/dl	12.9g/dl	Normal
		Sickling	Negative	Negative	Normal
		Grouping	A, B, AB, O	O	Normal
		Rhesus factor	Positive/negative	Positive	Normal
		HIV/AIDS	Negative	Negative	Normal
		Hepatitis	Negative	Negative	Normal
		VDRL	Negative	Non-reactive	Normal
		G6PD	Normal	Normal	Normal
12/08/2021	Urine	Sugar	Negative	Negative	Normal
		protein	Negative	Negative	Normal
	Blood	Haemoglobin level	12.2g/dl	12.6g/dl	Normal
07/10/2021	Urine	Sugar	Negative	Negative	Normal
		protein	Negative	Negative	Normal
	Blood	Haemoglobin level	12.9g/dl	12.2g/dl	Normal

COMPLETE DIAGNOSTIC INVESTIGATION

DATE	INVESTIGATION	NORMAL VALUE	FINDING	REMARKS
4/11|21	Sugar protein Haemoglobin level	Negative Negative 12.5g/dl	Negative Negative 12.5g/dl	Normal Normal Normal
16/11/2021	Sugar protein Haemoglobin level	Negative Negative 12.3g/dl	Negative Negative 12.3g/dl	Normal Normal Normal

APPENDIX II
PHARMACOLOGICAL DRUGS FOR MOTHER

NAME OF DRUG	CLASSIFICA-TION	DOSAGE	ROUTE	ACTION USES	ACTUAL EFFECT	SIDE EFFECT	SIDE EFFECT EXPERIENCED
Tablet folic acid	Vitamin preparation	5mg daily	Oral	Helps in the formation of normal blood cells	Maturation of red blood cells	Nausea and vomiting	None
Tablet Multivitamin	Vitamin preparation	200mg twice daily	Oral	Increases appetite and helps in the formation of red blood cell	Increased appetite	Gastrointestinal irritation	None
Tablet ferrous sulphate	Iron preparation	200mg daily for 30days	Oral	Helps in the formation of red blood cells	Formation of red blood cells	Abdominal discomfort, diarrhea dark stool	None
Tablet Sulphadoxine pyrimethamine	Anti-malaria and prophylaxis	3 tablets start from 16 weeks (quickening) and subsequent doses at 4 weeks interval till birth.	Oral	Prevention of malaria	Prevent malaria in pregnancy	Itching, vomiting, nausea	None

PHARMACOLOGICAL DRUGS FOR MOTHER CONT'

NAME OF DRUG	CLASSIFICATION	DOSAGE	ROUTE	ACTION & USES	ACTUAL EFFECT	SIDE EFFECT	SIDE EFFECT EXPERIENCED
Tetanus toxoid injection	Anti-tetanus	0.5miligram	Subcutaneous	Helps in the prevention of tetanus	Prevention of tetanus	Slight fever and chills	None
Oxytocin	Oxytocic drug	10units	Intramuscular	Increase uterine contraction and control of bleeding.	Increase contractions	Hypotension and hyper stimulation	None
Vitamin A	Group A vitamin supplement	200000unit once daily	Oral	Growth and development proper sight	Growth development, prevent infection and blindness	Vomiting	None
Tablet paracetamol	Analgesic	500mg	Oral	Helps to reduce increased body temperature and pain	Relieve pain	Liver damage with prolong use	None

APPENDIX III
PHARMACOLOGICAL DRUGS FOR BABY

NAME OF DRUG	CLASSIFICATION	DOSAGE	ROUTE	ACTION USES	ACTUAL EFFECT	SIDE EFFECT	SIDE EFFECT EXPERIENCED
Vitamin K	Group K vitamins	1milliliter	Intramuscular	Production of prothrombin that aids in clotting	No bleeding	Hypersensitive reaction	None
Chloramphenicol eye drop	Antibiotics	2 drops	Instillation	To prevent eye infection	Infection of the eye was prevented	None	None
Oral Poliomyelitis	Antigen vaccine	2 drops	Orally	Gives immunity against poliomyelitis	Baby is under observation	Diarrhea, fever	None
Injection Bacillus Calmette Guerin	Antigen vaccine	0.05 ml	Intradermal	Production and prevention of tuberculosis	Baby is under observation	Blister formation and slight fever	Blister was formed

PHARMACOLOGICAL DRUGS FOR BABY

NAME OF DRUG	CLASSIFI-CATION	DOSAGE	ROUTE	ACTION/ USES	ACTUAL EFFECT	SIDE EFFECT	SIDE EFFECT EXPERIENCED
Pneumococcal	Antigen	0.5 milligram	Intramuscularly	Vaccinates neonates against pneumonia	Pneumonia prevention	Redness at the side of injection and fever	None observed
5 in 1 vaccine (Pentavalent)	Antigen	0.5 milligram	Intramuscularly	Vaccinates neonates against diphtheria, pertussis (whooping cough), tetanus, hepatitis B, haemophilus influenza type B	Prevention of childhood preventable diseases	Low grade fever	None observed
Rota virus	Antigen	1.5 milligrams (2 drops)	Orally	Prevention of gastroenteritis	Gastroenteritis prevention	None	None observed

APPENDIX IV

ANTENATAL CHART

DATE	WEIGHT (KG)	BLOOD PRESSURE (MMHG)	URINE PROTEIN SUGAR	GESTATIONAL AGE	FUNDAL HEIGHT (CM)	PRESENT - ATION	DESCENT	FOETAL HEART RATE	COMPLAINS	TREATMENT	NAME AND SIGNATURE
14/06/21	75	110/80	Negative	16weeks	-	Varieable		134	No complain	Tablet (Multivite, folic acid, ferrous sulphate, Sulphadoxine Pyrimethamine)	A.N
15/7/21	78	110/70	Negative	20weeks	20	Cephalic	-	133	No complain	Tablet (Multivite, folic acid, ferrous sulphate, Sulphadoxine Pyrimethamine)	A.N
12/8/21	78	100/70	Negative	24weeks	22cm	Cephalic	-	136	No complain	Tablet (Multivite, folic acid, ferrous sulphate, Sulphadoxine Pyrimethamine)	A.N

ANTENATAL CHART CONT'

Date	Weight (kg)	Blood pressure (mmHg)	Urine Protein Sugar	Gesta-tional age	Fundal height (cm)	Presentation	Descent	Foetal heart rate	Complains	Treatment	Name and signature
13/9/21	75	100/60	Negative	28weeks	27cm	Cephalic	-	138	No complain	Tablet (Multivite, folic acid, ferrous sulphate, Sulphadoxine Pyrimethamine)	A.N
25/10/21	78	100/70	Negative	34weeks+ 5days	26	Cephalic	$5/5^{th}$	128beat per minute	Sleep disturbance	Tablet (Multivite, folic acid, ferrous sulphate, Paracetamol, Sulphadoxine Pyrimethamine	A.N
4/11/21	78	100/60	Negative	34+5days	29	Cephalic	$5/5^{th}$	133 beat per minute	Frequent micturition	Tablet (Multivite, folic acid, ferrous sulphate) Sulphadoxine Pyrimethamine	A.N

ANTENATAL CHART CONT'

DATE	WEIGHT (KG)	BLOOD PRESSURE (MMHG)	URINE PROTEIN SUGAR	GESTA-TIONAL AGE	FUNDAL HEIGHT (CM)	PRESENTA-TION	DESCENT	FOETAL HEART RATE	COMPLAINS	TREAT-MENT	NAME AND SIGNA-TURE
07/11/21	79	100/70	Negative	36weeks+ 4day	30	Cephalic	$5/5^{th}$	134 beat per minute	Constipation	Tablet (Multivite, folic acid ferrous sulphate.	A.N
07/11/21	79	110/70	Negative	36weeks+ 4days	34	Cephalic	$5/5^{th}$	135 beat per minute	Waist pain Complain	Tablet (Multivite, folic acid and ferrous sulphate.	A.N
17/11/21	79	100/60	Negative	37weeks+ 6days	37	Cephalic	$5/5^{th}$	138 beat per minute	Lower abdominal pains	Tablet (Multivite, folic acid and ferrous sulphate**.**	A.N
18/11|21	79	100|70	Negative	38weeks+ 5days	38	Cephalic	$5\|5^{th}$	134 beat per minute	Backache	Tablet (Multivite, folic acid and ferrous sulphate.	A.N

SIGNATORIES

NAME OF STUDENT MID WIFE

NAME: ALBERTHA NYARKO

SIGNATURE……

DATE……

THE MIDWIFE- IN -CHARGE(SUNYANI NORTH TANOSO HEALTH CENTRE)

NAME: ABENA BOAHEMAA

SIGNATURE……

DATE……

THE SUPERVISOR

NAME: ERNESTINA MENSAH

SIGNATURE…….

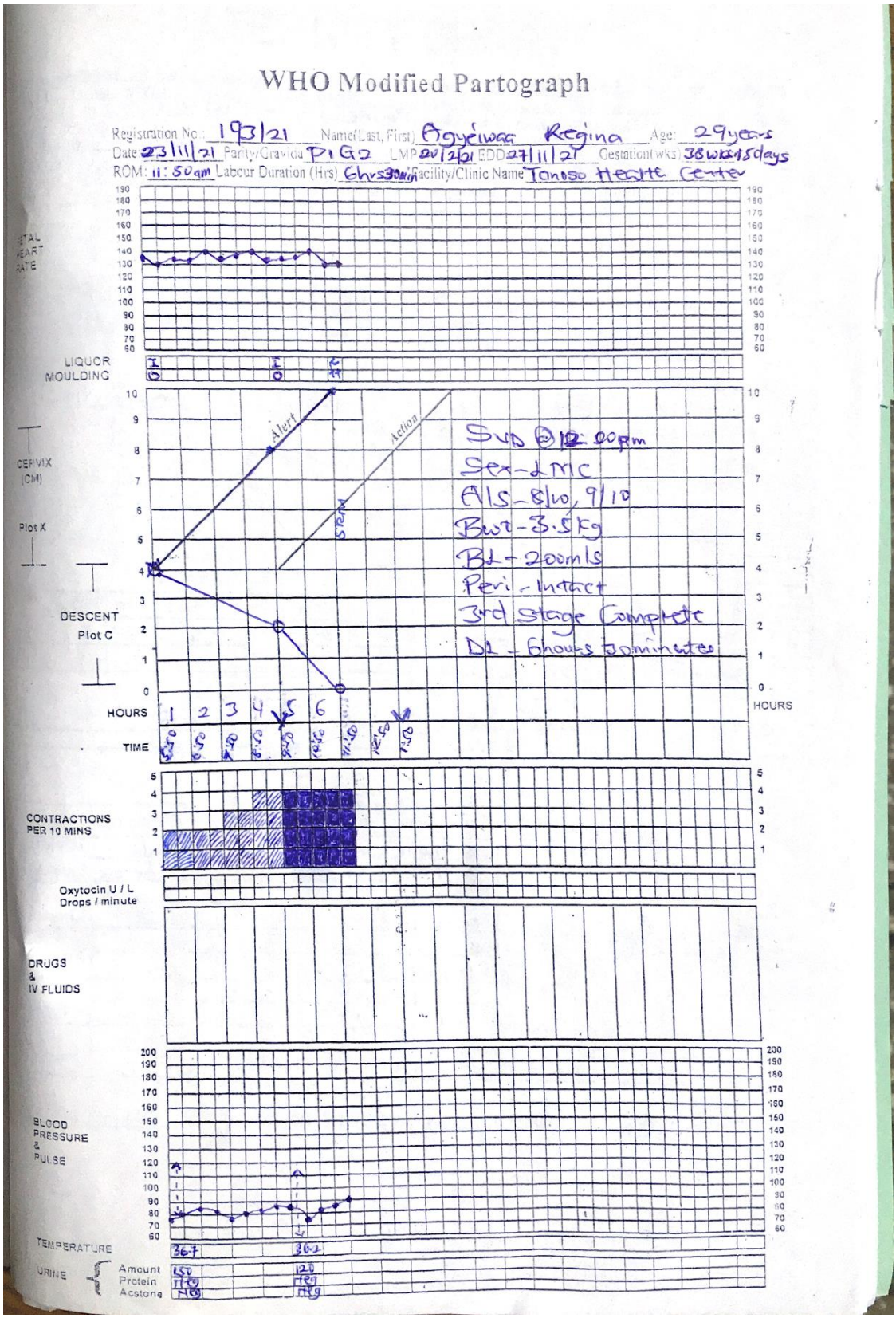
DATE:……

THE PRINCIPAL

NAME: MONICA NKRUMAH

SIGNATURE……

DATE:……..


WHO Modified Partograph
Registration No.: 193/21 Name(Last, First) Agyeiwaa Regina Age: 29years
Date: 23/11/21 Parity/Gravida P1G2 LMP 20/2/21 EDD 27/11/21 Gestation(wks) 38wks 5days
ROM: 11:50am Labour Duration (Hrs) 6hrs 30min Facility/Clinic Name Tanoso Health Centre
FETAL HEART RATE
LIQUOR MOULDING
CERVIX (CM)
Plot X
DESCENT Plot C
Alert
Action
SVD @12:00pm
Sex-2MC
AS-8/10, 9/10
Bwt-3.5kg
BL-200mls
Peri-Intact
3rd Stage Complete
DL-6hours 30minutes
HOURS
TIME
CONTRACTIONS PER 10 MINS
Oxytocin U / L Drops / minute
DRUGS & IV FLUIDS
BLOOD PRESSURE & PULSE
TEMPERATURE
36.7
36.2
URINE
Amount 150 120
Protein nil nil
Acetone nil nil

LABOR NOTES

Madam Regina G2p1 38weeks came to the facility accompanied by mother and 6hrs of lower abdominal and painful contractions. Client had SVD to a LIVE with A/S 8/9 @1'10, BWT-3.5kg, HC-33cm, FL-50cm. Perineum intact. IM Oxytocin 10 iunit given, Placenta was delivered with Control cord traction. Cord care done, Vitamin K was given, eye care was done as well as breastfeeding was initiated. Uterus was massaged and it was Contracted. Bladder was emptied. Mother and baby were cleaned and made Comfortable in bed.

Please circle or write responses.

DELIVERY

DATE: 23/11/21 TIME: 12noon METHOD: (Spontaneous) / Vacuum Extraction / C/S / Other

PERINEUM: (Intact) / Episiotomy / Laceration

ANESTHESIA: (None) / Local / General

THIRD STAGE

Active Management: (Yes) No Medication: Time 12:01pm Type/Dose Oxytocin (10unit)

PLACENTA: TIME: 12:02pm (Complete) / Incomplete

BLOOD LOSS AMOUNT: (Small (Less than 250 cc) 200mls) / Moderate (250-499 cc) / Large (more than 500 cc) / Significant for mother

BABY

Weight: 3.5kg

Sex: (Male) / Female

Baby Position: (Vertex) / Breech / Other

APGAR

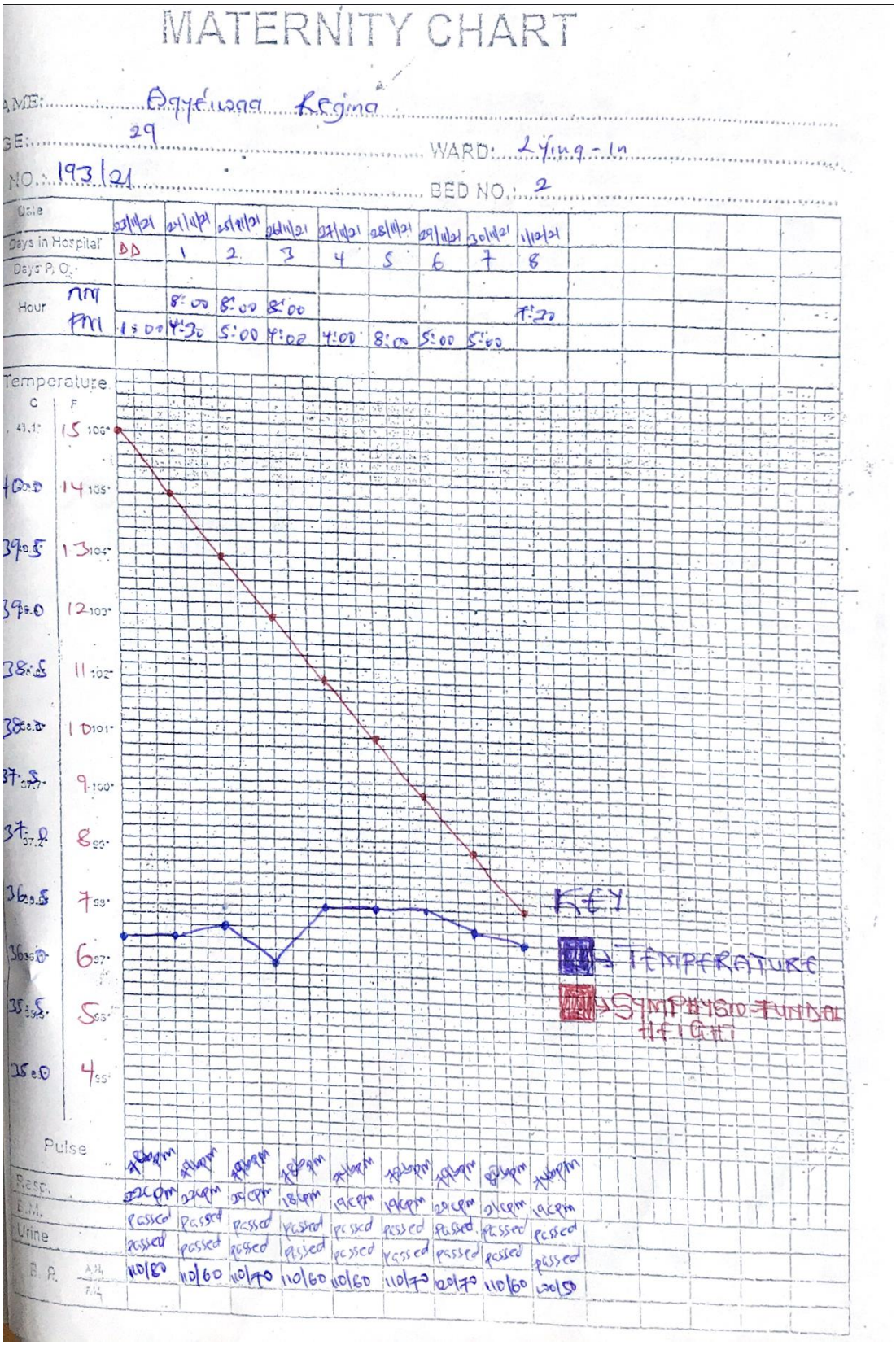
Time	Color	Breath	Heart	Tone	Reflex	TOTAL
1min	2	2	2	1	1	8/10
5min	2	2	2	2	1	9/10

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

FOURTH STAGE MONITORING

Frequency	Time	B/P.	Pulse	Fundus	Bleeding	Bladder
Every 15 minutes first 2 hours	12:15	110/70	69		200mls	100mls
	12:30	120/60	68		Moderate	Emptied
	12:45	115/60	75		Moderate	
	1:00	120/80	72	↓	Scanty	Emptied
	1:15	120/70	75	↓	Scanty	
	1:30	120/75	81	↓	Scanty	Emptied
	1:45	110/60	84	↓	Scanty	
	2:00	110/80	79	↓	Scanty	Emptied
Every 30 minutes For 1 hour	2:30	120/70	72	↓	Scanty	
	3:00	120/80	71	↓	Scanty	Emptied

Birth Attendant Nyarko Alberta Supervised by Mbrokoh Vera Date 23/11/21


MATERNITY CHART
NAME: Ayeiwaa Regina
AGE: 29
WARD: Lying-in
NO.: 193/21
BED NO.: 2
Date
Days in Hospital
Days P. O.
Hour
Temperature
C
F
Pulse
Resp.
Urine
B. P.
KEY
TEMPERATURE
SYMPHYSIO-FUNDAL HEIGHT

NEW BORN EXAMINATION FORM

Name: Baby Kwabena Agyemang Date of Assessment: 23/11/21 Time: 1:00pm

Date of Birth: 23/11/21 Time of Birth: 12:noon Sex: ☑ M ☐ F Age at time of Assessment (days/hrs) 1hour

Astational Age 38wks+5days ☐ Mode of Delivery: ☑ Vaginal Assisted Vaginal C-Section

APGAR: 1min 8/10 5min 9/10 Birth Weight: ☐ 3.0 kg ☐ Length: 50 cm Head Circumference: 33 cm

Temperature at time of Assessment: 36.5 °C Urine passed: (Yes) No Meconium passed: (Yes) No

Name of Assessor (Midwife/Doctor): Myerko Albertus

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

Tone

☐ Normal
☐ Floppy *
☐ Increased *

Colour

☐ Pink all over
☐ Pink body but blue hands/feet
☐ Blue all over *
☐ Pale *
☐ Jaundiced *

Cord

☐ Normal
☐ Red. draining pus
☐ Bleeding

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: 140
☐ Normal (100-160)
☐ <100 *
☐ >160*

19. Femoral pulse

☑ Present
☐ Not palpable*

20. Abdomen

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

21. Back (spine)

☑ Normal
☐ Abnormal Swelling *
☐ Hairly patch over spine
☐ Abnormal dimple
☐ Abnormal curvature

22. Limbs

☑ Normal
☐ Abnormal _____

23. Genitalia

Male Genitalia

☑ Normal
☐ Undescended testes
☐ Abnormal meatus
☐ Hernia
☐ Other: _____

Female Genitalia

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

24. Anus

☑ Patent
☐ Imperforate*

25. Resuscitation provided

☐ None
☐ Suction/stimulation
☐ Bag and mask
☐ Endotracheal Tube
☐ Ventilator/CPAP

26. Services provided

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

ay indicate severe disease that requires urgent referral

gnoses (if known) Normal baby

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

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

NEW BORN EXAMINATION FORM

Name: Baby Kwaben Agyeiwaa Date of Assessment: 24/11/21 Time: 7:00

Date of Birth: 23/11/21 Time of Birth: 12:noon Sex: ☑ M ☐ F Age at time of Assessment (days/hrs) 1da

Astational Age: 38 ~~Days~~ ☐ Mode of Delivery: ☑ Vaginal Assisted Vaginal C-Section

APGAR: 1min ☐ 5min ☐ Birth Weight: ☐ 2.9 kg ☐ Lenght 50 cm Head Circumference: 33 cm

Temperature at time of Assessment: 36.6 °C Urine passed: (Yes) No Meconium passed: (Yes)

Name of Assessor (Midwife/Doctor): Nyarko Alberta

1. Respiration
Rate 42
- ☐ 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: 142
- ☐ 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 vagina) *
- ☐ Large clitoria *
- ☑ Other: _____

24. Anus
- ☑ Patent
- ☐ Imperforate*

25. Resuscitation provide
- ☐ None
- ☐ Suction/stimulation
- ☐ Bag and mask
- ☐ Endotracheal Tube
- ☐ Ventilator/CPAP

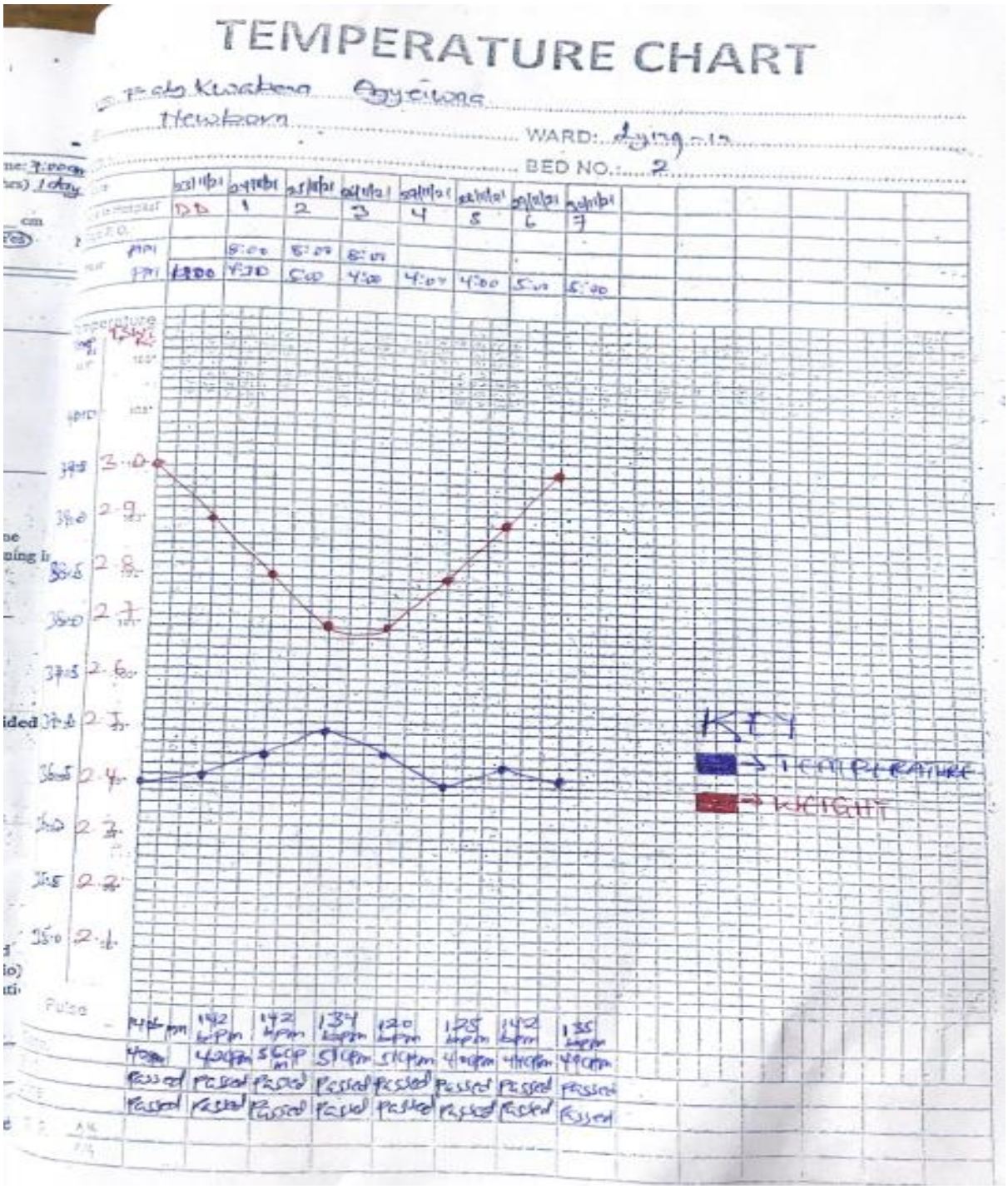
26. Services provided
- ☐ Vitamin K1 given
- ☐ Eye care provided
- ☑ Cord care provided
- ☐ Breastfeeding initiated
- ☑ Breastfeeding established
- ☑ Immunization (BCG/Poli
- ☑ BCG ☑ Polio Immuniza
- ☐ Antibiotics in mother
- ☐ Antenatal corticosteroids

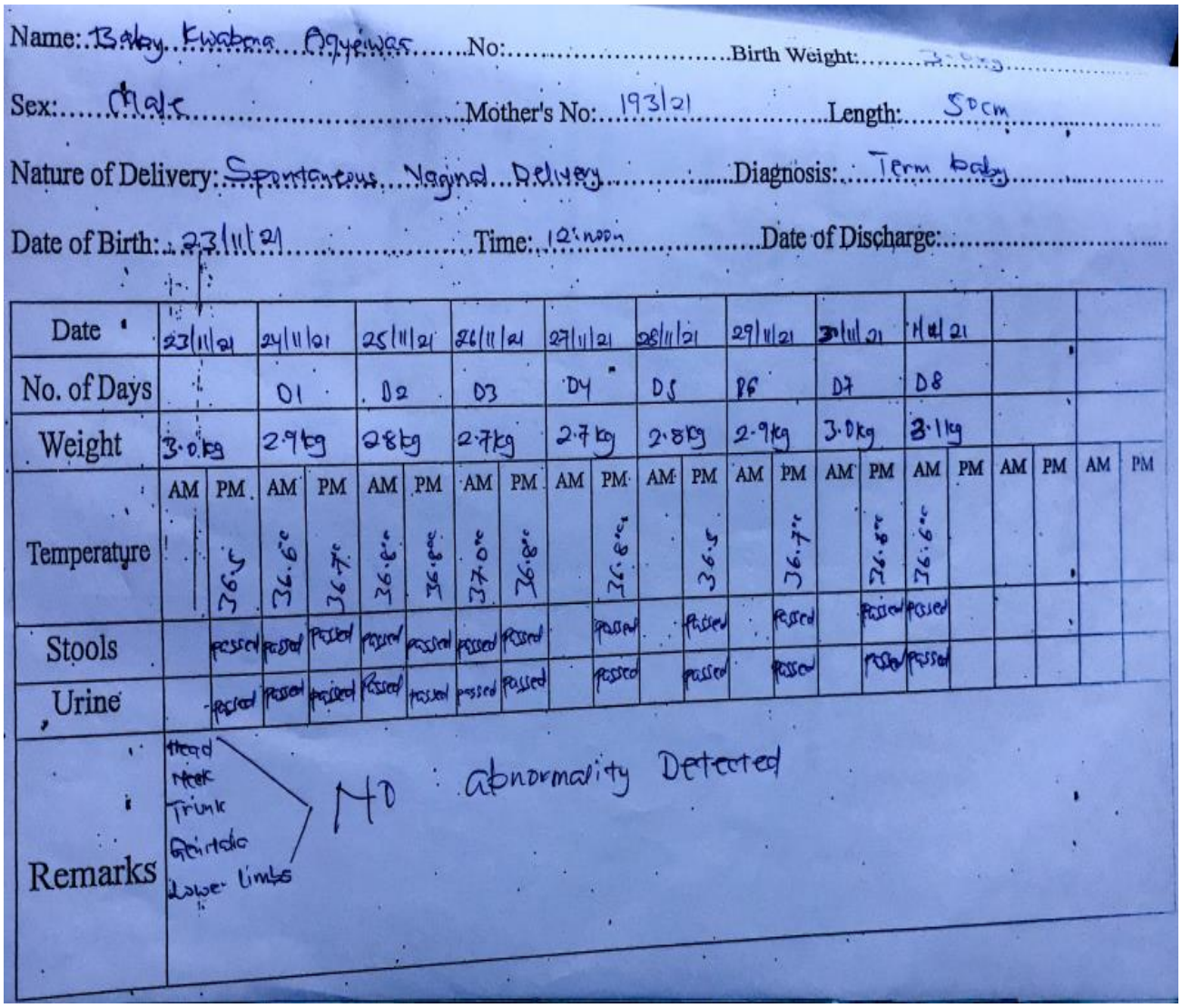
*May indicate severe disease that requires urgent referral

Diagnoses (if known) Normal 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[ ] Dischar


TEMPERATURE CHART
Newborn
WARD: Dying-in
BED NO.: 2
KEY
TEMPERATURE
WEIGHT



Name: Baby Kwabena Agyeiwaa ..... No: ..... Birth Weight: .....

Sex: Male ..... Mother's No: 193/21 ..... Length: 50cm .....

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

Date of Birth: 23/11/21 ..... Time: 12:noon ..... Date of Discharge: .....

Date	23/11/21		24/11/21		25/11/21		26/11/21		27/11/21		28/11/21		29/11/21		30/11/21		1/12/21					
No. of Days			01		02		03		04		05		06		07		08					
Weight	3.0kg		2.9kg		2.8kg		2.7kg		2.7kg		2.8kg		2.9kg		3.0kg		3.1kg					
	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	36.6°c	36.7°c	36.6°c	36.8°c	37.0°c	36.8°c		36.8°c		36.5		36.7°c		36.8°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 Genitalia Lower limbs		No abnormality Detected																			

SIGNATORIES

NAME OF STUDENT MID WIFE

NAME: ALBERTHA NYARKO

SIGNATURE.....

DATE...12/10/2022.....

THE MIDWIFE- IN -CHARGE(SUNYANI NORTH TANOSO HEALTH CENTRE)

NAME: ABENA BOAHEMAA

SIGNATURE.....

DATE...13/10/2022.....

THE SUPERVISOR

NAME: ERNESTINA MENSAH

SIGNATURE.....

DATE:..14/10/2022

THE PRINCIPAL

NAME: MONICA NKRUMAH

SIGNATURE.....

DATE:..15/10/2022.....

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