HOLY FAMILY NURSING AND MIDWIFERY TRAINING COLLEGE

BEREKUM

A CLIENT /FAMILY CENTERED MATERNITY CARE STUDY ON

MADAM AMANDA ASAMOAH

AT BANHART HOSPITAL (KENYASI)

BY

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

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PREFACE

Client/family centered maternity care study is a systematic way of administering midwifery care to a pregnant woman and her family throughout pregnancy, labor and puerperium.The client and family centered maternity care study also helps the student midwife to use new trends in midwifery like the partogragh which is recommended and tested by the world health organization (WHO) in the management of labor.

The active management of third stage of labor was also introduced to limit the occurrences of postpartum hemorrhage.

The client/family centered maternity care study helps the student midwife to put into practice the safe motherhood initiative which has been adopted in order to help reduce the maternal mortality among pregnant women to improve the quality of health care through antenatal, labor, and postnatal periods.

The client/family centered care study is a required study that every final year student of Registered Midwifery programme is supposed to undertake to satisfy the Nursing and Midwifery Council to help contribute to the award of professional certificate in Registered Midwifery. To achieve these aims, the client, family and the community are involved in the preparation towards the newborn. It is also necessary to establish good rapport, use a holistic care approach so that client's problems and minor disorders are solved through education, counseling and early measures taken to prevent complications.

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INTRODUCTION

The client/family centered maternity care study was carried out on Madam Amanda Asamoah, 27years old, Gravida 2 para 1, who was nursed during the community midwifery practical experience at Banhart hospital during pregnancy, labor and puerperium. Madam Amanda Asamoah was first met on the 28th November, 2022 when she came for antenatal follow up and was in 36weeks plus 1day of gestation. She was in good health.

Introduction was made to client and permission was sought if she could be used for the study which she accepted without hesitating. She was visited at home to assess her environment and community in which she lives. For the purpose of this study, Madam Amanda Asamoah will be used throughout the study.

Madam Amanda Asamoah`s problems identified during pregnancy, labor and puerperium was managed by the use of nursing process. Client was prepared to face the challenges with labor, puerperium, and how to initiate lactation and subsequent care of the baby. Client was cared from 36weeks+1day till she went through pregnancy and labor successfully and delivered in a good condition. Her condition from the beginning till the end of the study was to be monitored to ensure that client was in good state and both mother and baby was to be handed over to the ward in charge for the continuity of care after forty days of delivery. The interaction with client and her family from pregnancy to the end of puerperium has been compiled into four chapters.

Chapter one talks about the clients social, family, medical, surgical, menstrual, clients habits of daily living, past and present obstetrical histories. Chapter two also talks about client antenatal care: first contact with client, first and second antenatal home visit, subsequent visit to the clinic.

Chapter three talks about: admission of client during labor, management of the first and second stages of labor, immediate care giving to the baby, management of third and fourth stages of labor.

Chapter four is concerned with puerperium: monitoring and management of both the mother and baby during puerperium. At the end of chapter 2, 3, and 4 area care plans drawn to manage the problem identified. The document also includes summary and conclusion, bibliography, appendices which comprises complete diagnostic antenatal and postnatal records and signatories. Investigation, pharmacology of drugs for both the mother and the baby, antenatal and postnatal records and signatories.

LITERATURE REVIEW

PREGNANCY

Pregnancy: The state of carrying a developing embryo or fetus within the female body. This condition can be indicated by positive results on an over-the-counter urine test, and confirmed through a blood test, ultrasound, detection of fetal heartbeat, or an X-ray. Pregnancy lasts for about nine months, measured from the date of the woman's last menstrual period (LMP). It is conventionally divided into three trimesters, each roughly three months long (Davis, 2021). The most important tasks of basic fetal cell differentiation occur during the first trimester, so any harm done to the fetus during this period is most likely to result in miscarriage or serious disability. There is little to no chance that a first-trimester fetus can survive outside the womb, even with the best hospital care. Its systems are simply too undeveloped. This stage truly ends with the phenomenon of quickening: the mother's first perception of fetal movement. It is in the first trimester that some women experience "morning sickness," a form of nausea on awaking that usually passes within an hour. The breasts also begin to prepare for nursing, and painful soreness from hardening milk glands may result (Davis, 2021).

As the pregnancy progresses, the mother may experience many physical and emotional changes, ranging from increased moodiness to darkening of the skin in various areas. During the second trimester, the fetus undergoes a remarkable series of developments. Its physical parts become fully distinct and at least somewhat operational. With the best medical care, a second-trimester fetus born prematurely has at least some chance of survival, although developmental delays and other handicaps may emerge later. As the fetus grows in size, the mother's pregnant state will begin to be obvious. In the third trimester, the fetus enters the final stage of preparation for birth. It increases rapidly in weight, as does the mother (American College of Obstetricians and Gynecologist, 2018).

According to Davis (2021), conception to about the 12th week of pregnancy marks the first trimester. The second trimester is weeks 13 to 27 and the third trimester starts about 28 weeks and lasts until birth. Women gain weight all over their bodies while they are pregnant.

Fetal weight accounts for about 7 1/2 pounds by the end of pregnancy. The placenta, which nourishes the baby, weighs about 1 1/2 pounds. The uterus weighs 2 pounds. A woman gains about 4 pounds due to increased blood volume and an additional 4 pounds due to increased fluid in the body. A woman's breasts gain 2 pounds during pregnancy. Amniotic fluid that surrounds the baby weighs 2 pounds. A woman gains about 7 pounds due to excess storage of protein, fat, and other nutrients. The combined weight from all these sources is about 30 pounds (Davis, 2021).

The World Health Organization (WHO) envisions a world where “every pregnant woman and newborn receives quality care throughout the pregnancy, childbirth and the postnatal period” (Tunçalp, et al., 2019). Antenatal care (ANC) can be defined as the care provided by skilled health-care professionals to pregnant women and adolescent girls in order to ensure the best health conditions for both mother and baby during pregnancy (World Health Organization, 2016). According to the World Health Organization (2016), the components of ANC include: risk identification; prevention and management of pregnancy-related or concurrent diseases; and health education and health promotion.

ANC reduces maternal and perinatal morbidity and mortality both directly, through detection and treatment of pregnancy-related complications, and indirectly, through the identification of women and girls at increased risk of developing complications during labour and delivery, thus ensuring referral to an appropriate level of care (World Health Organization, 2016). In addition, as indirect causes of maternal morbidity and mortality, such as HIV and malaria infections, contribute to approximately 25% of maternal deaths and near-misses (9), ANC also provides an important opportunity to prevent and manage concurrent diseases through

integrated service delivery (World Health Organization, 2016). Through this form of preventive health care, women can learn from skilled health personnel about healthy behaviours during pregnancy, better understand warning signs during pregnancy and childbirth, and receive social, emotional and psychological support at this critical time in their lives. Through antenatal care, pregnant women can also access micronutrient supplementation, treatment for hypertension to prevent eclampsia, as well as immunization against tetanus (United Nations Children's Funnd (UNICEF), 2022).

LABOR

Labor consists of a series of rhythmic, involuntary or medically induced contractions of the uterus that result in effacement (thinning and shortening) and dilation of the uterine cervix (Artal-Mittelmark, 2022). The World Health Organization (WHO) defined normal birth as "spontaneous in onset, low-risk at the start of labor and remaining so throughout labor and delivery. The infant is born spontaneously in the vertex position between 37 and 42 completed weeks of pregnancy. After birth, mother and infant are in good condition" (WHO, 2020).

The stimulus for labor is unknown, but digitally manipulating or mechanically stretching the cervix during examination enhances uterine contractile activity, most likely by stimulating release of oxytocin by the posterior pituitary gland (Artal-Mittelmark, 2022). Normal labor usually begins within 2 weeks (before or after) the estimated delivery date. In a first pregnancy, labor usually lasts 12 to 18 hours on average; subsequent labors are often shorter, averaging 6 to 8 hours (Artal-Mittelmark, 2022).

As discussed by Artal-Mittelmark (2022) rupture of the chorioamniotic membranes or bloody show is diagnostic for onset of labor. Labor begins with irregular uterine contractions of varying intensity; they apparently soften (ripen) the cervix, which begins to efface and dilate. As labor progresses, contractions increase in duration, intensity, and frequency. As sepcified

by Marshall and Raynor (2014), the onset of labour is a process, not an event; therefore it is very difficult to identify exactly when the painless (sometimes painful) contractions of prelabour develop into the progressive rhythmic contractions of established labour.

Traditionally, three stages of labour are described: the first, second and third stage, but this is a rather pedantic view, as labour is obviously a continuous process. It has also been acknowledged that there are more than three stages of labour, namely the latent, active and transitional phases, and these not only encompass specific physical changes but should also account for the emotional effects observed in women during this time (Marshall & Raynor, 2014).

1. **The 1st stage**—from onset of labor to full dilation of the cervix (about 10 cm). Begins with regular rhythmic uterine contractions to the full dilatation of the cervix and is managed by a partograph. The first stage lasts for about twelve to fourteen hours in primi Gravida and six to twelve hours in multigravida (Artal-Mittelmark, 2022).
    a. The **latent phase of labour** is prior to the active phase stage of labour and may last 6–8 hours in primigravidae when the cervix dilates from 0 cm to 4 cm dilated. The latent phase of labour is so subjective and poorly understood that a normal range is difficult to measure. According to Marshall and Raynor (2014), the cervical canal shortens from 3 cm long to <0.5 cm in length during this time. A woman may believe herself to be laboring, whereas sound midwifery judgement and understanding of the physiology of the first stage of labour may lead the midwife to the diagnosis of the latent phase of labour. Both the woman and midwife being aware of the latent phase of labour, and allowing this time to pass with no intervention, can prevent the medical diagnosis of poor progress or failure to progress later in labour. In a hospital setting, it is good practice not to

commence the partogram until active labour has commenced. Assessing the active phase of labour has been highlighted as essential in reducing interventions in normal labour (Marshall & Raynor, 2014).

b. The **active phase** within the first stage of labour is the time when the cervix usually undergoes more rapid dilatation. This begins when the cervix is at least 4 cm dilated and, in the presence of rhythmic contractions, progressively dilates to 10 cm or full dilatation. When in labour, contractions will often be accompanied or preceded by a bloodstained mucoid show: that is, the release of the operculum from the cervical canal as effacement and dilatation progresses. Occasionally, the membranes will rupture, at which stage the midwife may seek assurance that there are no significant changes in the fetal heart rate due to the rare complication of cord prolapse and that meconium is not present in the liquor, indicating fetal compromise (Marshall & Raynor, 2014).

c. The **transitional phase** of the first stage of labour is from when the cervix is around 8 cm dilated until it is fully dilated or until expulsive contractions associated with the second stage of labour are felt by the woman. There is often a brief lull in the intensity of uterine activity at this time. Many women may feel the urge to push during transition. In addition to physiological responses, women can experience a range of experiences and emotions. The woman may verbalize her distress, direct it at her birth partner(s), alternatively she may be quiet and contemplative (Marshall & Raynor, 2014).

2. The second stage of labour has traditionally been regarded as the phase between full dilatation of the cervical os, and the birth of the baby (Marshall & Raynor, 2014). On average, it lasts 2 hours in nulliparous (median 50 minutes) and 1 hour in multiparas (median 20 minutes). It may last another hour or more if conduction (epidural)

analgesia or intense opioid sedation is used. For spontaneous delivery, women must supplement uterine contractions by expulsively bearing down. In the 2nd stage, women should be attended constantly, and fetal heart sounds should be checked continuously or after every contraction. Contractions may be monitored by palpation or electronically (Artal-Mittelmark, 2022). During the 2nd stage of labor, perineal massage with lubricants and warm compresses may soften and stretch the perineum and thus reduce the rate of 3rd- and 4th-degree perineal tears (Aasheim, et al., 2017).

3. The **third stage** can be defined as the period from the birth of the baby to complete expulsion of the placenta and membranes. It involves the development of the relationship between mother, baby and father, the separation, descent and expulsion of the placenta and membranes, the control of hemorrhage from the placenta site, and sometimes, the initiation of breast-feeding. Although traditionally labour is divided into three distinct component parts to aid comprehension, it should be viewed as one continuous process. With this in mind, it is important to understand that the physiology of the third stage depends, in part, on what has happened during pregnancy as well as during the first and second stage of labour, and on the woman's basic level of health and wellbeing. The midwife's knowledge and evidence-based skills play a crucial role in ensuring that the care received by the woman works with, not against, physiological processes. The placenta may shear off during the final expulsive contractions accompanying the birth of the baby or remain adherent for some time. The third stage usually lasts between 5 and 15 minutes, but any period up to 1 hour may be considered normal (Marshall & Raynor, 2014).

PUERPERIUM

The words "postpartum" and "postnatal" are sometimes used interchangeably. In this report we use the word "postpartum", except in sections exclusively dealing with the infant. In those

sections the word “postnatal” is used. The postpartum period (also called the puerperium) according to Western textbook definitions starts shortly after the birth of the placenta (American College of Obstetricians and Gynecologist, 2018).

Following the birth of a baby, placenta and membranes, the newly birthed mother enters a period of physical and emotional/psychological recuperation. Skin-to-skin contact is advocated immediately following birth and during the postnatal period as there is clear evidence of benefit to the mother and father. The puerperium starts immediately after birth of the placenta and membranes and continues for 6 weeks. In many cultures around the world 40 days for recuperation is a time-honored practice. A general expectation is that by 6 weeks after birth a woman’s body will have recovered sufficiently from the effects of pregnancy and the process of parturition. However, there has now been a recognition that the return to a non-pregnant state of health and wellbeing can take much longer (Marshall & Raynor, 2014).

According to Marshall and Raynor (2014), After the birth of a baby and expulsion of the placenta, the mother enters a period of physical and psychological preparation and this period, called the puerperium starts immediately after delivery of the placenta and membranes and continues for a period of 6 to 8 weeks. Puerperium is a period after childbirth where the uterus and other organs and structures which were affected by pregnancy returns to their non-gravid state. This period is also divided into three;

1. Immediate puerperium: this is the first 24 hours after delivery.
2. Early puerperium: is between the second and the seventh day after delivery.
3. Late puerperium: this is the period from the second week to the sixth week after childbirth.

During this time a number of physiological and psychological changes take place which are;

The reproductive organs return to the non-pregnant state.

1. Lactation is established

2. Bounding between infant and parents is also established

The mother recovers from the stresses of pregnancy and delivery, and assumes responsibility for the care and nurture of her infant. The main aim of management during puerperium is to;

1. Manage minor disorders in both mother and baby.
2. Counsel and teach on nutritional needs of the puerperal mother.
3. Counsel, teach and encourage the mother to breastfeed exclusively for six months and how to properly fix baby to breast.
4. Counsel and teach mother on importance of rest and sleep, ambulation and exercise as well as family planning.

The transition to parenthood involves major adjustments within a family and some mothers will welcome and actively seek help and support from a midwife during the postnatal period, but some women, for a range of reasons, may not. Women from different cultural backgrounds may have traditions that conflict with the current management of postpartum care consider that they already have sufficient skills and experience. Not being able to speak or understand English may also prevent a woman from seeking help. Although a visit to the home might have been planned, there will also be times when women are not at home when the midwife visits. It is important to keep in mind individual circumstances and whether these might have any bearing on a no-access visit. For example, parents with a disability such as hearing loss or poor mobility might not hear a doorbell. It is, therefore, important to make arrangements for contact to be made by alternative means (e.g. using a visual alarm or telephone to alert the woman of the visit beforehand). The midwife needs to recognize situations where the mother perceives she has different priorities from those routinely provided by the healthcare services (Marshall & Raynor, 2014)

WHY CLIENTS WAS CHOSEN

As required by the Nursing and Midwifery Council of Ghana every student midwife must undertake the client/family centered maternity care study to help contribute to the awards of professional certificate in Registered midwifery, the client should fall under the normal criteria, that is, the woman should have delivered at least one and at most three with no complications during pregnancy, labor, and puerperium. She should have regular antenatal attendance record and should be a woman whose labor presumably will be uneventful.

Madam Amanda Asamoah G2 para 1 reported to antenatal clinic on the 28th November 2022 and she complained of waist pains. She explained that her previous pregnancy was not like that. Client was advised that every pregnancy was different and it was a minor disorder of pregnancy. Enquiries were made from her after glancing through her antenatal record book, and she qualified to be used for the study. Opportunity was taken for the introduction as a student midwife from Holy Family Nursing and Midwifery Training College, Berekum on Community midwifery practical experience for a period of seven weeks. Permission was sought from her if she could be used for the study. She agreed and was told to share her problems. The midwife in charge was informed and permission was granted.

CHAPTER ONE

CLIENT PARTICULARS

1.0 INTRODUCTION

Assessment of client and family and the collection of information from patient which involves data from the client and her family. The information was obtained through observation and review of medical and maternal health record. Based on this information, the student midwife will be able to give appropriate care to the client and her family taking into consideration physical, social, emotional, psychological and spiritual needs of the client.

1.1 PERSONAL AND SOCIAL HISTORY

Madam Asamoah Amanda is 27years old. She is Gravida 2 Para 1(G2P1) and comes from Kumasi in the Ashanti Region of Ghana. She stays at Kenyasi specifically No2 with her husband. She is 158cm tall, 78kg in weight and dark in complexion. She speaks English and Twi.

She is a member of the Apostolic Church at Kenyasi No2. Her educational level is at Tertiary. She is a Teacher. Her partner Mr. Akwasi comes from Bono East region (Techiman) and stays at Kenyasi, No2 to be precise. He is a nurse and a member of the church of Pentecost. Mr. Akwasi is Madam Amanda's next of kin. Madam Amanda neither smoke nor drink alcohol.

1.2 FAMILY HISTORY

Madam Amanda comes from a family of three with two siblings, two female including the mother and father. She is the first born of her parents. According to the client she has lost her father (Mr Boateng) but the mother (Ms. Asantewaa) is still alive. Her mother is a native of Kumasi and also lives there.

According to her there is no chronic or hereditary disease such as Diabetes Mellitus, Hypertension, heart and sickle cell disease. There is no history of congenital abnormalities in the family but a history of multiple pregnancies. They die a natural death.

1.3 MEDICAL HISTORY

Client stated, she has never been hospitalized as far as she can remember and also has no history of conditions such as diabetes mellitus, hypertension, sickle cell, heart disease, respiratory disease, epilepsy or mental illness. She has no known records of drugs or food allergies. She said she has neither donated nor received blood transfusion in her life.

1.4 SURGICAL HISTORY

Madam Amanda said she has never undergone any surgical procedure and has also never sustained any injury either through road traffic accident or domestic accident that affected her pelvis. Upon examination, she had no scar indicating surgical procedure.

1.5 MENSTRUAL HISTORY

Madam Amanda had her menarche at age of fifteen (15**)**. She stated that she bleeds moderately with no dysmenorrhea for six (6) days. She uses sanitary pad and changes. Her Last Menstrual period was 13th march 2022 and the expected date of delivery was calculated to be in 20th December, 2022 and scan gave 25th December, 2022.

1.6 CLIENTS LIFESTYLE AND HOBBIES

Madam Amanda is a regular woman who goes about her days in a similar trend each day. She wakes up around 5:30 am and says her morning prayers, goes through her daily domestic chores such as sweeping her room, compound and sees to other household chores if any. Client then takes her bath and grooms herself for work. Her bowel movement is once daily and also bath twice daily. Her favorite food is banku and okro stew which she normally takes

at supper as well as rice and stew. Client's breakfast is usually porridge made from corn dough with bread. She goes to bed around 9pm after the family had finish watching television to entertain themselves. Has the child started school? And who prepares the child for school?

1.7 PAST OBSTETRIC HISTORY

PREGNANCY

Madam Amanda has two pregnancies with one birth (G2P1). Her first pregnancy in 2018, Client said she has never had complications in pregnancy such as anemia, pregnancy induced hypertension (PIH), pre-eclampsia, diabetes in pregnancy, and vaginal bleeding but she experienced some minor disorders of pregnancy such as vomiting, frequency of micturition, backache and waist pains. Madam Amanda attended antenatal care (ANC) regularly at Banhart hospital. Client had received the four doses of tetanus

Diphtheria injection in the previous pregnancies and she took all the doses of sulphadoximepyrimethamine. Client was asked about her family planning method and she said she was using depo Provera and her child was in good health.

LABOUR

According to Madam Amanda, she said her child was delivered at Sunyani Municipal hospital per vaginum with perineum intact and she cried immediately after delivery but could not remember the duration of Labour. Placenta and membranes were completely delivered with minimum blood loss. According to Madam Amanda, she was discharged a day after delivery at the ward.

PUERPERIUM

Madam Amanda said her puerperium was without any complication like puerperal infection or breast engorgement. The child had all the immunization against the childhood disease and client practiced exclusive breastfeeding for six (6) months and initiated complementary feeding like porridge and water. However, baby was breastfed up to one and half year before

weaning her completely. According to Madam Amanda, she used Depo-Provera as her family planning method. Her child did not suffer any kind of sickness while growing up and was monitored at the child welfare clinic.

1.8 PRESENT OBSTETRICAL HISTORY

Madam Amanda's first visit to the clinic was on 20th June, 2022 which she was 13 weeks gestation. Clients last menstrual period was on the 13th March,2022 therefore expected date of delivery was calculated as 20th December, 2022.The following vital signs and other assessment was checked and recorded as follows;

Temperature - 36.5degrees Celsius

Pulse - 88 beat per minute

Respiration - 18 cycles per minutes

Blood pressure - 120/80 millimeters of mercury

Weight - 78 kilograms

Height - 158centimeters

Other laboratory investigations were done and recorded as follows;

Hemoglobin - 14.1gram per deciliter

Sickling Test - Negative

Blood group - O

Rhesus factor - Positive

Hepatitis B - Negative

G6PD - No defect

Prevention of mother –to- child-Transmission -280

Stool - No abnormality detected

Urine - negative

Client's physical and abdominal examination was done and no abnormalities were detected. She was also given the following routine drugs.

Tablet Folic Acid 5 milligrams daily for 30days

Tablet ferrous sulphate 200 milligrams daily for 30days

Tablet multivitamin 200milligrams daily for 30days

She received fourth dose of Tetanus diphtheria immunization on 20th July 2022 which was confirmed in her antenatal book. She has taken four (4) doses of sulphadoximepyrimethamine and was a regular attendant at AN

CHAPTER TWO

ANTENATAL CARE

2.0 INTRODUCTION

This chapter entails first contact with client, first antenatal home visit, subsequent home visits and visits by the client to the clinic and nursing care plan drawn to solve problems encountered by the client. Antenatal services are important to prevent and promote health care.

2.1 FIRST CONTACT WITH THE CLIENT

Madam Amanda was first met on 28th November, 2022 at Banhart hospital around 10:30am. During antenatal care, it was realized that client did not wash her hands before eating. Looking at this, client was approached and educated on personal hygiene. Opportunity was taken to ask client her Gestational age and was confirmed in her antenatal book as 36weeks +1day. Self-introduction was made as student midwife from Holy Family Nursing and Midwifery Training College, Berekum, who has been stationed there for seven weeks studies to support her physically and psychologically through labor and puerperium and would like to take her as a client. She was then introduced to the Midwife in-charge for her approval.

Client vital signs and other assessment were checked and recorded as follow;

Temperature	36.3degree Celsius
Pulse	80 bpm
Respiration	22 cpm
Blood pressure	120/80 millimeters of mercury
Weight	87 kilograms
HB	11.7g/dl

A clean specimen bottle was given to client to void into it for urine test. It was explained to her that midstream urine was needed. After she had returned with the urine sample, hands were washed and dried with clean towel. Gloves were worn and urine reagent strip was dipped into the urine for about half a minute and the results were compared to the corresponding colour chart on the strip container. The result for both protein and glucose were negative, the urine was clear and not offensive. Hands were washed with soap under running water and dried. Results were recorded in the antenatal book.

Before the procedure of physical examination from head to toe was explained to her and her consent was sought. Client was assisted unto a couch for the examination. Privacy was provided; hands were washed with soap under running water and dried.

HEAD-TO-TOE EXAMINATION

A tray containing the following items was set

1. Sterile cotton wool swab in a sterile gallipot with a lid
2. Receiver for used cotton wool swabs
3. Fetoscope
4. Tape measure
5. A watch with a second hand
6. A pen and a client's folder

HEAD AND NECK

Standing at the right-hand side of the client, the hair was examined and it was neatly braided. Lice and dandruff were absent on the scalp. There was no edema and rashes on the face. The sclera was checked for jaundice and the conjunctiva for pallor but none was detected. The nose and the ears were examined for pain and discharge but none was present. The ears were in alignment with the eyes with no discharges. The lips were examined for dryness, pallor,

sore and cracks but none was detected. Client was engaged in conversation and there was absence of halitosis, the gum was inspected for bleeding, sores, lesions which were absent and the tongue was neither pale nor coated. The neck was inspected and palpated for enlarged lymph nodes, thyroid glands and distended veins and enlarged thyroid gland but none was detected.

BREAST EXAMINATION

The breast was exposed and inspected for size, shape, signs of pregnancy, dimpling and nipple retraction, and condition of the skin and no abnormality were detected. One breast was covered and she was asked to put the hand of the part to be examined under her head. The breast was palpated systematically in a circular manner using the inner aspect of the fingers and client was taught self-examination and no abnormality detected. Nipples were squeezed gently with cotton wool for fluid (colostrum) and were examined for odour or blood and colour. The same was done for the other breast and no abnormality was noted. Breastfeeding history was asked and her desire to breastfeed was positive as her first child was breastfed. Client was encouraged to wear a well-fitting brazier to support the breast and enhance comfort.

ABDOMINAL EXAMINATION

The hands were rubbed together in order to help prevent pre-mature induction of contractions Permission was asked to expose her abdomen for inspection after assisting her to lie on her back. The abdomen was examined to detect any deviation from normal. Items used for the examination were shown to her to allay fear.

BACK

The back was examined for spinal or vertebrae abnormalities such as kyphosis but none was detected.

VULVA EXAMINATION

Permission was sought to inspect the genital area and she agreed. Hands were washed with soap and water and dried with a clean towel. Examination gloves were worn. The vulva was inspected for edema, scar, rashes, ulcer of the vulva, discharges such as genital warts and varicocele but none was present. The mons pubis was well shaved. Client was encouraged to continue practicing good vulva hygiene. Client was asked to assume lateral position and sit up before getting out of bed. Hand washing was done and dried with clean towel.

ABDOMINAL INSPECTION

The shape of the abdomen was ovoid. The abdomen was inspected for scars, striae gravidarum and linea nigra and all of these, except scars were present. There was no evidence of foetal movement.

MEASURING OF SYMPHYSIO- FUNDAL HEIGHT

After locating the fundus, the zero end of the tape measure was placed on the fundus and extended along the midline to the upper border of the symphysis pubis. Her symphysio-fundal height was 37cm and her gestational week was 37.

ABDOMINAL PALPATION

On abdominal palpation, hands were rubbed to generate warmth. The palms were placed on either side of fundus for fundal palpation. The fingers were curved around the fundus to determine what lies in the upper pole. The abdomen was palpated for tenderness, masses, enlarged spleen and liver, suprapubic tenderness but none was present. She was asked if there is pain and she replied negatively.

Fundal palpation

On fundal palpation, eye contact was maintained as both hands were placed on either side of the fundus. The fingers were held closed together and gentle pressure was applied using palmer surface of the fingers, a soft mass was felt indicating the buttocks.

LATERAL PALPATION

On lateral palpation, hands were placed on each side of the uterus, midway between the symphysis pubis and the fundus, the uterus was stabilized with one hand and examined with the other and palpated the entire area from the abdominal midline to the lateral side and from the symphysis pubis to the fundus in a circular manner. A smooth curve was felt which indicated the back at the right side of the abdomen, the process was then repeated on the left side of the abdomen and an irregular mass and movement were felt which indicated the limbs. This helps to locate where to place the fetoscope to listen to the foetal heart sound. The position was therefore right occipito_anterior.

PELVIC PALPATION

Position was changed to face the feet of client. She was asked to bend the knees slightly and breathe in slowly. Palms were placed on either side of the uterus with palms just below the level of the umbilicus and the fingers directed inwards towards the symphysis pubis with thumbs almost meeting. The head was palpated as hard mass occupying the lower pole. The presentation was cephalic.

Descent; the anterior shoulder was first located using two fingers. The upper border of the symphysis pubis was also located. Five fingers were admitted between the anterior shoulder and the upper boarder of the symphysis pubis indicating descent of 5/5th above the pelvic brim.

On Auscultation; A fetoscope was rubbed in the palms to make it warm and was placed at the area where the back was located to listen to the fetal heartbeat. Whiles listening to the heart beat, one hand was placed at the maternal radial pulse to ensure that it is not the maternal pulse being listened to. As soon as the maternal pulse was heard, client hand was left. The fetal heart rate was checked for one minute noting the volume and rhythm and was recorded as 125 beat per minute.

From the above abdominal examination, lie was longitudinal, Descent was $5/5^{th}$ and presentation was cephalic.

Lower extremities

Client's upper and lower extremities were inspected for equality, edema of the finger and pallor of the palms and no abnormality was detected.

All findings were recorded in client's antenatal book and communicated to her. Client was educated on good nutrition and exercise. She was asked not to lift heavy objects and avoid prolong standing. She was advised to have enough rest and sleep. Client took the fifth dose of sulphadoximepyrimethamine and was given routine drugs but was asked to take the Folic Acid a day after because sulphadoximepyrimethamine counteracts the actions of Folic Acid. The routine drugs given to client were;

Tablet ferrous sulphate 1daily for 2 weeks

Tablet Folic Acid 1 daily for 2 weeks

Tablet multivitamin 1daily for 30 days

Client was asked to report to the clinic if any abnormality was observed. Education was given on birth preparedness and complication readiness. Appointment for home visit was scheduled for on 29^{th} November, 2022. Direction to her house was taken and contacts were exchanged. Permission was sought from the Midwife-in-charge to accompany client to the road-side and it was granted.

2.2 FIRST ANTENATAL HOME VISIT

Madam Amanda was visited on 29^{th} November, 2022 at around 4:00pm. The purpose of the visit was to know the environment in which she lives, check on the health status of client and her family, and inspect the items for Labour and delivery and to educate her on birth preparedness and complication readiness plan.

On arrival, warm welcome and a seat was offered. A quick assessment was made on the environment before sitting down. Water was served and gratitude was expressed. Madam Amanda was asked about her health and that of the family and responded that her family is doing well, as well as herself but she complained of finding it difficult to sleep at night. Client was educated to take a warm bath and warm drink before going to bed to induce sleep and to void before going to bed.

Client lives in a compound house with her child and other neighbors. The house is built with mud and well painted with a brown colour. There is one kitchen in the house which she has access to. Client stated that she goes to throw her rubbish at the back of her house and was educated on need to throw the rubbish at the refuse dump as it can cause cholera, malaria among others and to allow her child who is a female to help her in cleaning the back of the house.

The compound was very neat, all weeds cleared and their bathroom is located inside the house which was also clean but visits her neighbor's house for natures call. Madam Amanda fetches water from a pipe which is located just in front of their house opposite the GODCOS Bank in Kenyasi No 2. It was noticed that, client was not using insecticide treated net and when asked she gave a reason that she does not like it. She was however encouraged to sleep under it to prevent her and the unborn child from getting malaria. She was educated to hang it in the shade early in the morning for three days to prevent the irritation and also unfold it in the morning and refold it in the evening.

The position of the windows was good with a net for proper ventilation. Client was asked to assemble her layette. Client was educated on birth preparedness and complication readiness plan such us finding a blood donor, adding money to the layette, a taxi driver and among others. She was encouraged to take her routine drugs as prescribed. A day was scheduled for

the next home visit which was on 29th November, 2022. Madam Amanda was thanked for the nice reception and permission was sought to leave.

2.3 SECOND ANTENATAL HOME VISIT

The second home visit was made on 30th November, 2022 at 4:30pm. The purpose of the visit was to know how client was coping and her preparation towards her delivery. Madam Amanda was in the house cleaning her kitchen stools with her daughter. On reaching there, she gave a smiling welcome and offered a seat and water to drink. The aim of the visit was to see how client was coping with her term pregnancy and preparation so far. She was asked her preparation towards delivery and opportunity was used to inspect her items. On observation, she had fixed the insecticide treated net and sleeping in it. She was congratulated on sleeping in the insecticide net and asked how she and the family were faring and the response was good but she complained of waist pains. The physiology was explained to her as a result of the fetal head descending into the pelvis and she was reassured that it will resolve after delivery. She was educated on the danger signs of pregnancy which were severe headache, blurred vision, bleeding, and severe vomiting and advised that she should report immediately to the facility if she experiences any of them. She was educated on the true signs of Labour which includes the appearance of show and painful rhythmic regular uterine contractions. Client was told to also report to the facility as soon as she notices these signs. She was thanked for her cooperation and was reminded of her next antenatal care visit and permission was sought to leave and next meeting was schedule on 1st December, 2022.

On 30th November, 2022, Madam Amanda visited the clinic at 9:00 am. She was offered a chair and welcomed. An enquiry was made about her waist pain which she said it has resolved. She was asked about the signs of true Labour to know if she recall the education on the previous visit which she said she was coping and frequent urination at night had reduced, and also, she repeated the education on the rhythmic painful uterine contractions and the

appearance of show and was congratulated. Client was examined from head to toe and no abnormality was detected. Vital signs and other assessment are as follows:

Temperature	36.0 degree Celsius
Pulse	78 beats per minute
Respiration	22 cycles per minute
Blood pressure	140/80 millimeters of mercury
Weight	87.5kilograms
SFH	38centimeters
Descent	$5/5^{th}$
Fetal heart rate	150 beats per minute

Urine was tested for protein and glucose and was negative. She was educated to have enough sleep and to eat foods rich in energy and vitamins. She was accompanied to the road side and bid farewell.

2.5 SUBSEQUENT VISIT TO THE CLINIC

Madam Amanda visited the hospital on 2^{nd} December, 2022 at 10:00am. She was welcomed and given a chair to sit. An enquiry was made about her health and that of the family and she said they are all doing well.

Madam Amanda health was enquired and she complained of constipation and loss of appetite. She was encouraged to take in more fluid and fruits to aid her move her bowels and also have enough rest. Concerning the loss of appetite, she was encouraged to clean her mouth twice daily and to take food in bit but frequently. Client was examined from head to toe and no abnormality was detected. Vital signs and other assessment were checked and recorded as follows;

Temperature	36.4 degree Celsius
Pulse	83 beats per minute
Respiration	18 cycles per minute
Blood pressure	120/70 millimeters of mercury
Weight	88.2kilograms
SFH.	35centimeters
Descent	$5/5^{th}$
Fetal heart rate	150 beats per minute

Urine was tested for protein and glucose and was negative.

Client was educated to take in food rich in vitamins, minerals and proteins. She was also educated to take in enough fruits that contains roughages and was encouraged to take in more fluid. She was educated on perineal hygiene and encouraged to take in her routine drugs. She was accompanied to the road side and was bid farewell. Further home visit was made.

2.6 ANTENATAL CARE PLAN

Nursing care plan seeks to identify problems and assisting to solve the ones involving the client and family.

Problems identified during antenatal care

1. 28/11/2022 client complained of insomnia
2. 28/11/2022-client stated she dispose her refuse at the back of her house.
3. 2/12/2022- client complained of constipation
4. 2/12/2022- client complained of loss of appetite
5. 30/11/2022- client complained of waist pains

Short term objectives

1. Client will be able to sleep at least 8 hours within 24 hours.

2. Client will be able to dispose her refuse at the right place within 24 hours.

3. Client will regain her normal bowel movement at least once daily.

4. Madam Amanda will be able to tolerate meals within 24hours.

5. Client will be relieved of waist pain within 48 hours

Long term objectives

Madam Amanda will go through pregnancy, without any complications to both the mother and baby.

ANTENATAL CARE PLAN

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES	NURSING ORDERS	NURSING INTERVENTIONS	DATE/ TIM	EVALUATION	SIGN
28/11/22 4:00pm	Insomnia related to frequency of micturition	Client will sleep for at least 8 hours within 24 hours as evidenced by 1. Client having 30 minutes rest during the day and 8 hours sleep at night within 24	1. Reassure her that she will have enough sleep. 2. Advice client to keep bedpan at bedside. 3. Educate client on the physiology of frequency of micturition. 4. Encourage client to void before going to bed. 5. Encourage client to take in small amount of fluid prior to bed.	1. Client was reassured that she will have enough sleep. 2. Client was advised to keep bedpan at bedside when sleeping. 3. Client was educated on the physiology on frequency of micturition. 4. Client was encouraged to void before going to bed. 5. Client was encouraged to take in small amount of fluid prior to bed time.	24/11/22 4:00pm	Goal fully achieved as client had 30 minutes rest during the day and 8 hours sleep at night within 24hours.	M.H.N

		hours.					

ANTENATAL CARE PLAN CONTINUED

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

28/11/22 4:00pm	potential risk for parasitic infections (poor disposal of refused dump) related to knowledge deficit on the effect on her heath.	Client risk for parasitic infections will Reduce within 24 hours as evidence by; 1. Client verbalizing that she has taking her refuse to the public refuse dump.	1. Reassure client 2.educate client on parasitic infections 3. Educate client on the need to dispose her refuse at the refuse dump. 4. Encourage client's mother to help her in cleaning the back of the house. 5. Educate client on the effect of poor disposal of refused dump.	1.client was reassured that she will be at low risk of parasitic infection 2. Client was educated on parasitic infections such as malaria. 3. Client was educated and encouraged on the need to dispose her refuse at the refuse dump. 4. Client's mother was encouraged to help her in cleaning the back of the house. 5. Client was educated on the effect of poor disposal of refused dump like malaria, cholera and others.	25/11/22 4:00pm	Goal fully met as client took her refuse to the public refuse dump.	M.H.N

ANTENATAL CARE PLAN CONTINUED

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

2/12/22	Constipation related to activity of progesterone causing decreased peristalsis and relaxation of the smooth muscle of the large bowel during pregnancy	Madam Amanda will empty her bowel at least once daily within 48 hours as evidenced by 1. Client passing stools in normal consistency.	1.Reassure client 2. Explain the physiology of constipation to the client. 3. Encourage client to take in more fluids. 4. Encourage client to take in fresh fruit and vegetables. 5. Advice client on passive exercise.	1. Client was reassured. 2. The Physiology of constipation was explained to client as relaxation of the large intestine by progesterone. 3. Client took in about 1500mls of fluid a day. 4. Client agreed to take in fresh fruit and vegetables after eating like orange, lettuce and among others. 5. Client walked around as a form of passive exercise.	2/12/22	Goal fully met as client passed stool in normal consistency (once daily)	M.H.N

ANTENATAL CARE PLAN CONTINUED

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

2/12/22 4:30pm	Imbalanced Nutrition less than body requirement related to loos of appetite as evidence by client not able to tolerate meals.	Madam Amanda will maintain a normal nutritional balance within 24hours as evidenced by 1. Client verbalizing that she can eat half of her food. 2. The midwife observing client maintaining a normal weight.	1. Reassure client. 2. Encourage client to observe good oral hygiene. 3. Encourage client to take food in bit but frequently. 4. Encourage to take in easily digestible foods. 5. Encourage client to take her routine drugs.	1. Client was reassured. 2. Client was educated to ensure proper oral hygiene such as brushing of teeth twice daily. 3.Client was encouraged to Take food in bit but frequently. 4. Client was encouraged to eat easily digestible foods such as porridges. 5. Client was encouraged to take her routine drugs such as haemetics.	2/12/22 4:30pm	Goal fully met as client verbalized that she ate half of her food served and midwife observed that client maintained a normal weight.	M.H.N

ANTENATAL CARE PLAN CONTINUED

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

30/11/22 4:30pm	Impaired comfort (waist pain) related to the effects of pregnancy hormones on the musculoskeletal system	Madam Amanda Will cope with the waist pains within 48 hours as evidenced by client verbalizing the rationale behind the waist pain.	1. Reassure client to cope with the waist pains. 2. Explain physiology behind waist pain to the client. 3. Encourage client to have enough rest. 4. Encourage client to wear low heel shoes. 5. Teach client the body mechanics. 6. Serve prescribed analgesic such as paracetamol.	1.client was reassured to cope with the waist pains 2. The physiology behind waist pain was explained to client. 3. Client had enough rest. 4. Client agreed to wear low heel shoes. 5. Client should squat when picking items from the floor. 6. Paracetamol 1g was served.	24/12/20 4:30pm	Rationale behind the waist pain was verbalized by client so goal fully met.	M.H.N

CHAPTER THREE

LABOR

3.0 INTRODUCTION

This chapter talks about the management of labor, the immediate care of the new born, examination of the newborn and the care plan drawn for the management of the problems encountered during labor and delivery. The aim of care during labor and delivery is to ensure the most positive outcome which is a healthy mother and baby.

3.1 ADMISSION AND MANAGEMENT OF FIRST STAGE OF LABOR

LABOR

Admission

On Friday 16th December, 2022, Madam Amanda came to the labor ward at Banhart hospital at 5:00am with her sister-in-law. Rapport was established and they were offered seat. Client was taken to the nurse's station for necessary information to be taken while going through her antenatal card. She was asked if she had experienced any danger signs like bleeding from the vagina, leakage of liquor and persistent vomiting and she said no. An enquiry about her last meal was made and she had her last meal at 6:00am which was a day before and it was fufu and light soup and also moved her bowel that evening. She appeared anxious and she was told that she was in competent hands and that the staff will make sure she had safe delivery. Madam Amanda complained of lower abdominal pains, nausea and vomiting which started 4:45am and also the appearance of show, Client was then served with a bottle of malt to urge in pushing in the need comes. Madam Amanda and her sister in-law were reassured that everything was going to be better. Madam Amanda was sent to the examination room and assisted to change her clothing. Permission was sought to examine her and all procedures were explained to her. She was then asked to pass urine and sample was taken for albumin

and sugar. But the results were negative. She was assisted to lie on a couch in a supine position and a quick examination from head to toe revealing no abnormalities.

Her vital signs were recorded and checked as

Temperature……..……37.0

Pulse…….……80bpm

Respiration…… 22cpm

Blood pressure…….120/90mmhg

Client was helped unto the couch, hands were washed and dried with towel. Client was examined from head to toe and no abnormalities were detected. On abdominal examination, the shape was ovoid with normal size and there was linea nigra present. The Symphysiofundal height was 36cm while the gestation was 38weeks +5day, fetal buttock was felt occupying the upper pole of the uterus. Fetal limbs were palpated at the left side and the fetal back was felt at the right side of the mother's abdomen, lie was longitudinal and the presentation was cephalic with the descent of $3/5^{th}$ above the pelvic brim. The fetal heart rate 146bpm.

After the palpation, hands were warmed by rubbing them together in order to check for contractions. There was two (2) in ten (10) minute lasting 23seconds.

Permission was sought from Amanda Asamoah for vaginal examination. A tray already set had two sterile gallipot with one containing cotton, savlon lotion, sterile gloves, a receiver for the used swabs and a sanitary pad. Hands were washed with soap under running water and dried with clean dry towel. A pair of sterile gloves was put on and client was asked to assume a dorsal position with the knee flexed for examination. The vulva was inspected for edema, wart, scars and varicose veins but there was none present. The dominant hand was used to pick the cotton wool and dipped into the lotion; swab was dropped from dominant hand into the non dominant hand and swab per stroke. Labia majora was wiped from anterior to

posterior and the used swab was disposed off into a receiver. Labia minora wiped from anterior to posterior and the used swab was disposed. The vestibule was pated using the non-dominant hand and the dominant hand was used to swab the vestibule from anterior to posterior. The used swab was disposed into the receiver. Client's permission was sought and the right middle and index finger was inserted into the vagina by firmly pressing downwards. This caused relaxation of the vaginal walls and muscles. The condition of the vagina was warm and moist and cervix was soft, thin and well applied to the presenting part. The cervix was effaced and dilatation was 4centimetres as at 5:30am. Ischial spines were blunt and pubic arch was wide, sacral promontory was not reached. Membranes were intact and there was no moulding (0). A clean perineal pad was applied on the vulva and client was asked to lie on her left side to prevent supine hypotension syndrome. Glove was disposed off. All findings and the progress of labor were explained to client. The dilatation board was used to explain the cervical dilatation and progress of labor to her. Client was thanked for cooperating and all information gathered was recorded. Client was made comfortable in bed and encouraged to ambulate.

3.2 PREPARATION FOR BIRTH

A staff midwife was identified who was skilled enough to supervise the delivery. The non-skilled helper was the clients sister in-law and she was made aware that she would be called to help when needed. Emergency plan was reviewed and the phone numbers of the referring hospital was made available in case of any emergency and also a driver was informed that he would be called in case of an emergency. At 7:15am vital signs were checked and recorded as temp-36.5, BP-126/76mmhg, descent-3/5th, pulse- 87bpm and contractions 2:10:23seconds.

The delivery room was made clean and warm, light was switched on, and the emergency portable light was also made available and functioning in an event of light off. The delivery pack and oxytocin and other emergency drugs like magnesium sulphate were made available.

Resuscitation area was cleaned and made ready by switching on the light to keep the place warm if needed, all equipment such as ventilation bag and mask, stethoscope needed to help baby breath were assembled and tested for its function. The client was informed that, she would be assisted to wash her abdomen, chest, and hands for skin to skin contact when the second stage is due.

3.3 MANAGEMENT OF FIRST STAGE OF LABOR

The fetal heart rate, maternal pulse, durations of contractions in 10minutes was done every 30minutes, temperature, blood pressure, respiration as well as vaginal examination was done 4hourly and the results was plotted on the partograph. She complained of being anxious. She was reassured she is in the hands of competent midwives. Madam Amanda was reassured that labor was progressing well and was encouraged to pass urine frequently to prevent full bladder, since this could impede descent of the fetus and contractions of the uterus.

At 7:45am madam Amanda was due for the next assessment which was explained to client and permission was granted. Madam Amanda was asked to lie on her left lateral to prevent supine hypotension syndrome she complained of loss of appetite and was reassured, sacral massage was performed for her. She was also encouraged to eat light diet bit by bit. Vagina examination done and cervix was 9cm dilated and descent was $0/5^{th}$, spontaneous rupture of membranes with clear liquor and moulding of one (+).

She was asked to empty her bladder which could impede progress of labor. Client was reassured of being in the hands of competent midwifery care.

7. A trolley was then set which contained the following:

Top shelf containing sterile items are as follows;

- Scissors
- Four towels
- Two artery forceps

- Drape
- Cord scissors
- 2 gallipots with cotton swabs and gauze
- Receiver for placenta
- Episiotomy scissors

Bottom shelf

- Drum containing gauze and cotton wool
- Chittle forceps
- Jug for measuring the amount of blood loss
- Urethral catheter and drainage bag
- Examination gloves
- Identification band
- Episiotomy set
- Perineal pad
- Mackintosh
- Cord clamp in his pack
- Oxytocin drug, vitamin k
- Examination gloves
- Antiseptic lotion
- Fetoscope
- Sterile gloves in his pack

Other instruments include sutures, lidocaine, face mask, google, boots, plastic apron, baby's cot with cot sheets and baby's dress, bed pan, light source was directed to the bed immediately.

At 10.00am madam Amanda complained of severe bearing down sensations with the uterine contractions becoming more expulsive. Another vaginal examination was done and cervical dilatation was 10cm, descent $0/5^{th}$ moulding of two ++, anus gapping with the perineum bulging.

3.4 MANAGEMENT OF THE SECOND STAGE OF LABOUR

Madam Amanda was transferred to the second stage room and was positioned on the delivery bed at 10:05am. She was told to be cooperative during delivery. Madam Amanda was asked to empty her bladder and then was assisted to lie in the dorsal position with knees flexed and wide apart. She was reassured and every procedure to be done was explained to her. Protective clothing such as mackintosh apron, rubber boots and googles were worn. Hands were washed with soap under running water, dried with sterile towel and sterile gloves were worn on both hands. She was reminded that her baby would be delivered unto her abdomen to provide warmth and initiate bonding. The delivery trolley and instrument were checked. A clean perineal pad was applied to the anus to keep the delivery area clean. Madam Amanda was encouraged to push with each contractions and rest in between contractions.

As Labour progressed, the head advanced gradually and flexion was aided by gently pressing the occiput downwards in other to allow the smallest diameter of the skull to distend the vulva and the perineum. Descent of the fetal head continued till crowning of the head occurred, madam Amanda was asked to stop pushing and pant at this stage to prevent rapid expulsion of the head which could lead to perineal tears and intracranial injury. The sinciput, face and chin swept the perineum and the head was slowly delivered by extension by holding the two parietal bones. The eyes were cleaned with separate sterile swabs from the inners canthus of the eye outwards. The mouth and nose were cleaned with gauze swabs. Baby's neck was checked for cord around it but there was none felt.

Restitution took place and few seconds later there was external rotation of the head which indicated that there has been internal rotation of the shoulders. This brought the shoulders into anterior-posterior diameter of the pelvic outlet. She was asked to push with the next contractions. Both palms were placed on either side of the baby's ear and gently pressed the head downwards to deliver the anterior shoulder which escaped under the symphysis pubis. The posterior shoulder swept the perineum and was delivered. The rest of the body was delivered by lateral flexion unto the mother's abdomen at 10:40am.

An alive female baby was delivered and cried soon after delivery. The baby was quickly cleaned from head to toe with a clean cot sheet and covered with another clean cot sheet while on her mother's abdomen. The cord clamp was placed two finger breadths away from baby`s umbilicus and the second clamp three finger breadths away from the first clamp the cord was then cut in between the two clamps and baby separated from the mother. Client's abdomen was gently palpated to rule out any undiagnosed twin. The midwife in-charge gave 10 units of injection oxytocin intramuscularly on the outer mid-thigh of client within one minute after palpating the uterus.

APGAR score for the first minute 8/10 and 9/10. The baby was showed to her mother to identify the sex. Client was congratulated for her efforts. The baby was moved in between her breast for an hour to improve bonding and initiate breastfeeding. The Apgar score assessment was as follows:

INDICATOR	**FIRST MINUTE**	**FIFTH MINUTE**
Appearance	2	2
Pulse	2	2
Grimace	1	1
Activity	1	2

Respiration	2	2
Total	8/10	9/10

3.5 IMMEDIATE CARE OF THE BABY

The immediate care of the baby started as soon as the head of the baby was born. Different sterile gauze was used to clean the baby's eyes from the inner canthus to the outer canthus to prevent infection. Baby was delivered unto mother's abdomen. Baby was dried thoroughly to keep the baby warm and stimulate breathing. The cord was clamped 2 finger breadths away from the baby's abdomen and the 3 finger breadths from the first clamp. The cord was then cut between the two clamps. The baby was shown to mother to confirm the sex of the baby. Identification band was prepared with the mothers name around the baby's wrist. Baby was then placed on the mother's abdomen to initiate skin to skin. The wet sheet was removed and mother baby were covered with a warm sheet and the head covered with a cap to prevent hypothermia. The baby was put to breast to ensure the natural release of oxytocin to help with the contraction of the uterus, initiate lactation and promote bonding between mother and baby. The baby was then nursed on the mother's chest to continue skin to skin for an hour with head turned to one side, in order to facilitate drainage of secretions to prevent aspirations.

3.6 MANAGEMENT OF THE THIRD STAGE OF LABOUR

The procedure was explained to Madam Amanda. Abdomen was palpated to exclude undiagnosed twin and there was none. 10 units of oxytocin was injected intramuscularly in the right thigh by the midwife in-charge. The cut end of the cord was reclamped closer to the client's vulva with a forceps, a sterile receiver was placed close to the perineum to collect the

placenta, membranes as well as blood loss. The non dominant hand was placed on the fundus and as soon as there was contraction, one hand was placed above client's pubic bone and the other hand held the clamped cord. The cord was reclamped and waited for strong uterine contractions. The non dominant hand was turned with the palm facing the client abdomen and counter pressure was applied to avoid inversion of the uterus and with controlled cord traction, when the uterus contracted, the cord was downwardly and steadily pulled to deliver the placenta. This procedure was repeated until placenta became visible at the vulva. The dominant and non dominant hands were used to receive the placenta and gently twisted till membranes were expelled out at 10:50am A quick examination was done and placenta placed in a receiver for examination later at the sluice room. The uterus was massaged until it was well contracted and client was taught how to massage her uterus to expel blood clots. Expelled blood clots were added to the blood loss. Gauze was wrapped on two fingers of both hands to examine the vagina for laceration or tears. There were no tears and lacerations on examination. She was cleaned and sterile pad was applied. She was made comfortable in bed with baby still on the abdomen and covered with dry cloth. Blood loss was extimated as 120mls.

3.7 EXAMINATION OF THE PLACENTA AND MEMBRANES

Under a good source of light, a thorough inspection of the placenta and membranes is done in order to ensure that no part of it being retained during delivery. The placenta was dipped inside a 0.5% chlorine solution. The cord was of normal size and the cut edge of the umbilical cord had two arteries and one vein surrounded by Wharton's jelly. The cord insertion was central. The placenta was held by the cord with the membranes hanging. The membranes were checked for completeness by spreading out hand inside the membranes and it was intact. The placenta was put on a flat surface and was examined, the amnion was peeled from the chorion up to the umbilical cord to permit full visualization of the chorion.

The fetal surface was shinny and bluish grey. The branches of the cord vessels were seen radiating on its surface. The placenta was placed in the palm with the maternal surface facing upward. The lobes were intact with no infarcts or extra lobes nor edematous.

It was then decontaminated and disposed appropriately. The working surface was wiped off with 0.5% chlorine solution. All findings were recorded on the labor ward sheet, delivery book and summary of delivery in the antenatal booklet. The partogragh was then completed.

3.8 MANAGEMENT OF FOURTH STAGE OF LABOUR

Client and her baby were transferred to the lying –in ward after putting the baby skin to skin for an hour. Monitoring of Madam Amanda and the baby continued strictly for the first 6 hours after expulsion of the placenta and membranes and arresting of haemorrhage. Vital signs were checked every 15minutes for 2hours, 30minutes for 1hour and one hourly for the remaining three hours and recorded behind the partograph.

Post-delivery vital signs were checked and recorded as

MOTHER

Temperature……...36.5

Pulse……..80bpm

Respiration……18cpm

Blood pressure……...110/85mmHg

She was encouraged to micturate frequently and change perineal pad when soaked. Lochia was red (rubra) in color with small flow, fundal height was 17cm. she was educated on how to massage her uterus to aid in contraction. Mother was advised to show pad for color of lochia, amount of blood loss and odour before discarding it. Client was seen to be fatigued and was encouraged to have some rest. Her husband was allowed into the lying-in to see the baby and ask client what she wanted to eat. He was very happy on seeing the baby. Client and

support person were educated on the need for rest and sleep and also education and demonstration on proper positioning when breastfeeding was done. Mother and baby were in good condition. She was served with rice and soup. Mother was encouraged to breastfeed the baby on demand and also exclusively since the source of nutrient for the baby is the breastmilk.

BABY

PREVENTION OF DISEASE IN THE NEWBORN

After the birth of the head the eyes were cleaned from the inner canthus to the outer canthus. Care was given to the eye to prevent eye infection were chloramphenicol eye drop was instilled on each of the eye. Vitamin K injection was given to prevent bleeding. Cord was also dressed with chlorhexidine to prevent any infection and to keep the cord dry at all times. Infection prevention techniques were also ensured to prevent any cross infection. Mother was also educated on the need to use only chlorhexidine given to her to dress the cord and to avoid application of herbs, other creams and cow dungs on the cord to prevent infection of the cord.

3.9 EXAMINATION OF THE NEWBORN

The procedure to be carried out on the baby was explained to the mother. Hands were washed, dried with a clean towel and an examination glove was worn. The baby was put on a flat surface for examination in the presence of the mother. Baby was then exposed systematically as it was examined from head to toe. Its color was pink on observation.

Head and neck:

The head was examined for shape and size, widened sutures depressed fontanelles, edematous swelling, caput succedaneum, microcephaly, anencephaly and hydrocephaly but none was detected. The middle and the index finger was used to run through the head to feel for widened sutures and was absent. A tape measure was used to encircle its head starting from the occipital protuberance to the supra orbital ridges to measure the head circumference and it was 33cm. The ears were examined for size, shape, patency, softness of the cartilage, the eyes were in alignment with the ears. The eyes were examined for the presence of eye ball and redness of the eyes, jaundice on the sclera and any abnormal discharges. The nose was examined for shape, discharges, size, patency and deviated septum. The mouth was examined for false teeth, tongue tie, cleft lip and palate by using the little finger to feel for palate for any sub mucous cleft and no abnormalities was detected. Rooting, suckling and swallowing reflexes were present, the neck for congenital goiter, but no abnormality was detected.

Chest and abdomen

On the chest, respiratory movement was normal, nipples were in alignment and breast had no mass. The abdomen was examined for shape and size, enlarge spleen and liver, bleeding from the umbilical cord and abnormalities such as gastrochisis and among others were absent. All findings were normal.

Upper extremities

The upper extremities were equal with no extra digits. Grasping and Moro reflexes were present. There were palmer creases and no webbed fingers.

Lower extremities

The lower extremities were inspected for equality, clubbed feet, extra digits, talipes.congenital hip dislocation was also checked and it was absent.

Back

The baby was turned on her side, the thumb was used to run through the back to exclude abnormalities like, missing vertebrae and inspected for spina bifida, meningocele but none was found. The skin of the back was also examined for its color and any hairy patches. No hairy patches were seen.

Genitalia and anus

The labia majora was fully developed and larger in size; urethra and anus were patent as its passed urine and meconium respectively.

Gloves were removed and discarded aseptically before washing and drying hands with a clean towel. The length of the baby, weight and head circumference was checked and gloves were removed and disposed off according to infection prevention guidelines. Hands were washed and dried, weight and height checked and recorded as 3.0kg and 48centimetres respectively and head circumference was 33centimetres when measured. Vital signs were checked and findings were communicated to mother as follows;

Apex heart beat	140beat per minute
Temperature	36.5 degree Celsius
Respiration	33cycles per minute

The baby was classified as normal after the examination and routine plan.

3.10 SUMMARY OF LABOUR AND DELIVERY

CONDITIONS OF BABY AT BIRTH

After birth, baby was wrapped with warm cot sheet and was sent to mother to start breastfeeding and her general condition was satisfactory.

The following findings were obtained and recorded as;

Temperature	36.2 degrees Celsius
Apex heart rate	140beat per minute
Respiration	34cycle per minute

Baby's weight	3.0kilograms
Head circumference	33centimetres
Length	48centimetres
General condition of the baby	satisfactory
Meconium	passed
Urine	passed
Sex	female

SUMMARY OF LABOUR

Date and time of delivery	16th December 2022, at 10:40pm
Type of delivery	Spontaneous vaginal delivery
Time of expulsion of placenta and membranes	10:50pm
Drug given	injection oxytocin (10unit)

DURATION OF LABOUR

1st stage 5hours, 40minutes

2nd stage 20minutes

3rd stage 10minute

Total time 6hours, 10minutes

CONDITION OF MOTHER AT BIRTH

General condition of the mother was stable as evidence by the following findings.

Condition of mother	stable
Perineum	intact
Fundal height	16cm
Temperature	36.4 degree Celsius
Pulse	88cycles per minute

Respiration 22cycles per minute

Blood pressure 110/80mmHg

CONDITION OF THE PLACENTA

Lobes intact

Membranes intact

Fetal surface greyish blue in color

Maternal surface dark red in color

State of placenta complete and healthy

Blood loss 120mls

Cord vessels two arteries and one vein

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PROBLEMS IDENTIFIED DURING LABOUR

On 16/12/22

Client complained of lower abdominal pain

Client complained of being anxious

Client complained of frequency of micturition

SHORT TERM OBJECTIVES

1. Client will be able to cope with her lower abdominal pain within 8hours
2. Client anxiety will resolve within 7hours
3. Client will be able to cope with frequency of micturition throughout labor
4. Client will change her perineal pad within 7hours
5. Client will be able to tolerate nausea and vomiting within 3hours.

LONG TERM OBJECTIVES

Madam Amanda will go through Labour, without any complications to both the mother and baby.

LABOUR CARE PLAN

DATE/ TIME	NURSING DIAGNOSIS	OBJECTIVES/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTIONS	DATE/ TIME	EVALUATION	SIGN
16/12/22 8:00am	Impaired comfort (Lower abdominal pains) related to uterine contractions.	Madam Amanda will cope with the lower abdominal pains within 8 hours as evidenced by client 1.client coping with the lower abdominal pains 2. The midwife observing that client has a good facial expression.	1. Assure client to cope with the lower abdominal pains. 2. Explain the process of Labour to client. 3. Encourage client to practice the deep breathing exercise. 4. Encourage client to empty her bladder frequently. 5. Engage client in a conversation as a form of divisional therapy. 6.Encourage ambulation	1. Client was reassured to cope with the lower abdominal pains. 2. The process of first and second stage of Labour was explained to the client. 3. Client was encouraged to practise the deep breathing exercise. 4.client was encouraged to empty her bladder as it impedes the progress of Labour 5. Client was assisted to watch television during leisure time. 6. Client was encouraged to walk around her bed.	16/12/22 8:00am	Goal fully met as client verbalized the rationale behind the pain. The midwife reported that client had a good Facial expression.	M.H.N

LABOUR CARE PLAN

DATE/ TIME	NURSING DIAGNOSIS	OUTCOME CRITERIA/ OBJECTIVE	NURSING ORDERS	NURSING INTERVENTIONS	DATE/ TIME	EVALUATION	SIGN
16/12/22 10:00am	Altered fluid volume related to nausea and vomiting.	Client will be relieved of nausea and vomiting within 3 hours as client 1. Verbalizing resolution of excessive vomiting and nausea. 2. Midwife observing that client feels comfortable.	1. Assure client. 2. Encourage client to take in more fluids. 3. Educate client and her partner on the coping mechanism for the nausea and vomiting. 4. Remove nauseated items from client. 5. Explain the importance of the hydration to the client.	1. Client was reassured. 2. Client was encouraged to take in more liberal fluids like malt and water. 3. Client and partner were educated on the need for the wife to wear loose fitting clothing when eating so that the stomach does not feel pinched. 4. All nauseated items were removed from client's side. 5. The importance of the hydration was explained to the client such as replacement of electrolyte.	16/12/22 10:00am	Goal fully met as Madam Amanda Verbalized that the nausea and vomiting had resolved and midwife observed that client feels comfortable.	M H.N

LABOUR CARE PLAN CONT'D.

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES	NURSING ORDERS	NURSING INTERVENTIONS	DATE/ T IME	EVALUATION	SIGN
16/12/22	Risk for infection (Infrequent changing of perineal pad) related to inadequate Knowledge on the effect of infrequent changing of pad.	Client will change her perineal pad 3 to 4 times within 7 hours as evidenced by 1. Client stating the number of times she has changed her perineal pad. Midwife observing that client has changed her perineal pad frequently.	1. Assure client. 2. Educate client on hand washing the hand before and after changing the perineal pad. 3. Educate client on the effect of infrequent changing of pad. 4. Educate client on signs and symptoms of perineal infection. 5. Educate client on the need to put on the perineal pad.	1. Client was reassured. 2. Client was educated on proper hand washing after putting on her perineal pad. 3. Client was educated on the effect of infrequent changing of pad such as foul vaginal smell and among others. 4. Client was educated on the signs and symptoms on perineal infection such as fever, foul vaginal discharges and many more. 5. Client was educated on the need to put on her perineal pad.	**16/12/22**	Goal fully met as Client stated she had changed her perineal pad frequently (3 to 4) within 7 hours and midwife observed that client had changed her perineal pad at frequent interval.	**M.H.N**

LABOUR CARE PLAN CONT'D.

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES	NURSING ORDERS	NURSING INTERVENTIONS	DATE/ TIME	EVALUATION	SIGN
16/12/22	Frequency of micturition related to pressure of the presenting part on the bladder.	Client will cope with frequent of micturition till the end of Labour as evidenced by client verbalizing that she is coping with frequency of micturition.	**1.** Assure clients condition is temporal and it will resolve after delivery. 2. Explain the physiology of frequency of micturition to client. 3. Encourage client to urinate whenever she has the urge. 4. Encourage client to ambulate to enhance descent of presenting part. 5. Educate client on the importance of micturition.	**1.** Client was reassured that condition was temporal and it will resolve after delivery. 2. The physiology of frequency of micturition was explained to client as pregnancy competing with the bladder. 3. Client was encouraged to urinate whenever she has the urge to enhance descent of the fetal head. 4. Client was educated to ambulate to aid descent of the presenting part. 5. Client was educated on the importance of frequency of micturition.		Goal fully met as evidenced by client verbalizing it in good facial expression.	**M.H.N**

LABOUR CARE PLAN CONT'D

DATE/ TIME	NURSING DIAGNOSIS	OBJECTIVES/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN

16/12/22 1:00pm	Anxiety related to unknown outcome of Labour	client anxiety will resolve within 7 hours as evidenced by 1. Client cooperating with the progress of Labour. 2.. Midwife observing that client has relax in bed	1. Assure client that her anxiety will resolve. 2. Explain every procedure to be carried to her to allay fear. 3. Educate her on possible outcome of Labour. 4. Encourage the deep breathing exercise. 5. Introduce client to other staff who will attend to her.	1. Client was reassured that her anxiety will resolve. 2. Every procedure to be carried out was explained to client. 3. Client was educated on possible outcome of Labour. 4. Client was encouraged to do the deep breathing exercise. 5. Client was introduced to other staff.	2/01/21 5:30pm	Goal fully met as client's anxiety was resolved as Client cooperated and midwife observed.	M.H.N

CHAPTER FOUR

PUERPERIUM

4.0 INTRODUCTION

This chapter describes the management of both mother and baby from day of delivery up to six weeks postpartum and care plan drawn for the various problems identified.

4.1 DAY OF DELIVERY

On 16th December, 2022 Madam Amanda was cleaned and transferred to the lying-in ward at 11:50am after skin to skin. She was served with porridge and bread. She was educated on the need to empty her bladder to prevent post-partum hemorrhage. Symphysiofundal height was 17centimeters. Her first vital signs were checked and recorded as follows:

VITAL SIGNS

Temperature	36.4 degree Celsius
Pulse	78 beat per minute
Respiration	22 cycles per minute
Blood pressure	110/70 millimeters of mercury

Lochia was bright red (rubra) and flow was small. Perineum was intact and mother was educated to massage her uterus and report any bleeding per vaginum. She was educated to feed baby on demand 1-2 hourly or 8 to 12 times daily to ensure adequate feed and to serve as a method of family planning and also increase bonding. She was told to change perineal pad frequently and wash hands before breastfeeding the baby and also after changing pad. Head to toe examination was done and no abnormalities were detected. She was nicely asked to take her bath.

4.2 SUBSEQUENT CARE OF THE BABY

This is a care given to the baby after delivery. This consists of bathing the baby, dressing of the cord and also monitoring of vital signs.

BABY BATH

REQUIREMENTS

Top shelf

2 gallipots one with cotton and the other one with sterile water.

Cord dressing tray

Bottom Shelf

Soap

Sponge

Cream/ powder

Basin

Towels: 1 big towel and 3 small ones

Cot sheets 2

Gloves

A clean baby dress, cap and socks (if available)

Mackintosh

2 jugs containing hot and cold water each

Two receptacles for used water and dirty linen

A receiver for used swab

Chlorhexidine for cord dressing

Baby was bathed six hours after delivery, procedure was explained to mother. All items to be used for the procedure were assembled, as above.

BABY BATH

The procedure to be carried out was explained to the mother and it was done in her presence. A plastic apron was put on and hands were washed with soap and water and dried with clean towel. Examination gloves were worn and the baby was put on a safe flat surface and was undressed. Baby was then wrapped with a cot sheet and examined thoroughly. The head was exposed for it to be bathed. The eyes were cleaned (wiped) with clean cotton wool swabs soaked in clean water and the face cleaned with damp face towel and dried. The nape of the baby's neck was supported with one hand. The head was supported and the baby's ears plugged with two fingers. The head was then washed with soapy sponge. Baby was then lifted off flat surface, still supporting at the nape of the neck and the body resting in the elbow and brought, to the edge of the basin and soap rinsed off baby's hair and dried. Baby was then put on protected flat surface and exposed. The arms and front of trunk were washed paying attention to the skin folds. Then baby was turned with one arm supporting the chest and with the other hand holding the distal arm of the baby. The back was washed down to the feet, paying attention to the skin folds. Baby was supported firmly and immersed in a bath of warm water which temperature was tested with the elbow and confirmed by the mother and rinsed thoroughly. She was then placed on the flat surface covered with a bath towel. A small towel was used to dry baby, paying attention to the skin folds. Baby oil as well as powder was applied on the baby. A diaper was put on and the baby dressed and wrapped with cleaned cot sheet.

CORD DRESSING

A tray was set aside containing (sterilized gallipot, cotton wool swab and chlorhexidine). Procedure for dressing the cord was explained to the mother and procedure performed still in her presence. Hands were washed with soap and water and dried with a clean towel. Sterile gloves worn and cord exposed. The cord would be cleaned with chlorhexidine. The cord was

inspected for bleeding, pulsation and the tip of the cord held with a swab. The skin around the base of the cord was cleaned 5cm away from the base with chlorhexidine. Hands were immersed in 0.5% chlorine solution, gloves removed and disposed. Hands were washed and dried with towel. Baby was then dressed and given to the mother to breastfeed. Client was advised to use only the chlorhexidine given to her to dress the cord and always keep the cord exposed after dressing, she was advised how to apply diaper below the umbilicus.

Mother was encouraged to maintain baby's temperature to prevent the baby becoming too cold or too hot by dressing baby with clothing before wrapping her. Mother was encouraged to breastfeed baby exclusively and on demand or 8 to 12 times a day. She was also educated on breastfeeding problems and how she would manage the problem like breast engorgement, sore nipple and cracked nipple and to report if problem persist. Mother was advised to use only prescribed drug for cord care. Client was advised to wash hands before and after handling the baby. All findings were communicated to the mother and recorded afterwards.

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

Temperature	36.5 degree Celsius
Apex heart rate	142 beat per minute
Respiration	43 cycles per minute
Weight	3.0kilogram

4.3 FIRST DAY POST DELIVERY AND DISCHARGE

The first day post-delivery was on 16th December, 2022. She woke up looking strong and healthy at the lying-in ward. She was assisted to take her bath. She was served with porridge and bread by her partner. Head to toe examination was done and no abnormalities were detected on both mother and baby. She was taught how to dress the cord with chlorhexidine. She complained of after pain and was encourage to empty her bladder whenever she has the urge.

Symphysio fundal height was 17 centimeters. First day post-partum check done on client and recorded as follows:

	MORNING VITALS		EVENING VITALS
Temperature	36.7 degrees Celsius	Temperature	36.5
Pulse	80 beat per minute	pulse	79bpm
Respiration	19 cycles per minute	Respiration	22cpm
Blood pressure	120/60 millimeters of mercury	Blood pressure	110/70

Lochia was bright red with small flow and also not offensive. The baby passed meconium and urine. No abnormalities detected on head to toe examination. Weight was 3.0kilograms.

Baby's vital signs and assessment were;

	MORNING VITALS		EVENING
Temperature	36.2 degree Celsius	Temperature	36.4
Apex heart beat	136 beat per minute	Apex heart rate	130bpm
Respiration	44 cycles per minutes	respiration	46cpm

The baby was reexamined head to toe and confirmed by the midwife in charge to exclude any abnormality of the baby before discharge. Baby was dressed nicely in a warm and clean baby sheet and handed over to her mother for breastfeeding. A demonstration on how to position the baby during breastfeeding was done in the presence of the sister-in-law and was educated to blow air after feeding. Baby was intradermally injected with Bacilli Calmette Guerin (BCG) and oral polio '0' vaccine by Community Health Nurses. She was educated on the effects of BCG and not to apply anything at the site of injection. She was educated to report on danger signs of the baby such as fever, difficulty in breastfeeding and breathing problems. She was assisted to pack her belongings because she would be discharged home. Education

was given to her on how to take the prescribed medications. She was served the following drugs per hospitals protocol:

Caps Iron (111) polymaltose 100mg once daily x 30days

Tablet folic acid 5mg once daily x 30days

Tablet metronidazole 400mg three times daily x 7 days

Capsule amoxicillin 500milligram three times daily x 7days

Tablet paracetamol 1 gram three times daily x 5days

She was told she would be visited at home to provide care for her and baby. She was also reminded to come for one week postnatal care on 23rd December, 2022. She was reminded to do exclusive breastfeeding, recognizing and management of common breastfeeding problems like breasts engorgement. She was educated on proper hand washing (washing hand with soap under running water) before and after each feed which is a way of helping to prevent infections. The mother was educated to complete immunization schedule. She was taught to eat well balanced meal, fruits to enhance in the prevention of constipation and also promote growth and development in the baby. She was told to change her perineal pad every 4 hours or when soiled, proper disposal of it and hand washing after removing the pad. Client had registered with the National Health Insured scheme so her bills were taken care off. Her partner was advised to give support to the mother in the care of the baby and the other child. All documents were signed and recorded. At 3:00 pm, client was discharged and was reminded that she would be visited at home the next seven days continuously to ascertain the progress of the mother, baby and the entire family. She thanked all the staff and also bid farewell to the other clients at the ward. She was accompanied to the junction for them to board a taxi home.

4.4 FIRST POST NATAL HOME VISIT

On 17th December 2022, at 7:20am and 5:30pm, Madam Amanda was visited in her house. She was asked how she and her baby were doing after exchanging greetings, she said her condition was getting better and her previous complaints had improved and she also said that the baby was feeding and sleeping well. The family was much pleased to be visited. Explanation was given to Madam Amanda that she and the baby were going to be examined from head to toe to detect any abnormality for early treatment. The client's conjunctiva was examined and there was no pallor, the breasts were firm, soft and were lactating well, the uterus was well contracted and the symphysio fundal height measured 16cm. The perineum was clean when inspected the lochia was red with moderate flow and without odour.

Baby was examined from head to toe and no abnormality was found. She was not jaundiced and pale. Baby's weight was checked and recorded as 3.0 kilograms. Baby's vital signs were taken and recorded as follows;

OBSERVATION ON BABY (17th December, 2022)

OBSERVATION	**MORNING**	**EVENING**
Temperature	36.2	36.6
Apex heart beat	132 bpm	136 bpm
Respiration	44 cpm	43cpm
Skin Colour	Pink	Pink
Cord bleeding	No	No
Cord	Drying	Drying
Suckling	Yes	Yes
Weight	3.0 kg	3.0kg
Stool Colour	Yellowish brown	Yellowish brown

Madam Amanda was encouraged to breastfeed the baby on demand and at least 8 to 12 times a day. Permission was sought to top and tail the baby and it was granted. Baby was toped and tailed. As the baby was being toped and tailed, the procedure was also demonstrated to Madam Amanda and her sister-in-law paying attention to the skin folds. The cord was also dressed with chlorhexidine; it was clean and quite dry. The baby had passed meconium and urine when the diaper was removed and it was inspected for meconium and urine. She complained of after pains and it was explained to her that the pain was due to the involution of the uterus and was asked to continue taking paracetamol given to her as prescribed. A promise was made to visit them again the following day and client said good bye and the family were bide fare well.

Assessment made was:

OBSERVATION ON MOTHER (17th December, 2022)

OBSERVATION	**MORNING**	**EVENING**
Temperature	36.0	36.4
Pulse	78 bpm	74 bpm
Respiration	20 cpm	20 cpm
Blood pressure	110/70mmHg	110/60mmHg
Lochia	Rubra	Rubra
Fundal height	16cm	
Condition of the uterus	Contracted	Contracted
Breast	Lactating	Lactating

Baby was given to mother to be breastfeed. All findings were communicated to her and recorded.

She was told of the visit the next day. Permission was sought to leave.

4.5 SECOND POSTNATAL HOME VISIT

On the 18th December 2022, the second visit was made to client's house at 7:00am and 4:00pm. Madam Amanda said her pain has resolved. The baby was also doing well. Permission was sought to inspect her perineal pad and the lochia was found to flow scanty, the colour was red (rubra) and not offensive. The head to toe examination was also done and everything was normal. The symphysio fundal height was 15 centimeters.

The baby was toped and tailed paying attention to the skin folds and general examination was carried out and no abnormality was present. The cord was neatly dressed with no abnormality detected and was getting dried. The baby passed stools and urine everyday according to Madam Amanda, baby weight was 2.9kilograms. She complained of inadequate sleep and backache. She was educated to feed the baby on demand and adequately prior to bed time. Concerning the backache, a demonstration on proper position of the baby during breastfeeding was done in the presence of the mother.

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

OBSERVATION ON MOTHER (18th December, 2022)

OBSERVATION	**MORNING**	**EVENING**
Temperature	36.1^0C	36.4^0C
Pulse	78 bpm	74 bpm
Respiration	22 cpm	20 cpm
Blood pressure	110/60mmHg	110/60mmHg
Lochia	Rubra	Rubra
Fundal height	15cm	
Condition of the uterus	Contracted	Contracted

Breast	Lactating	Lactating

OBSERVATION ON BABY (18th December 2022)

OBSERVATION	**MORNING**	**EVENING**
Temperature	36.0^0C	36.2^0C
Apex heart beat	136 bpm	134 bpm
Respiration	48 cpm	46 cpm
Skin Colour	Pink	Pink
Cord bleeding	No	No
Cord	Clean and dry	
Suckling	Yes	Yes
Weight	2.9kg	
Stool Colour	Yellowish brown	Yellowish brown

4.6 THIRD POSTNATAL HOME VISIT

On the 19th December, 2022, the third home visit was made to Madam Amanda's house at 7:00am and 4:30 pm. Greetings were exchanged. Mother and baby were doing well. Permission was sought to inspect client's perineal pad and it was pink, scanty flow without

any offensive smell. Her breast was lactating well. Symphysio fundal height was 14 centimeters when measured. Her vital signs were checked and recorded as follows;

OBSERVATION ON BABY

	3rd day (19th December, 2022)	
Observations	**MORNING**	**EVENING**
Temperature	36.3^0C	36.6^0C
Apex heart beat	134 bpm	132 bpm
Respiration	44 cpm	48 cpm
Skin Colour	Pink	Pink
Cord bleeding	No	No
Cord	Clean and dry	Clean and dry
Suckling	Yes	Yes
Weight	2.8kg	2.8kg
Stool Colour	Dark Yellowish	Dark Yellowish

Baby was toped and tailed paying attention to the skin folds and general examination was carried out and no abnormality was present. The cord was dressed aseptically with no abnormality detected. The baby also passed stools and urine. Weight was 2.8 kilogram.

Madam Amanda complained of inability to pass stool, she was educated to take in a lot of fluids and fruits. Permission was sought to leave and Madam Amanda said she was very grateful and appreciated the care that was given to them.

THIRD DAY POSTPARTUM

OBSERVATION ON MOTHER

	3rd day (19th December,2022	
Observation	**MORNING**	**EVENING**
Temperature	36.3^{0}C	36.2 ^{0}C
Pulse	76 bpm	78 bpm
Respiration	22 cpm	20 cpm
Blood pressure	110/60mmHg	110/60mHg
Lochia	Rubra	Rubra
Fundal height	14cm	
Condition of the uterus	Contracted	Contracted
Breast	Lactating but engorged	Lactating but engorged

4.7 FOURTH POSTNATAL HOME VISITS

The fourth home visit was made to Madam Amanda's house at 7:00am on 20st December, 2022. The health status of mother was inquired and she said the pain in her breasts had subsided except the fullness. Lochia was pink (serosa) with scanty flow without odour on inspection. Head to toe examination was done and everything was normal. Symphysio fundal height was measured and it was 13 centimeters.

Baby was top and tailed paying attention to the skin folds and the general examination was carried out, no abnormality was found. The cord was aseptically dressed and no abnormality was detected and baby was doing well. The baby had already passed stools and urine. Her weight was 2.8kilograms when checked. Baby's stool was bright or mustard yellow. She complained of heaviness in the breast which was as a result of fullness. She was educated to continue breastfeeding the baby on demand and frequently, and to apply warm compress on them to reduce the pain and was asked to breastfeed baby on demand and to make sure one breast is emptied before the other and to wear well-fitting brassier.

She was encouraged to breastfeed the baby on demand and to ensure adequate warmth to baby. During the visit, client under wear was washed and dried in her room and was advised to dry them under the sun to prevent any infection since they thrive in moist area and was also educated to take nutritious meals and to take in fruits in addition since she was prone to getting infections.

OBSERVATION ON MOTHER (20st December, 2022)

	MORNING
Temperature	36.2^0C
Pulse	78 bpm
Respiration	22cpm

Blood pressure	110/70mmHg

	MORNING
Lochia	Rubra
Fundal height	13 cm
Condition of Uterus	Contracted
Breast	Lactating but slightly engorged

OBSERVATION ON BABY (20st December 2022)

	MORNING
Temperature	36.1^0C
Apex heart beat	136 bpm
Respiration	48cpm
Skin Colour	Pink
Cord bleeding	No
Condition of cord	Shrinking
Suckling	Yes
Weight	2.8kg
Stool Colour	Dark yellow

4.8 FIFTH POSTNATAL HOME VISIT

The fifth postnatal home visit was on 21st December, 2022 at 7:20am. Greetings were exchanged with client and her family after which a seat was offered in client's room. Mother and baby were both in a healthy condition and when it was inquired. She was reassured and was advised to breastfeed baby regularly. Inspection of the lochia was done and the colour was pink (serosa) without any bad odour and flow was scanty. After the head to toe examination, no abnormality was detected. Symphysio fundal height was 12 centimeters when checked.

Baby was top and tailed paying attention to the skin folds, head to toe examination was done and no abnormalities were found on the baby. Her cord showed signs of detachment and was dried. Weight was 2.9 kilograms when checked.

Madam Amanda complained of inadequate sleep at night she was advised to sleep when baby was asleep and support person that is sister-in-law was asked to assist in the care of the baby during the day. She was reminded of the next visit and she said she was very grateful. Permission was sought to leave.

OBSERVATION ON MOTHER

OBSERVATION	**5th day (21st December,2022)**
	MORNING
Temperature	36.0^0C
Pulse	76 bpm
Respiration	20 cpm
Blood pressure	110⁄70mmHg
Lochia	Serosa

	MORNING
Fundal height	12cm
Condition of the uterus	Contracted
Breast	Lactating

OBSERVATION ON BABY

OBSERVATION	**5th day 21stDecember,2022**
Temperature	36.1^0C
Apex heart beat	136 bpm
Respiration	44 cpm
Skin Colour	Pink
Cord bleeding	No
Cord condition	Shrinking
Weight	2.9kg
Suckling	Yes
Stool Colour	Yellow

4.9 SIXTH POSTNATAL HOME VISITS

The sixth day postnatal home visit was made on 22nd December, 2022 at 7:20am. Greetings were exchanged with client and her family and a seat was offered in client's room. Mother and baby were both in a healthy condition and Madam Amanda said the baby's cry had minimized and now sleeps a lot. On head to toe examination, no abnormalities were detected. Her breast was soft and lactating well. Inspection of the lochia was done and the colour was

pink (serosa) flow was very scanty without any bad odour. Measurement of symphysio fundal height was 11 centimeters when checked. She moved her bowel as well as that of the baby.

Baby was given a warm bath paying attention to the skin folds since the cord was off the previous evening and head to toe examination was done with no abnormality found on the baby.

The stump was then dressed and the area was cleaned with chlorhexidine. Weight was 3.0kilograms.

Client complained of backache. She was educated on proper positioning when breastfeeding and how to put baby to breastfeed. She said she appreciated that a lot, and she was thanked for her co-operation. She was reminded that the next day was going to be the last visit to her house and permission was sought to leave.

MOTHER

OBSERVATION ON MOTHER	**6th day (22nd December,2022**
	MORNING
Temperature	36.2^0C
Pulse	78 bpm
OBSERVATION ON MOTHER	**6th day (22nd December,2022)**
Respiration	23 cpm
Blood pressure	110/80mmHg
Lochia	Serosa

Fundal height	11cm
Condition of the uterus	Contracted
Breast	Lactating

OBSERVATION ON BABY

OBSERVATION	**6th day (22ND December,2022)**
Temperature	36.3^0C
Apex heart beat	136 bpm
Respiration	45cpm
Skin Colour	Pink
Cord bleeding	No
Cord condition	off
Weight	3.0kg
Suckling	Yes
Stool Colour	Yellow

4.10 SEVENTH POST NATAL HOME VISITS

The last visit for the week was on 23rd December at 7:00am. The condition of mother and baby was very good. Head to toe examination was done after explaining the procedure to her. Permission was sought and perineal pad was inspected. Lochia was creamy white (Alba) but very little and not offensive. Nothing abnormal was detected. Symphysio fundal height was 10 centimeters when checked.

Baby was bathed by the client and cord stump dressed and it went on well, under supervision. Head to toe examination was done and no abnormality was found. Weight was 3.1kilograms.

All the findings were explained to the client and she was educated on the importance of visiting the clinic for the first weeks postnatal and the importance of immunizing the baby fully. She was thanked for her support and co-operation and farewell was done

MOTHER (7th day postnatal)

	23rd December,2022
	MORNING
Temperature	36.3^0C
Pulse	74 bpm
Respiration	20cpm
Blood pressure	110/70mmHg
Lochia	Serosa
	23rd December,2022
	MORNING
Fundal height	10cm
Condition of uterus	Contracted
Breast	Lactating

BABY

	(23rd December,2022)
Temperature	36.3^0C
Apex heart beat	143bpm
Respiration	43cpm
Skin colour	Pink

Cord bleeding	No
Cord stamp	Healing
Weight	3.1kg
Suckling	Yes
Stool colour	Dark Yellow

4.11 FIRST POSTNATAL VISIT TO THE CLINIC

Madam Amanda came to the postnatal clinic on 23rd December 2022 at 8:40am with her sister-in-law who accompanied her; they were welcomed immediately and offered seats. Client said her family was doing well when asked. Every procedure to be done was explained to her to gain her consent her weight was 85 kilograms when checked. Vital signs were checked and recorded as follows:

Temperature	36.8 degrees Celsius
Pulse	80 beat per minute
Respiration	20 cycles per minute
Blood pressure	110/60 millimeters of mercury

She was asked to take specimen of urine as she went to empty bladder. Her urine was tested and it was negative for both protein and sugar. Hemoglobin level was 11.5 grams per deciliter. Privacy was provided and she was helped onto the examination bed and head to toe examination was performed. Client's hair looked very nice, the eyes and nose were inspected and no abnormality was found. The conjunctiva was neither pale nor jaundiced. Breasts were examined but there was no abnormal mass, soreness of the nipples, engorgement present. The upper and lower extremities were inspected and no abnormality was present. On abdominal

examination, the spleen was not enlarged, there was no tenderness after palpating the liver and symphysio fundal height was also 7 centimeters when measured. The vulva was examined for any perineal infection, and lochia flow was Alba. No abnormality was found in all. Findings were communicated to Madam Amanda and she was commended for her cooperation and she was also thanked as well.

Baby was also examined from head to toe. The conjunctiva was not pale, neither was there jaundice of the sclera nor eye discharges. The ears and nose were inspected as well as the lips and mouth, but no abnormality was found. The umbilical stump was neatly healed. Baby's weight was 3.1kg when checked. Vital signs were checked and recorded as follows:

Temperature	36.2 degree Celsius
Apex heart beat	135 beat per minute
Respiration	44 cycles per minutes

After the examinations, findings were communicated to Madam Amanda that nothing abnormal was detected on the baby. Client was educated on family planning, to help her and the partner space their birth and give birth to the number of children they could cater for. She agreed and said that since the partner was not present at that time, she would come later with him for more information but gave an assurance to practice the lactational amenorrhea method as a natural method which is temporal. Madam Amanda was also reminded on the need to completely attend baby clinic to complete the child's immunization schedules and also attend six weeks post-natal clinic for examination.

4.12 TERMINATION OF CARE

Madam Amanda and her family were made aware on the first time of interaction that the care would be terminated during postnatal review visit where she and her baby would be handed over to the public health in-charge for continuity of care.

4.13 SECOND POST NATAL VISIT TO THE CLINIC

According to the midwife in charge, on the 30th January 2023. Madam Amanda came to the clinic for six weeks visit. They were warmly welcome and they all looked very healthy. General examination was conducted on the client from head to toe as well as vital signs after her permission was sought. Her vital signs were checked and recorded as follows:

Temperature	36.4ºC
Pulse	78bpm
Respiration	20cpm
Blood Pressure	110/70mmHg

Hemoglobin	12.2 g/dL
Urine protein	Negative
Glucose	Negative

Madam Amanda was sent to the palpation room where privacy was provided by drawing the curtains and closing doors and windows. She was helped to lie on the examination bed. Hands were washed with soap under running water and dried with a clean dry towel.

Head to toe examination was carried out on both mother and baby and no abnormalities were detected.

Temperature	36.2ºC
Respiration	34cpm
Apex heart beat	134bpm
Weight	4.5kg

4.14 CARE PLAN DURING PUERPERIUM

PROBLEMS IDENTIFIED DURING PUERPERIUM

1.18/12/22 client complained of after pain.

2. 19/12/22 client complained of inadequate sleep.

3.23/12/22 client complained of backache.

4. 20/12/22 client complained of inability to pass stool.

5. 21/12/22 client complained of breast engorgement.

SHORT TERM OBJECTIVES

1. Client's after pain will subside within 24hours.

2. Client insomnia will resolve within 24 hours.

3. Mother's backache will be resolved within 48hours

4. Client's breast engorgement will subside within 48 hours

5. Client will have a normal bowel movement within 48hours.

LONG TERM OBJECTIVES

Madam Amanda and baby will go through puerperium successfully without any complication.

PUERPERIUM CARE PLAN CONTINUED

DATE/ TIME	NURSING DIAGNOSIS	OBJECTIVE/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
23/12/22 7:20 am	Backache related to poor body posture during breast feeding	Client will be relieved of pain within 48hours hours as evidenced by; 1. Client verbalizing that her pain has being relieve. 2. Midwife reporting that client's pain has resolve by her facial expression	1. Assure client. 2. Demonstrate to client on how to position herself when breast feeding her baby. 3. Explain the reason of backache to client. 4. Encourage client to assume proper position when sitting. 5. Serve prescribed analgesics (paracetamol)	1.Client was reassured 2.A demonstration was done on how to position herself when breastfeeding such as selecting a firm chair and sitting upright when breast feeding. 3. Reason of backache was explained to client as it being the normal physiology during pregnancy. 4. Client was encouraged to support her back with pillows when sitting. 5. Paracetamol 1gm was served as prescribed.	25/12/22 07:20 am	Goal met as client verbalized that her pain is relieved. 2.Midwife Reporting that client pain has resolved by her facial expression.	M.H.N

PUERPERIUM CARE PLAN CONTINUED

DATE/ TIME	NURSING DIAGNOSIS	OBJECTIVE/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
18/12/22 07:20 am	Impaired comfort (After pain)related to involution of the uterus	Client after pain will resolved within 24 hours as evidenced by 1.client verbalizing that pain has subsided 2.midwife visualizing that client is Showing a good facial expression.	1. Assure client that the pain will be resolved. 2. Reason of after pain was explained to the client. 3. Encourage client to empty her bladder whenever she has the urge. 4. Encourage client to adopt a comfortable position when breast feeding. 5. Serve analgesics as prescribed. E.g. paracetamol	1. Madam Amanda was reassured. 2. It was explained to the client that her pain was due to the involution of the uterus that is the uterus returning back to it non pregnant state. 3. Client was encouraged to empty her bladder whenever she has the urge. 4. She was encouraged to adopt a comfortable position when breast feeding by applying supporting pillows. 5. Client was served with tab paracetamol1g tds x3 days	18/12/22 07:20 am	Goals achieved as 1.client reported that her pain has resolved. 2. Midwife verbalized that client showed a good facial expression.	M.H.N

PUERPERIUM CARE PLAN CONTINUED

DATE/ TIME	NURSING DIAGNOSIS	OBJECTIVE/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
19/12/22 7:20am	Interrupted sleeping pattern (inadequate sleep) related to caring of baby at night	Client will have a normal sleeping pattern of 2-4 hours apart during the night and 2 hours during the day within 24hours as evidenced by client verbalizing that she can sleep at night.	1. Assure client that baby demand is important so she should be assisted. 2.Encourage client to feed baby on demand 2. Encourage client to feed baby adequately before going to bed. 4. Educate client relative to help in taking care of the baby. 5. Encourage client and family to reduce the number of visitors.	1. Client was reassured that baby demand is important so she will be assisted. 2. Client fed baby on demand by 1-8times per day. 3. Client was encouraged to feed baby adequately before going to bed to make sure baby is well fed to sleep well. 4. Client relative helped her in taking care of the baby. 5. Client and family were encouraged to reduce the number of visitors in order for client to have enough sleep during the day.	22/12/22 7:20am	Goal fully met as client reported she can sleep 2-4 hours apart.	M.H.N

PUERPERIUM CARE PLAN CONTINUED

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUA-TION	SIGN
20/12/22 8:00 am	Constipation related to fear of pain caused by trauma during delivery.	Madam Doris will have a normal bowel movement within 48hours evidence by client verbalizing that she is able to move her bowel at least once a day.	Assure client that her constipation would be relieved 2.Explain the cause of constipation during puerperium to the client 3. Educate client on the need to take in foods that increase bowel movement. 4. Encourage client to take in food containing fiber. 5. Encourage client to perform mild exercise to promote free bowel movement.	1. Client was reassured that her constipation will be relieved. 2. The cause of constipation during puerperium was explained to client such as inadequate fluid intake. 3. Client was educated to take in more fruit and a lot of fluid. 4. Client was encouraged to take in foods containing fiber such as orange and oat. 5. Client has been encouraged to do mild exercise to promote free bowel movement.	22/12/22 8;00am	Goal fully achieved as client verbalized that she is able to move her bowel at least once a day.	M.H.N

PUERPERIUM CARE PLAN CONTINUED

DATE/ TIME	NURSING DIAGNOSIS	OBJECTIVE/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
21/12/22 7:00am	Breast engorgement related to poor attachment of the baby to breast	Client' engorged breast will subside within 48 hours as evidence by the midwife and the 1. Client verbalizing that she is relieved of breast engorgement.	1. Assure client her breast engorgement will subside. 2. Demonstrate to client on correct attachment of the baby to the breast. 3.Encourage client on gentle manual expression of breast milk and store it 4. Encourage her to continue breast feeding the baby. 5. Encourage client to apply warm and cold compress on both breasts.	1.Client was reassured 3. Demonstration was done how to properly fix baby to breast and stored. 3.Client was encouraged on gentle manual expression of breast milk 4. Client was encouraged to continue breast feeding the baby on demand and frequently. 5. Client was encouraged to apply warm and cold compress on both breasts.	23/12/22 7:00am	Goal met at client reported that her breast engorgement subsides.	M.H.N

SUMMARY AND CONCLUSION

The care study is an important and managerial tool which gives opportunity to student midwives to put into practice theoretical knowledge and to be able to deal with obstetric problems as midwifery professional.

The Client/Family Centered Maternity Care Study was conducted on Madam Amanda Asamoah a 27-year-old gravida 2 para1 and her entire family through pregnancy, Labour and puerperium and she went through these processes safely without any complications.

Madam Amanda became a regular attendant to the Hospital since 22nd June, 2022. She was managed through pregnancy, Labour and puerperium safely through which all minor disorders experienced were managed using the nursing care plan. She had a spontaneous vaginal delivery to a live female baby on 16th December, 2022 and discharged on the same day. Client and family were visited for the first seven days after delivery.

She visited the child welfare clinic on her first week and six weeks postnatal. Madam Amanda and her baby were in a healthy condition and they were handed over to the Midwife-In-Charge of ANC for continuity of care.

Client and her family were much grateful at the end of the study.

1. The care rendered to Madam Amanda has helped in equipping me with skills necessary to meet the needs of pregnant, laboring and puerperal women. It has also established between us a good interpersonal relationship

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APPENDIX I

ANTENATAL CHART

Date	Weight (kg)	Blood pressure (mmHg)	Urine Protein Sugar	Gestational age	Fundal height (cm)	Presentation n	Descent	Foetal heart rate	Complains	Treatment	Name and signature
22/06/20	78.9	120/80	Negative	13	15	-	-	-	No complain	Tablet (Multivite, folic acid, ferrous sulphate,	M.H.N
20/07/20	81.6	100/70	Negative	17	20	-	-		Chills	Tablet (Multivite, folic acid, ferrous sulphate,Sulphadoxine,Pyrimethmine)	M.H.N
17/08/20	83.3	120/70	Negative	21	23	Cephalic	-		No complain	Tablet (Multivite, folic acid, ferrous sulphate,	M.H.N
14/09/20	86.3	120/80	Negative	25	27	Cephalic	$5/5^{th}$	140 beat per minute	Waist pains	Tablet (Multivite, folic acid, ferrous sulphate, sulphadoxinepy remethamine	M.H.N

ANTENATAL CHART

Date	Weight (kg)	Blood pressure (mmHg)	Urine Protein Sugar	Gestational age	Fundal height (cm)	Presentation	Descent	Foetal heart rate	Complains	Treatment	Name and signature
12/10/20	86.6	120/80	Negative	29	30	Cephalic	$5/5^{th}$	142 beat per minute	No complain	Tablet (Multivite, folic acid, ferrous sulphate, Paracetamol	M.H.N
9/11/20	86.9	120/70	Negative	33	34	Cephalic	$5/5^{th}$	146 beat per minute	No complain	Tablet (Multivite, folic acid, ferrous sulphate) Sulphadoxine Pyrimethmine	M.H.N
14/12/20	87	120/80	negative	37	37	Cephalic	5/5	134 beat per minute	No complain	Tablet (Multivite, folic acid ferrous sulphate.	M.H.N
21/12/20	87.5	120/80	Negative	38	38	Cephalic	$5/5^{th}$	135 beat per minute	Constipation	Tablet (Multivite, folic acid ferrous sulphate. Sulphadoxine Pyrimethmine	M.H.N

28/12/2022	88.2	120/80	Negative	39	42	Cephalic	5/5th	140	No complain	-	M.H.N

Table 1: Antenatal Chart

ITN Given – 11/02/2019

INTERMITTENT PREVENTIVE TREATMENT (IPT)FOR Malaria	1ST dose SP* 3 tabs (Directly Observed Therapy) 17/08/2022	Gestation age In weeks 21weeks	2nd dose (1 month after 1st dose (Directly Observed Therapy) 14/09/2022	Gestation age In weeks 25weeks	3rd dose (1 month after2nd dose(Directly Observed Therapy)12/10/2022	Gestational age in weeks 29weeks
	4th dose 3 tabs (Direct observed therapy)09/11/2022	Gestation age in weeks 33weeks	5th dose 3 tabs (Direct Observed Therapy)14/12/22	Gestation age in weeks 37 weeks		

*NB: - Sulphadoximepyrimethamine – (SP) should be given to pregnant women after 16 weeks or when mother feels baby's movement (after quickening) till delivery and should be given at least 1month after last dose.

APPENDIX II

COMPLETE DIAGNOSTIC INVESTIGATION

DATE	SPECIMEN	INVESTIGATION	NORMAL VALUE	FINDING	REMARKS
22/06/2022	Urine Blood	Sugar protein Hemoglobin level Sickling Grouping Rhesus factor HIV/AIDS Hepatitis VDRL G6PD	Negative Negative 11.4g/dl-16g/dl Negative A,B,AB,O Positive/negative Negative Negative Negative Normal	Negative Negative 14.1g/dl Negative O Positive Negative Negative Non- reactive Normal	Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal
20/07/2022	Urine	Sugar protein	Negative Negative	Negative Negative	Normal Normal
17/08/2022	Urine	Sugar Protein	Negative Negative	Negative Negative	Normal Normal
14/09/2022	Urine	Sugar protein	Negative Negative	Negative Negative	Normal Normal
12/10/2022	Urine	Sugar protein	Negative Negative	Negative Negative	Normal Normal
9/11/2022	Urine	Sugar protein	Negative Negative	Negative Negative	Normal Normal
14/12/2022	Urine	Sugar Protein Hemoglobin	Negative Negative 11.4g/dl-16g/dl	Negative Negative 11.7g/dl	Normal Normal
21/12/2022	Urine	Sugar Protein	Negative Negative	Negative Negative	Normal Normal
28/12/2022	Urine	Sugar Protein	Negative Negative	Negative Negative	Normal Normal

NAME OF DRUG	CLASSIFICATION	ROUTE	DOSAGE	ACTUAL EFFECT	SIDE EFFECT	SIDE EFFECT EXPERIENCED
Tablet folic acid	Vitamin preparation	Oral	5mg daily for 30days	Maturation of red blood cells	Nausea and vomiting	None
Tablet Multivitamin	Vitamin preparation	Oral	200mg daily for 30days	Increased appetite	Gastrointestinal irritation	None
Tablet ferrous sulphate	Iron preparation	Oral	200mg daily for 30days	Formation of red blood cells	Abdominal discomfort, diarrhea dark stool	None
Tablet Sulphadoxine pyrimethmine	Anti-malaria and prophylaxis	Orally	3 tablet start from 16weeks intervals/quickening and the rest are taken in 4 weeks interval and after 36 weeks	Prevent malaria in pregnancy	Itching, vomiting, nausea	None
Oxytocin	Oxytocic drug	Intramuscular	10units	Increase contractions	Hypotension and hyper stimulation	None
Vitamin A	Group A vitamin supplement	Oral	200000unit once daily	Growth development, prevent infection and blindness	Vomiting	None

Tablet paracetamol	Analgesic	Oral	500mg	Relieve pain	Liver damage with prolong use	None

APPENDIX III

PHARMACOLOGY OF DRUGS

NAME OF DRUG	CLASSIFICATION	DOSAGE	ROUTE	ACTUAL EFFECT	SIDE EFFECT	SIDE EFFECT EXPERIENCED
Vitamin K	Group K vitamins	1milliliter	Intramuscular	Production of prothrombin that aids in clotting	Hypersensitive reaction	None
Chloramphenicol eye drop	Antibiotics	2 drops	Instillation	To prevent eye infection	None	None
Oral Poliomyelitis	Antigen vaccine	2 drops	Orally	Gives immunity against poliomyelitis	Diarrhea, fever	None
Injection Bacillus Calmette Guerin	Antigen vaccine	0.05 ml	Intradermal	Production of antibodies and prevention of tuberculosis	Blister formation and slight fever	Blister was formed

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

APPENDIX IV

Time	**12:30**	**1:00**	**1:30**	**2:00**	**2:30**	**3:00**	**3:30**	**4;00**	**4:30**
Contractions	2:10 19s	3:10 20s	3:10 42s	3:10 42s	4:10 42s	4:10 42s	4:10 42s	4:10 42s	4:10 42s
Descent	4/5th							2/5th	
FHR	140	146	142	130	138	140	140	140	146
VE	4cm							9cm	10cm
Temp, pulse, **BP**	36.5 82	82	82	82	36.7 84	82	82	120/60 82	82
Membranes	Intact							Ruptured Clear Liquor	

WHO Modified Partograph

Registration No. 1298/10 Name (Last, First) A Enoch Amanda Age 27
Date 16/12/2022 Parity/Gravida 2 / 1 LMP 13/03/22 EDD 20/12/22 Gestation (wks) 38+1
ROM (Time, Date) / Labour Duration (Hrs) Facility/Clinic Name Banket

FETAL HEART RATE

LIQUOR MOULDING

CERVIX (CM)

Alert

Action

16/12/22 (G.) SVD 10:40am
AS = 8/10, 9/10
BW = 3.0 kg
3rd stage - Completed
Perineum - Intact
EBL - 120mls
Duration of labor - 4hrs 45 minutes

Plot X

DESCENT

Plot O

HOURS

TIME 5:30 6:30 7:30 8:30 9:30 10:30 11:30 12:30

CONTRACTIONS PER 10 MINS

Oxytocin U / L
Drops / minute

DRUGS & FLUIDS

BLOOD PRESSURE & PULSE

TEMPERATURE

URINE
Amount
Protein
Acetone

LABOR NOTES

Client admitted at the facility at 5:30am with complains of labour pains. Labour progressed well. Client had spontaneous vaginal delivery to a live female baby with a birth weight of 3.0kg. Head circumference = 33cm, length of baby = [illegible]. Third stage monitored actively and completed by extended blood loss = 120mls. Apgar score for first and fifth minute are 8/10, 9/10 respectively. Mother and baby looks active and healthy.

Please circle or write responses.

DELIVERY

DATE: 16/12/22 TIME: 10:40am METHOD: Spontaneous / Vacuum Extraction / C/S / Other

PERINEUM: (Intact) / Episiotomy / Laceration

ANESTHESIA: (None) / Local / General

THIRD STAGE

Active Management: Yes / No Medication: Time 10:40am Type/Dose Injection of oxytocin

PLACENTA: TIME: 10:50am Complete / Incomplete

BLOOD LOSS AMOUNT: 120mls Small (Less than 250 cc) / Moderate (250-499 cc) / Large (more than 500 cc) / Significant for mother

BABY

Weight: 3.0kg

Sex: Male (Female)

Baby Position: (Vertex) / Breech / Other

APGAR

Time	Color	Breath	Heart	Tone	Reflex	TOT
1min	2	2	2	1	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	11:50am	100/60	80	17cm	No active bleeding	100mls
	12:05pm	100/70	82	well Contracted	No active bleeding	Nil
	12:20pm	110/70	78	well Contracted	No active bleeding	Nil
	12:35pm	110/60	78	well Contracted	No active bleeding	Nil
	12:50pm	100/60	80	well contracted	No active bleeding	120mls
	1:05pm	110/70	80	well contracted	No active bleeding	Nil
	1:20pm	100/60	82	well Contracted	No active bleeding	Nil
	1:35pm	120/80	79	well Contracted	No active bleeding	Nil
Every 30 minutes For 1 hour	1:50pm	110/70	80	well Contracted	No active bleeding	150mls
	2:05pm	100/60	80	well Contracted	No active bleeding	Nil

Birth Attendant Mensah Helena Naana/Ms. Margaret Anarfi Date 16/12/22

MATERNITY CHART

NAME: Asamoah Amanda

AGE: 27yrs WARD: Lying-In

NO.: BH 4113 BED NO.: 3

Date	16/11/24	17/11/24	18/11/24	19/11/24	20/11/24	21/11/24	22/11/24	23/11/24
Days in Hospital	DD	1	2	3	4	5	6	7
Days P. O.								
Hour AM		7:20	7:20	7:00	7:00	7:00	7:20	7:20
Hour PM	5:30	5:00	5:30	4:00	4:30			
Temperature C / F								
Pulse								
Resp.								
B.M.								
Urine	Passed	Passed	Passed	Passed	Passed	Passed	Passed	
B. P. AM	110/90	120/60	119/70	119/60	110/70	110/70		
B. P. PM		110/70	110/70	110/60				

Temperature

Symptomatic relief

NEW BORN EXAMINATION FORM

Baby Afia Agmach

Date of Assessment: _____ Time: 10:40am

Date of Birth: 16/12/22 Time of Birth: 10:40am Sex: ☐ M ☑ F Age at time of Assessment (days/hrs) _____

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

Apgar: 1min ☐ 5min ☐ Birth Weight: ☐ 3.0kg ☐ Length 46 cm Head Circumference: 33 cm

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

Name of Assessor (Midwife/Doctor): _____

Respiration
- 33cpm
- ☐ <30 b/m *
- ☐ <60 b/m *
- ☐ >60 b/m
- ☐ Retractions *
- ☐ Grunting *
- ☐ Tachypnoea *

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

Tone
- ☐ Normal
- ☐ Floppy *
- ☐ Increased *

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

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

Cry
- ☐ Normal
- ☐ Shrill *
- ☐ Absent *

7. Suck
- ☑ Good
- ☐ Weak
- ☐ Absent

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

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

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

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

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

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

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

16. Clavicle
- ☑ Normal
- ☐ Swelling/Fracture

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

18. Heart rate
Rate: 140bpm
- ☐ Normal (100-160)
- ☐ <100 *
- ☐ >160*

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

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

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

22. Limbs
- ☑ Normal
- ☐ Abnormal _____

23. Genitalia

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

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

24. Anus
- ☑ Patent
- ☐ Imperforate*

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

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

May indicate severe disease that requires urgent referral

Diagnoses (if known) Spontaneous Vaginal delivery

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

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

NEW BORN EXAMINATION FORM

Name: Baby Afia Asamoah Date of Assessment: _____ Time: 10.4a

Date of Birth: 16/12/22 Time of Birth: _____ Sex: ☐ M ☐ F Age at time of Assessment (days/hrs) _____

Astational Age ☐ 9to ☐ 9to Mode of Delivery: ☑ Vaginal Assisted Vaginal C-Section

APGAR: 1min 9to ☐ 5min ☐ 9to Birth Weight: ☐ 3.0kg ☐ Length: 46 cm Head Circumference: 33 cm

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

Name of Assessor (Midwife/Doctor): _____

1. Respiration
Rate 33bpm
- ☐ Rate < 30 b/m *
- ☐ Rate < 60 b/m *
- ☐ 30-60 b/m
- ☐ Retractions *
- ☐ Grunting *
- ☐ Stridor *

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

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

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

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

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

7. Suck
- ☑ Good
- ☐ Weak
- ☐ Absent

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

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

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

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

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

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

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

16. Clavicle
- ☑ Normal
- ☐ Swelling/Fracture

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- ☑ Immunization (BCG/Polio)
- ☑ BCG ☑ Polio Immunization
- ☐ Antibiotics in mother
- ☐ Antenatal corticosteroids

*May indicate severe disease that requires urgent referral

Diagnoses (if known) Spontaneous vaginal delivery

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

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

NEW BORN CHART

Name: Baby Of. Asmoah No: BH 1298/10 Birth Weight: 3.0kg

Sex: Female Mother's No: Length: 48cm

Nature of Delivery: SVD Diagnosis: Term Baby

Date of Birth: 16/12/2022 Time: 10:40am Date of Discharge: 16/12/2022

Date	16/12/22		17/12/22		18/12/22		19/12/22		20/12/22		21/12/22		22/12/22		23/12/22							
No. of Days	DOD		D1		D2		D3		D4		D5		D6		D7							
Weight	3.0		3.0		2.9		2.8		2.8		2.9		3.0		3.0							
	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM
Temperature	36.2		36.2	36.6	36.0	36.2	36.3	36.6	36.1		36.1		36.3		36.3							
Stools	Passed	Passed	Passed	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	Passed	Passed	Passed							
Remarks	Head Neck Trunk Limbs → No abnormality Detected.																					

TEMPERATURE CHART

NAME: Baby Afia Asamoah

AGE: 2 days WARD: Lying-In

H.NO.: BH 4113 BED NO.: 3

Date	16/12/22	17/12/22	18/12/22	19/12/22	20/12/22	21/12/22	22/12/22	23/12/22
Days in Hospital	DD	1	2	3	4	5	6	7
Days P. O.								
Hour AM		7:20	7:20	7:00	7:00	7:00	7:20	7:20
PM	5:30	5:00	5:30	4:00	4:30			

Temperature

C	F
41.0	105°
40.0	104
39.0	102
38.0	100
37.0	98
36.0	96
35.0	94

= weight
= temperature
Scale: 1cm. limit

Pulse	142	136	132	136	134	136	136	136
Resp.	43	44	44	44	48	44	44	45
		46	43	46	48	48	48	
		120	136	134	132	136	136	136
E.M.	—	—	—	—	—	—	—	—
Urine	Passed	Passed	Passed	Passed	Passed	Passed	Passed	Passed
B. P.								

SIGNATORIES

THE STUDENT

NAME: MENSAH HELENA NAANA

SIGNATURE: .....

DATE: 20/06/2023

THE MIDWIFE IN CHARGE (BANHART HOSPITAL – KENYASI)

NAME: MS. MAGARET ANARFI

SIGNATURE .....

DATE: 14/07/2023

THE SUPERVISOR

NAME: MS. UBAIDA ABDUL-KARIM

SIGNATURE: .....

DATE: 20/07/2023

THE PRINCIPAL

NAME: MONICA NKRUMAH

SIGNATURE: .....

DATE: 14/07/2023