

**HOLY FAMILY NURSING AND MIDWIFERY TRAINING COLLEGE BEREKUM**

**A CLIENT/FAMILY CENTERED MATERNITY**

**CARE STUDY ON**

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**A CLIENT FAMILY CENTERED MATERNITY CARE STUDY SUBMITTED TO THE  
NURSING AND MIDWIFERY COUNCIL OF GHANA IN PARTIAL FULFILMENT  
FOR THE AWARD OF LICENSE TO PRACTICE AS A PROFESSIONAL  
REGISTERED MIDWIFE**

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## **PREFACE**

Client Family Centered Maternity care is a structured and comprehensive care given to the pregnant woman and her family to prepare them physically, spiritually and socially toward the arrival of the new born. This care is a required study that every final year student offering Registered Midwifery Program is supposed to undertake to satisfy the Nursing and Midwifery Council of Ghana to help contribute to the award of the Professional Certificate in Registered Midwifery. Also the client family centered maternity care study enables the student Midwife to put into reality the theoretical aspect of midwifery into practice and also uses the knowledge acquired in pharmacology, sociology, psychology, nutrition, dietetic and nursing perspective to identify client's problem. This knowledge would help the student physically, socially and psychologically to manage the woman during pregnancy, labour and puerperium. The student during the care establishes good relationship with the entire family. The care study equips the Student midwife with the skills needed to give quality care, identify deviation from normal during the period of care, and also the study involves family members in the care from the first visit of the pregnant woman till the end of puerperium. From the above reasons, the client family centered maternity care is necessary and also helps to reduce and prevent the possible causes of maternal and child morbidity and mortality rate.

## **ACKNOWLEDGEMENT**

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I wish to express my heartfelt appreciation to the Midwife- in - charge, Miss Edna Kyraa and other supportive staff of happy hospital Berekum for their directions, advice and encouragement.

I am much grateful to my client madam Deborah her family, for their cooperation and right information given to me throughout my study. Also I would like to acknowledge Mr kwabena Effah for his support, encouragement and prayers. Lastly my heartfelt gratitude goes to my family, my husband, and Mr kwabena Effah. for their immeasurable sacrifice and support both spiritually and physically throughout my care study, I say thank you all.

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

## 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 wellbeing. 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 was carried out on client 25years old woman who was gravida 2 para 1alive at the time of encounter. She comes from Senase in the Bono west region but stays at Nyametease. Client was first met on the 12<sup>th</sup> of January 2024 during one of her regular attendances to the Antenatal clinic around 9:30am at Happy hospital. It was her sixth antenatal visit and her gestational age was also 38weeks. After a comprehensive introduction to her, I informed about the desire to choose her for the client/family centered maternity care study which she happily agreed. I thanked her for cooperation and accepting the request.

During the interaction, she looked worried and when approached, client said she was tired due to advanced stage of pregnancy and after counseling she became relieved. My interactions with her last for six (6) weeks.

From pregnancy to puerperium the individual experiences a lot of physical and psychological changes due to the influence of some hormones that affects almost all the systems of the body especially the reproductive organs.

In view of this, the pregnant woman suffers from some minor disorders such as frequency of Micturition and waist pain. Although it seems not to be life threatening, they should never be ignored since it could be the beginning of serious conditions such as pre-eclampsia and eclampsia. This therefore gives the midwife a duty to supervise, explain and educate the

expectant mother to understand and be able to cope with all these changes. The Midwife is able to do all these with the help of the Nursing Process and the partograph to rule out any complication.

Client Family Centered Maternity Care study consists of four chapters.

Chapter one talks about client's particulars which are social, family, medical, surgical, menstrual, Client's lifestyle and hobbies, past and present obstetrical histories.

Chapter two also talks about antenatal care, first contact with client, first and second antenatal home visits and client subsequent visit to the clinic.

Chapter three deals with admission of client during labour, management of first, second, third and fourth stages of labour, immediate care of the baby.

Chapter four is concerned with puerperium, the period after expulsion of the placenta and its Membranes up to the end of six weeks after delivery. At the end of the last three chapters are care plans drawn to solve identified client's problems. This script also includes summary, conclusion, bibliography and appendices which comprises of complete diagnostic investigation, pharmacology of drugs for both the mother and the baby, Antenatal records, labour records, post-natal records and signatories as well.

## **LITERATURE REVIEW**

### **PREGNANCY LITERATURE REVIEW**

In King (2014), pregnancy is a time of profound anatomic and physiologic changes in a woman's body. In addition to the reproductive organs, all maternal physiologic systems make adaptations needed to support the developing fetus and at the same time, maintain maternal homeostasis.

According to Perry (2013), pregnancy is the period of physical and physiological preparation for child birth and parenthood. According to him, the expectant mother ideally should begin prenatal visit soon after the first missed menstrual period for early detection of complications and to ensure good health of the expectant mother and fetus. He also stated that normal pregnancy last for about forty (40) weeks or two hundred and eighty (280) days and healthcare providers refer to early, middle and late pregnancy as trimesters. The first trimester last from week one (1) to thirteen (13) weeks and the second from fourteen (14) to twenty-six (26) weeks whereas the third trimester from twenty-seven (27) weeks to forty (40) weeks. Any pregnancy that advances from thirty-eight (38) to forty (40) weeks is considered to be at term.

Marie (2013), also defines pregnancy as when the woman's egg and a man's sperm cell unite to form zygote. The duration of pregnancy has traditionally been calculated by the clinicians in terms of 10 lunar months or 9 months and 7 days or 280 days or 40 weeks, calculated from the first day of the last menstrual period. This is called menstrual or gestational age. It is divided into 3 trimesters. First trimester (first 12 weeks), second trimester (13 to 28 weeks) and last trimester (29 to 40 weeks), Third trimester - 27<sup>th</sup> week to 42<sup>nd</sup> of week gestation. Ideally this should be more flexible depending on the need, and the convenience of the patient.

According to Marshall and Raynor (2014) there are few experiences in the life of a woman such as mood swing. The woman herself often diagnoses pregnancy even before she has missed her

period because of the changes she feels within herself. She normally experiences further states that these changes are as a result of increases in production of estrogen and progesterone.

Marshall and Raynor (2014) enumerated that changes experienced in a woman's emotional state are due to hormonal factors, examples of these hormones are progesterone, estrogen and human chorionic gonadotrophin. These emotional levels help in the development of the fetus, prepares the expectant mother for labor as well as puerperium. Myles further states that, the signs and home pregnancy test. There are three signs of pregnancy which are as follows: Possible or presumptive signs which include amenorrhea, bladder irritability and quickening. Probable signs such as presence of human chorionic gonadotrophin hormone in blood and urine, softened isthmus (Hegar's sign), bluish of the vagina (Chadwick's sign), pulsation of the fornices (Oslander's Sign), changes in skin pigmentation and uterine soufflé. Positive signs which include visualization of gestational sac by trans-vaginal and trans-abdominal ultrasound, fetal heart sounds by Doppler and fetal stethoscope then, fetal movements by palpation or visibility in late pregnancy.

According to Tiran (2015) pregnancy is from conception to delivery of baby normal duration (280days) or nine (9) months and seven (7) days counted from the last day of the last menstrual period to delivery, or 265days from conception to delivery

## **LABOUR**

In (King, 2014), puerperium is the time the woman begins the physiologic transition to the non – pregnant state. Traditionally, puerperium has been defined as lasting for 6 weeks, because by 6 weeks most women have completed the last of the physiologic transitions; uterine involution is complete, lochia has ceased, and lactation is well established.

According to Perry (2013) stated that five factors affect the process of labour and birth. These are the Passenger which is the fetus and placenta, Passageway which is the birth canal, Powers which is the contractions, Position of the mother and Psychological responds. He further identifies the stages of labour as follows; the first stage of labour begins with the onset of regular uterine contractions, effacement, dilatation of the cervix and progress in descent of the presenting part. The first stage of labour has been divided into three phases namely; the latent phase where there is more progress in effacement of the cervix and a little increase in descent. Active phase and transitional phase where there are more rapid dilation of the cervix and increase rate of the descent of the presenting part. The second stage of labour; this stage begins with full cervical dilation (10 centimeters) and complete effacement and ends with the baby's birth. He continued that, the second stage takes an average of 20 minutes for multiparous women and 50 minutes for nulliparous women. The third stage of labour which lasts from the birth of the fetus until the placenta is delivered. He stated that the placenta normally separates with the third or fourth strong contractions after the infant has been born. The duration of the third stage may be as short as 3-5minute although up to 1 hour is considered within the normal limits. Lastly, the fourth stage of labour last for 6 hours after delivery of the placenta. It is the period of immediate recovery when homeostasis is re-established. It is an important period of observation for complication such as bleeding.

Marie (2013) defines labour as a series of events that takes place in the genital organs in effort to expel the viable products of conception out of the womb through the vagina into the outer world. Labour is called normal if it fulfills the following criteria; Spontaneous in onset. With vertex presentation, without undue prolongation Natural termination with minimal aids, without having any complication affecting the health of the mother and/ or the baby. The features of true labour

signs are: Painful uterine contraction at regular intervals. ‘‘Show’ Progressive effacement and dilatation of the cervix. Formation of the ‘bag of waters’ The events of labour are divided into four stages; first, second, third and fourth stage. First stage starts from the onset of true labour pain and ends with full dilatation of the cervix. Its average duration is 6 hours in multipara. Second stage starts from full dilatation of the cervix and ends with expulsion of the foetus from the birth canal. Third stage begins after the expulsion of foetus and ends with the expulsion of the placenta and membranes (afterbirth). Average duration is about 15 minutes in both multi and primigravidae. Fourth stage is the stage of observation after the expulsion of the afterbirth. Four factors are significant in the process of labour; that is the pelvis, passenger, powers and psyche. These are known as the four P’s (Ricci, 2016).

According to Marshall and Raynor (2014) 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 centimeters 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 first 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.

According to Ricci, (2016). Normal labour occurs spontaneously after 37weeks gestation with vertex presentation of single foetus completed within 24hours without maternal and foetal trauma physiology depend on interaction between uterus, maternal pelvis and fetus.

## **PUERPERIUM**

In Ricci (2016). Puerperium is the time the woman begins the physiologic transition to the non – pregnant state. Traditionally, puerperium has been defined as lasting for 6 weeks, because by 6 weeks most women have completed the last of the physiologic transitions; uterine involution is complete, lochia has ceased, and lactation is well established.

Perry (2013) defined postpartum period as the interval between the birth of the newborn and the return of the maternal reproductive organs to their normal non pregnant state. He said that the term puerperium refers to the six weeks period elapsing between the termination of labour and the return of the reproductive organs to their normal condition. This includes both the progressive changes in the breast for lactation and involution of the internal reproductive organ. He also enumerates that, there are 3 types of lochia namely, lochia rubra: it is seen in the first 3 days and consists of blood, decidua and trophoblastic debris and may contain some small clots. It is bright red in colour. Lochia serosa: it is seen during the next 4-9 days. It consists of old blood serum, leucocytes and tissue debris. It is pinkish in colour. Lochia alba: it is seen after 10 days and consists of leucocytes, decidua, epithelial cells and cervical mucus. It is white in colour and continues for 10-14 days.

According to Marie (2013) puerperium is the period following childbirth during which the body tissues, especially the pelvic organs revert back approximately to the pre-pregnant state both anatomically and physiologically. The period is divided into; Immediate –within 24 hours. Early-

up to 7 days, Remote –up to 6 weeks. Immediately following delivery, the uterus becomes firmer and retracted with alternating hardening and softening. At the end of 6 weeks, its measurement is almost similar to that of the non-pregnant state and it weighs 60 grams. The vaginal discharge for the first fortnight during puerperium is the lochia. The lochia originates from the uterine body, cervix and vagina. Depending upon the variation of the colour of the discharge it is named as: Lochia rubra (red) 1 -4 days. Lochia serosa (yellowish or pink or pale brownish) 5-9 days. Lochia alba (pale white) 10 -15 days. The average amount of discharge, for the first 5-6 days is estimated to be 250 ml.

Marshall and Raynor (2014) also stated that, puerperium starts immediately after delivery of the placenta and membranes and continue to six weeks during which the uterus and other organs which were affected during pregnancy return to their non- pregnant state. Marshall and Raynor 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.

Tiran (2015) Puerperium is a period of 6-8 weeks following childbirth during which the uterus, other organs and structures are returning to their non-pregnant state.

## **WHY CLIENT WAS CHOSEN**

On January, 12<sup>th</sup>, 2024, at 9:30am, client was met at Happy hospital. After going through her antenatal card, client was 38weeks pregnant. She was fit to be use as my client for the family centered care study. During our interaction, she showed interest and asked questions pertaining to family planning because she had her current pregnancy unplanned. This was evident by the age of the last child which was 1year 6months before her current pregnancy which I gathered from her. For this reason, I decided to take her as my client so that I could educate her on the importance of family planning. All her laboratory results were good and expected date of delivery (EDD). Client was informed about my interest to take her as my client and she agreed. The midwife in- charge also recommended her, and reassured her of confidentiality which she gladly accepted. Introduction was made. Client was welcoming and had interest in knowing what I have for her. On thorough interaction, client had little knowledge in pregnancy, labour and puerperium. This made me chose her as my client for the care stud, I then took her number and thanked for her cooperation.

## **CHAPTER ONE**

### **CLIENTS PARTICULARS**

#### **1.0 INTRODUCTION**

This chapter deals with the assessment of the client and her family, which involves a systematic collection of data from the client and her family. Information was acquired through observation, interview, medical records and antenatal records. This information helps the student midwife to provide holistic care for the client and her family taking into consideration the physical, psychological and spiritual needs.

#### **1.1 PERSONAL AND SOCIAL HISTORY**

Madam Deborah 25 year old gravida 2 para 1 live expectant mother hails from Senase in the Berekum West District in the Bono Region but lives in Nyametease house number NYT/5. She is fair in complexion and is 165cm tall and weight 55kg. She speaks Twi and English. Madam Deborah schooled at Grace D/C where she completed junior high school. Madam Deborah is a trader and she is married to Mr. Phillips who is a driver. They have been married for three (3) years now.

Mr. Phillips speaks Twi and English too. He also comes from Senase. He is fair in complexion. She and her husband intended to deliver at Happy hospital. The couple are Christians and worships at the Roman Catholic Church. Client has one beautiful daughter called Daniella. Madam Deborah said her next of kin is her mother.

#### **1.2 FAMILY HISTORY**

Mr. Appiah and Madam Serwaa are her parents. They are all alive and live at Senase too. Her parents are farmers. She is the last born among her three siblings. According to her, there are no

known hereditary conditions such as diabetes mellitus, sickle cell disease, mental disorder, epilepsy and asthma in her family. She further stated that there is history of multiple pregnancies in her family. Death in the family to her, is natural.

### **1.3 MEDICAL HISTORY**

According to client, she has never been hospitalized before. Client mentioned that she sometimes experienced minor illness which is treated on Out-Patient Department basis. Client does not have any condition like asthma, hypertension, diabetes mellitus and tuberculosis. She has no known allergies to food and drugs given. She is also not on any medication for chronic illness and that has never received blood transfusion or donated blood before.

### **1.4 SURGICAL HISTORY**

Madam Deborah said, she has never had an accident that has affected her pelvis and any part of her body before. She has neither undergone any surgical operation that has affected her pelvis, spine nor reproductive organs and did not also have episiotomy done during her delivery

### **1.5 MENSTRUAL HISTORY**

According to Madam Deborah she has a twenty-eight days' menstrual cycle and bleeds for five days with mild lower abdominal pains. She had her menarche at the age of 17years and since she has had a regular menstrual flow. She said she does not take any medication for her dysmenorrhea. She changes the sanitary pads twice a day and does not bleed between periods. she remembers her last menstrual period to be 10<sup>th</sup> may, 2023 and her Expected date of delivery was calculated to be on 4th January, 2024.

### **1.6 CLIENT LIFESTYLE AND HOBBIES**

Madam Deborah goes to bed around 9:00pm and wakes up around 5:00am. She washes her face

and brushes her teeth with tooth brush and tooth paste. The next thing she does is to sweep her compound, mop her room and prepares breakfast for the family. She takes her bath, baths her daughter and prepares her for school while she also goes to work. When her child closes from school at 3:00pm, she comes home and prepares supper for the family. She eats three times and empties her bowel at least once a day. She neither smokes cigarettes nor takes any alcoholic drink. On Thursday, client cleans the house, goes to the market to buy food stuff and shops for the items that she would need in the upkeep of the house for one week. On Saturday, client cleans the house washed her dirty clothes as well as her husband and child and dried in the sun. Client favorite food is banku with light soup. She enjoys conversing, watching movies and listening to radio but uses her leisure time mostly to sleep. On Sundays, Madam Deborah goes to church with her family around 9:00am and closes around 11: 30am. She then comes home and prepares lunch for her family.

## **1.7 PAST OBSTETRIC HISTORY**

### **Pregnancy**

Madam Deborah gravid 2 Para 1 alive, went through her previous pregnancy without any ill-health and had term pregnancy. There was no complication like ante partum hemorrhage or abortion in her pregnancy. She said she had all her doses of tetanus diphtheria injections and had all doses of Sulphadoxine pyrimethamine as prophylaxis against malaria in her first pregnancy. She said the intervals between her pregnancy were 1year 4month when inquired.

### **Labour**

She had spontaneous vaginal delivery to a live female infant in 20/2/2022 at Happy Hospital. According to Madam Deborah her labour lasted for 14 hours but when she was finally instructed to push, it did not take long and baby was delivered. The baby cried lustily at birth. She also said

she never had any perineal tear or been given episiotomy during her previous delivery. The third stage did not also take long. Blood loss was not specific, but she said she had no postpartum haemorrhage after her delivery

### **Puerperium**

Madam Deborah's puerperal period, according to her was also normal. She had no puerperal problems or psychosis after her delivery. Client said, she visited the postnatal clinic as per her appointments and so she and her baby were healthy throughout their postnatal periods. She practiced exclusive breastfeeding for six months for her baby and introduced complementary feeds while she continued the breastfeeding till baby was two years one month. According to client, her child received all the immunizations against childhood preventable diseases. She also said, she received support from her husband and mother during her previous delivery. Her first baby was healthy till one year eleven months when she started to experience symptoms like fever and diarrhoea but was well. Madam Deborah said, she practiced family planning by using contraceptives. She also stated that her family supported in taking care of the baby, herself and some of the household chores

### **1.8 PRESENT OBSTETRIC HISTORY**

Madam Deborah visited the antenatal clinic on 11<sup>th</sup> September 2023. According to her antenatal card, her last menstrual period was 8<sup>th</sup> May 2023. and her Expected date of delivery was calculated to be on 12<sup>th</sup> February, 2024. The first ultrasound scan estimated date of delivery was 15<sup>th</sup> February 2024.

On her first antenatal clinic visit, her history was taken and recorded which included personal, family, medical, surgical and obstetrical histories. Laboratory investigations were also taken and

physical assessment was done and recorded. Results of investigations which were carried out were as follows;

Hemoglobin Level	-	12.3g / dl
Sickling Test	-	Negative
Blood group	-	O
Rhesus factor	-	positive
G6PD	-	No Defect
Syphilis (VDRL)	-	Non-reactive
HIV status	-	Negative
HBsAg	-	Negative
Urine R/E	-	Clear
Stool R/E	-	No abnormalities detected

The following observations were made and recorded;

Temperature	-	36.5 <sup>o</sup> C
Pulse	-	72bpm
Respiration	-	23cpm
Blood Pressure	-	120/60mmHg
Weight	-	55 kg
Height	-	165cm

Records on Madam Deborah's antenatal card indicated that she was examined from head to toe and no abnormalities were detected. She said she has no complains, therefore she was served with the following routine drugs;

Tablet Folic acid 5mg (1 daily) for 30 days

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

Tablet Multivitamin 200mg (1 daily) for 30 day

She was scheduled for the next visit, which she followed correctly and carried out all the laboratory investigations requested. On her next visit, she was served with her first dose of sulphadoxine pyrimethamine and 3<sup>th</sup> dose of tetanus diphtheria. She had no complains, therefore she was served with routine drugs and scheduled for the next visit. Madam Deborah was a regular attendant until she was met on the 12<sup>th</sup> January, 2024 when she was 37weeks pregnant according to her scan and her sixth visit to the antenatal clinic. All findings were recorded in her Antenatal card until she was met.

## **CHAPTER TWO**

### **ANTENATAL CARE**

#### **2.0 INTRODUCTION**

This chapter gives a brief insight of the care given to client during pregnancy specifically from the 38 weeks. It lays more emphasis on the first contact with client, various home visits and subsequent visits and also the nursing care plan drawn to solve her problem during pregnancy.

## **2.1 FIRST CONTACT WITH THE CLIENT**

Madam Deborah was met for the first time on 12<sup>th</sup> January, 2024 at Happy hospital during the antenatal day when she was 37weeks pregnant. It was her sixth visit to the hospital. Client was approachable, and ready to share any information when given the mandate. Introduction was made as Achiama Comfort, a student midwife from Holy Family Nursing and Midwifery Training College, Berekum, sent to happy hospital for clinical to have a practical experience in midwifery. Her antenatal book was collected and found out that she fall within the criteria and she have being attending antenatal clinic regularly and have no abnormal condition which can be a threat to her pregnancy. A brief information was given to her about the care study and why she was chosen and she readily accepted it and pledged her full support and co-operation. She was then taken through the general examination when it got to her turn with procedure explained. She was encouraged to ask questions. Her vital signs were checked and recorded as follows;

Temperature	36.2°C
Pulse	78bpm
Respiration	18cpm
Blood Pressure	110/70mmHg
Weight	67kg

## **LABORATORY INVESTIGATION**

Urine tested for protein and glucose were negative.

Hemoglobin level.....12.3g/dl.

VDRL..... Non-reactive.

HIV status.....Negative (280).

Midstream urine sample was taken from client and mackintosh apron and gloves were worn. The colour was amber with no sediments. Strip for checking sugar and urine was dipped in urine and removed immediately and tapped at the edge of the container. Findings were negative as recorded above. Urine was discarded and protective clothing's removed. Hand washing was done and findings were recorded in client's antenatal record booklet and findings explained to her.

After the above procedures, education was offered to her on the following; warning signs in pregnancy like bleeding per vaginum, oedema and losing of liquor.

Client's permission was sought to perform physical examination from head to toe and the procedure was explained to her. Having emptied her bladder already, privacy was ensured and was helped to undress, assisted to lie on the examination couch and covered with a clean cloth. Hands were washed with soap and water and dried with clean dry towel. Client was examined from head to toe, under supervision of the midwife in charge.

**Client's hair** was examined and it was neatly braided with no dandruff or lice. The sclera and conjunctiva were normal with no yellowish discoloration. There were no discharges from the nose and ears. The mouth, tongue and teeth were clean. On neck palpation, no lymph nodes were obvious or easily palpable.

**The breasts** had no lumps, dimples or discharge during palpation. The areolae were gently pressed, and colostrum was expressed and it was swabbed with a sterile cotton wool swab and smelt for bad odour, but it was not offensive. She was educated that the colostrum would serve as the first line of immunity and prevents allergies to the child and she was educated to feed the baby with it when delivered. Client was taught how to do self-breast examination and she was educated to examine her breast regularly for early detection and reporting of any abnormalities.

**The hands and fingers** were inspected the palms were inspected for pallor, the nails including the capillary refill using the nails were checked and they appeared to be pink in colour. and the nails were short and neat. Her upper limbs were of equal size and length. Client was asked if she had tingling and tightness of the fingers on making a fist and she said no. On examination of the **lower extremities**, legs were palpated for oedema, tenderness of the calf muscle and none was present. Also there were no varicose vein and they were of equal size and length. Her toe nails were neatly trimmed and kept short too.

**The back** was also inspected for oedema at the sacral region, scoliosis, kyphosis was inspected and her vertebral column was normal. There was no oedema at the areas inspected and the condition of the skin was good.

#### **Abdominal palpation**

Permission was asked to expose her abdomen for inspection after assisting her to lie on her back. Before abdominal examination, then standing on her right side the abdomen was inspected for scars, rashes and striae gravidarum and none of these were detected. The size and shape were globular and medium respectively with obvious linea nigra and foetal movements.

**Measuring of Symphysis-fundal height;** commenced by first rubbing the palms together to generate warm in order to stimulation of contractions. The zero end of the measuring tape was placed on the fundus and the tape extended to the symphysis pubis of the uterus and the symphysis-fundal height measured 36centimetres and gestational age of 37weeks.

**On fundal palpation;** upon facing the head of the woman on her right hand side, the fundus was palpated with both palms and the foetal buttocks were found.

**On lateral palpation;** with one hand stabilizing the right side of the maternal uterus, the other hand was moved gently on the left side where rough parts were felt indicating the foetal limbs

as palpated. This was repeated at the right side and a smooth round part was observe indicating the foetal back and this will also help to locate the position of the foetus to help listen to the foetal heart sounds by using the foetal stethoscope. The position was therefore right occipito anterior.

**On pelvic palpation;** upon facing the woman's lower limbs with her knees(legs) slightly flex and breathing through her mouth, the palms of both hands on either side of the lower abdomen below the umbilicus and fingers pointing downwards and inwards, the head was palpated. The lie therefore was longitudinal, presentation was cephalic.

**Descent;** The anterior shoulder was located and five fingers were admitted between the shoulder and the symphysis pubis indicating 5/5<sup>th</sup> above the pelvic brim.

**On auscultation;** foetal stethoscope was warmed by rubbing it in the palm and placed at the back of the foetus to listen to the foetal heart sounds. Foetal heart beat was counted for one full minute and whiles comparing it with the maternal radial pulse and was 148 beats per minutes bounding volume and regular rhythm.

### **Vulva examination**

Permission was sought to examine the vulva and it was granted. Hands were washed under running water with soap and dried with a clean towel and gloves were put on. On inspection, the mons pubis was well shaved; there were no scars, oedema, varicose veins and genital warts. Also, there was evidence of good vulva hygiene so she was applauded for the good work done and was asked to continue with it. She was however encouraged to wear cotton panties. She was also educated on washing the vulva with clean water. Client was asked to lie laterally and sit up before getting out of the couch and also assisted her to dress up. She was congratulated for

allowing the procedure to be done on her. Hands were washed and dried and all findings were explained to her and recorded in her antenatal book and she was encouraged to ask questions which she said she had none. However, when asked of her complaints, she complained of pains in the lower abdomen and waist which she thought would affect the baby during delivery. She was reassured and educated that it was due to the pregnancy since the fetus is engaging into the pelvis thereby exerting pressure on other organs and nerves in the sacral region and also due to relaxation of the joints of the pelvic bone by pregnancy hormone and she was taught to bend from kneel and also rest in between activities. She was thanked for her cooperation. The true signs and stages of labour were explained to her. That was; appearance of show, painful rhythmic uterine contractions and first, second, third and fourth stages also respectively. Madam Deborah was educated to report to the clinic if she sees anything unusual. Then Client having agreed to be used for the study, she gave direction to her house and phone numbers were exchanged. Arrangement was made to visit her house on 23<sup>rd</sup> January,2024, he was thanked and was escorted to the entrance of the happy hospital. She was also reminded of her next visit to the clinic as 23rd January 2024

She was served with routine drugs as below;

- Tab Ferrous sulphate 200mg daily for 7 days
- Tab Multivitamin 200mg daily for 7 days
- Tab Folic acid 5mg daily for 7 days

## **2.2 FIRST ANTENATAL HOME VISITS**

First home visit to Madam Deborah was on the 18th January 2024 at 3:00 pm. The main aim was to know where she lives to ascertain if there are health treats, and also how she relates with her family members and neighbors. The journey was made by motor bike to the client's house and

the directions given. The house was about 5minute drive from the hospital. It was located behind church of Pentecost- Nyametease. She was very glad for the visit. Seat and a glass of water was offered, after which interaction with her started. She was asked how herself and the family were doing which she replied they were all fine. Introduction was made to the family and her co-tenant. The house is a compound house built with blocks, cemented, plastered and roofed with aluminum sheets. There are six single rooms in the house and a detached structure used as kitchen by all tenants. Outside walls of the house are not painted but inside of her room is a combination of white and blue pain. Client, her husband and child use the room. Their surroundings were neat and not bushy. There was a bathroom and toilet in the house. She uses plastic container with a lid to collect her refuse and empties her bin regular when it is full into the community's refuse disposal site.

They fetched water from a nearby pipe water in the area and they have electricity as a source of light. They use the pipe born water for drinking and other purposes such as cooking, bathing and washing. And so it is stored in a blue colored barrel covered with a lid.

Items for delivery were brought for inspection and it was complete. She was congratulated for purchasing all the items and was encouraged to add her National Health Insurance and take money along. As the interaction continued, she complained bitterly about abundance mosquitoes in the environment and so the opportunity was taken to brief her on malaria in pregnancy. Enquires were made about the preventive measures. Client said she hardly gets malaria because she uses the treated mosquito bed net. Client and her co-tenants were made aware that sleeping in the insecticide treated mosquito net effectively helps in the prevention of mosquito bites especially at night. She was encouraged to continue using the net even after delivery. She was informed about the next visit on the 23<sup>rd</sup> January 2024

### **2.3 SECONDANTENATAL HOME VISIT**

On the 23rd January, 2024 4.00pm, client was paid a visit as she was promised. A cheerful welcome was given by client. Madam Deborah husband and her child were met; they were all happy. After exchange of pleasantries, she complained of constipation, vaginal discharges and frequency of micturition but was reassured and the physiological change in pregnancy was and she was assured that, they are manageable and that of micturition will subside after delivery.

Client was asked about the previous complain and she replied that she is coping. Madam Deborah's permission was sought to leave. She was thanked for her co-operation and reminded on the next antenatal visit.

### **2.4 SUBSEQUENT VISIT TO THE CLINIC**

Client came to the hospital on 23<sup>rd</sup> January, 2024 at 9:00 am as scheduled. She was warmly welcomed and a seat was offered to her. She was asked how she was faring and she said she was fine. She was helped through the normal routine procedures and her vital signs were checked and recorded as follows;

Temperature	-	36.7°C
Pulse	-	78bpm
Respiration	-	21cpm
Blood pressure	-	110/70mmHg
Hemoglobin	-	12.3 g/dl
Weight	-	70kg

Client was asked to empty her bladder; midstream urine sample was tested for protein and glucose which were negative.

Client was helped onto the examination couch and privacy was ensured. General examination was carried out under the supervision of the midwife in-charge and no abnormalities were found. On abdominal examination, symphysio –fundal height was 36cm and her gestational age 38weeks, lie was longitudinal, presentation was cephalic with a descent of 5/5th above the pelvic brim.

On lateral palpation, the position was right occipito-anterior. On auscultation; the foetal heart rate was 142bpm with regular rhythmic and good volume.

All findings were communicated to her and recorded in her antenatal card. She was asked to continue her routine drugs and report to the health center notices anything unusual s or the sign of labour because she was almost due.

## **2.5 NURSING CARE PLAN DURING ANTENATAL PERIOD**

Nursing care plan is a written document designed to render total, individualized care to client and her family taking into consideration their needs. It involves identifying problems, analyzing them, setting objectives and implementing interventions to meet the set objectives. The care is then evaluated to know whether set goals have been achieved.

### **PROBLEMS IDENTIFIED ANTENATAL PERIOD**

On 1<sup>st</sup> February, 2024, client complained of

1. Lower abdominal pain.
2. Waist pain.

On 1<sup>st</sup> February, 2024, client complained of

3. Constipation
4. Vaginal discharge (leucorrhoea)

5. Frequency of micturition

### **SHORT TERM OBJECTIVES**

1. Client will cope with reduced lower abdominal pain within 24hours.
2. Client's waist pain will reduce within 48hours.
3. Client will move her bowel (once daily) within 24 hours.
4. Client will cope with vaginal discharge within 48hours.
5. Client will understand the reason for the frequency of micturition within 3hours

### **LONG TERM OBJECTIVE**

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

## NURSING CARE PLAN FOR PREGNANCY

DATE / TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES /OUTCOME CRITERIA	NURSING ORDERS.	NURSING INTERVENTIONS	DATE / TIME	EVALUATION	SIGN
01/02/24 at 9.30am	Lower abdominal pains related to descent of the foetal head.	Client will cope with reduced lower abdominal pains within 24hours as evidenced by 1.Client verbalizing that her pain has reduced.	1. Reassure client that her pain will reduce after the intervention. 2. Explain the cause of lower abdominal pains to her 3.Give analgesics 4. Encourage client to reduced household activities 5. Encourage client to rest in-between activities	1. Client was reassured that her pain will subside. 2. Client was taught that this pain is due to “give” of the pelvis. 3. Client was given paracetamol tablet to reduce the pain 4. Client reduced household activities drastically 5. Client was taking rest in between activities.	02/02/24 at 9:30am.	Goal fully met as evidenced by client 1.verbalizing that the pain has reduced.	<b>AC</b>

## NURSING CARE PLAN FOR PREGNANCY

<b>DATE / TIME</b>	<b>NURSING DIAGNOSIS</b>	<b>NURSING OBJECTIVES/ OUTCOME CRITERIA</b>	<b>NURSING ORDERS</b>	<b>NURSING INTERVENTIONS</b>	<b>DATE / TIME</b>	<b>EVALUATION</b>	<b>SIGN</b>
5/2/24 at 9:30am	Waist pain related to relaxation of the pelvic joints and exaggeration of the lumber curve due to actions of pregnancy hormones.	Client will cope with reduced waist pain within 48hours as evidenced by; 1.Client verbalizing that pain has reduced and 2.Midwife visualizing that client is ambulating without pain	1. Reassure client that she will be relieved of waist pain. 2. Encourage her to always bend on the knee and not from waist. 3. Teach husband how to do sacral massage for her 4. Educate client to lift only light objects 5. Administer prescribed analgesic (paracetamol 1g).	1. Client was reassured that she will be relieved of waist pain. 2. client was encouraged to bend on her knee and not from the waist. 3. Client's husband was giving her sacral massage. 4.Client avoided lifting heavy objects 5. Client was served paracetamol tablet 1g tds x 3 to reduce the pain.	06/2/24 at 9:00am	Goal fully met as evidenced by client verbalizing that pain has reduced and she is able to carry out her home chores	<b>AC</b>

**NURSING CARE PLAN FOR PREGNANCY**

<b>DATE / TIME</b>	<b>NURSING DIAGNOSIS</b>	<b>NURSING OBJECTIVES /OUTCOME CRITERIA</b>	<b>NURSING ORDERS</b>	<b>NURSING INTERVENTIONS</b>	<b>DATE / TIME</b>	<b>EVALUATION</b>	<b>SIGN</b>
05/02/24 at 3.30pm	Constipation related to inadequate fibre and fluid intake	Client will move her bowel at least once a day within 48hours as evidenced by: 1.Client verbalizing that she is able to pass stool once daily.	1. Reassure client that she will be fine, since it is normal physiology. 2. Explain the physiology of constipation to the client. 3. Encourage client to take at least 8 glasses of water daily. 4. Educate client on the intake of roughages. 5.Educate on mild exercise	1. Client was reassured that she will have free bowel. 2. Client was told constipation is due to reduced peristalsis, fluid and roughage intake. 3. Client was encouraged to take about 8 glasses of water daily. 4. Client included roughages such as fruits and vegetables in her meal 5. Client was educated to performed mild exercise like walking.	06/02/24 at 3.30pm	Goal fully met as evidence by client verbalizing that she passes stools once daily and relieve from discomfort of constipation.	<b>AC</b>

**NURSING CARE PLAN FOR PREGNANCY CONTINUES**

DATE / TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTIONS	DATE / TIME	EVALUATION	SIGN
05/02/24 at 3:30pm	Profuse Vaginal discharge related to increased vascularity and mucus productions.	Client will understand and manage vaginal discharge within 12 hours to prevent infection as evidenced by: 1.Client verbalizing proper perinea care and 2.Midwife visualizing that client presented no vulval itchiness	1. Reassure client that the discharge is physiological 2. Explain the physiology of vaginal discharge to client. 3. Encourage client to wear cotton panties. 4. Teach client to practice good personal hygiene. 5. Encourage client to dry panties in the sun if possible or iron them.	1. Client was reassured that the discharge wear off. 2. Client was told it is due to pregnancy hormone and the dodalins bacilli. 3. Client was encouraged to wear cotton panties. 4. Client cleaned herself from anterior to posterior and applied panty liner. 5. Client dried her panties in the sun to prevent infections.	06/02/24 at 3:30pm	Goal fully met as evidence by client verbalizing that her amount of vaginal discharge has reduce and she present no vaginal itchiness.	AC

**NURSING CARE PLAN FOR PREGNANCY CONTINUES**

DATE /	NURSING	NURSING	NURSING ORDERS	NURSING INTERVENTIONS	DATE	EVALUATION	SIGN
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<b>TIME</b>	<b>DIAGNOSIS</b>	<b>OBJECTIVES/O UTCOME CRITERIA</b>			<b>/TIME</b>		
05/02/24 at 3:30pm	Frequency of micturition related to the growing uterus exerting pressure on the bladder	Client will understand the reason for the frequency of micturition within 3 hours as evidence by: 1.client verbalizing she understands and so she is coping with the frequency of micturition. 2. Midwife observing that client complains less of the frequent voiding.	<ol style="list-style-type: none"> <li>1. Reassure client that, it is a normal physiology of pregnancy</li> <li>2. Encourage her to lean forward when voiding to help empty her bladder.</li> <li>3. Encourage her to urinate whenever she has the urge.</li> <li>4. Educate her on the use of panty liners.</li> <li>5. Educate her on personal hygiene</li> </ol>	<ol style="list-style-type: none"> <li>1. Client was reassured and reminded of the physiology of frequency of micturition.</li> <li>2. Client leaned forward when voiding to help empty her bladder.</li> <li>3. Client was encouraged to urine immediately when she has the urge.</li> <li>4. Client used panty liners to absorb the secretions.</li> <li>5. Client was educated on the need to keep nails short and bath at twice daily.</li> </ol>	06/2/2024 at 3:30pm	Goal fully met as evidence by client verbalizing that, she understood the physiology of frequency micturition the stated all the orders mentioned During the education.	<b>AC</b>

## **CHAPTER THREE**

### **LABOUR**

#### **3.0 INTRODUCTION**

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

#### **3.1 ADMISSION AND MANAGEMENT OF FIRST STAGE LABOUR**

##### **ADMISSION OF CLIENT**

Client reported to happy hospital with her husband and her sister on the 13th February, 2024 at 12:30am with complains of severe waist and lower abdominal pains. They were warmly welcomed and were offered seats. Client's antenatal card was collected and quickly glanced through with midwife in- charge. Labour history was taken and according to her, she started experiencing severe lower abdominal pain, show, and waist pain on the same day at 2:30pm the previous day. She, her husband and sister were reassured and items for delivery were collected and it was explained to her that it was engagement of the fetal head which is putting pressure on the sacral nerves. She was asked about her last meal, bowel action and any drug taken. She was made comfortable in bed and all procedure to be carried out was explained to her and her consent was sought. She was seen to be anxious. She was reassured that she was in the hands of competent staffs. Physiology of the stages of labour was explained to her. She was encouraged to ask questions. She was taken to the labour room and was offered a bedpan to empty her bladder. The quantity of urine was 150 milliliters. The midstream urine was tested for protein and glucose and it was negative for both.

Her vital signs were checked and recorded as follows;

Temperature	-	36.8°C
Pulse	-	78bpm
Respiration	-	22cpm
Blood Pressure	-	120/70mmHg
Hemoglobin	-	11.5g/dl

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

On palpation, fundal, lateral and pelvic were performed. The symphysis-fundal height was 35 cm, the lie was longitudinal, and presentation was cephalic. The descent of the head was 3/5<sup>th</sup> above the pelvic brim, and uterine contraction was 2 in 10 minutes lasting 20 and 34seconds respectively.

On auscultation, fetal heart rate was 140 beats per minutes which also regular in rhythm.

Procedure for vaginal examination was explained to Madam Deborah. A mackintosh and towel was placed under client and she was helped into a dorsal position with knees flexed. Hands were washed under running water with soap and dried with a clean dry towel and sterile gloves were put on. Client was encouraged to part her legs. The vulva was cleaned with sterile cotton wool swab soaked with savlon with strokes from upwards downwards starting with the labia majora. The vulva was normal and clean with no varicose veins or oedema and also it was inspected for episiotomy scars, Female Genital Mutilation, warts, sores and vaginal discharge. Vaginal discharge was present. The discharge was whitish and with normal odour without itching.

On vaginal examination, the vagina was warm and moist. The cervix was soft, thin, effaced and the presenting part well applied to it.

The cervical dilatation was four centimeters (4cm) at 1:00am and was also monitored 4 hourly. No moulding was noticed. The sacrum was well curved. The sacral promontory was not reached; the ischia spines were blunt. A fist was made and it fitted into the intertuberous diameter. The perineum was cleaned and a clean pad was applied to the vulva. The gloves were immersed in 0.5% chlorine solution. Gloves were removed by turning the inside out and were disposed into a yellow polythene bag placed in a black plastic container. Hands were thoroughly washed with soap under running water and dried with a clean towel. She was helped to lie on her left side. Client complained of thirst and intensified pain so she was served with a cup of water, was reassured that she would be relieved of waist pain after delivery. She was encouraged not to sit for a very long period but to walk around. Sacral massage was also given. Client was encouraged to lie on her left side when she feels tired. She was also advised to pass urine frequently and change her perineal pad when soiled to prevent infection. Client was informed about the progress of labour and findings were recorded on the labour chart. Dilatation was explained to her using the dilatation board. Fetal heart rate contractions and pulse were monitored every 30 minutes. Cervical dilatation, descent of the fetal head, moulding, membranes, blood pressure and temperature were also monitored every 4 hours.

### **PREPARATION FOR BIRTH**

Helpers were identified both skilled (the ward in-charge) and non-skilled (husband and sister) to assist in labour and delivery when needed. Emergency plan was also reviewed which included; calling of a taxi driver to help in transporting the client to referral center when the need arises. The room was well lighted and a portable lamp was also in place in case of lights out. Preparation of the area for ventilation and checking of equipment was also done by preparing a dry, flat and safe space for receiving the baby for ventilation when needed and equipment to help

the baby breathe were checked for their function and were all functional. The items included the suction device, ventilation bag and mask, stethoscope, scissors, timer, head covering, clothes and gloves. Delivery set and emergency drugs were available.

### **3.2 MANAGEMENT OF FIRST STAGE OF LABOUR**

The foetal heart rate, maternal pulse and uterine contractions were checked every 30 minutes, temperature, blood pressure, descent as well as vaginal examination was done 4 hourly and the results plotted on the partograph. She complained of tiredness and was reassured and encouraged to avoid screaming but perform deep breathing exercise when there are contractions. Again, milo and biscuit were served.

At 5:00am client was due for vaginal examination so the procedure was explained to client, she was reassured and taken to the labour room to empty her bladder before doing the next examination. Client was assisted onto the couch. At this time fetal heart rate was 138beats per minute with good volume and rhythm. Descent of the fetal head was 2/5th and uterine contractions were 4 in 10-minute all lasting above 40 seconds. On vaginal examination cervical dilatation was 8cm with intact membranes and moulding was not felt. Client looked anxious, so she was reassured that it will resolved after delivery.

Her vital signs were checked and recorded as follows.

Temperature	-	36.6°c
Pulse	-	82 beats per minute
Respiration	-	18 cycles per minute
Blood pressure	-	120/60 mmHg
Urine		100mls

All the findings were communicated to her and recorded on the partograph. She was reassured, encouraged to continue with the relaxation techniques and do deep breathing exercise.

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

- Four clean towels
- Two artery forceps
- Two dissecting forceps
- Two gallipots with cotton swabs and gauze respectively
- One cord scissors
- Receiver
- Episiotomy scissors

Bottom shelf containing;

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

- ❖ Three clean cot sheets
- ❖ Lidocaine
- ❖ Identification band

At 6:00am, client complained of severe bearing down sensations with the uterine contractions becoming more expulsive and frequent with membranes bulging so artificial rupture of membranes was done and amniotic fluids were clear. Vaginal examination was repeated and cervix was fully dilated, moulding was (++) descent was 0/5<sup>th</sup> and contractions were 4 in 10 lasting 48seconds, fetal heart rate was 140 beats per minute, then disposable catheter was pass to expel the urine. Client shouted that she feels easing and wanted to push. The In-charge was informed about the progress of labour and also asked to confirm my findings and she said client was fully dilated after confirming the vaginal examination which marked the beginning of second stage. Client was assisted into lithotomy position as per her preference and asked to avoid lifting the buttocks to prevent possible perineal trauma.

### **3.3 MANAGEMENT OF SECOND STAGE OF LABOUR**

Madam Deborah was transferred into the second stage room. She was put in a lithotomy position. A gown, mackintosh apron, masks and boots were worn. After that, hands were washed under running water with soap and dried. Sterile gloves were put on. The midwife in-charge, who was supervising, checked the fetal heart rate and maternal pulse after each contraction. The cervix, the vulva, perineum, pubis and the inner thighs of the client were swabbed with gauze soaked in savlon solution and client was draped with a clean towel. A clean perineal pad was applied over the anus to prevent faecal matter from contaminating the delivery field. She was encouraged to push with each contraction and rest in between contraction to prevent exhaustion. Client was also given oral fluid and provision of reassurance and encouragement during each

contraction. Fingers of the left hand were placed on the advancing head to maintain flexion in order to allow the smallest diameter to distend the perineum.

Descent of the foetal head continued till it crowned. As soon as the baby's head crowned, she was asked to pant and give only small pushes with contraction to prevent rapid expulsion of the 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. The mother was reminded that the baby would be delivered unto her abdomen while waiting for restitution and external rotation of the fetal head. This was accompanied by internal rotation of the shoulders. With palm on each side of the baby's head, client was asked to push with the next contractions. The anterior shoulder was delivered by 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 unto the mother's abdomen at 6:30am, baby cried immediately after birth. Madam Deborah was then congratulated for her effort and cooperation.

### **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 mouth and nose were also sucked and cleaned with sterile gauze to enhance patent airway. The baby was dried thoroughly paying attention to skin folds and hair. Then the Apgar scores were noted. The umbilical cord was clamped about 2 centimeters away from the baby's abdomen and again clamped about 3 centimeters away from the first clamp with artery forceps. The cord was cut in between the two clamps by covering the scissors with gauze to prevent splashing of blood. This was done 2-3 minutes after the delivery

of the baby. And baby was placed on the mother's abdomen to continue skin to skin as mother and baby were covered with a warm cot sheet to maintain warmth and prevent hypothermia. The baby's Apgar score assessed at the first and fifth minutes were 8/10 and 9/10 respectively. An identification band with mother's name, sex of the baby, date and time of delivery was put around baby's wrist. The baby was breathing quietly and easily. Baby was then shown to mother for identification and she identified the baby as a male.

### **APGAR SCORE**

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

### **3.5 MANAGEMENT OF THIRD STAGE OF LABOUR**

Client still in the lithotomy position, the clamped and cut end of the cord was placed in a receiver in between the thighs near the perineum to receive the placenta, membranes and blood loss. A gentle palpation of the abdomen was done by the in-charge to rule out undiagnosed twin. There was no other fetus, so 10 unit of oxytocin was 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 was held with the right hand. The left hand was placed on the fundus to check for contractions. With contractions, the hand was repositioned just above the symphysis pubis with the palm facing the woman's umbilicus. The uterus was pushed in an upward direction to serve as counter traction to prevent inversion of the uterus. The cord and the forceps were also held firmly at the same time and 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 6:35am. Quick examination of the placenta was done to make sure that there were no retained products. The placenta was placed in a receiver for a thorough examination to be done. 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 the contracted uterus. She was educated to massage the uterus by herself and report any change immediately. Client was cleaned off the liquor and blood with a clean pad after the examination. A new perineal pad was applied at the vulva and she was made comfortable. She was asked to cross her legs to keep the perineal pad in position.

### **3.6 EXAMINATION OF THE PLACENTA AND MEMBRANES**

The placenta was sent to the sluice room for examination. The cord was situated at the middle of the placenta with two arteries and a big vein in the cord with no knot. The maternal surface of the placenta was intact with no missing lobe and was also checked with no infarcts. The membranes were examined for any blood vessel and it was separated to check whether they were intact. The fetal surface was intact with no abnormality. Blood clots from the maternal surface were added to the blood loss. Blood loss measured was 200 milliliters. After the examination, the instruments were decontaminated in 0.5% chlorine solution for 10 minutes. The instruments were removed, washed, rinsed, dried and made ready for sterilization.

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

### **3.7 PREVENTION OF DISEASES**

Cord was dressed with chlorhexidine gel. Injection 1mg of vitamin K was given intramuscularly to prevent bleeding disorder. Tetracycline Hydrochloride 1% ointment was smeared on each conjunctiva of the eye to prevent infection. Hands were washed under running water with soap and cleaned with a clean towel. Mother was also educated to wash hands before and after breastfeeding baby and after attending to natures' call. She was further educated to breastfeed baby on demand.

### **3.8 MANAGEMENT OF THE FOURTH STAGE OF LABOUR**

The fourth stage of labour is a period of close and vigilant monitoring and observations of mother and baby for the next six hours following the delivery of the placenta, membranes and subsequent arrest of heamorrhage.

### **3.9 EXAMINATION OF THE NEW BORN**

The procedure was explained to client to which she consented. Hands were washed with soap and water and dried with a clean towel, then. disposable gloves were worn and the baby was examined in the presence of the mother in a clean, warm environment, where nearby windows were closed. Baby was put on a covered flat surface and only the part to be examined was exposed. The general condition of baby was checked to be normal.

A detailed head to toe examination was carried out to rule out any deviation from normal. The head was examined for bulging fontanelles, size and shape, oedematous swelling that is caput succedaneum and lacerations, but no abnormality was detected. Head circumference was measured by encircling the head with a tape measure from the occipital protuberance to the supra-orbital ridges and it measured 34cm.

The ear was examined for alignment, shape, size and patency and the cartilage in the pinna was checked for its softness. Eyes were also examined for colour, discharges, redness and conjunctiva haemorrhage but no abnormality was found.

The nose was inspected for size and shape and examined for deviated septum but the septum was normal. The nostrils were inspected for patency and discharges and the mucosa for colour and polyps. For the mouth, the little finger was used to feel the palate for any sub-mucous cleft then the gum was checked for presence of false teeth and the tongue for tongue tie and no cleft lip was observed. No abnormalities were detected. Sucking, rooting and swallowing reflexes were checked and found present.

The neck was examined for congenital goiter, swelling, growth and rigidity of the neck but no abnormality was present. The chest was inspected for shape and the chest wall for movement and expansion. Breasts were palpated for lumps and the nipple was checked for position and witches' milk and everything was normal. Apex beat was present (136 bpm) and respiratory rate (44cpm). Examination of the upper extremities was done and the hands were inspected for clubbing, extra or missing digits, nails over growth and webbing. Hands and arms were inspected for symmetry, movement and paralysis, and the palm for the number of palmer creases. Shape and colour of nail beds were inspected and reflexes (grasping, Moro) checked. Everything was normal.

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

The genitalia were examined, and they were well developed. The anus was patent on inspection, while the baby also passed meconium, the urethral meatus was at the tip not below the shaft or above and both testicles on palpation have descended. With the lower limbs, the legs and feet

were inspected for extra digits, webbing, symmetry, movement, clubbed feet, paralysis, but no abnormality was found. The hip had no dislocation and the reflexes (knee jerk/patella, plantar) were present. The baby was turned on his back with the head turned on one side and the spine was checked for swelling, dimples or hairy patches (spinal bifida), and for missing vertebra, meningomyelocele, but no abnormalities were detected. On examination of the skin, there was no abnormality found. Gloves were removed and disposed off. Hands washed and dried with clean dried towel. Findings were then communicated to the mother and recorded.

### **3.10 MANAGEMENT OF THE MOTHER AND BABY**

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

Temperature - 36.5 degree Celsius  
Pulse - 78 beats per minute  
Respiration - 20 cycles per minute  
Blood Pressure - 110/60 millimeters per mercury

She was encouraged to empty the bladder frequently to prevent postpartum complications such as postpartum haemorrhage. She was educated on rest, sleep and exclusive breastfeeding.

### **CONDITION OF MOTHER**

Blood pressure	-	100/60 millimeters per mercury
Fundal height	-	18 centimeters
Uterus	-	Contracted
Lochia	-	Red (Rubra)
Urine output	-	115mls

Mother's condition was satisfactory.

### **CONDITION OF BABY**

Sex	-	male
Temperature	-	36.2 degree Celsius
Birth weight	-	3.0 kilograms
Length of the baby	-	51centimeters
Head circumference	-	34 centimeters
Apgar score		
First minute score	-	8/10
Fifth minute score-		9/10
Meconium	-	Passed
Urine	-	Passed

Baby's condition was satisfactory.

### **DURATION OF LABOUR**

Duration of first stage	-	5hours
Duration of second stage	-	15 minutes
Duration of third stage	-	20minutes

Total duration of labour - 5 hours 35minutes

### **3.11 NURSING CARE PLAN ON LABOUR**

#### **PROBLEMS IDENTIFIED**

On 13<sup>th</sup> February, 2024 Client complained of

1. Lower abdominal pain
2. Anxiety
3. Waist pain
4. Fatigue

#### **SHORT TERM OBJECTIVES**

1. Client's lower abdominal pain will subside within 30minutes at delivery
2. Client will be relieved of anxiety after knowing the outcome of labour within 30minutes.
3. Client will be relieved of waist pain at the end of labour within 30minutes.
4. Client's fatigue will resolve within 30minutes.

#### **LONG TERM OBJECTIVE**

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

### NURSING CARE PLAN ON LABOUR

DATE /TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE /TIME	EVALUATION	SIGN
13/2/2024 6:00am.	Acute pain related strong expulsive uterine contractions.	Client will understand and cope with lower abdominal pains within 1 hour and throughout labour as evidenced by:1.Client verbalizing that, she is coping pain 2.Midwife visualizing that client has stop screaming	1. Reassure client and explain physiology of lower abdominal pain. 2. Provide diversional therapy 3. Encourage client to adopt a comfortable position. 4. Encourage and supervise client to practice deep breathing exercise during uterine contraction. 5. Give sacral massage to relieve pain.	1. Client was reassured and taught that the pain is due contractions of the uterus 2. Client was engaged in conversation during labour. 3. Client laid in the left lateral position to reduce pain. 4. client was encouraged to do deep breathing exercises during contractions 5. client's sacral area was massaged especially during contractions.	13/2/2024 at 8:00am	Goal fully met as Madam Blessing verbalized that she coped with labour pains.	AC

### NURSING CARE PLAN ON LABOUR

<b>DATE /TIME</b>	<b>NURSING DIAGNOSIS</b>	<b>NURSING OBJECTIVE/ OUTCOME CRITERIA</b>	<b>NURSING ORDERS</b>	<b>NURSING INTERVENTION</b>	<b>DATE /TIME</b>	<b>EVALUATION</b>	<b>SIGN</b>
13/2/2024 at 6:00am	Anxiety related to unknown outcome of labour.	Client will be relieved of anxiety within 30minutes as evidenced by; Client verbalizing that she is no more anxious Midwife visualizing that, client has stop questioning and also has relaxed facial expression	1. Reassure client that she is in the hands of competent staffs. 2. Explain the stages of labour to client. 3. Allow client to ask questions and answer them tactfully. 4. Communicate findings of all procedures to client. 5.Introduce client to other staffs	1. Client was reassured that she was in the hands of competent staff. 2. The physiology of the stages of labour was explained to client in simple terms. 3. Client questions were tactfully answered. 4. Findings on the progress of labour and foetal condition. were communicated to client 5. Client was introduced to other staffs and rapport was established.	13/2/2024 at 6:30am	Goal fully met as client expressed relaxed face and verbalized that she is relieved of anxiety.	<b>AC</b>

**NURSING CARE PLAN ON LABOUR**

<b>DATE /TIME</b>	<b>NURSING DIAGNOSIS</b>	<b>NURSING OBJECTIVE/ OUTCOME CRITERIA</b>	<b>NURSING ORDERS</b>	<b>NURSING INTERVENTION</b>	<b>DATE /TIME</b>	<b>EVALUATION</b>	<b>SIGN</b>
14/2/24 At 6:00am	Waist pain related to descent of the fetal head and painful uterine contraction.	Client will cope with waist pain within 30minutes as evidenced by; 1. Client verbalizing that waist pain has reduced. 2. Midwife observing client coping with waist pains.	1. Reassure client that she would be relieved of waist pain. 2. Encourage client not to sit for a very long period. 3. Give sacral massage to relieve her of pain. 4. Explain the physiology of waist pain to client. 5. Encourage deep breathing exercise along contraction.	1. Client was reassured that she will subside after delivery. 2. Client was encouraged not to sit for a very long period but to walk around. 3. Sacral massage was given to client to relieve her of pain. 4. Client was taught that the waist pain is due to the “give” of the pelvis as it allows the head to exit. 5. Client was doing the deep breathing exercise.	14/02/24 at 6:30am	Goal met as evidenced by client verbalizing that she is relieved from her waist pain.	AC

## NURSING CARE PLAN ON LABOUR

<b>DATE /TIME</b>	<b>NURSING DIAGNOSIS</b>	<b>NURSING OBJECTIVE/O UTCOME CRITERIA</b>	<b>NURSING ORDERS</b>	<b>NURSING INTERVENTION</b>	<b>DATE /TIME</b>	<b>EVALUATION</b>	<b>SIGN</b>
14/2/2024 at 7:30am	Fatigue related to stress of labour.	Client will demonstrate improve energy level and reduced fatigue within 30minutes as evidenced by client ability to engaged in effective conversation and walk around.	<ol style="list-style-type: none"> <li>1. Reassure client that she would be relieved of fatigue.</li> <li>2. Encourage client to rest in between uterine contractions.</li> <li>3. Explain to her why she feels tired.</li> <li>4. Encourage client to practiced deep breathing exercise.</li> <li>5. Give client oral fluid to hydrate her.</li> </ol>	<ol style="list-style-type: none"> <li>1. Client was reassured that she would be relieved of fatigue.</li> <li>2. Client was seen resting in between uterine contractions to prevent further exhaustion.</li> <li>3. Education on fatigue was given to client and she knew it was normal for her to be tired during labour.</li> <li>4. Client was encouraged to practicing deep breathing exercise.</li> <li>5. Oral fluid (malt) was given to client to hydrate her.</li> </ol>	14/2/2024 at 8:00am	Goal fully met as evidence by client verbalizing that she feels less tired and active.	AC

## CHAPTER FOUR

### PUERPERIUM

#### 4.0 INTRODUCTION

This chapter consists of the care given to the mother and the baby from the day of delivery till the second postnatal visit. It begins immediately after the expulsion of placenta and membranes and control of hemorrhage and ends at the 40th day or six (6) weeks after delivery.

#### 4.1 DAY OF DELIVERY

Madam Deborah and baby were sent to the lying-in for close monitoring and observation. She was made comfortable in bed with her baby. Both mother and baby were kept warm. She was encouraged to put the baby to breast to promote bonding between them and also stimulate uterine contractions to aid involution of the uterus. She was again encouraged to empty the bladder whenever she has the urge to help prevent the occurrence of postpartum hemorrhage.

An opportunity was taken to educate her on the benefits of exclusive breastfeeding and how it is done. Also, she was taught to empty one breast before the other and the need to feed the baby frequently at least 8 to 12 times a day, as well as how to fix the baby to breast. She was also educated to keep the baby warm to prevent hypothermia, and to change the baby's soiled diaper frequently to prevent nappy rash and to make the baby comfortable. She was encouraged to wash her hands with soap and water after visiting the lavatory, changing her perineal pad, and also before touching and breastfeeding the baby.

It was explained to her the need to change her perineal pad when soiled. Madam Deborah took rice with light soup. vital signs were checked and recorded as follows;

Temperature	-	36.2°C
Pulse rate	-	86bpm

Respiratory rate - 19cpm  
Blood pressure - 100/70mmHg

The breasts were not lactating The symphysio fundal height was measured to be 18centimeters. Lochia was inspected and it was red (rubra) in colour and small in amount with no bad odour. The baby was examined from head to toe and no abnormality was detected. The client's relatives were asked to excuse mother and baby so that they could have some rest and sleep. Client complained of after pains. Physiology of after pain was explained to her, that it will resolve by itself. Warm compresses were applied to the lower abdomen. Client was educated to urinate frequently since full bladder could alter uterine contractions and bring about postpartum hemorrhage.

She was also encouraged to try and walk about in order to aid in drainage of lochia.

Madam Deborah was educated to eat good nourishing and balanced diet, adequate intake of fluids, more fruits and roughages to enhance bowel movement and to help repair all worn out tissues. She was again encouraged to have rest and sleep and exercise especially the abdominal and pelvic floor exercises

## **4.2 SUBSEQUENT CARE OF THE BABY**

### **BABY'S FIRST BATH**

The baby had the first bath after six hours of birth. The mother was informed that the baby was going to be bathed, so all items for bathing were gathered, which include

### **TOP SHELF**

- ❖ Chlorhexidine gel
- ❖ Sterile cotton wool swabs and gauze in a galipot

- ❖ Surgical gloves
- ❖ Baby's diapers
- ❖ Baby's dress
- ❖ Baby's towel and cot sheet to wrap the baby
- ❖ Baby's oil or Vaseline
- ❖ Baby's sponge
- ❖ Baby soap in a soap dish

### **BOTTOM SHELF**

- ❖ Disposable gloves
- ❖ Jug of hot water
- ❖ Jug of cold water
- ❖ A bowl for mixing water
- ❖ Kidney dish for used gauze and swab
- ❖ A receptacle for used water
- ❖ Mackintosh apron

The water was mixed and temperature tested with elbow. Plastic apron was put on, hands washed and dried, and gloves worn.

The baby was placed on a flat surface, undressed and wrapped with a cot sheet. The baby's eyes were cleaned from inside out with cotton wool swab and face was cleaned with damp face towel. The nape of the baby's neck was supported and the ears plugged with two fingers to prevent water from entering the ears. The head was washed with soapy sponge, rinsed and dried, the

chest, abdomen and front was bathed with soapy sponge. The baby's back was further turned with one arm supporting the chest and washed the back down to the feet.

The baby's body was immersed in the warm water with the head suspending above the water level and rinsed thoroughly. The baby was removed and placed on a clean dry towel paying attention to the skin folds a piece of towel was used to dry baby thoroughly.

Baby was smeared with pomade, powdered and dressed up with only cord exposed and hair neatly combed. Hands were washed and dried. Sterile gloves were worn. The cord clamp was observed if it is loose, tip for bleeding and base for redness, and there was none. The stem of the cord was held with one hand and dressed with chlorhexidine gel Mother was encouraged to observe bathing and dressing of the cord.

The baby was dressed nicely and wrapped in a warm dry sheet to maintain body temperature and she was placed beside her mother to breastfeed. The mother was educated not to smear anything apart on the cord with the exception of chlorhexidine gel that will be given to her. The general condition of the baby was good and baby was assessed 90minutes after delivery

Vital signs were also checked and the findings were communicated to the mother and documented as follows:

Head circumference- 34 centimeters

Length -51 centimeters

Weight - 3.0kilograms

Apex beat - 138bpm

Temperature - 36.0°c

Respiration - 42cpm

Stools - Meconium

### **4.3 DAY OF DISCHARGE**

On 14<sup>th</sup> february, 2024. Client and baby were closely monitored until discharge. She was informed of discharge 12hours after her delivery. Prior to discharge, puerperal assessment was made and no abnormality was detected. She had already emptied her bladder, privacy was provided and hands were washed with soap under running water and dried with clean towel and procedure was explained to client.

The conjunctiva was inspected for sign of anemia but there was none. The breasts were lactating very well. The uterus had contracted very well and the symphysio fundal height remains 18cm. The perineal pad was inspected and the Lochia was red (rubra), with moderate flow and there was no offensive odour. During the assessment she complained of lower abdominal pains (after pains) while breast feeding the baby. She was reassured and educated on the physiology of after pain that is a normal physiology as a result of suckling which triggers the release of oxytocin and causes uterine contraction and therefore causes lower abdominal pain.

Madam Deborah also said she has less rest and sleep because of the noise within the environment. She was reassured that they are going to be discharged very soon. Madam Deborah's vital signs were checked and recorded as follows;

Temperature - 36.4degree Celsius

Pulse - 72 beats per minute

Respiration - 20cycles per minute

Blood pressure - 110/80 millimeters of mercury.

Head to toe examination was done for baby as well and no abnormality was detected.

Mother was educated not to apply hot compress on baby's head with the intention of closing the fontanel and was explained to her that the fontanel close naturally. Baby's cord was dressed with chlorhexidine gel. Baby was immunized with Bacilli Chalmette Guerin (BCG) 0.05 mls and oral polio 'O' vaccine 2 drops in the mouth to protect child against tuberculosis and poliomyelitis respectively.

After this, client was advised not to apply anything at the injection site but to continue immunizations at the child welfare clinic when the child gets six weeks old in order to protect against the childhood diseases like measles, yellow fever, pertussis among others. Some minutes after dressing the cord, the baby's vital signs were checked and recorded as follows;

Temperature - 36.6degree Celsius.  
Pulse - 136 beats per minute.  
Respiration - 40 cycles per minute.  
Weight - 3.0 kilograms.  
Stools - Meconium

Client took her super before going home. Mother was reminded on personal hygiene, good nutrition, and provision of warmth to the baby and prevention of infection by changing her perineal pad whenever it was soiled. After which she was assisted by her mother, to pack her belongings, and her health insurance card was used to settle her bills. Prescribed drugs were given as below; metronidazole

Iron III polymaltose complex capsule (daily) for 30 days

Paracetamol tablet 1g (three times daily) for 5days

The dosage and time for taking the drugs were explained to her. Madam Deborah was also told that she would be visited for one week to check on her condition and that of the baby and

continued with their care. She was discharged home at 6:40pm and was escorted with her items into a car brought in by her husband. They were reminded of the visit to their house.

#### **4.4 FIRST DAY POST NATAL HOME VISITS**

Madam Deborah was visited on the 17<sup>th</sup> February 2024 in her home in the morning at 9:00am. and evening at 4:00pm. as promised, greetings were exchanged, a seat and warm welcome by the husband and mother were offered. They were excited to be visited. They were asked how they are faring and they responded they were doing very good. According to client she had enough sleep over the night without any disturbance just as assured.

Then came to physical examination be done on her and the baby, at the end, baby's condition was satisfactory as baby could suckle breasts very well, cord has no bleeding and showing signs of drying and it has been able to pass meconium and urine. After the examination, baby was topped and tailed, cord was dressed with chlorhexidine gel.

Mother was also examined from head to toe and there was no abnormal change. The breasts were somehow lactating, uterus was contracted and fundal height measured 17cm. The perineum was inspected and was found to be cleaned; lochia was red (rubra) with moderate amount of flow. Her vital signs were taken and recorded as follows;

#### **MOTHER**

OBSERVATION	MORNING	EVENING
Temperature	36.0°c	37.0°c

Pulse	88bpm	83bpm
Respiration	19cpm	21cpm
Blood pressure	112/72mmHg	110/70mmHg

Baby was not jaundiced or pale and was able to suckle well. Baby's vital signs were taken and recorded as follows;

OBSERVATION	MORNING	EVENING
Temperature	36.2°c	37.2°c
Apex heart beat	130bpm	40bpm
Respiration	40cpm	47cpm
Weight	2.9 kilogram	2.9 kilogram
Stool	meconium	
Cord	Drying	Drying

Madam Deborah was encouraged to breastfeed the baby on demand. A promise was made to visit them again the following day.

#### **4.5 SECOND DAY POSTNATAL**

On the next day, 15/2/ 2024, a visit was made again to Madam Deborah’s house at 8:30am in the morning and 4:00pm in the evening as scheduled to assess their health condition. Greetings were exchanged as usual and the family were doing well. Permission was sought from her to do head to toe examination and everything was normal. The breasts were firm and well lactating, uterus was well contracted, inspection of her perineal pad and perineal area was clean and the lochia was red (rubra), not offensive and the flow was moderate. Client complained of backache which is exaggerated when the baby suckles. She was reassured and encouraged to perform the postnatal exercise and also to continue to breastfeeding the baby on demand as it helps in contraction thus aiding involution of the uterus. Symphysis fundal height measured 16cm. General examinations were carried out on the baby from head to toe and no abnormality was detected. The baby was examined and top and tailed. Cord was clean and dry and dressing was done. The baby passed stools and urine. She was then taught to position herself well when breastfeeding. Mother and baby’s vital signs were taken and recorded as follows;

#### **MOTHER**

OBSERVATION	MORNING	EVENING
Temperature	36.0°c	37.0°c
Pulse	78bpm	83bpm
Respiration	19cpm	22cpm
Blood pressure	100/60mmHg	110/70mmHg

#### **BABY**

OBSERVATION	MORNING	EVENING
Temperature	36.6°C	36.8°C
Apex heart beat	134bpm	138bpm
Respiration	38cpm	38cpm
Weight		2.8kilogram
Stool	meconium	meconium
Cord	Drying	Drying

All the findings were communicated to the client and her family. Permission was sought to leave and Madam Deborah and family were very grateful and appreciative of the care that was given to them.

#### **4.6 THIRD DAY POST-NATAL HOME VISIT**

On the 16<sup>th</sup> February 2024, Client was visited again in the morning 7:30am and evening 4:30 respectively to continue the care of the baby, mother and the family as well. Mother and baby were doing well. Permission was sought to do Head to toe examination and it was granted. And the procedure revealed no abnormality. Breast milk was flowing freely, uterus felt contracted and on inspect her perineal pad, the lochia was red (rubra) without offensive odour. and Symphysio fundal height measured 15cm

The baby's general condition was good and no abnormality was present, on head to toe examination. The baby was top and tailed, and baby suckled well on the breast on observation

The cord was neatly dressed and was dry without bad odor. The baby also passed stools and urine. Mother and baby's vital signs were checked and recorded as follows;

### **MOTHER**

OBSERVATION	MORNING	EVENING
Temperature	36.4°c	36.9°c
Pulse	80bpm	84bpm
Respiration	20cpm	18cpm
Blood pressure	110/70mmHg	110/60mmHg

### **BABY**

OBSERVATION	MORNING	EVENING
Temperature	37.0°C	36.9°C
Apex heart beat	137bpm	146bpm
Respiration	36cpm	38cpm
Weight	2.7kilogram	2.7 kilogram
Stool	Yellow	Yellow
Cord	Dried	Dried

Madam Deborah complained of interrupted sleeping pattern because baby now cries at night. She was reassured and encouraged to breastfeed baby well before bed time and to change the baby's

diapers when soiled. She was reminded on exclusive breastfeeding and on demand, maintenance of personal hygiene, eating of fruits and highly nutritious diet and to take warm bath just before bed. Permission was sought to leave and Madam Deborah was very grateful and appreciative of the care that was given to them very much.

#### **4.7 FOURTH DAY POST-NATAL HOME VISIT**

Madam Deborah and her baby as well as her entire family were visited again on 17<sup>th</sup> February, 2024 morning at 8:30am to continue with the postnatal care. She and her baby were physically examined and nothing abnormal was detected. Lochia was rubra on inspection, no odor and breasts were lactating normally, baby was looking healthy and suckles well on the breast on observation. Head to toe examination was done and everything was normal. Symphysis fundal height measured 14cm. Baby had been top and tailed by client's mother on arrival. No abnormality was detected. The cord was neatly dressed and has shrunk with no abnormality detected on it. The baby passed stools and urine. Mother and baby's vital signs were checked and recorded as follows;

#### **MOTHER**

OBSERVATION		MORNING
Temperature	-	36.5oc
Pulse	-	80bpm

Respiration - 19cpm  
Blood Pressure - 110/60mmHg

### **BABY**

Temperature - 36.5oc  
Apex heart rate - 133bpm  
Respiration - 34cpm  
Weight - 2.7kg  
Stool - Yellowish  
Cord - shrinkle

Madam Deborah complained of fullness in the breast. She was educated to continue breastfeeding the baby, do some manual expressed and to apply cold and warm compress on them to reduce the pain. She was educated to ensure that one breast emptied before offering the other to the baby. Permission was sought to leave, client and her family were very grateful and permission was granted

### **4.8 FIFTH DAY POST-NATAL HOME VISIT**

The fifth day postnatal home visit was on 18<sup>th</sup> February, 2024 at 8:00am to continue with the post- natal care. Mother and baby were both in a healthy condition after a head to toe examination. Inspection of the lochia was done and the colour was serosa (pink) with symphysio fundal height measuring 13cm. The cord was dry and was almost falling off. The baby urinated

and passed yellowish stool and was cleaned immediately. Client and baby's vital signs were checked and recorded as follows:

### **MOTHER**

Temperature - 36.7oc  
Pulse - 88bpm  
Respiration - 20cpm  
Blood Pressure - 100/80mmHg

### **BABY**

Temperature - 36.5oc  
Pulse - 136bpm  
Respiration - 34cpm  
Weight - 2.8 kg.  
Stools - Yellowish  
Cord - Dried

Madam Deborah was reminded of the next visit and she said, she was very grateful. She was thanked and permission was sought to leave.

### **4.9 SIXTH DAY POST-NATAL HOME VISIT**

The sixth day postnatal home visit was made on 22<sup>st</sup> December, 2022 at 8:00am. Greetings were exchanged with client and her family and a seat was offered. Mother and baby were both in a healthy condition and client said she feels better with the fullness of breast. She was reassured and encouraged to feed the baby well and change diaper before she sleeps. Her breasts were no longer tensed, uterus still contracted and symphysio fundal height measured 12cm, inspection of

the lochia was done and the colour was serosa (pink) without bad odour indicating no infection rather, good personal hygiene. She was also educated on family planning. After head to toe examination, no abnormality was detected.

Head to toe examination was done and no abnormality was found on the baby. During the examination of the baby, it was realized that the cord had fallen off, so the baby was bathed in the presence of grandmother who is going to take over, client's sister and client herself. The stump was then dressed and the area was cleaned and kept dry.

Client's vital signs were checked and recorded as follows:

### **MOTHER**

Temperature	-	36.1°c
Pulse	-	80bpm
Respiration	-	18cpm
Blood pressure	-	100/60 mmHg.

### **BABY**

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

Temperature	-	36.0°c
Apex heart beat	-	134bpm
Respiration	-	42cpm
Weight	-	2.9kg
Stools	-	Yellowish
Cord	-	fallen off

Madam Deborah was reminded that the next visit is going to be the last home and she was very grateful. Permission was sought to leave.

#### **4.10 SEVENTH DAY POSTNATAL HOME VISIT**

On the 19<sup>nd</sup> February, 2024, madam Deborah visited the same day evening after she came for her first postnatal visit to the clinic at 5:00pm to access their health condition. Mother and baby were fine. Client's permission was sought to perform physical examination and vital signs. Inspection of lochia was done and the colour was serosa (pink), flow was scanty without any bad odour. Symphysis fundal height measured 11cm. After the head to toe examination, no abnormality was detected and baby was bathed and cord dressed. Mother and baby's vital signs were as follows;

#### **BABY**

Temperature	-	36.7°C
Respiration	-	40cpm
Apex heart rate	-	132bpm
Weight	-	3.1kg
Stools	-	Yellowish
Stump	-	Healing

#### **MOTHER**

Temperature	-	36.0°C
Pulse	-	76bpm
Respiration	-	20cpm
Blood pressure	-	110/70mmHg.

Education was given to her on the importance of ensuring good personal hygiene and the need to feed the baby continuously on demand. The need for registration of the child at the Births and Deaths Registry was emphasized. Client was encouraged not to hesitate to visit the clinic anytime she has any health problem before the date of appointment. She was educated to practiced exclusive breastfeeding for the baby for six months

Client's husband and the mother, and sister were encouraged to assist her in the household duties and caring of the baby to ensure adequate rest and sleep. She said she appreciated a lot, and she was thanked for her co-operation and permission was sought to leave.

#### **4.12 FIRST POSTNATAL VISIT TO THE CLINIC**

client and her baby reported to the health center on 19<sup>th</sup>February 2024 accompanied by her husband. Mother and baby looked healthy and cheerful. They were welcomed to the postnatal site and a seat was offered to them to listen to a health talk on immunization against the preventable childhood diseases, exclusive breastfeeding and family planning. Client complains that her second pregnancy was unplanned due to knowledge deficit on family planning.

After the talk, client and baby were taken to the examination room to be examined. With permission from mother, baby was undressed and wrapped in a clean cot sheet and was put on a flat surface in the presence of the mother. Procedure was explained to Madam Blessing and hands were washed and dried. The fontanel and sutures were examined for any bulging or widening sutures but there were none. The eyes, nose and ears were examined and no abnormalities were detected. Baby had no rashes or bruises on the skin. The abdomen was soft, not distended, and the stump was completely healed. The extremities and the back were also examined and there were no abnormalities. During the examination, I realized baby has passed

stools in the diapers and he was cleaned and a new diaper was given by the mother to be put on.

All findings were communicated to mother and recorded

Baby's and his vital signs checked and recorded as follows:

Weight 2.6kg

Temperature - 36.0°C

Pulse rate - 136bpm

Respiratory rate - 42cpm

Stump - healed

Stools yellowish

Client was also examined and her vital signs were checked and recorded as

Blood Pressure - 100/70mmhg,

Pulse - 71bpm,

Respiration - 19cpm

Weight - 58kg

Temperature - 36.6°C

She was asked to empty her bladder for physical examination after the procedure has been explained to her. She was assisted onto the examination couch and privacy was provided. Hands were washed and dried.

Head to toe examination was done and no abnormality was detected. Fundal height measured 8cm. The lochia was scanty and creamy white (Alba). She was helped out of the examination couch after the examination. Findings were communicated to her and documented.

Madam Blessing was advised to maintain good personal and environmental hygiene in the care of herself and the baby. She was again educated on her nutrition and was asked to eat foods that

are rich in proteins and vitamins, she was encouraged to continue with exercise and have adequate rest and sleep. Client said the backache has subsided. Madam Blessing was encouraged to register her baby at the birth and death registry since there was none at the health center. Baby was sent to the midwife-in-charge for circumcision for the baby to be circumcised. Client was reminded of the six weeks postnatal visit to the clinic. Client was educated to continue and complete with baby's immunization schedule at well baby clinic. This would help prevent baby contracting any of the childhood preventable diseases.

Gratitude and thanks were expressed to Madam Deborah and the entire family for their support and co-operation throughout the writing of the care study.

#### **4.13 SECOND POSTNATAL VISIT TO THE CLINIC**

According to the midwife in-charge, Madam Deborah six weeks postnatal visit was on 18<sup>th</sup> march, 2024. At 8:30am client came to the facility with her husband. Head to toe examination was done on her and nothing abnormal was present. Her vital signs were checked and recorded

Madam Deborah urine was also checked for protein and sugar and it was negative for both, and the haemoglobin was 12.0g/dl. Her fundus was not palpable and no lochia observed.

The baby was also examined from head to toe and no abnormality was found. The anterior fontanel was palpated for pulsation and it was normal and the posterior fontanel had closed. Baby's vital signs were checked and recorded.

Mother was encouraged to practice exclusive breastfeeding for 6 months to inhibit ovulation and prevent infection or any disease to the baby. She had not resumed her menses when asked. She was educated on the need to start a family planning method to prevent unwanted pregnancy. Client was congratulated for taking good care of the baby as seen in the baby's weight gain. She

also expressed her gratitude for all the support offered to them. She was also taken to the public health unit for the child to be immunized and continuity of care.

#### **4.14 NURSING CARE PLAN DURING PUERPERIUM**

##### **PROBLEMS IDENTIFIED**

- On 14<sup>th</sup> February, 2024, Madam Deborah complained of after pain
- . On 15<sup>th</sup>February 2024, client complained of backache
- On 16<sup>th</sup>February, 2024, client complained of interrupted sleeping pattern during the night.
- On 17<sup>th</sup>february, 2024, client complained of fullness in the breasts.
- On 18february, 2024, knowledge deficit on family planning
- .

##### **SHORT TERM OBJECTIVES**

- Client after pain will reduce within 24hours.
- Client will have at least 8hours uninterrupted sleep within 24hours.
- Client's breast engorgement will reduce within 48hours.
- Client will gain adequate knowledge on family planning method within 2 hours.
- Client's backache will subside within 24 hours.

##### **LONG TERM OBJECTIVE**

Mother and baby will pass through puerperium without any complications.

### NURSING CARE PLAN ON PUERPERIUM

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVE/OU TCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
14/2/24 at 7.30am	After pain related to involution of the uterus	Client's after pain will resolve within 24hours as evidenced by; 1.Client verbalizing that, the pain has resolved. Midwife visualizing that client looks cheerful	1. Reassure client that, measures will be put in place to resolve pain. 2. Explain the physiology of the after pain to client. 3. Encourage client to continue breastfeeding 4. Encourage client to empty her bladder whenever she feels the urge 5. Serve her with prescribed analgesics.	1. Client was reassured that, the pain is temporary 2. Client was taught that it is due the contracting uterus to take its position in the pelvis 3. Client was breastfeeding the baby on demand. 4. Client was emptying her bladder whenever the urge is felt to ensure a contracted uterus. 5. Client was served with analgesics (Paracetamol 1g).	15/2/22 at 7:30am	Goal fully achieved as 1. Client verbalizes that her pain has resolved Midwife observed a relaxed facial expresssion	AC

### NURSING CARE PLAN ON PUERPERIUM

<b>DATE/ TIME</b>	<b>NURSING DIAGNOSIS</b>	<b>NURSING OBJECTIVE/ OUTCOME CRITERIA</b>	<b>NURSING ORDERS</b>	<b>NURSING INTERVENTION</b>	<b>DATE/ TIME</b>	<b>EVALUATION</b>	<b>SIGN.</b>
15/2/24 at 5:00pm	Interrupted sleep pattern related to excessive crying of the baby at night	Client will be able to sleep at least 2hours within the day and 6hours in the night within 24hours as evidenced by; 1.Client verbalizing that she was able to sleep for 6hours uninterrupted sleep at night.	1. Reassure the client that she would be managed.  2. Check dipper and ensure baby's comfort  3. Encourage client to feed baby well before bed time.  4. Encourage mother to break the wind after breastfeeding.  5.Encourage family support	1. Client was reassured that measures will be put in place to promote sleep  2. Mother ensured to change baby's soiled dipper before she goes to bed  3. Client was encouraged to feed baby well before bed time.  4. Mother was educated to break wind after breastfeeding.  5. .Husband and sister were encouraged to support client	16/2/24 at 5:00pm	Goal fully met as client verbalized that she had uninterrupted sleep throughout the night.	AC

**NURSING CARE PLAN ON PUERPERIUM**

<b>DATE/</b>	<b>NURSING</b>	<b>NURSING</b>	<b>NURSING ORDERS</b>	<b>NURSING INTERVENTION</b>	<b>DATE/</b>	<b>EVALUATION</b>	<b>SIGN</b>
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<b>TIME</b>	<b>DIAGNOSIS</b>	<b>OBJECTIVE/OUTCOME CRITERIA</b>			<b>TIME</b>		
16/2/24 at 5:00pm	Breast engorgement related to inadequate emptying of breast.	Client's breast engorgement will resolve within 48 hours as evidenced by Client verbalizing that she is relieved of breast engorgement and the midwife observing the absence of breast heaviness and warmth.	<ol style="list-style-type: none"> <li>1. Reassure client that the engorged breast will subside.</li> <li>2. Teach her on how to fix baby correctly to the breast.</li> <li>3. Demonstrate to client how to correctly position herself when breastfeeding.</li> <li>4. Encourage client to empty one breast before the other.</li> <li>5. Encourage client to continue breastfeeding the baby exclusively.</li> </ol>	<ol style="list-style-type: none"> <li>1. Client was reassured that the condition is treatable</li> <li>2. Client was taught how to fix baby correctly to the breast.</li> <li>3. Demonstration was done to client on how to position baby during breastfeeding.</li> <li>4. Client was emptying one breast before offering the other</li> <li>5. Client was encouraged to continue breastfeeding the baby exclusively.</li> </ol>	17/2/24 at 5:00pm	Goal fully met as evidenced by Client verbalized that the engorged breast has reduced and Midwife reporting that breasts were soft and no longer heavy.	AC

**NURSING CARE PLAN ON PUERPERIUM**

<b>DATE/TIME</b>	<b>NURSING DIAGNOSIS</b>	<b>NURSING OBJECTIVE/OUT</b>	<b>NURSING ORDERS</b>	<b>NURSING INTERVENTION</b>	<b>DATE/TIME</b>	<b>EVALUATION</b>	<b>SIGN</b>
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		<b>COME CRITERIA</b>					
18/2/24	Knowledge deficit on family planning methods related to inadequate information on family planning methods.	Client will gain adequate knowledge on family planning methods within 2hours as evidenced by client verbalizing that she understands and the midwife visualizes that client asked and answer questions correctly and she is eager to make a choice.	<ol style="list-style-type: none"> <li>1. Educate client on family planning method.</li> <li>2. Introduce client to different types of family planning methods and help her choose one.</li> <li>3. Encourage client to practice family planning method.</li> <li>4. Encourage client to ask questions</li> </ol>	<ol style="list-style-type: none"> <li>1. Client was educated on family planning method during the puerperium</li> <li>2. Client was introduced to the different types of family planning methods and was helped to choose one.</li> <li>3. Client was encouraged to practice family planning method.</li> <li>4. Client's concerns were addressed</li> </ol>	18/2/24	Goal was fully met as evidenced by client willingness to choose a method.	AC

**NURSING CARE PLAN ON PUERPERIUM**

<b>DATE/ TIME</b>	<b>NURSING DIAGNOSIS</b>	<b>NURSING OBJECTIVE/ OUTCOME CRITERIA</b>	<b>NURSING ORDERS</b>	<b>NURSING INTERVENTION</b>	<b>DATE/ TIME</b>	<b>EVALUATION</b>	<b>SIGN</b>
19/2/24 at 8:30am	Backache related to poor feeding techniques sitting position	Client's backache will reduce within 24 hours as evidenced by client verbalizing a reduction of pain.	<ol style="list-style-type: none"> <li>1. Reassure client that she will be relieve from backache</li> <li>2. Explain the causes of the backache to client.</li> <li>3. Educate client on the proper use of body mechanics and good posture.</li> <li>4. Demonstrate to client the correct position during breastfeeding</li> <li>5. Educate client on other alternative position used for breastfeeding.</li> </ol>	<ol style="list-style-type: none"> <li>1. Client was reassured that pain will resolve</li> <li>2. Client became enlightened that it is due to poor posture during feeding.</li> <li>3. Client was educated on the proper use of body mechanics and good posturing.</li> <li>4. Client was educated to sit up straight with back supported.</li> <li>5. Client was educated to lie on her bed and breastfeed</li> </ol>	19/2/24 at 8:30am	Goal was fully met as client verbalized a reduced backache.	

## **SUMMARY AND CONCLUSION**

This script is a Family Centered Maternity Care, given to Madam Deborah, a 25 years old woman gravida 2 Para 1 alive. She hails from Senase in the Bono Region. She was met at happy hospital, on 12<sup>th</sup> January, 2024 when she was 37weeks pregnant. Various observations, examinations and Laboratory investigations were carried out to aid in her care. Client went through pregnancy with some minor disorders which were managed successfully. Madam Deborah's labour and delivery were managed carefully without any complications. She delivered spontaneously an alive male infant with birth weight 3.0 kg on the 13<sup>th</sup> february, 2024 at 6:30am who cried immediately after birth.

Madam Deborah's puerperium was successful, mother and baby were visited at home and finally handed over to the midwife in charge for further management on 18<sup>th</sup> February, 2024.

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

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

In conclusion, the client/family centered maternity care study has exposed me to situation where the knowledge received in the classroom has practically been demonstrated on the client and family from pregnancy to puerperium. This has also enhanced the ability to perform and render them to any pregnant woman in the course of practice wherever to help reduce maternal and infant morbidity

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**APPENDIX I**

**COMPLETE DIAGNOSTIC INVESTIGATION**

<b>DATE</b>	<b>SPECIMEN</b>	<b>INVESTIGATION</b>	<b>NORMAL VALUES</b>	<b>FINDINGS</b>	<b>REMARKS</b>
12/07/2024	Blood	Haemoglobin	11.0-16g/dl	11.3g/dl	Normal
		Blood group	A, B, AB, O	O	Normal
		Rhesus factor	Positive/Negative	Positive	Normal
		Sickling	Negative	Negative	Normal
		HIV status	Negative	Negative	Normal
		HBsAg	Negative	Negative	Normal
		VDRL/PRP	Negative	Negative	Normal
		Malaria	Negative	Negative	Normal
	urine	Protein	Negative	Negative	Normal
		Glucose	Negative	Negative	Normal
10/8/2024	Urine	Protein	Negative	Negative	Normal
		Glucose	Negative	Negative	Normal
	Blood	Hemoglobin	11.0-16g/dl	-	-
07/9/2024	Blood	Haemoglobin	11.0-16g/dl	11.4g/dl	Normal
	Urine	Protein	Negative	Negative	Normal
		Glucose	Negative	Negative	Normal
6/10/2024	Urine	Protein	Negative	Negative	Normal
		Glucose	Negative	Negative	Normal
	Blood	Hemoglobin	11.0-16g/dl	11.6g/dl	Normal

**COMPLETE DIAGNOSTIC INVESTIGATION CONTINUED**

<b>DATE</b>	<b>SPECIMEN</b>	<b>INVESTIGATION</b>	<b>NORMAL VALUES</b>	<b>FINDINGS</b>	<b>REMARKS</b>
31/8/2024	Urine	Protein	Negative	Negative	Normal
		Glucose	Negative	Negative	Normal
	Blood	Haemoglobin	11.0-16g/dl	12.6g/dl	Normal
30/10/2024	Urine	Protein	Negative	Negative	Normal
		Glucose	Negative	Negative	Normal
	Blood	Haemoglobin	11.0-16g/dl	12.6g/dl	Normal

**APPENDIX II**

**PHARMACOLOGY OF DRUGS USED**

<b>DRUG NAME</b>	<b>CLASSIFICATION</b>	<b>DOSAGE</b>	<b>ROUTE</b>	<b>ACTION</b>	<b>SIDE EFFECT</b>	<b>EFFECTS OBSERVED ON CLIENT</b>
Tablet Ferrous sulphate	Iron Preparation	200mg three times daily for 30 days	Oral	Prevention iron deficiencies Treat iron deficiencies anemia	<ul style="list-style-type: none"> <li>• Gastro intestinal disturbance</li> <li>• Diarrhoea</li> <li>• Dark stool</li> </ul>	1.Dark stool observed 2.Hemoglobin level increased
Tablet Folic Acid	Vitamin preparation	5mg daily for 30 days	Oral	<ul style="list-style-type: none"> <li>• Helps in the formation of red blood cells.</li> <li>• Prevention of birth defects</li> </ul>	Gastro intestinal disturbance	None observed.
Tablet Multivite	Vitamin preparation	5mg daily for 30days	Oral	<ul style="list-style-type: none"> <li>• Helps in the prevention and treatment of anaemia</li> </ul>	<ul style="list-style-type: none"> <li>• Nausea and vomiting</li> <li>• Abdominal disturbance</li> </ul>	None observed
		daily for 30 days		<ul style="list-style-type: none"> <li>• Anaemia.Improves appetite</li> </ul>	Discomfort	
Tablet Albendazole	Anthelmintic (Benimidazole)	400mg single start dose	Oral	To Prevent and treat worm infections.	<ul style="list-style-type: none"> <li>• Headache and stomach pains</li> <li>• Nausea and vomiting</li> <li>• Liver problem will occur as a prolong use</li> </ul> Fever and dizziness	Observed vomiting

**PHARMACOLOGY OF DRUGS USED CONTINUED**

<b>DRUG NAME</b>	<b>CLASSIFICATION</b>	<b>DOSAGE</b>	<b>ROUTE</b>	<b>ACTION</b>	<b>SIDE EFFECT</b>	<b>EFFECTS OBSERVED ON CLIENT</b>
Tablet Paracetamol	Analgesic Antipyretic	1000mg three times daily for 5 days	Oral	<ul style="list-style-type: none"> <li>To relieve pain</li> <li>To reduce body temperature</li> </ul>	<ul style="list-style-type: none"> <li>Prolong use may result in liver damage.</li> </ul>	None observed
Tablet sulphadoxine Pyrimethamine	Anti-Malaria	3 tablet starts 16 weeks /after quickening and other 5 doses 4 weeks interval till 40 weeks gestation	Oral	Prevention of malaria.	<ul style="list-style-type: none"> <li>Nausea</li> <li>Itching headache</li> </ul>	None
Injection Tetanus Diphtheria	Vaccine	0.5ml	Intramuscularly or subcutaneous	<ul style="list-style-type: none"> <li>Stimulate the formation of antibodies against tetanus organism</li> </ul> <p>Given to prevent women to transfer infection to fetus</p>	<ul style="list-style-type: none"> <li>Slight rise in temperature</li> <li>Pain and tenderness at the injection site</li> </ul>	-Rise in temperature -Inflammation occurred at the injection site.
Injection Oxytocin	Oxytocin	10 units	Intramuscularly	<ul style="list-style-type: none"> <li>Stimulate uterine muscularly contraction and controls bleeding</li> </ul> <p>Use for induction and augmentation of labour</p>	Uterine rupture if overdose is given	None observed

**PHARMACOLOGY OF DRUGS USED CONTINUED (BABY)**

<b>DRUG NAME</b>	<b>CLASSIFICATION</b>	<b>DOSAGE</b>	<b>ROUTE</b>	<b>ACTION</b>	<b>SIDE EFFECT</b>	<b>EFFECTS OBSERVED ON CLIENT</b>
Injection Vitamin K	Group K vitamins	0.5 - 1 mg	Intramuscularly	Help in clotting of blood Help to prevent haemorrhage disease of the new born	Rashes on the face	None observed
Tetracycline Hydrochloride 1% eye ointment	Antibiotics	Applied on both eyes	Instillation	To prevent eye infection	Transient stinging ,increase risk of aplastic anaemia	None
Injection Bacillus Calmette Guerin (BCG)	Vaccine	0.05 ml	Intradermal Injection	Stimulate production of anti-bodies against tuberculosis	A mole ,a scar	Blister observed
Polio O Vaccine	Vaccine	2 drops	Oral	Stimulate production of antibodies against poliomyelitis	No side effect	None observed
Penta 1	Vaccine	0.5ml	Intramuscular	To stimulate the body to produce antibodies against diphtheria, hepatitis B, tetanus, pertussis and haemophilus influenza B	Fever, redness, swelling or tenderness at the site,	Fever
Pneumococcal 1	Vaccine	0.5ml	Intramuscular	To stimulate the body to produce antibodies against pneumonia	Tenderness at the site	None
Rotavac	Vaccine	5drops	Oral	To stimulate the body to produce antibodies against Rota virus	None	None

**APPENDIX III**

**ANTENATAL CHART**

<b>Date</b>	<b>Weigt</b>	<b>Blood Pressure (mmHg)</b>	<b>Urine (protein and sugar)</b>	<b>Haem o-globin level (g/dl)</b>	<b>Gestati-onal age (weeks)</b>	<b>Funda l height (cm)</b>	<b>Present ation</b>	<b>Des cent (th)</b>	<b>Foetal heart rate (bpm)</b>	<b>Complains</b>	<b>Treatment and advice</b>	<b>Remarks</b>
30/10/24	57.1	114/63	Negative Negative	11.2	18weeks	-	-	-	-	No complains	Tablet folic acid, multivitamin, Fersolate, 1st dose SP given, Advice on good nutrition, insecticide treated net given.	Healthy
27/11/24	58	131/65	Negative Negative	-	22 weeks	21	-	-	+	No complains	Tablet folic acid, multivitamin, fersunate, 2 <sup>nd</sup> SP given under DOT.	Well
18/12/24	58	100/70	Negative Negative	11.4	26weeks	25	Cephalic	-	+	No complains	Folic Acid, Multivitamin, Fersolate, Iron given 3 <sup>rd</sup> SP given under DOT, albendazole and educated to take more fluids, fruits and vegetables	Well

**ANTENATAL CHART CONTINUED**

<b>Date</b>	<b>Weigg t</b>	<b>Blood Pressure (mmHg)</b>	<b>Urine (protein and sugar)</b>	<b>Haemo- globin level (g/dl)</b>	<b>Gestati- -onal age (weeks)</b>	<b>Fundal height (cm)</b>	<b>Presenta tion</b>	<b>Desc ent (th)</b>	<b>Foetal heart rate (bpm)</b>	<b>Complains</b>	<b>Treatment and advice</b>	<b>Remarks</b>
13/1/24	55	124/76	Negative Negative	11.6	29	30	Cephalic	5/5	140	Lower abdominal pain and waist pain	Routine drugs served, and educated on personal hygiene	Healthy
/11/24	56	100/60	Negative Negative	11.8	33	32	Cephalic	5/5	138	No complains	Routine drugs served,4 <sup>th</sup> dose of SP given under DOT,and educated on rest and sleep	Well
30/11/24		110/70	Negative Negative	-	37+2	34	Cephalic	5/5	136	No complains	Routine drugs served, educated on birth preparedness and complication readiness	Well
07/12/24	57	100/60	Negative Negative	11.5	38	36	Cephalic	5/5	140	Lower abdominal pains and waist pains.	To continue with routine drugs, paracetamol 1g three times daily served to relieve pain.	Well

### TETANUS DIPHTHERIA IMMUNISATION SCHEDULE

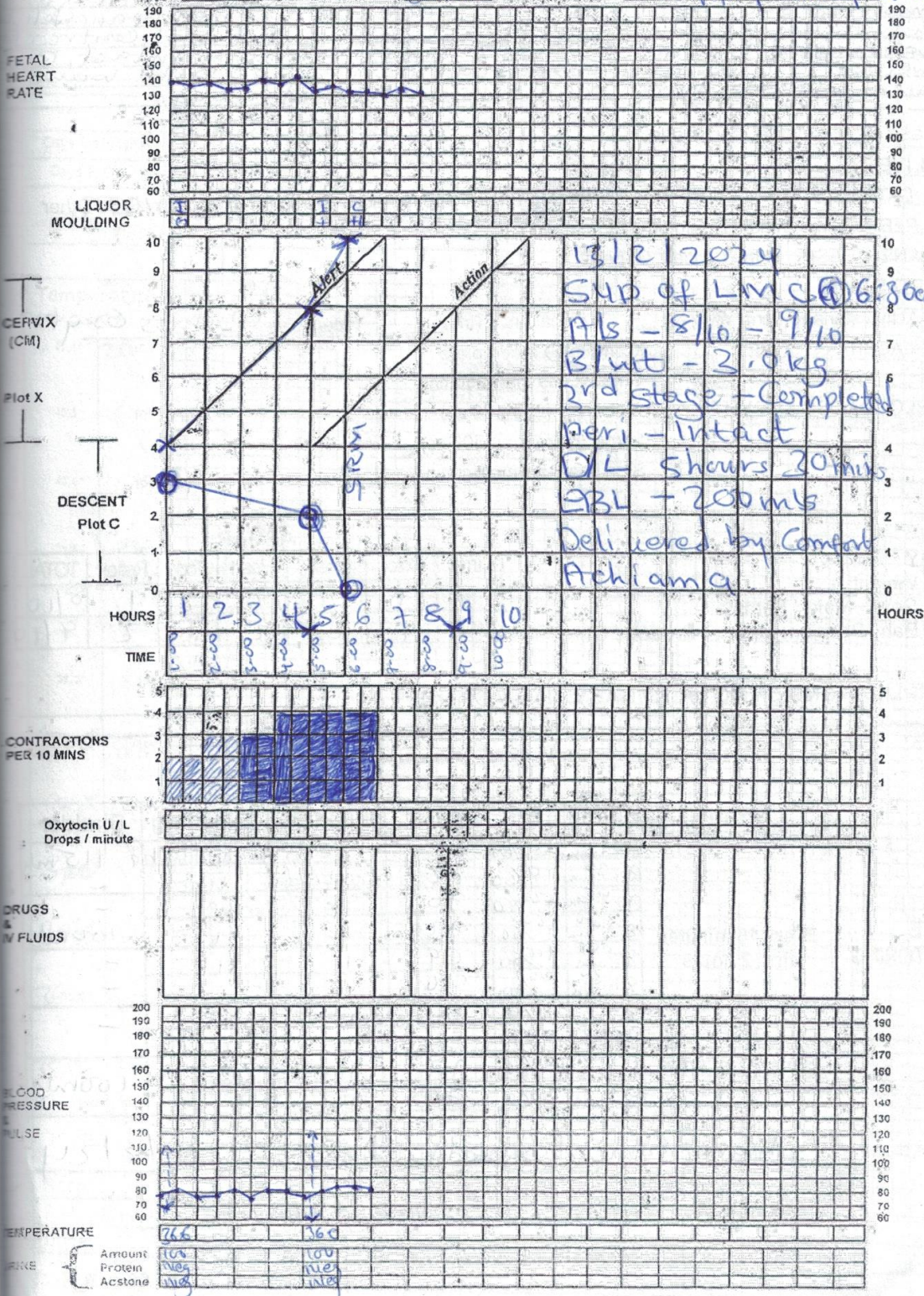
<b>Tetanus diphtheria</b>	<b>Date given</b>	<b>Batch Number</b>	<b>Next visit</b>
Tetanus diphtheria1	3/8/2023	22600620B	31/08/2023
Tetanus diphtheria2	01/09/2023	2331X004B	28/9/2023
Tetanus diphtheria3	28/9/2023	2225443BA	30/10/2023
Tetanus diphtheria4	30/10/2023	1500XBA2	27/11/2023
Tetanus diphtheria5			

### INTERMITTENT PREVENTIVE TREATMENT

<b>INTERMITTENT TREATMENT</b>	<b>PREVENTIVE</b>	<b>DATE GIVEN</b>	<b>GESTATIONAL AGE IN WEEKS</b>
IPT1		3/08/2023	17WEEKS
IPT2		31/09/2023	21WEEKS
IPT3		30/10/2023	28WEEKS
IPT4		27/11/2023	32WEEKS
IPT5		18/12/2023	36WEEKS
IPT6		08/1/2023	40WEEKS

# WHO Modified Partograph

Registration No: 1988/24 Name (Last, First): Deborah Yeboah Age: 25 yrs  
 Date: 12/12/24 Parity/Gravida: 1/2 LMP: 5/12/23 EDD: 12/12/24 Gestation (wks): 40 weeks  
 ROM: \_\_\_\_\_ Labour Duration (Hrs): 5 hours 30 mins Facility/Clinic Name: Happy Hospital



**LABOR NOTES**

Client progress to second stage and had a spontaneous vagina delivery to an alive male at 6:30am with A1s of 8/10 and A2s of 9/10 for the first and fifth A1s respectively. Third stage completed successfully with given placenta and membranes delivered and uterus massage to extract blood clot and clots. Estimated blood loss is 200mls. Perineum intact. Baby weight 3.0kg and essential care done. Both baby and mother were monitored respectively.

Please circle or write responses.

**DELIVERY**

DATE: 13/2/24 TIME: 6:30am METHOD: Spontaneous / Vacuum Extraction / C/S / Other

PERINEUM: Intact / Episiotomy / Laceration

ANESTHESIA: None / Local / General

**THIRD STAGE**

Active Management:  Yes / No Medication: Time \_\_\_\_\_ Type/Dose 10 units Oxytocin

PLACENTA: TIME: Complete / Incomplete  
Small (Less than 250 cc)

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

**BABY**

Weight: \_\_\_\_\_  
Sex: Male / Female  
Baby Position: Vertex / Breech / Other

**APGAR**

Time	Color	Breath	Heart	Tone	Reflex	TOTAL
1min	1	2	2	2	1	8/10
5min	2	2	2	1	2	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	7:15 am	110/60	75	18cm	Normal lochia	115mls
	7:30 am	104/60	82	Contracted	11	-
	7:45 am	124/60	70	11	11	-
	8:00 am	110/60	73	11	11	100mls
	8:15 am	110/60	69	11	11	-
	8:30 am	100/60	80	11	11	-
	8:45 am	110/60	79	11	11	-
Every 30 minutes For 1 hour	9:00 am	120/60	80	11	11	-
	10:00 am	100/60	77	11	11	100mls
		110/60	76	11	11	

Birth Attendant Achiama Comfort assisted by Edina Kye Date 13/2/24



NEW BORN CHART

Name: Babry Yeboah No: ..... Birth Weight: 3.0kg

Sex: male Mother's No: 1988/24 Length: 51cm

Nature of Delivery: Spontaneous vaginal Delivery Diagnosis: SVD

Date of Birth: 13/12/24 Time: 6:30am Date of Discharge: 14/12/24

Date	13/12/24		14/12/24		15/12/24		16/12/24		17/12/24		18/12/24		19/12/24		20/12/24	
	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM
No. of Days	D0D		D1		D2		D3		D4		D5		D6		D7	
Weight	3.0		2.9		2.8		2.7		2.7		2.8		2.9		3.1	
Temperature	36.0	36.9	36.2	37.2	36.9	36.8	37.0	36.9	36.5		36.5		36.0		36.7	
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	<p>Head Neck Trunk Genitalia Extremities</p> <p style="text-align: right;">MAD</p>															

Day of Discharge

NEW BORN EXAMINATION FORM

Name: Baby Yelsoah Date of Assessment: 13/2/24 Time: 6:45  
 Date of Birth: 12/2/24 Time of Birth: 6:30am Sex:  M  F Age at time of Assessment (days/hrs) \_\_\_\_\_  
 Astational Age  40wks Mode of Delivery:  Vaginal  Assisted Vaginal  C-Section  
 APGAR: 1min 8 5min 10 Birth Weight:  3.0 kg  Length 51 cm Head Circumference: 34 cm  
 Temperature at time of Assessment: 36.6 °C Urine passed:  Yes  No Meconium passed:  Yes  No  
 Name of Assessor (Midwife/Doctor): \_\_\_\_\_

<p><b>1. Respiration</b>                  Rate <u>40cpm</u>  <input type="checkbox"/> Rate &lt; 30 b/m *  <input type="checkbox"/> Rate &lt; 60 b/m *  <input type="checkbox"/> 30-60 b/m  <input type="checkbox"/> Retractions *  <input type="checkbox"/> Grunting *  <input type="checkbox"/> Stridor *</p> <p><b>2. Activity/Movement</b>  <input checked="" type="checkbox"/> Spontaneous symmetric movements  <input type="checkbox"/> Reduced/Absent Movement in ≥ 1 limb *  <input type="checkbox"/> No Movement</p> <p><b>3. Tone</b>  <input checked="" type="checkbox"/> Normal  <input type="checkbox"/> Floppy *  <input type="checkbox"/> Increased *</p> <p><b>4. Colour</b>  <input checked="" type="checkbox"/> Pink all over  <input type="checkbox"/> Pink body but blue hands/feet  <input type="checkbox"/> Blue all over *  <input type="checkbox"/> Pale *  <input type="checkbox"/> Jaundiced *</p> <p><b>5. Cord</b>  <input checked="" type="checkbox"/> Normal  <input type="checkbox"/> Red, draining pus  <input type="checkbox"/> Bleeding</p> <p><b>6. Cry</b>  <input checked="" type="checkbox"/> Normal  <input type="checkbox"/> Shrii *  <input type="checkbox"/> Absent *</p>	<p><b>7. Suck</b>  <input checked="" type="checkbox"/> Good  <input type="checkbox"/> Weak  <input type="checkbox"/> Absent</p> <p><b>8. Head swelling</b>  <input type="checkbox"/> Caput succedaneum  <input type="checkbox"/> Cephalhaematoma  <input type="checkbox"/> Subgaleal hemorrhage  <input checked="" type="checkbox"/> No swelling</p> <p><b>9. Sutures</b>  <input checked="" type="checkbox"/> Normal  <input type="checkbox"/> Overlapping  <input type="checkbox"/> Fused  <input type="checkbox"/> Widely Separated *</p> <p><b>10. Fontanel</b>  <input checked="" type="checkbox"/> Normal  <input type="checkbox"/> Sunken *  <input type="checkbox"/> Raised *  <input type="checkbox"/> Wide (&gt;5cm) *</p> <p><b>11. Eyes</b>  <input checked="" type="checkbox"/> Normal  <input type="checkbox"/> Subconjunctival bleed  <input type="checkbox"/> White pupil or cornea  <input type="checkbox"/> Eye discharge  <input type="checkbox"/> Other _____</p> <p><b>12. Ears</b>  <input checked="" type="checkbox"/> Normal (size / shape / position).  <input type="checkbox"/> Abnormal: _____</p> <p><b>13. Mouth</b>  <input checked="" type="checkbox"/> Normal  <input type="checkbox"/> Cleft palate  <input type="checkbox"/> Cleft Lip  <input type="checkbox"/> Other: _____</p>	<p><b>15. Neck</b>  <input checked="" type="checkbox"/> Normal  <input type="checkbox"/> Swelling  <input type="checkbox"/> Webbed  <input type="checkbox"/> Other: _____</p> <p><b>16. Clavicle</b>  <input type="checkbox"/> Normal  <input type="checkbox"/> Swelling/Fracture</p> <p><b>17. Chest</b>  <input checked="" type="checkbox"/> Normal (Shape/movement)  <input type="checkbox"/> Abnormal _____</p> <p><b>18. Heart rate</b>                  Rate: <u>136 bpm</u>  <input type="checkbox"/> Normal (100-160)  <input type="checkbox"/> &lt;100 *  <input type="checkbox"/> &gt;160 *</p> <p><b>19. Femoral pulse</b>  <input checked="" type="checkbox"/> Present  <input type="checkbox"/> Not palpable *</p> <p><b>20. Abdomen</b>  <input checked="" type="checkbox"/> Normal  <input type="checkbox"/> Distended*  <input type="checkbox"/> Scarphoid*  <input type="checkbox"/> Abdominal defect*  <input type="checkbox"/> Maases: _____  <input type="checkbox"/> Other _____</p> <p><b>21. Back (spine)</b>  <input checked="" type="checkbox"/> Normal  <input type="checkbox"/> Abnormal Swelling *  <input type="checkbox"/> Hairly patch over spine  <input type="checkbox"/> Abnormal dimple  <input type="checkbox"/> Abnormal curvature</p>	<p><b>22. Limbs</b>  <input checked="" type="checkbox"/> Normal  <input type="checkbox"/> Abnormal _____</p> <p><b>23. Genitalia</b>  <b>Male Genitalia</b>  <input checked="" type="checkbox"/> Normal  <input type="checkbox"/> Undescended testes  <input type="checkbox"/> Abnormal meatus  <input type="checkbox"/> Hernia  <input type="checkbox"/> Other: _____  <b>Female Genitalia</b>  <input checked="" type="checkbox"/> Normal  <input type="checkbox"/> Fistula (meconium/urine through abnormal opening in vagina) *  <input type="checkbox"/> Large clitoria *  <input type="checkbox"/> Other: _____</p> <p><b>24. Anus</b>  <input type="checkbox"/> Patent  <input type="checkbox"/> Imperforate *</p> <p><b>25. Resuscitation provided</b>  <input type="checkbox"/> One  <input checked="" type="checkbox"/> Suction/stimulation  <input type="checkbox"/> Bag and mask  <input type="checkbox"/> Endotracheal Tube  <input type="checkbox"/> Ventilator/CPAP</p> <p><b>26. Services provided</b>  <input checked="" type="checkbox"/> Vitamin K1 given  <input checked="" type="checkbox"/> Eye care provided  <input checked="" type="checkbox"/> Cord care provided  <input checked="" type="checkbox"/> Breastfeeding initiated  <input checked="" type="checkbox"/> Breastfeeding established  <input checked="" type="checkbox"/> Immunization (BCG/Polio)  <input checked="" type="checkbox"/> BCG <input type="checkbox"/> Polio Immunization  <input checked="" type="checkbox"/> Antibiotics in mother  <input type="checkbox"/> Antenatal corticosteroids</p>
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\*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  Discharge

Day of Delivery

NEW BORN EXAMINATION FORM

Name: Baby Yeboah Date of Assessment: 13/12/24 Time: 6:45h
Date of Birth: 13/12/24 Time of Birth: 6:30am Sex: M Age at time of Assessment (days/hrs) 12 hours
Astonal Age 40w Mode of Delivery: Vaginal Assisted Vaginal C-Section
APGAR: 1min 8/10 5min 7/10 Birth Weight: 3.0 kg Length: 51 cm Head Circumference: 34 cm
Temperature at time of Assessment: 36.2 °C Urine passed: Yes No Meconium passed: Yes No
Name of Assessor (Midwife/Doctor):

1. Respiration

Rate 44cpm
Rate < 30 b/m \*
Rate < 60 b/m \*
30-60 b/m
Retractions \*
Grunting \*
Stridor \*

2. Activity/Movement

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: 136bpm
Normal (100-160)
<100 \*
>160\*

19. Femoral pulse

Present
Not palpable\*

20. Abdomen

Normal
Distended\*
Scaphoid\*
Abdominal defect\*
Maases:
Other

21. Back (spine)

Normal
Abnormal Swelling \*
Hairy patch over spine
Abnormal dimple
Abnormal curvature

22. Limbs

Normal
Abnormal

23. Genitalia

Male Genitalia

Normal
Undescended testes
Abnormal meatus
Hernia
Other:

Female Genitalia

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

24. Anus

Patent
Imperforate\*

25. Resuscitation provided

One
Suction/stimulation
Bag and mask
Endotracheal Tube
Ventilator/CPAP

26. Services provided

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

May indicate severe disease that requires urgent referral diagnoses (if known)

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

# TEMPERATURE CHART

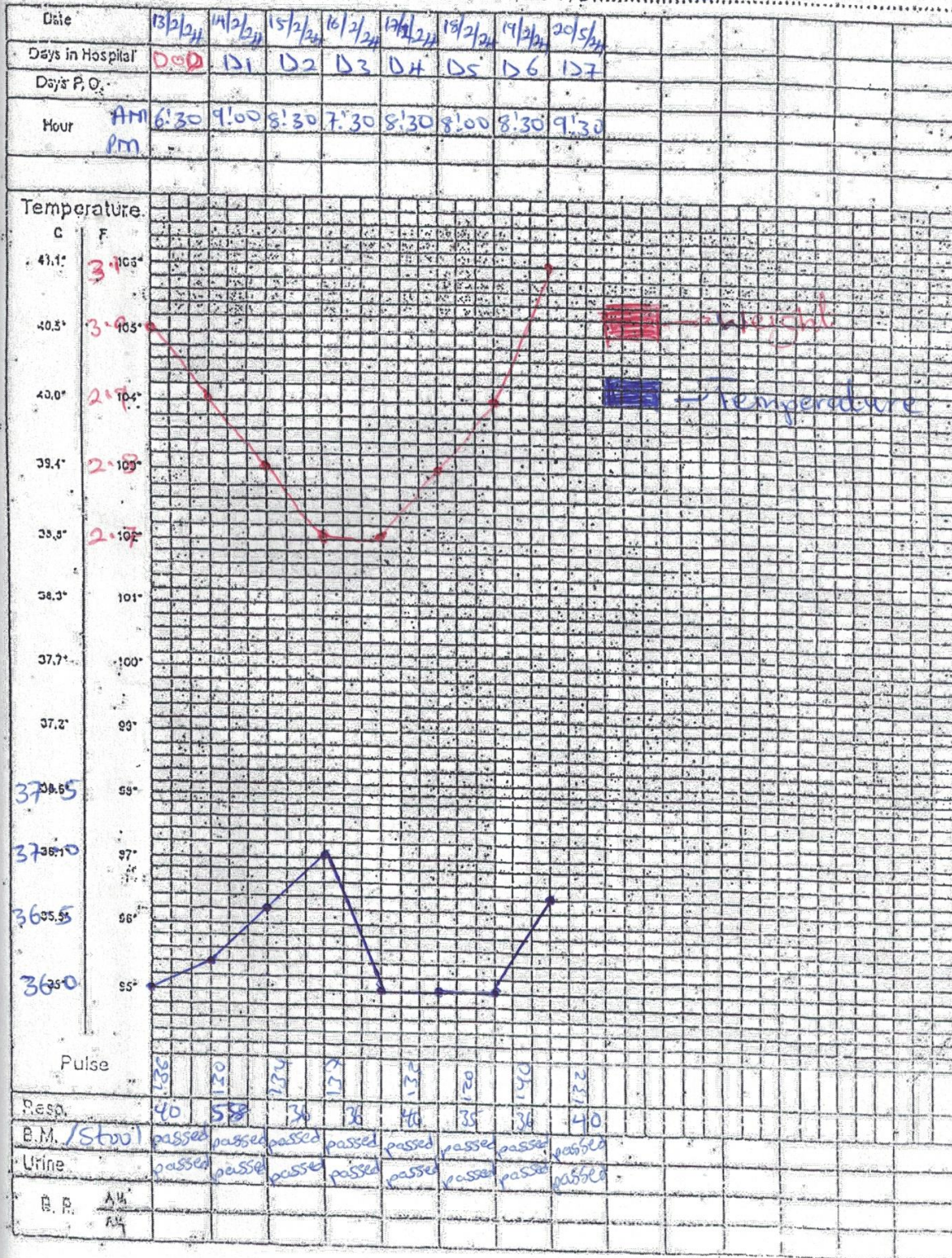
NAME: BABY YEBOAH

AGE: NEW BORN

WARD: LING IN WARD

IP NO.:

BED NO: 3



**SIGNATORIES**

**STUDENT**

NAME: ACHIAMA COMFORT

SIGNATURE ..... 

DATE ..... 7 - 06 - 2024

**MIDWIFE INCHARGE**

NAME: MRS. EDINA KYERAA

SIGNATURE ..... 

DATE ..... 07 - 06 - 2024

**SUPERVISOR**


NAME: MS MENSAH ERNESTINA.

SIGNATURE ..... 

DATE ..... 07/06/2024

**PRINCIPAL**

NAME: MS MONICA NKRUMAH

SIGNATURE ..... 

DATE ..... 10/6/2024

**PRINCIPAL  
HOLY FAMILY NURSING AND  
MIDWIFERY TRAINING COLLEGE  
BEREKUM**