HOLY FAMILY NURSING AND MIDWIFERY TRAINING COLLEGE BEREKUM

A CLIENT/FAMILY CENTERED MATERNITY CARE STUDY

ON

MADAM MARY MARFOWAA

WRITTEN BY

DERY PATIENCE

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

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PREFACE

Midwifery is a branch of health care that basically focuses on pregnant women and their entire families. It is an individualized care rendered to a pregnant woman with the involvement of her family, bearing in mind that, the woman is unique with specific problems.

The study again enables student midwife with this concept in mind to apply the knowledge and skills acquired during her period of training, to care for clients and their families during pregnancy, labour and puerperium.

The family centred maternity care study also helps the student to use partograph which is a managerial tool for monitoring labour to manage client in order to identify complications promptly and intervene. The nursing process is also used and it provides a framework for solving problems and making decisions in the management of the client and family in a systematic manner. The study also enables student midwife to educate the client and family and also promote cordial relationship between the student midwife, the mother and her family.

More so, the study requires the student midwife to put into practice the concept of safe motherhood initiative which has being adapted to render quality maternity care through antenatal, labour and puerperium which will eventually reduce maternal and neonatal mortality. Finally, the family centered maternity care study is a requirement by the nursing and midwifery council of Ghana towards the awards of the license to practice as professional midwife.

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INTRODUCTION

Client family centred maternity care study involves all care given to a particular client and family right from the first day of contact during antenatal through labour up to six weeks postnatal without any complication to both mother and baby.

This study gives accurate information to the student midwife on professional standard of care of client. This care given is based on identification of an individual's problem, analysing them and some possible solutions provided.

This family centred maternity care study was carried out on Madam Marfowaa, a 25-year-old woman, gravida two (2) Para one (1) alive during the latter part of her pregnancy, throughout labour and puerperium.

The interaction with client started on the 9th May, 2022 during her 36th week of pregnancy at Monica's Health Centre and Antenatal Clinic. Interactions with her started after health education given to the pregnant women on signs of true labour and danger signs in pregnancy.

Madam Marfowaa encountered some minor disorders during pregnancy, labour and puerperium such as insomnia and backache. These minor disorders were managed with the knowledge of the nursing process.

The client went through pregnancy successfully and delivered a healthy baby girl on 31st May, 2022. Mother and baby were handed over to the community midwives for continuity of care in the good condition at the end of my study.

There are four chapters outlined in this script. Chapter one (1) deals with the client particulars and her various histories, Chapter two (2) also entails the antenatal care given which includes first contact and home visits. Chapter three (3) is the care given to the woman during all the four stages of labour and the Chapter four (4) also entails with the care rendered to client during puerperium which includes postnatal home visits and termination of care.

Finally, at the end of chapter 2, 3 and 4 are care plans drawn to problems identified and the management given with the use of the nursing process. Attached, is also summary, conclusion, bibliography as well as appendixes such as complete diagnostic investigation, pharmacology of drugs, antenatal records labour records, postnatal records and baby chart.

LITERATURE REVIEW

PREGNANCY

A layman understands pregnancy as when is miraculously with another human growing inside of her womb. It is from conception to delivery of the foetus (Tiran, 2008). Pregnancy begins when an ovum is being fertilized by a matured sperm at the fallopian tube; usually this fertilized ovum is propelled to the inner lining of the uterus to be implanted for nourishment to develop to the full term pregnancy (Marshall & Raynor, 2014).

Every pregnancy poses a threat to mother's health because she may be exposed to many high risk conditions like, eclampsia, severe anaemia and if not managed well can deteriorate her health and even cause death.

According to Ricci, (2016). The body goes through changes under the influence of oestrogens and progesterone hormones during pregnancy. This hormone contributes to the maintenance of pregnancy to term, the changes experienced is called Physiological Changes. The physiological changes cause conditions which are termed minor disorders of pregnancy like constipation, headache, heart burns, nausea and vomiting etc. which needs guidelines, directions and care from a health care provider to go through them. When these conditions become excessive and risk mother's health, it is termed as danger signs of the pregnancy such as excessive vomiting, severe abdominal pains and severe headache. At this serious point the woman should seek immediate care at the hospital. The guidelines, direction and care are mostly given at antenatal session where she received optimum health care (Marshall & Raynor, 2014).

Most of the times, the pregnant mother is cared for by one midwife throughout pregnancy called Focus antenatal care. Focus Antenatal Care is an individualized client centred comprehensive antenatal care that placed emphasis on disease detection rather than risk assessment (Oduro-Kwarteng, 2012). The aim of antenatal care is to ensure that woman stay healthy throughout pregnancy and detect any complications of pregnancy that may arise during pregnancy.

Antenatal care is also concerned with the growth and development of the foetus Normal duration of pregnancy is 280 days (40 weeks or 9 months and 7 days) This duration is divided into three periods each termed as trimester. The first trimester (1^{st}-12^{th}) weeks where most organs like the heart, lungs, brain and others form, develop and function. The second trimester (13^{th}-27^{th}) weeks is where movement of the foetus can be felt by mother called quickening and foetus is able to recognized mother and father's voice. The third trimester (28^{th}-40^{th}) weeks is where all the five sense is working, foetal head gradually drops into the pelvis 'engagement' and is ready to be corn from there, the woman goes into labour to deliver baby (Adanu, 2013).

LABOUR

Labour is defined as the process by which the foetus, placenta and membranes are expelled through the birth canal (Korah & Philip 2009). Labour is divided into four stages. The 1st stage is marked by painful rhythmic uterine contraction which causes the mouth of the uterus (cervix) to relax, dilates and thins out. During this time there is a discharge of blood stained mucous substance 'show' getting to the end of this stage the water may break known as rupture of membranes.

This stage ends when the cervix has opened wide and shortens enough to allow the birth of the baby. We then say cervix is fully dilated and completely effaced. The 1st stage normally lasts for 8-16hours.

The 2nd stage starts from fully dilation of the cervix, pushing by mother of the baby through the birth canal (vagina) to deliver baby. Episiotomy may be performed to prevent the perineum from tearing and last for about an hour for woman giving birth for the first time and about 30minutes for woman of subsequent birth. Delivery of the placenta and its membranes and controlling of bleeding donate the third stage and last for 5-15 minutes. The last stage (4th stage) is where mother and baby are closely monitored for six (6) hours after delivery for any complications.

PUERPERIUM

Puerperium is a period of about 6 weeks following childbirth where the reproductive organs are returning to their normal state (Weller, 2000) for this to happen, a number of physiological changes occurs like after pain and lower abdominal pains due to involution of the uterus. During puerperium, mother is relieved of stresses of pregnancy and labour and assumes responsibility of motherhood with lactation well established (Ricci, 2016).

Mother is assisted to restore health, prevent diseases and maintain infant health as well. She is counselled on family planning methods and services that are provide to her. Education is also given on rest and sleep, nutrition, personal hygiene as well as exercise to promote good health. (Ghana Health Service, 2008). The couples were advised on the proper care of the baby and feeding practices to prevent abnormal conditions like puerperal sepsis and other neonatal conditions like infection of the cord (Titan 2008).

The infant is also given immunizations against the child killer diseases.

According to Fraser and Cooper (2009), the care is based on three principles that is;

- Promoting the development of good maternal and child relationship
- Strengthening the mother's confidence
- Enabling her to fulfil her motherly role.

Mother is then introduced to family planning services afterwards to help regain her health and have time for the baby and other children if any before involving herself in another pregnancy if she wishes to.

WHY CLIENT WAS CHOSEN

Madam Marfowaa was chosen as a client for the care study on the 9th May, 2022 at Monica's Health Centre during her usual visit to the antenatal clinic. Madam Marfowaa approached me after health education and asked if she can use concoction via enema to prevent ('*asseram'*) a spiritual disease of the new-born because she has few weeks to deliver and she has seen some pregnant women used it and her mother is trying to convince her but she is having doubt. She was discouraged from using the local herbs via enema and an experience was shared with her on the negative effects of using the concoction, she was encouraged to dress well by not exposing her body and be careful of how she relates or talk to people.

Madam Marfowaa's antenatal book and her scan were checked if there was any deviations or abnormalities, she was asked if she has any complaints or problems and she said no, I explained to her that she would be examined and the baby as usual through abdominal examination to detect any abnormalities, it was further explained to her that congenital abnormalities occurs as a result of some predisposing factors like genetics, environment, teratogenic factors etc. she understood everything I explained and promised not to use it but she asked if I could come to her house to explain to the mother so she can also understand, so I agreed. She was very grateful for the message she had that day.

As I was glancing through her antenatal book, I realized she fell within the criteria for the care study, thus gravida 2 para 1with no complications in her previous pregnancy, labour and puerperium and also she was in her 36th weeks of gestation.

She was chosen as my client to help her to go through pregnancy, labour and puerperium successful without any complication to both the mother and baby.

The procedure and the care to be rendered were explained to her and she agreed to be taken as my client for the care study.

CHAPTER ONE

ASSESSMENT OF CLIENT/FAMILY

1.0 INTRODUCTION

This chapter talks about the client and the family. It comprises personal/social, family, medical, surgical, lifestyle, menstrual, past obstetrical and present obstetrical histories.

1.1 CLIENT PARTICULARS/SOCIAL HISTORY

Madam Marfowaa is a 25-year-old woman comes from Dormaa-Amaasu in the Bono Region. She is dark in complexion with the average height of 159 centimetres and a weight of 55 kilograms during her first antenatal visit to the clinic, according to Madam Marfowaa, she completed J.H.S but she couldn't further her education because there were no funds to support her education. Madam Marfowaa is an apprentice seamstress at New Dormaa in Sunyani. She is the only wife of Mr. Katre who is 30-year-old Painter and a Caterer. They are both Christians and are blessed with 1 child, thus a girl. Madam Marfowaa speaks bono and twi and Mr Katre speaks Ewe because he is from Togo and they speak English when communicating. Her next of king is Mr Katre her husband. Madam Marfowaa does not drink Alcohol neither does she smokes.

1.2 FAMILY HISTORY

Madam Marfowaa is the fourth born of six siblings to Mr. Gyau and Madam Badu. According to Madam Marfowaa, her family has no medical history of diseases or illnesses like diabetes, hypertension, heart disease, epilepsy, liver disease, sickle cell disease, mental disorder, no multiple pregnancy, birth defect or congenital abnormalities as well as her husband family. Madam Marfowaa and her family visit the hospital whenever they are sick. She said there have been some incidence of death not associated with any medical condition but natural death.

1.3 MEDICAL HISTORY

Madam Marfowaa has never been diagnosed of any medical disease like diabetes, heart disease, hypertension, sickle cell disease, liver disease, jaundice, respiratory disease, mental disease, asthma, tuberculosis or epilepsy that had lead her admission in the hospital, she always reports to the outpatient department whenever she is not feeling well and always admitted when she is in labour. She has no known allergy to any food or drugs prescribed by the midwife, doctor or environmental hazards like scent of perfumes, dust, spices and among others. She has never been transfused with blood.

1.4 SURGICAL HISTORY

Madam Marfowaa explained she had never encountered any injury, fracture or cut on any part of the body which has been sutured as a result of domestic accident or road accident. She has no previous caesarean section or never undergone any surgical operation on her body especially on her pelvis that could affect her labour.

1.5 MENSTRUAL HISTORY

Madam Marfowaa had her first menstruation at the age of fifteen (16); she has a regular 28 days' cycle with moderate blood flow of four days. Her menstrual flow is regular with no menstrual disorders like dysmenorrhoea, menorrhagia etc. she gets amenorrhoea only when she is pregnant. She uses sanitary pad every month in her menstrual flow and changes it twice daily.

1.6 CLIENT LIFESTYLE AND HOBBIES

Madam Marfowaa told me she normally wakes up around 6:30am. She brush her teeth, sweeps, bath her daughter, prepare breakfast, feeds her and send her to school, she comes back and also take her bath and take her breakfast, afterwards washes her bowls every morning when she wakes up. She then prepares and go to work at 9:00am each day and comes home at 5:30pm but her younger sister always picks her daughter from school every day. So she gets home and help prepare supper for the family, her favourite food is fufu with wirewire soup. She does her general cleaning every Wednesday which is her off day and Saturdays, she goes to church every Sundays and goes to bed around 9:00pm.

1.7 PAST OBSTETRICAL HISTORY

Pregnancy

According to Madam Marfowaa's antenatal book and she also explained, she is G2P1 with no history of abortions or miscarriages and experienced minor disorders like; nausea, frequent urination in her first trimester and backache at the later part of her pregnancy but was managed at the clinic, she had no danger signs in pregnancy such as severe headache, anaemia, vaginal bleeding and among others. She had all the doses of sulphadoxine Pyrimethamine (SP) as a prophylaxis against malaria, she was given Albendazole 400mg at 20 weeks of gestation as prophylaxis against worm infestation and received the first and second doses tetanus diphtheria injection in her first pregnancy with a month interval according to her antenatal record booklet, she was a regular attendant and her pregnancy went to term. The interval between her first and second pregnancy is four years and records of various examinations and investigations were all good.

LABOUR

Madam Marfowaa had spontaneous vaginal delivery of live female child at term, she delivered at the hospital with no complications during delivery and placenta was delivered soon after baby was out and she had no history of postpartum haemorrhage in her first delivery. She added that blood loss was very scanty and the duration of labour did not exceed 18 hours. She had no tear or episiotomy that had been sutured. The weight of her baby was 3.0kg at birth. Her baby cried immediately after birth.

PUERPERIUM

Madam Marfowaa explained her puerperium was smooth as she had support from her mother. She had no mood swings and post-partum haemorrhage. She visited the clinic regularly for her postnatal services and had her baby fully immunized against childhood preventable diseases. She explained that she practiced exclusive breastfeeding for six (6) months and then introduced complimentary feeding when the baby attained six months and she wean her off the breast when the baby was one year six month and the baby had no condition like constipation or diarrhoea. Her baby did not suffer any serious illness as she grew up. She was not practicing family planning but she did not get pregnant because her husband travelled.

1.8 PRESENT OBSTETRIC HISTORY

According to Madam Marfowaa, her last menstrual period was on 23rd August, 2021 and her expected date of delivery was calculated as 30th May, 2022. She attended her antenatal clinic at Monica's Health Centre on 30th December, 2021 at 18 weeks of gestation. Her first weight was checked and recorded as 55kg and height as 159cm. she experienced quickening at 16 weeks of gestation. She was experiencing backache and frequent urination as minor disorders with no danger signs in pregnancy, she sleeps 8 hours and 30 minutes in the night and rest 2 hours in the day.

Head to toe examination was done with no abnormalities detected. Vital signs were checked and recorded as well as her laboratory investigations were done;

Haemoglobin	-	11.3g/dl
Blood group	-	O
Rhesus factor	-	Positive
Sickling test	-	Negative
G6PD	-	No defect
Hepatitis B	-	Negative

VDRL/Syphilis	-	Negative
HIV antibody	-	280
Repeat HIV antibody (before 34 weeks)	-	280
BF for Malaria	-	Negative
Urine for protein and sugar	-	Negative

Vital signs recorded as:

Temperature	-	36.6°C
Blood pressure	-	80/40mmHg
Pulse	-	78bpm
Respiration	-	21cpm

Madam Marfowaa said she had no complaints and that she is doing well and had the following routine drugs served;

Tablet fersolate 200mg daily for 30days

Tablet folic acid 5mg daily for 30days

Tablet multivite 200mg daily for 30days

According Madam Marfowaa's antenatal records book, she has been a regular attendant and never misses her appointments.

CHAPTER TWO

ANTENATAL CARE

2.0 INTRODUCTION

This chapter includes the first contact with the client, first antenatal home visit, subsequent visit to the clinic, second antenatal home visit and care plans drawn to solve any problem the client encountered.

2.1 FIRST CONTACT WITH THE CLIENT

The first contact with Madam Marfowaa was on Monday 9th May, 2022, at 9:30am when she came to the facility for her routine antenatal visit at 36th weeks of gestation. She was welcomed and offered a seat. Madam Marfowaa was chosen after the health education on signs of true labour, she approached to inquire if she can use concortion to prevent the spiritual neonatal disease (assiram), she was discouraged and the dangers associated with using concortion was explained to her, she fell within the criteria for the care study after checking her antenatal book showing that she has no problem herself, the foetus and the scan she took previously and she has no complaints too, that could affect her pregnancy. Madam Marfowaa was chosen to be motivated, educated, encouraged and to ensure that she prepares adequately for her delivery and she is delivered at the health centre by a skilled birth attendant when her date of deliver is due. An introduction of myself was made as a student midwife from Holy Family Nursing and Midwifery Training College, Berekum on a domiciliary midwifery practice at the facility, she was informed that she would be taken as a client for care study and nurse during her pregnancy, labour and puerperium. All questions asked by the client concerning the care study process were answered and all doubts was cleared, she was happy and pleased to be chosen and agreed to be used. She was thanked for her co-operation. The in charge of the facility was informed about the selected client and she agreed.

Vital signs and weight were checked and recorded as;

Temperature - 36.5°C

Blood pressure - 100/50mmHg

Pulse - 81bpm

Respiration - 21cpm

Weight - 63kg

Head to Toe Examination

The procedure for the head to toe examination was explained to Madam Marfowaa and she was asked to empty her bladder and a specimen bottle was given to her for mid-stream specimen of urine for protein and sugar which was negative after testing with test strip, privacy was provided, she was assisted to undress and onto the examination bed, hand washing was done with soap under running water and dried with clean and dry tissue. She was asked to sit on the bed then lay on her right side and assume a supine position.

The head was examined first, her scalp was checked for dirt, dandruff, distribution, lice and infection, she has a natural hair which was clean with no dandruff, lice, infection and the hair was well distributed, she was congratulated and encouraged to continue with what she did with the hair. Her face was checked for puffiness, rashes and spots. The eyes for pallor, jaundice and discharges, ears for growths and discharges, nose for growths and discharges, lips for cracks dryness, sores and her mouth for tooth decay and halitosis through a conversation during the procedure, neck for pains, lymph nodes, enlarged thyroid gland and distended neck veins, the **breasts examined** for size, shape, dimpling, discolouration, nipple for discharges and for problems like inverted or flat, large nipple, axillary was palpated for axillary lymph nodes, palpable masses in the breast and there were no abnormalities detected in the above examinations. She was thought how to self-examine her breast which she demonstrated afterwards and she was asked to report to the facility of she recognize any mass in her breast. **Her upper extremities** were examined for oedema, palm for paleness, nail beds for anaemia and her nails for overgrowth and neatness. **The lower extremities** were checked for oedema, varicose veins, calf pains and equalities of the legs, nail beds for anaemia and nail neatness. The back for rashes, oedema of the sacral region, pains at the sacrolumber region. The skin was checked for rashes, colour, cracks, pallor and no abnormalities were found.

Abdominal examination

On Inspection, there was no rashes, sores, the abdomen was ovoid in shape, medium in size with linea nigra and traces of striae gravidarum all over the abdomen. The upper quadrant of the abdomen was examined to detect enlarged and tender liver and spleen but nothing of such were found.

Measurement of the symphysio fundal height The upper border of the symphysis pubis and the fundus were located and the zero end of the tape measure was placed on the upper border of the fundus and extended along the contour of the abdomen to the upper border of the symphysis pubis and it measured 36cm.

Fundal palpation: Standing at her right side and facing her head, the palms were placed on each side of the fundus, curved around the top of the fundus to determine what was occupying the upper pole. A soft mass was felt which indicated the buttocks.

Lateral palpation was done with palms on both sides of the uterus midway between the umbilicus and her flank, the uterus was stabilized with one hand and examined with the other hand using the leopard manoeuvre. The palpation was done through the entire midline to the lateral side of the abdomen and from the symphysis pubis to the fundus in a leopard manner, the foetal back (the smooth part) was located at the right side of her abdomen and the limbs (rough part) were felt at the left side of the mother. The position was right occipito anterior and the lie is longitudinal.

Pelvic palpation: This was done by facing Madame Mary's feet. She was asked to flex her knees slightly and breathe in and out slowly to aid in the relaxation of her abdominal muscle. The palms were placed just below the level of the umbliclicus with the fingers directed towards the symphysis pubis and thumb almost meeting, a hard mass was felt indicating the head of the foetus.

Descent: location of the anterior shoulder was made and two fingers of the non-dominant hand was placed on it, the upper border of the symphysis pubis was located, then with the ulna border of the dominant hand placed on the upper border of the symphysis, all five fingers occupied the space between the anterior shoulder and the upper border of the symphysis pubis indicating descent of $5/5^{th}$. The presentation was cephalic.

On auscultation: a foetal stethoscope (foetoscope) was placed on the area where the back of the foetus was located on the abdomen of the mother and closer to the chest, the ear was placed aginst the stethoscope, making sure hands were not touching the stethoscope when the foetal heart beat was counted, comparing the rate with the maternal pulse and counting how many beats were heard for one minute, it was 136bpm with regular rhythm.

She was congratulated after the examination for taking good care of herself and encouraged to continue with it. She was assisted to lie on her right side in order to wake up from the examination bed, she was made comfortable by helping her to get down from the examination bed, was assisted to dress up and was offered a seat afterwards. Hand washing was done again with soap under running water and dried with clean tissue. Both of us were seated facing each other and findings were discussed with her that no abnormalities were detected throughout the examination and the foetus was growing and doing well. she was asked to go and do haemoglobin at 36 weeks of gestation and it was 12.6g/dl. She was encouraged to continue with what she was doing with her diet and was education adequate nutrients in her diet, eating more of fruits and vegetables in order to boost her haemoglobin level in order for the preparation for labour, she was as well educated on rest and sleep, personal and environmental hygiene, danger signs in pregnancy examples severe frontal headache, vaginal bleeding, pitting oedema etc, and to report to the hospital immediately if she sees any of the above, we discussed about birth preparedness and complication readiness, she said she would deliver at that health centre and has a two tricycle's number who she can call for transportation on the day of labour and she mentioned some of the layette she had organized so far and she was told it would be inspected when she is being visited in her house on the first antenatal home visit for the care study.

Permission was asked from Madam Marfowaa for her antenatal home visit and she accepted and then directions to her house as well as her telephone numbers were received. These are the drugs served;

Tablet fersolate 60mg daily for 7days

Tablet Folic Acid 5mg daily for 7days

Tablet Multivitamin 200mg daily for 7days

4th dose of Sulphadoxine Pyrimethamine was given to her on Directly Observed Therapy.

She was education on the importance of the routine drugs which was being served and the need to sleep under Treated Mosquito Net. She was asked to report to the health centre the following week on 16th May, 2022 for review.

2.2 FIRST ANTENATAL HOME VISIT

On 11th May, 2022, at 6:35am, Madam Marfowaa was visited in her house as arranged. The main purpose for the visit was to check her physical environment, how she was coping with the pregnancy and the family, her complaints during her antenatal visit, to attend to the needs of the family and to explain to her mother on the dangers for insisting that her daughter uses the concoction to prevent neonatal spiritual illness (aserram). The journey to her house was made by tricycle using the direction she gave on the previous antenatal visit she made to the clinic. On arrival, Madam Marfowaa, her mother and her younger sister were outside sweeping the compound, they were greeted and a seats was offered, Madam Marfowaa introduced me to her mother and the purpose of the visit was explained to them. The community has a cool environment with scattered house, the house has five (5) rooms, four rooms were uncompleted and Madam Marfowaa, her daughter, mother and her younger sister were all staying in the only completed room with a veranda where cooking utensils are packed, one of the uncompleted room was packed with woods. There is a toilet and a bath house outside the house used by the entire household. She moved from her husband house to stay with her mother to deliver. The house is built with cement blocks and roofed with aluminium sheets but the house was not plastered, inside the room is one bed with two hanged mosquito net which she and her daughter sleeps under one and the other by the mother and the sister, there was one table in the room which their bags were kept on it and covered with lace just by the bed, the room was spacious enough to allow proper ventilation with two windows. Their source of water supply is a mechanized borehole from their neighbour's house which they fetch from every day for their domestic purpose and drinking as well. there is no electricity supply to their house so their source of power supply is chargeable lumps and touch light which they charge everyday together with their phones at the next house. Their environment was well swept with no stagnant water and not bushy but they have a small farm around the house which they cultivate maize, beans, pepper, garden eggs and tomatoes.

Refuse are collected every day and burnt in a small pit which is covered with plywood, they cook outside the house and sometimes in the Veranda when it is raining. An opportunity was taken to inspect her layette using the list given to her at the clinic, everything on the list was packed in her bag ready for labour, her mother was educated on the negative effects of using the concoction via enema to prevent the disease of the newborn and her daughter Madam Marfowaa also contributed well due to the education she had during our first contact at the clinic, she understood and agreed not to convince her daughter in doing it, signs of true labour was also discussed with her which she contributed very well. she explained her mother would accompany her to the hospital on the day of delivery and the younger sister would be in the house to take care of her daughter while in the hospital, her layette was inspected using the list which was given to her at the clinic, everything was prepared and packed in her bag leaving some few things so she was encouraged to buy the rest of the things for labour. She complained of sleepless night due to frequent urination in the night so she was educated to keep a pail by her bed side. She was reminded of her next antenatal visit to the clinic after which the family was appreciated and thanked for their warm reception and their contributions, permission was asked to leave and Madam Marfowaa saw me off.

2.3 SECOND ANTENATAL HOME VISIT

Madam Marfowaa and family was visited on 21st May, 2022 at 4:08pm in her house. They were greeted and a seat was offered and she was asked about their wellbeing and they were doing well, luckily enough they had returned from the farm and were eating fufu with light soup and smoked fish so that gave me the opportunity to observe if the food was adequate with the necessary nutrients and there were washed mangoes which they will take after eating.

She and the mother joined me after eating, their welfare, health and how she was coping with her pregnancy was inquired and if she had recovered from the complaints she gave when she came to the facility, and she said she feels better with the management, she was encouraged to continue to adhere to the education given.

Madam Marfowaa's husband came around and he was also greeted, and during interaction with him, he said that, the family is ready to welcome the new born into the family except his daughter. So Madam Marfowaa was encouraged to introduce her child to the pregnancy to prevent sibling rivalry. She was therefore encouraged to take in more fluids, fruits and vegetables rich in fibre such as pineapples, oranges, water melon, pawpaw and so on, vegetables such as lettuce, carrot etc. which will aid in peristaltic movement. She was encouraged to do exercise.

Client was reminded on the true signs of labour and deep breathing exercise. She said that her husband and her sister assist her in doing the house hold chores. She also said that, she has been able to arrange for a taxi cab and has collected the driver's contact as discussed for which she was congratulated. Permission was sought to leave. She was thanked for her cooperation and an escort was given as permission was granted.

2.4 SUBSEQUENT VISIT TO THE CLINIC

On the 17th May, 2022, Madam Marfowaa came for antenatal visit at the facility which was supposed to be on the 16th May, 2022 but she explained of an emergency she had on that day. She was warmly welcomed and offered a seat. Her weight was checked and recorded as 59kg. her vital signs were checked and recorded as;

Temperature - 36.6°C

Blood pressure - 100/60mmHg

Pulse - 68bpm

Respiration - 20cpm

Procedures to be performed on her were explained to her and permission was sought to carry out head to toe examination. She was asked to empty her bladder and she was sent to the palpation room where she was assisted to undress and also to position herself on the examination bed. After hand washing with soap and under running water and dried with clean tissue. Head to toe examination was done and no pallor, no jaundice and no abnormalities detected.

On abdominal inspection, the abdomen was ovoid in shape with few traces of stretch marks (striae gravidarum) and present of linear nigra. On palpation, the gestation was 37weeks, symphysio-fundal height was 37cm, the lie was longitudinal, the presentation was cephalic, descent was 5/5th, foetal heart rate was 136bpm on auscultation. She was thanked and assisted to get down the examination bed, findings were communicated to her. She complained of general body pains and itching vulva so she was requested to do urinalysis and blood film for malaria parasite and both were negative. She was educated on personal hygiene and the need for cotton underwear, she was asked to come her antenatal visit in a week time (24th May,2022) if she had not delivered. She was not served with routine drugs because her stock is not finished. She was encouraged to report to the facility immediately if she sees any danger signs in pregnancy the true signs of labour. She was thanked and seen off to the entrance.

2.5 CARE PLAN DURING ANTENATAL CARE

Problems Identified During Antenatal Care

On 17/05/2022, Madam Marfowaa complained of:

1. Sleeplessness
2. Frequency of micturition

On 17/05/2022, Madam Marfowaa complained of

3. General body pains
4. Headache
5. Itching vulva

Short Term Objectives

1. Clients will be able to have at least 1hour during the day and 6hours during the night within 48hours
2. Client will cope with frequency of micturition within 4hours
3. Clients will be relieved from general body pains within 24 hours.
4. Madam Marfowaa will be relieved from headache within 24hours
5. Clients will be able to understand and cope with itching vulva within 24 hours

Long Term Objectives

Madam Mary will pass through pregnancy, labour and puerperium smoothly and successfully without any anomalies or complications to both the mother and foetus.

Antenatal Care Plan

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVE/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
17/5/22 at 9:50am	General body pains related to stress from pregnancy	Client will be relieved from general body pains within 24 hours as evidenced by client verbalizing that she feels better now Midwife visualizing that client has stop complaining	1. Reassure client that it shall be well 2. Encourage client to have enough rest during the day. 3. Teach client energy conservation techniques 4. take blood sample for laboratory investigations 5. Administer analgesics such as paracetamol as prescribed.	1. Client was reassured that it will subside with nursing management. 2. Client took some days to rest off her work and farm 3. Client was sitting when washing and also took rest between activities 5. malaria, typhoid, UTI or elevated WBC's were ruled out 5.Analgesics were served as prescribed	18/5/22 At 9:50pm	Goal met as Madam Mary reported that she is relieved from the general body pains	DP

Antenatal Care Plan Continued

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVE/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
17/5/22 At 9:05am	Headache related to stress of pregnancy	Client's headache will be relieved with 8 hours as evidence by clients reporting that the headache is no more and midwife examining and observing client with relaxed facial expression.	1. Reassure client that she will be relieved. 2. Monitor client vital signs. 3. Encourage client to have rest. 4. Encourage client to drink 8glasses of water every day. 5. Encourage client to empty her bowel often. 6. Serve prescribe analgesics.	1. Client was reassured of being in competent hands. 2. Client vital signs was checked and they were within normal ranges. 3. Client took rest most of the time. 4. Client drunk at least 8 glasses full of water daily. 5. Client was encouraging to empty her bowel whenever she has the urge. 6. Client was served with 1000mg paracetamol tds x 3days.	21/5/22 At 5:05pm	Goal met as Madam Marfowaa reported that her headache has subsided and relaxed facial expression	DP

Antenatal Care Plan Continued

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVE/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
17/5/22 At 9:05am	Insomnia in related to frequent in micturition at night	Client will be able to sleep at least 6 hours within 24 hours by evident of she verbalizing that she is able to sleep at least 2hours in the day and at least 8 hours in the night.	1. Reassure client. 2. Encourage client to keep a pail at night. 3. Encourage client to take warm bath in the night before going to bed. 4. Plan sleeping pattern with client. 5. Encourage client to take warm beverages before bed.	1. Client was reassured 2. Client kept a pail and voided into it at night so she will not walk distances. 3.Client was taking warm bath at night before bed. 4.Sleeping pattern was planned with client. 5. Client was encourage to take warm beverages before bed.	18/5/22 AT 9:06pm	Goal met as Madam Mary reported of being relieved from insomnia	DP

NURSING CARE PLAN DURING ANTENATAL CONTINUED

DATE / TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE / TIME	EVALUATION	SIGN
17/6/22 At 8:30 am	Itching at the vulva related to poor vulval hygiene	Client will experience relieve from the itching and burning sensation within 48hours evidence by client verbalizing	1.Reassure client to ally anxiety 2. Educate client to practice good hygiene after visiting the washroom 3. Educate client to desist from douching	1. Client was assured that the condition can be treated 2. Client wiped her perineum from front backwards after visiting the washroom 3. Client was discouraged from douching as it alters the vaginal pH	18/6/ 2022 At 8:30 am	Goal fully met as evidenced by client verbalizing relief of the itching and burning sensation within her vulva	DP

CHAPTER THREE

LABOUR

3.0 INTRODUCTION

This chapter talks about client's admission to the facility, the management of labour from the first stage of labour, second stage, third stage and the immediate care of the newborn, examination of the newborn and the care plans drawn for the management of the problems encountered during labour. The goal of care during labour and delivery is to ensure the positive outcome of a healthy mother and baby.

3.1 ADMISSION AND MANAGEMENT OF FIRST STAGE OF LABOUR

On 31st May, 2022, Madam Marfowaa called around 9:20am with the complaints of waist pain which started around 12:00am and she had seen the presence of show around 6:30am, she was asked to report to the facility with her layette and her support person. She arrived at the facility around 10:40am with her mother and the husband, they were welcomed, rapport was established and they were offered seats. Client's antenatal card was glanced through; She was asked if she had experienced any danger signs like, bleeding from the vagina, leakage of liquor and persistent vomiting and Madam Marfowaa replied that she had not seen any of the signs mentioned above. they were convinced of being in a competent hands and that she would have a safe delivery. History of her last meal, last bowel action and if she has taken any medication were taken.

Madam Marfowaa 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. Her haemoglobin was 12.5g/dl

Her vital signs checked and recorded were as follows:

Temperature	-	37.0^{o}C
Pulse	-	82 beat per minute
Respiration	-	20 cycle per minute

Blood pressure - 110/70 mmHg

She was asked to pass urine and measured 150mls, midstream sample was tested for albumin, sugar and acetone but the results were negative. Hand washing was done with soap under running water and cleaned with cleaned tissue. Privacy was established and she was assisted on the examination bed and head to toe examination was done.

Head to toe examination: client's hair was neatly tied with a rapper and free from lice and dandruff on inspection. Her conjunctiva was neither pale nor jaundiced, no discharges from the nose and ears. Her mouth was inspected but there was no cracked or sore lip, there was no coating on the tongue, her month was smooth. There were no enlarged lymph nodes at the neck, the breast was examined but there were no masses or lumps in the breast with no breast problem, skin for rashes, legs for oedema and varicose veins but none was detected. The abdomen was inspected for scars or rashes but there was no abnormality detected.

On abdominal examination: linear nigra and straie gravidarum was prominent and the foetal movement could be noticed. The abdomen was ovoid in shape and the size was medium and the gestational age which was 38 weeks.

On palpation: the lie was longitudinal, presentation was cephalic, descent was $2/5^{th}$ and symphysio fundal height was 38 centimetres.

On auscultation: the foetal heart beat was 141beats per minute. Her uterine contraction was checked for 10 minutes and it was 4 in 10 lasting for 36 seconds.

Permission was sought to continue with vaginal examination at 11:30am, a sterile tray for vaginal examination was brought to the bed side and the procedure was explained to her. Hands were washed under running water and dried clean tissue, a pair of sterile gloves was worn. She was asked to flex her knee a part her legs The vulva was inspected for rashes, various veins, warts, scars and oedema but none was detected. The vulva was swabbed with savlon solution, using sterile swabs, the labia majora were swabbed with two sterile cotton wool soaked in savlon solution, the labia minora was also swabbed the same way and a single cotton wool soaked in savlon solution was used to swab the vestibule after which vaginal examination was carried out.

The vagina was moist, warm and slippery due to the mucus discharges. The cervix was thin, soft, effaced and the presenting part well applied to it. The cervical dilatation was 6cm with membranes intact, moulding was +, the sacral promontory could not be assessed because of the descent, the sacrum was well curved, the ischial spines were blunt and the pubic arc was wide. The midwife in-charge confirmed these findings Client was cleaned from all discharges after the examination and a new clean perineal pad was applied to the vulva.

Madam Marfoeaa was thanked, all findings were explained to her and she was encouraged to cope with the pain and relax, she was encouraged to ambulate and empty her bladder if she feels the urge to do so, to do deep breathing exercise as the cervix is not fully dilated and was reassured that labour was progressing well. Gloved hand was immersed in 0.5% chlorine solution, gloves were removed and disposed into a bin. Hand washing was done with soap under running water and dried with clean tissue. All procedures were done under the supervision of the midwife-in-charge and all findings were recorded on a partograph.

Preparation for birth

A skilled and unskilled helper were identified, that was the midwife in-charge of the clinic on duty who was also supervising the delivery. The unskilled helper was the client husband and he was also 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 emergence.

The delivery room was made clean and warm, light was switch 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 ti skin contact when the second stage is due.

3.2 MANAGEMENT OF FIRST STAGE OF LABOUR

There was continues monitoring of the foetal heart rate, maternal pulse and uterine contractions were checked every 30 minutes, the temperature was monitored for every 2 hours, blood pressure, descent as well as vaginal examination was done 4 hourly and the results plotted on the partograph. Her urine passed was tested for presence of acetone, protein and glucose and they were negative. She was asked to lie on her left side to prevent the uterus from pressing on the descending aorta to prevent supine hypotension syndrome and she can as well ambulate to help in descent. She complained of painful uterine contraction, she was encouraged to perform deep breathing exercise when there are contractions to cope with pains. She was informed about the progress of labour and was given light soup to drink and was encouraged to drink water to prevent thirst and dehydration and to keep her mouth moist and throat wet. Sacral massage was given gently from time to time. Madam Marfowaa was encouraged to empty her bladder frequently to help descent of the foetal head.

At 2:30 pm, there was spontaneous rapture of membranes, client complained of bearing down sensation. Vagina examination was done to rule out cord prolapse and confirm full dilatation of the cervix. The cervical Os was 9cm dilated with moulding (++), uterine contractions were stronger which was 4 in 10 lasting 48 seconds, descent was $0/5^{th}$, foetal heart beat was 142bpm. She was asked to cooperate and was reassured that she should not have any fear because she would come out save with no complication to her and the baby as she was in the hand of competent midwifes. All findings were communicated to her and recorded on the partograph. Her vital signs were checked and recorded as follows.

Temperature - 36.8 ^{o}C

Pulse - 79 beats per minute

Respiration - 20 cycles per minute

Blood pressure - 110/60 mmHg

Urine obtained was 50mls and sample was tested for acetone and protein and they were all negative, a new perineal pad was applied on her. The progress of labour was communicated to her using the cervix dilation board.

The delivery trolley was set containing the following;

The top shelf

it contains the sterile instrument which is the delivery pack and is made up of

- One sterile cord scissors
- Sterile gloves
- Two sterile artery forceps
- Sterile drape
- Sterile membrane pierce
- Cord clamp
- Sterile receiver for placenta
- Sterile episiotomy park containing scissors and suturing forceps
- Sterile gallipots
- Injection tray containing 10 units of oxytocin, vitamin k, syringe and needle

Bottom shelf

- Drum containing gauze and cotton wool
- Chitle forceps
- Bulb syringe
- Measuring jug
- Perineal pads
- Savlon
- Urethral catheter and drainage bag
- Examination gloves
- Cot sheets
- Identification band

Other items included sutures, lidocaine and baby's dress, bed pan, light source were brought closer. Protective clothing's such as a cap, face mask, goggle, boots, plastic apron were worn,

curtains drawn and fans were switched off to provide privacy and warmth. Madam Marfowaa complained the urge to defecate and severe bearing down sensations with the uterine contractions becoming more expulsive and frequent and on examination, perineum was bulging with her anus gaping and vaginal examination was done to confirm full dilatation of the cervix. The midwife in-charge confirmed the findings.

3.3 MANAGEMENT OF THE SECOND STAGE OF LABOUR

At 3:00pm, full dilatation of the cervix was confirmed, her bladder was emptied and she was then assisted to lie in the lithotomy position which she was comfortable with. Trolley was pushed to the bedside. She was reassured and every procedure to be done was explained to her. Hands were washed with soap under running water and dried with sterile towel and sterile gloves were worn on both hands. The vulva and the upper thigh were swabbed with savlon solution and sterile pad was placed closer to the anus in other to prevent contamination of the sterile field with faecal matter, a sterile small bed mat was placed on her abdomen to receive the baby. Madam Marfowaa was encouraged to bear down with each contraction and rest in between contractions.

As labour progressed, the head advanced gradually and flexion was aided by two fingers gently pressing the occiput downwards in other to allow the smallest diameter of the skull to distend the vulva to prevent perineal and intracranial injuries. Descent of the foetal head continued till crowning of the head occurred, Madam Marfowaa was asked to stop pushing and pant or breathe through her month to prevent rapid expulsion of the head which could also lead to perineal tears and intracranial injury. By extension, the sinciput, face and chin swept the perineum and the head was slowly delivered. The eyes were cleaned with separate sterile swabs from the inner cantus to the outer cantus of the eyes. The nose and the mouth were cleaned with a sterile gauze swabs. The cord around neck was quickly felt for but there was none.

Restitution took place and in some few seconds internal rotation of the shoulders occurred as indicated by external rotation of the head. The shoulders were in the anterior-posterior diameter of the pelvic outlet. Both palms were placed on either side of the baby’s ear and gently pressed the head downwards towards the anus to deliver the anterior shoulder which escaped under the symphysis pubis and the baby was lifted up towards mother’s abdomen and

the posterior shoulder was also delivered, the rest of the body was delivered onto mother's abdomen by lateral flexion at 3:05pm. Baby cried soon after it was born, Client was congratulated for her efforts.

3.4 IMMEDIATE CARE OF THE NEW BORN AT BIRTH

As soon as the head of the baby was born, the eyes of the baby was cleaned with sterile gauze from inner canthus outwards, the face was wiped with guaze and the baby was dried thoroughly with warm sheet to keep the baby warm and stimulate breathing, wet sheet was removed and replaced with clean dried sheet. The cord was clamped two finger breaths away from the baby's abdomen and the second clamp was placed three finger breaths from the first clamped and with covered with sterile gauze to prevent splashing of blood and cut in between the two clamps. The baby was shown to the mother to identify the sex and it was female, the baby was left on the mother's abdomen with head turned to one side to facilitate drainage of secretions to prevent aspirations, to ensure skin to skin contact and promotion of bonding. Baby was then cleaned and wrapped in a warm sheet with the head covered with a cap to prevent hypothermia. Breastfeeding was initiated. Identification band was prepared bearing the mother's name, time of delivery, baby's sex, weight and date of birth and was tied around the baby's wrist. facilitate drainage of secretions to prevent aspirations. The first minutes Apgar score was 8/10 and the fifth minute was 9/10.

3.5 ACTIVE MANAGEMENT OF THE THIRD STAGE OF LABOUR

The procedure was explained to Madam Marfowaa, her abdomen was palpated to rule out undiagnosed twin after the cord separation and there was none, 10 units oxytocin was injected intramuscularly at the right thigh one minutes after the delivery of the baby to aid in contraction of the uterus and separation of the placenta, a sterile receiver was placed near the vulva in between the thighs to receive the end of the cord, the placenta and its membranes. The placenta was delivered by controlled cord traction. The cord was re-clamped closer to the perineum. Left hand was placed on the fundus of the uterus to feel for contraction, as soon as there was contraction, the left palm was placed just above the symphysis pubis and palm facing the fundus of the uterus to steadily support the uterus to prevent inversion of the uterus. The clamped cord was held by the right hand, with a contracted uterus, a gentle downward traction in a downward and backward direction was applied while counter pressure was maintained with the left hand on

the suprapubic area, the process continued until the placenta was visible at the vulva. Both hands were used to receive the placenta and twisting the membranes into a rope like manner, the placenta including the membranes was expelled completely at 3:08 pm.

The placenta and membranes were examined quickly, and all the membranes and lobes were complete and healthy before placing it into the sterile receiver. The uterus was massaged to stimulate uterine contraction to expel blood clots. Perineum, vaginal walls and cervix were inspected with gauze under a light source and there were no tears, lacerations and cracks.

Client was thought to massage her uterus and she was asked to feel the hardness of the uterus which indicated that the uterus was well contracted. This procedure was done every 15minutes for two hours making sure the uterus was firm, while blood loss was checked. The blood loss was approximately 200mls. Client was cleaned and a new clean perineal pad was applied at the perineum and she was made comfortable in bed and to rest at the lying in ward. Client was encouraged to change her pad and urinate frequently to prevent postpartum haemorrhage and infections and to help in involution of the uterus

Madam Mary was congratulated for her cooperation. The delivery bed was cleaned and the instruments used were decontaminated in o.5% chlorine for 10 minutes and then washed in warm soapy water, rinsed under running water. The instruments were later boiled for 15 minutes and stored. Clients mother and husband were informed of the save delivery and sex of the baby and they were permitted to visit her

EXAMINATION OF PLACENTA AND MEMBRANES

The placenta was examined thoroughly in the sluice room. There were two arteries and one big vein in the cord, the cord was situated at the centre of the placenta and there was no true knot or false knot. The placenta was held by the cord allowing membranes to hang down and the membranes were examined by pulling the amnion from the chorion and it was intact.

The placenta was washed in 0.5% chlorine solution and placed on a flat surface to examine the completeness of the cotyledons which was complete and separated by grooves (sulci), it was red in colour, there were no infarts seen at the maternal surface. The foetal surface was smooth with shiny and bluish-grey in colour, the blood vessels radiating at the foetal surface was not leading to any extra lobe in the membrane.

The placenta was decontaminated in 0.5% chlorine solution and placed in the placenta container and it was discarded. The instruments and equipment used were soaked in 0.5% chlorine solution and were removed after 10 minutes, washed, rinsed, dried and boiled after which the instruments were stored. Hands were dipped in 0.5% chlorine solution before discarding the gloves.

3.6 MANAGEMENT OF FOUTH STAGE OF LABOUR

This is the period of six hours after delivery of the placenta during which both the mother and baby are under continuous observation and monitored for six hours before transferring both mother and bay to the lying-in-ward in order to detect any abnormality and complications that might occur.

Prevention of Diseases in New-born

After the baby is delivered, care is given to the eyes as prophylaxis treatment to some eye infections and so two (2) drops of chloramphenicol eye drop was instilled on each eye, the cord was dressed with chlohexidine to prevent any infection and the client was taught how to dress the cord and not to apply anything on it and vitamin K 1.0mg intramuscularly was given to the baby after the head to toe examination was done due to the pain. Baby skin was smeared with baby oil to provide warmth. Infection prevention techniques were also ensured to prevent any cross infection. Hands were washed with soap under running water and cleaned with dry towel.

Examination of the new born

The procedure was explained to Madam Marfowaa that the baby would be examined from head to toe, examination gloves were worn and the baby was examined to detect any birth defect for early and necessary intervention and to identify any deviation from normal, findings would be communicated to her after the procedure and she was encouraged to observe the procedure.

Hand washing was done, dried and examination gloves were worn. Baby was put on a covered flat surface, undressed but covered with clean cot sheet and only the part to be examined would be exposed. A general inspection on the baby revealed that; the baby’s skin colour was pink, the muscle tone was good, chest movement was normal and respiration was also normal. The baby was covered and examined systematically.

Head and face; The head was examined and measured from occipital protuberance to the supra orbital ridges as (35cm), no caput succedaneum, no bulging and sunken of fontanels and it pulsating normally. The mother was educated not use hot water or anything on it, she was further educated that the posterior fontanels would close naturally at 6 weeks and the anterior would close naturally at 18 months. The face was pink in colour with no birth marks.

The eyes; the eyes were in their normal position with the sclera being clear and conjunctiva being pink in colour with no pallor, jaundice or discharges.

The ear; the ears and eyes were in alignment without any discharges, the pinnae of the ears were soft and the external auditory meatus was patent.

The nose; The nose was also inspected for size, shape and nostrils checked to rule out deviated septum but everything was normal.

The month; The mouth was examined by pressing the angle of the jaws which opened and the lips, tongue, gums, and palate were inspected for cleft or lip palate, tongue tie, false teeth and suckling, rooting and swallowing reflexes were checked during breastfeeding but everything was normal. The palate was high arched, intact and centrally placed.

The neck; The neck was examined for congenital goitre and enlarge lymph nodes but there was none. Rotation and flexion were good.

The chest, breast and abdomen; The chest was inspected for shape, size and chest wall movement and the respiration rate was 46 cycles per minute with no sternal recession and the apex heart beat was also 141 beats per minute. Breasts were palpated and there was no engorgements and masses extra nipple and everything was normal, The nipples were checked for position and it was normally situated.

The abdomen was soft and round but not distended with any palpated masses at the spleen and liver the size and shape were examined and they were normal. The cord was inspected but no bleeding was noted.

The limbs and digits; Examination of the upper extremities was done and hands were inspected for clubbing, extra or missing digits and webbing. Hands and arms were inspected for symmetry, movement and paralysis, and the palm for the number of palmer crease. Shape and colour of nail

beds were inspected and reflexes (grasping, Moro) checked but were normal. With the lower limbs, no webbing, extra toes and club foot were found. Planter creases was present and there was no dislocation of the hips.

Spine; the spine was examined with baby lying on a prone position and head turned to one side, the back was palpated for swellings, dimpling and hair patches to rule out spinal bifida and any other abnormalities but there were none.

Genitalia and anus; The anus and the rectum were inspected for patency, masses, sphincter tone, tenderness and no abnormality was detected since the baby had passed meconium and urine.

The baby was weighed and it recorded as 3.4kg, full length was 51cm, head circumference was 35cm. The temperature was recorded as 36.5 degrees Celsius. Vitamin K 1ml was given to the baby intramuscularly to prevent bleeding. The baby was classified as a normal baby because there was no abnormality detected and the routine care of the baby was initiated.

Gloves were removed and disposed off according to the infection prevention protocol. Hand washing was done and dried with clean towel. All findings were then communicated to the mother and documented. The baby was wrapped in a warm dry cot sheet and was placed beside her mother to breastfeed.

Management of the Mother

Mother was assisted to put the baby to breast to feed for oxytocin to release naturally to aid in involution and bonding between the mother and the baby and also as a form of family planning. Permission was sought from Madam Mary to check her vital signs as well as her uterus and lochia every 15 minutes for two hours, 30 minutes for an hour and hourly for three hours. Her vital signs were checked and recorded as follows:

Temperature - 36.8°C

Pulse - 80 beat per minute

Respiration - 22 cycle per minute

Blood pressure - 120/80 mmHg.

Madam Marfowaa's lochia was checked and the colour was red (rubra) with small amount and not offensive, she was asked to empty her bladder frequently in order to help contractions of the uterus to prevent postpartum haemorrhage and also to change soiled pads to prevent infection and she should practise hand washing with soap under running water and dried with clean towel before attending to the baby.

Madam Marfowaa was examined from head to toe, her conjunctiva was pink and no abnormality detected, areolar of the breast was squeezed gently and the breast was not really lactating. Uterus was well contracted with symphysio-fundal height of 17cm, she was encouraged to report if she see any profuse bleeding. Client was served with rice with light soup, she complained of after pains and tiredness, so she was educated on involution of the uterus causing the pains which will disappear as time goes on, she was given paracetamol 1 gram as prescribed. The baby slept after suckling and mother was encouraged to sleep.

3.7 SUMMARY OF LABOUR

Madam Marfowaa was admitted to the labour ward with complaints of labour pains and presence of show. Labour progressed normally and client had spontaneous vaginal delivery of a live female child at 3:05pm, duration of labour was 5 hours 33mintes. The third stage was actively managed, oxytocin 1 ml was given intramuscularly at 3:06pm, the placenta was delivered at 3:08pm and both the placenta and membrane were complete. The perineum was intact and blood loss was moderate (200mls). Both the mother and the baby were doing fine and active. Apgar score was 8/10, 9/10, birth weight 3.4kg, head circumference 35cm, full length 51cm.

3.8 CARE PLAN DURING LABOUR

Problems Identified During Labour

On 31/05/2022, Madam Mary complained of;

1. Waist and lower abdominal pain
2. Tiredness.
3. Painful uterine contractions
4. Thirst.

SHORT TERM OBJECTIVES

1. Client will cope with waist pains and lower abdominal with 3 hours.
2. Client's tiredness will resolve within 30 minutes.
3. Client will cope with painful uterine contractions within 2 hours.
4. Client's thirst will resolve within 10 minutes.

LONG TERM OBJECTIVES

Client will go through a successful labour without complications to both mother and baby.

Labour Care Plan

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTIONS	DATE/ TIME	EVALUATION	SIGN
31/5/22 2:00pm	Waist and Lower abdominal pains related to physiology of labour.	Client will cope with lower abdominal and waist pains within 3 hours as evidenced by client verbalizing that she is coping and midwife observing that client no longer complains.	1. Explain the physiology of labour pains to her. 2. Reassure client that labour will soon end 3. Encourage client in a comfortable position 4. Encourage client to perform breathing and relaxation exercises 5. Provide diversional therapy 6. Perform sacral massage for client.	1. The physiology of labour pains was explained to her 2. Client was reassured that labour would soon end 3. Client laid in the left lateral position. 4.Client was performing deep breathing and relaxation exercises 5. Client was stayed with and engaged in a conversation 6. Client's sacral region was massaged by her support person.	31/05/22 3:00pm	Goal fully met as client said she was coping with waist and lower abdominal pains	DP

Labour Care Plan Continued

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVE/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
31/5/22 1:30 pm	Tiredness related to advance state of labour.	Client will regain her strength within 30 hours as evidence by the client verbalizing that she is relieved of fatigue.	1. Reassure client. 2. Encourage client not to scream during contractions. 3. Encourage client to continue with the relaxation technique. 4. Support client to perform deep breathing exercise during 5. Serve client with light diet	1. Client was reassured that she will regain her strength. 2. Client was encouraged not to scream during contractions. 3. Client was encouraged to continue with the relaxation technique. 4. Client was supported to perform deep breathing exercise during contraction. 5. Client was served with milo and biscuit/	31/5/22 2:00 pm	Goal fully met as client verbalized she had been relieved of tiredness.	DP

Labour Care Plan Continued

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVE/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
31/5/22 1:00 pm	Painful uterine contraction related to physiology of labour.	Client will cope with painful uterine contractions till the end of labour as evidence by; client behaviour during uterine contraction.	1. Reassure client. 2. Encourage client on deep breathing exercise. 3. Encourage client to empty her bladder whenever she has the urge. 4. Give sacral massage.	1. Client was reassured and the cause of the pain was explained to her. 2. Client was encouraged to do deep breathing exercise. 3. Client was encouraged to empty her bladder whenever she has the urge. 4. Client was given sacral massage.	31/5/22 3:00 pm	Goal met as client said she was coping and was calm during uterine contractions.	DP

Labour Care Plan Continued

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVE	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
31/5/22 2:15pm	Thirst and related to the process of labour.	Clients' thirst will resolve within 10 minutes as evidenced by client verbalizing she is no longer thirsty	1. Reassure client. 2. Explain the process of labour to client. 3. Support client to perform deep breathing exercise. 4. Give client sips of water. 5. Serve client with fluid diet.	1. Client was reassured that measures will be put in place to relieve her off the thirst. 2. Process of labour was explained to client. 3. Client was supported to perform deep breathing exercise during contraction. 4. Client was given sips of water and ice to suck. 5. Client was served with light soup.	31/5/22 2:25pm	Goal fully met as evidenced by client verbalizing she does not feel thirsty.	DP

CHAPTER FOUR

PUERPERIUM

4.0 INTRODUCTION

This chapter describes the management of both mother and baby from day one to six weeks after delivery. Care plan was drawn for the management of the problem met during pueperium.

4.1 FIRST DAY OF DELIVERY

ON 31st May, 2022, Madam Marfowaa was transferred from the lying-in ward after one-hour observation in the labour ward where she and her baby was made comfortable in bed. She was encouraged to breastfeed her baby and empty her bladder frequently in order to prevent the occurrence of postpartum haemorrhage and then to ambulate to promote effective circulation and drainage of lochia, she was encouraged to change her perineal pad when soiled to prevent ascending infection and was educated to wash her hands with soap under running water after removing her perineal pad, after visiting the toilet and before touching her breast and the baby. Sympysio fundal height was checked and recorded as 17 centimetres. Madam Marfowaa's vital signs were checked and recorded as follows;

Temperature - 36.5^0C

Pulse - 79 beat per minute

Respiration - 20 cycle per minute

Blood pressure - 120/80 mmHg

All vital signs were checked every 15 minutes for one hour, 30 minutes for another one hour and hourly for the next two hours, then four hourly when she was stable, after delivery. She was served with corn dough porridge with bread after delivery and she breastfed her baby for a while and slept comfortably for about two hours, 30 minutes. A head to toe examination was performed on the baby for abnormalities, in the presence of Madam Marfowaa but none was detected. The baby passed meconium and voided which confirmed that his urethra and anus were patent. Vital signs were checked as followed;

Temperature - 36.8°C

Apex beat - 141 beats per minutes

Respiration - 46 cycle per minutes

With the puerperal examination, the breast was not lactating well and mother was asked to put baby to breast to maintain lactation, lochia was checked with the colour being red (rubra), and uterus was well contracted. After the puerperal examination, no abnormalities were detected on both the mother and baby. The mother was once again congratulated for a successful delivery.

4.2 SUBSEQUENT CARE

After Six hours of birth, Madam Marfowaa was informed about the importance of the baby to be bathed and she consented to it.

BABY BATH

REQUIREMENT

- Sponge
- Soap
- Cream/powder
- Sterile cotton in a galipot
- Towels, 1 big towel and 3 small towels
- Cot sheets 2
- Gloves
- Plastic apron
- A clean baby dress, cap and socks
- 2 jugs containing hot and cold water each
- Two receptacles for used water and dirty linens
- A receiver for used swabs

Madam Marfowaa was asked to bring out the toiletries for the baby and clothing for the baby to be bathed. The place was set up with baby soap, sponge, towel, diaper, baby oil and baby dress and a sterile tray was set for cord dressing containing sterile glove cord clamp chlorhexidine gel and a plastic apron was worn. The hands were washed with soap under running water and dried with a clean dry towel. Both cold water and hot water were mixed together and the temperature of the water was checked using the elbow. Examination gloves were worn and the baby was taken from her mother.

The baby was put on a flat surface and the mother was given the opportunity to observe the procedure. The baby was undressed and wrapped with a cot sheet. Her eyes were cleaned with cotton wool swab soaked in sterile water from the inner canthus to the outer canthus of each eye. Her face was cleaned with a dam face towel and dried. The nape of the head was supported with one hand. The baby's ears were plugged with the middle finger and thumb to prevent water from entering into the ears. The head was washed with soapy sponge, the baby was lifted off the flat surface with the body resting in the cruck of the elbow and still supporting the nape, the head was rinsed with clean water and dried. The baby was placed on the flat surface and the body was exposed. The neck, arms and front of trunk were bathed paying attention to the skin folds. The back was turned with one arm supporting the chest and the other hand bathing the back down to the feet, paying attention to the skin folds. The baby's body was supported firmly and was immersed into the warm water with the head supported above the level of the water. The body was rinsed thoroughly. The baby was removed from the water onto the working surface and was covered with clean dry cot sheet and with a soft baby towel the body was dabbed thoroughly to dry paying attention to skin folds. Baby oil was smeared on the body and the baby was dressed up with just the cord exposed. The gloves were removed and hands were washed with soap under running water and dried with a clean dry towel.

CORD DRESSING

A sterile glove was worn and the cord was exposed and was inspected for bleeding but there was none. The tip of the cord was held with sterile cotton wool swab, the base of the cord was held and the chlorhexidine was applied on the apex of the cord in a circular motion. The whole cord was smeared with chlorhexidine. The cord was left exposed to air dry. Both gloved hands were immersed in 0.5% chlorine solution and were removed. Hands were washed with soap under running water and dried with a clean dry towel. Baby was dressed and diaper put on. The baby was wrapped with clean dry cot sheet to maintain his temperature and was given to his mother. Client was thanked for her co-operation and she was accompanied to the bedside. Her things were packed and used items were discarded. The working surface was disinfected and the instruments used were decontaminated with 0.5% chlorine solution for 10 minutes, rinsed, washed and rinsed. Hands were washedwith soap under running water and dried with a clean dry towel. Findings were communicated to the mother and were recorded.

The mother was encouraged to use only the chlorhexidine to dress the cord. She was also educated and encouraged not expose the baby or bath the baby when the weather is cold, to breastfeed the baby on demand and allow her to empty one breast completely before the other.

Madam Marfowaa was again encouraged to maintain baby's temperature to prevent the baby becoming too cold. Mother was encouraged to breastfeed baby exclusively and on demandor 8 to 12 times a day. She was also educated on breastfeeding problems and how she will manage them, like breast engorgement, sore nipple and cracked nipple and to report if symptoms persist. Client was encouraged to wash hands before and after handling the baby. All findings were communicated to the mother and baby's vital signs were checked and recorded as follows;

Temperature 36.4^{o}C

Apex beat	136bpm
Respiration	42cpm

4.3 THE FIRST DAY POST DELIVERY

The first day post-delivery was on 1st June 2022, she woke up around 6:15am and brushed her teeth. Permission was sought to examine her from head to toe. On examination of the eyes, the conjunctiva was checked for pallor and jaundice and none was found. Her breasts were examined and it was soft but not lactating well. She was encouraged to put baby to breast frequently to help in lactation. Madam Marfowaa's abdomen was soft and uterus was well contracted, symphysio- fundal height was 16 centimeters above the symphysis pubis. The colour of the lochia was red (rubra) small in quantity and not offensive when checked. She complained of having insomnia due to after pains on which she was reassured and was given paracetamol 1gram as prescribed to help relieve her pain and was encouraged on getting enough sleep when the pains subside, she was educated to sit upright and good attachment was demonstrated to her when breastfeeding to prevent backache. Her vital signs were then checked with the recorded as follows:

Vital Signs	Morning
Temperature	36.5^0C
Pulse	79bpm
Blood pressure	120/70mmHg

She was served with porridge and bread as breakfast. With permission from the mother after hand washing with soap under running water and dried with a clean towel. The baby was also reexamined and the findings were confirmed by the midwife in-charge. There was no abnormality detected and after the examination,

meconium and urine was passed. The cord was inspected for bleeding and discharge but nothing was detected and was also educated on care of the cord toprevent infections. The baby was topped and tailed and the cord dressed with chlorhexidine. Weight checked and recorded as 3.4 kg. and baby's vitals were as follows;

Morning

Temperature	37.1^0C
Apex beat	142bpm
Respiration	40cpm

She was dressed and wrapped loosed in a warm sheet and was given to his mother to breastfeed. All findings were communicated to the mother.

Proper positioning and attachment was demonstrated to her again. She was asked to give a return demonstration and it was perfectly done. She was told that she would be discharged that day. She was educated on adequate nutritious diet to help in the production of more breast milk and improve her immunity as well, this also could help repair worn out tissues, post-natal exercises, immunization of the baby and Madam Marfowaa was introduced to the various family planning methods available. The essence of the exercise was explained to her that it would help the pelvic organs to return to their non-pregnant state. Madam Marfowaa was then encouraged to attend the child welfare clinic for growth monitoring to complete the immunization schedule in order to prevent the baby from any of the childhood preventable disease like Measles, Tetanus, and Diphtheria, whooping, cough, yellow fever among others. She was told to report tothe clinic with high or cold temperature, abnormal breathing, diarrhea, and vomiting since they are all danger signs of the baby. She ate fufu with light soup at 11:00am, She was a health insured registered client; therefore, her medicines were collected for her.

She was given; Tablet Multivite and folate1 daily for 7 days.

Madam Marfowaa was further told Lactational Amenorrhea Method is a short term method of birth control in which the mother relies totally on breastfeeding after birth to prevent pregnancy, and that she will have to meet these criteria for this method to be effective, she should breastfeed her baby exclusively and on demand at least 8 to 12 times a day, she should have not resumed her menstrual flow and her baby must be less than 6months old, and it was added that, this method helps to promote mother to child bonding and protect the baby from infections, the method is also effective and safe and non-hormonal contraceptive and is suitable for most woman but it provides temporal protection for pregnancy, effectiveness after 6months uncertain and has no protection against sexuallytransmitted infection and HIV. Client showed interest in this method and all questions were answered. She was discharged around 9:00 am. She was helped to pack her belongings and was educated on intended post-natal visits for a period of one week was explained and then told she would be visited at home for seven days which would start in the evening and she agreed. Good bye message was exchanged and she was accompanied to the road side to pick a taxi cab together with her husband.

4.4 FIRST POST NATAL HOME VISIT (1ST DAY POST DELIVERY)

On 1st June, 2022, at 5:31pm, Madam Marfowaa was visited in her house. She was asked how she and her family were doing after greeting, she said her condition was getting better and her previous complaints had improved and she also said that the baby was doing good. The family were happy to be visited.

Explanation was given to Madam Marfowaa that she and the baby were to be examined from head to toe to see if there is any deviation from normal for early treatment or management, she then emptied her bladder as requested. Client's conjunctiva was examined and there was no pallor or jaundice, the breasts were firm, soft and were lactating well, the uterus was well contracted and the symphysio fundal height measured 19cm.

The perineum was inspected and cleaned lochia was red with moderate flow and no offensive odour.

Her vital signs were taken and recorded as;Mother

Evening

Temperature 36.8^0C

Pulse 80bpm

Respiration 18cpm

Blood pressure 100/70mmHg

Permission was sought to examine the baby and was granted. Baby was examined from head to toe and no abnormality was found. She was not jaundiced or pale, baby was also suckling well, the cord was not bleeding but has started drying and he has passed meconium and urine when the diapers were removed and it was inspected before bath. As the baby was being topped and tailed, it was also demonstrated to Madam Marfowaa and her mother as they were educated that the ears had to be plugged with the index finger and the thump to prevent water from entering. The cord was also dressed with chlorhexidine. Baby's weight was checked and recorded as 3.3 kilograms. Baby's vital signs were taken and recorded as follows;

Evening

Temperature 37.1^o C

Apex beat 142bpm

Respiration 42cpm

All findings were communicated to Madam Marfowaa and recorded, a promise was made to visit them again the following morning around 7:20am and client and family were thanked and they said good bye.

4.5 SECOND POST NATAL HOME VISIT

On the 2nd June 2022 the second visit was made to client's house at 7:30am and 5:29 pm. The baby wasdoing well. Permission was sought to inspect her perineal pad and the flow of the lochia was scanty but the

colour was red (rubra) and not offensive. The head to toe examination was also done and everything were normal with no abnormalities. The symphysio fundal height was 15 centimeters. Her vital signs were checked and recorded as follows;

Mother

	Morning	**Evening**
Temperature	36.7^0C	36.6^0 C
Pulse	80bpm	78bpm
Respiration	20cpm	19cpm
Blood pressure	116/80mmHg	110/78mmHg

The baby was topped and tailed after general examination was carried out and no abnormality was present.The cord was neatly dressed with no abnormality detected and it was getting dried. The baby passed stools and urine everyday according to Madam Marfowaa, the baby's weight was 3. 2kilograms and vital signs were taken and recorded as follows;

Baby	**Morning**	**Evening**
Temperature	36.8^0C	36.5^0C
Apex beat	144bpm	139bpm
Respiration	40cpm	41cpm

Permission was sought to leave and Client said she was very grateful and thankful for the care that was given to them. She was informed that the next day will be the last day for the morning and evening visit but will continuous visiting in the morning till the seven day.

4.6 THIRD POSTNATAL HOME VISIT

On the 3rd June, 2022, the third home visit was made to Madam Marfowaa's house at 6:32am and 5:30pm respectively, greetings were exchanged. Mother and baby were fine and healthy.

Permission was sought to conduct head to toe examination once again and it was granted, Madam Marfowaa's breast was lactating, involution of the uterus was ongoing and inspection of client's perineal pad revealed pink, scanty flow lochia without any offensive smell. Symphysio fundal height was 14 centimeters when measured. Her vital signs were checked and recorded as follows;

Mother		
Indicator	**Morning**	**Evening**
Temperature	36.3°C	36.6°C
Pulse	79bpm	80bpm
Respiration	20cpm	18cpm
Blood pressure	110/70mmHg	110/76mmHg

Head to toe examination was carried out and no abnormalities were not detected.The baby was topped and tailed and cord care was done with no abnormality detected. The baby also passed stools and urine. Weight was 3.2 kilogram when checked. Baby's vital signs were taken and recorded as follows;

Baby **Indicator**	**Morning**	**Evening**
Temperature	37.0^0C	36.8^0C
Apex beat	140bpm	136bpm
Respiration	44cpm	42cpm

Madam Marfowaa complained of less sleep as a result of baby not sleeping at night, backache and loss of appetite, She was educated to sleep day time and the time the baby is sleeping and Madam Marfowaa's mother was encouraged to help her with the house chores and care of the baby.
In the evening, the mother of Madam Marfowaa was still in the process of top and tailing the baby which was being done just as she was taught. Head to toe examination was done, baby and mother had no abnormalities detected. Vital signs recorded.Permission was sought to leave and Madam Marfowaa said she was very grateful for the care that was given to them.

4.7 FOURTH POSTNATAL HOME VISIT

The fourth home visit was made to Madam Marfowaa's house at 6:10am on 4th June 2022. She was asked of how she was faring and she said her problems are better now. Head to toe examination was done and everything was normal. Lochia was pink (serosa) with scanty flow without odour on inspection. Symphysio fundal height was measured and it was 13 centimeters. Her vital signswere checked and recorded as follows

Temperature 36.8 degrees Celsius

Pulse 78 beats per minute

Respiration 20cycles peminutes,

Blood pressure 110/70 millimeters of mercury

Baby also had head to toe examination was carried out, no abnormality was found. The baby was top and tailed by client herself under supervision, the cord was dressed with chlorhexidine as Madam Marfowaa's mother has rushed to the farm to bring food stuffs. The baby was active and doing well. The baby had already passed stools and urine. His weight was 3.3 kilograms when checked.

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

Temperature 36.3^{o}C

Apex heart beat 130bpm

Respiration 42cpm

She was encouraged to breastfeed the baby on demand and to ensure adequate warmth to baby and was also advised to take adequate diet and to take in fruits in addition since she was prone to getting infections.

Mother and baby were thanked and permission was sought to leave.

4.8 FIFTH POSTNATAL HOME VISIT

The fifth postnatal home visit was on 5th June, 2022 at 7:40am. Greetings were exchanged with client and her family after which a seat was offered in room as usual. Mother and baby were both active and in a healthy state and when it was inquired and observed, Madam Marfowaa said the baby still cries a lot at night, she was reassured that it is typical of newborns 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 usual head to toe examination, no abnormality was detected. Symphysio fundal height was 12 centimeters when checked. Client's vital signs were checked and recorded as follows:

Temperature 37.0° C

Pulse 78bpm

Respiration 20cpm

Blood pressure 110/80 mmHg

Head to toe examination was done and no abnormalities were found on the baby. His cord was dried. Baby had a bathe as her ground mother was worried about why baby is not being bathed. Weight was 3.4kilograms when checked. Vital signs weretaken and recorded as follows:

Temperature 37.1degrees Celsius

Apex heart beat 132 beats per minute

Respiration 40cycles per minute

4.9 SIXTH POSTNATAL HOME VISIT

The sixth day postnatal home visit was done on 6th June, 2022 at 7:30am. 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 active and Madam Marfowaa said the baby's crying had minimized and now sleeps a lot. On head to toe examination, no abnormalities were detected. Her breast was lactating well and soft. 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.

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

Temperature	36.47^{o}C
Pulse	78bpm
Respiration	19cpm
Blood pressure	110/70 mmHg

Baby had already been bathed by her mother, and so head to toe examination was done and no abnormality was found on the baby. The baby's cord was cleaned and dry with chlorhexidine. Weight was 3.5kilograms. Baby's vital signs were taken and recorded as follows:

Temperature	36.8^{o}C
Apex heart beat	130bpm
Respiration	46cpm

Education was given to her on the importance of ensuring good personal and environmental hygiene and the need to feed the baby continuously on demand both day and night.

Mother was informed that the following day would be the last visit to her house. She was thankful me and said she appreciates everything done for her throughout her pregnancy till now, she was thanked and appreciated for her co-operation and permission was sought to leave.

4.10 SEVENTH POST NATAL HOME VISITS

The seventh day was on 07th June, 2022 at 5:31pm. This was my last day visit to her house. The condition of mother and baby was good and active. 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. Madam Marfowaa's vital signs were taken and recorded as follows;

Temperature	36.4^{o}C
Pulse	79bpm
Respiration	18cpm
Blood pressure	110/60mmHg

The baby was bathed by her grandmother and the cord stump was dressed with chlorhexidine. Head to toe examination was done and no abnormalities was detected. All the findings were explained to the client and recorded. Weight was 3.6 kilograms.

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

Temperature	36.8^{o}C
Apex heart beat	142bpm
Respiration	40cpm

Madam Marfowaa was asked if she had any question or complaints and she expressed her concern about the cord stump not being off but it was explained to her that the chlorhexidine takes time about a week or two to fall off. She expressed her appreciation and gratitude for the care given and she added that she has really learnt a lot from this section of care rendered and she had enjoyable labour experiences. She was thanked for her support and co-operation and our good byes was done.

4.11 FIRST POSTNATAL VISIT TO THE CLINIC

Madam Marfowaa came to the postnatal clinic on 7th June 2022 at 10:25am with her husband 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 and her consent was soughed, her antenatal card was collected and her weight was 56 kilograms when checked and symphysio fundal height was 10centimeters when measured. Vital signs weretaken and recorded as;

Temperature 36.7ºC

Pulse 84bpm

Respiration 22cpm

Blood pressure 100/70mmHg

Madam Marfowaa was asked to bring mid-stream urine as she went to empty her bladder. Her urine was tested for protein and sugar and it was negative. Hemoglobin level was 12.1 grams per deciliter. Privacy was provided and she was assisted onto the examination bed and head to toe examination was performed.

Client has a natural hair which looked nice with no dirt, lice or dandruff. The eyes and nose were inspected and no abnormality was detected. The conjunctiva was neither pale nor jaundiced. Breasts were examined but there were no masses, soreness of the nipples or engorgement of the breast present.

The upper and lower extremities were inspected and no abnormality was present. On abdominal examination, the spleen was not enlarged and there was no tenderness after palpating the liver with soft

abdomen. The vulva was examined for infection, and no lochia. No abnormality was detected on inspection. Madam Marfowaa was informed about the findings and was commended for her co-operation. The baby was also examined from head to toe. Her hair was neatly combed. No pallor of the conjunctiva and there was also no jaundice of the sclera and no discharges. The ears and nose were inspected as well as thelips and mouth, but no abnormality was found. The umbilical cord was dried and about detaching. Baby's weight was 3.7 kg. Vital signs were taken and recorded as follows;

Temperature 36.6^{o}C

Apex heart beat 138bpm

Respiration 42cpm

After the examinations, the findings were communicated to Madam Marfowaa that nothing abnormal was detected on the baby. Client was educated on personal hygiene because she complained of itching vulva and headache, family planning to help her and the husband to space their birth. Madam Marfowaa was later referred to the child welfare clinic for bacillus Calmette Guerin(BCG) against tuberculosis and polio 0 against poliomyelitis and was finally handed to the midwife in-charge for continuity of care.

4.12 SECOND POST NATAL VISIT TO THE CLINIC

On the 12th July, 2022, Madam Marfowaa visited the clinic with the baby and was warmly welcomed by themidwife in-charge. Mother and baby were in healthy and was doing well, she had no complaints to be made.

Hemoglobin level of mother was 12.8g/dl as checked and urine test for protein and sugar were negative. Weight was 57 kilograms.

Her vital signs were recorded as;

Temperature 36.6^{o}C

Pulse 80bpm

Respiration 18cpm

Blood Pressure 100/60mmHg

Baby weight was 6.0 kilograms and vital signs were also checked and recorded as;

Temperature 36.9^{o}C

Respiration 38cpm

Pulse 140bpm

Physical examination was carried out and no abnormality detected. Breast was lactating well, uterus was well involuted and menstruation had not yet commenced and no lochia seen.

Baby's general condition was good on head to toe examination; baby's posterior fontanels were closed. Client was handed over to the child health care unit for baby's immunization (against polio, diphtheria, tetanus, hepatitis B (penta), pneumococcal and rotavirus was also given for protection against pneumonia and diarrhea respectively was given to children at six weeks. These were recorded in the baby's record booklet. They were then handed over to the child welfare clinic and family planning unit to ensure continuity of care. Client was educated to report to them in case of any problem. All findings were communicated to client and she was congratulated.

4.13 CARE PLAN DURING PUERPERIUM

Problems Identified During Puerperium

On 01/06/22, Client complained of

1. After pains

On 02/06/22, Madam Marfowaa complained of

2. Insomnia

On 5/06/21, Madam Marfowaa complained of

3. Headache

On 7/06/22, Madam Marfowa complained of

4. Loss of appetite

Short Term Objectives

1. Client will be relieved from after pains within 12 hours
2. Madam Marfowaa will cope with insomnia within 48 hours.
3. Client will be relieved from headache after 8 hours
4. Client will be able to eat two-thirds of her meal served within 24hours

Long Term Objectives

Madam Mafowaa and her baby will go through peurperium successfully without any complication and abnormalies.

Puerperium Care Plan.

DATE / TIME	NURSING DIAGNOSIS	NURSING OBJECTIVE/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
01/06/22 7:30 am	After pains related to involution of the uterus	Client will be relieved of after 12 hours as evidenced by client verbalizing that her pain has subsided and have a relaxed facial expression	1. Reassure client. 2. Encourage client to empty her bladder whenever she hasthe urge. 3. Apply warm compress onclient's abdomen 4. Encourage client to adopt acomfortable position when breast feeding. 5. Serve analgesics as prescribed.	1. Madam Marfowaa was reassured the pain willsubside. 2. Client was advised to empty her bladder whenever she has the urge. 3. Warm compress was applied to her abdomen 4. She was advised to adopt a comfortable position when breast feeding 5. Client was served with tab paracetamol1g tds x3	01/06/22 7:30pm	Goal achieved as client reported that her pain subsided and relaxed facial expression.	DP

Puerperium Care Plan Continued.

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVE/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
2/06/22 07:30 am	Insomnia related to baby crying at night	Client will be able to sleep for at least 3 hours continuous within 48 hours as evidenced by; client verbalizing that she was able to sleep.	1. Reassure client. 2. Encourage client to feed baby well before going to bed. 3. Encourage client to ensure baby is comfortable before going to bed. 4. Client's relatives were encouraged to assist in baby's care at night too 5. Encourage client to take warm beverages before bed.	1. Client was reassured 2. Client fed baby well before they went to sleep 3.Client change baby's dippers and clothed her well before going to bed 4.client's mother and sister in-law assisted in the care of the baby at night 5. Client took warm beverages before bed.	4/5/22 At 7:15pm	Goal met as Madam Marfowaa reported of being relieved from insomnia	DP

Puerperium Care Plan

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVE/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
05/6/22 At 7:05am	Headache related to stress from sleepless nights	Client's headache will be relieved with 8 hours as evidence by clients reporting that the headache is no more and midwife examining and observing client with relaxed facial expression.	1. Reassure client that she will be relieved of the headache 2. Encourage client to have at least 2 hours' rest in the day and sleep 8 hours at night. 3. Encourage client relatives to assist with the household chores. 4. Encourage client to reduce workload. 5. Encourage client to limit time spent with visitors so that she can rest and sleep.	1. Client was reassured that the headache will subside 2. Client had at least 2 hours' rest in the day and sleep 8 hours at night. 3. Client relatives were encouraged to assist with the household chores. 4. Client reduced the workload. 5. Client was able to reduced the time spent with visitors so she was able to rest and sleep.	06/6/22 At 7:32pm	Goal met as Madam Mary reported that her headache has subsided and relaxed facial expression	DP

Puerperium Care Plan Continued

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVE/OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
7/06/22 10:40am	Loss of appetite related to stress of labour and hormonal changes	Madam Marfowaa will regain her normal eating pattern within 24hours as evidenced by client verbalizing that, she is able to eat and support person reporting that client ate two-thirds of meal served.	1.Reassure client that, she will regain her normal eating pattern. 2. Serve client with appetite stimulants 3. Plan meals with client. 4. Serve foods attractively 5. Encourage client to drink multi fruit juice as desert or snack	1.Client was reassured that her eating pattern would return to normal. 2. vitamin B Complex and multivitamin preparations were served 3.Client was part of the planning of her meal 4. Ganish food and serve in a clean environment 5. Client took a fruit juice multi fruit juice as desert or snack	8/06/22 10:40 am	Goal achieved as Client said she ate half of meal served and Support person reported that client ate two-thirds of meal served.	DP

SUMMARY AND CONCLUSION

This family centered maternity care study was conducted on Madam Marfowaa and her family. She was an expectant mother who was taken care of from her third trimester at Monica's Health Centre. She was met on 9th May, 2022 in good condition. She was given holistic and individualized care was rendered to client from the time she was met, which was during third trimester of her pregnancy through to labour and peurperium.

She encountered minor problems during pregnancy, labour and peurperium but they were well taken care of. Madam Marfowaa had a successful care during her antenatal periods, labour and peurperium which weredue to quick analysis of problems, good counseling, client's understanding and co-operation and also by involving the family members in her care.

She had a spontaneous vaginal delivery on 31st May, 2022 to a live female child without any complications, since she was well managed during pregnancy and the time of labour. She had a normal peurperium with all visits and her two weeks post-natal examination performed on her as required. She was then handed over to the midwife in charge of the facility to ensure continuity of care.

In conclusion, the family centered maternity care study has helped gained more experience in the antenatal care, care during labour and care during puerperium. It has also helped to identified every pregnant woman and as individual with special problems. The opportunity to render efficient and comprehensive to Madam Marfowaa and recognized her as unique individual with special problem was achieved.

Data collection and setting of objectives, has helped to achieve the goals of caring for Madam Marfowaa and her family during the late pregnancy, labour and puerperium successfully. So wherever taken torender quality health care services, it will be successfully done, during antenatal, labour and taking care of puerperal women and their babies

BIBLIOGRAPHY

Baker, P. N. & Kenny, L. (2017). *Obstetrics by ten teachers* (20th ed.). Florida: CRC Press.

Ghana Health Service, (2008). *National Safe Motherhood Service Protocol.* Accra: Yamens Press Limited.

Korna, H (2013), *D.C Dutta's textbook of obstetrics.ed. Kolkata*; New Central Book Agency (P) Ltd

King TLMC (2014). *Varney's midwifery (5th edition).* New Delhi; Jonas and Bartlett India PVT.Ltd

Marshall J. E. & Raynor, M. D. (2014). *Myles textbook for midwives (16th ed.).* Edinburgh: Churchill Livingstone.

Ricci, S. S. (2016). *Essentials of maternity, newborn, and women's health nursing* (4th ed.). Philadelphia: Lippincott Williams & Wilkins.

Verrals, S. (2000) *Anatomy and Physiology Apply to Obstetrics.* 3rd Edition, London Churchill Livingstone.

Tiran, D. (2008). *Bailliere's Midwives Dictionary (11th ed.)*London: Bailliere Tindall Elsevier

APPENDICES

APPENDIX I
Complete Diagnostic Investigation

DATE	SPECIMEN	INVESTIGATION	NORMAL VALUE	FINDINGS	REMARKS
12/01/2022	Blood	Hemoglobin	11-16g/dl	11.3g/dl	Normal
	Blood	Sickling test	Negative	Negative	Normal
	Blood	HIV status	Negative	Negative	Normal
	Blood	Grouping and Rhesus	A,B,AB,O	O	Normal
	Blood	factor	Positive	Positive	Normal
	Blood	PMTCT	280	280	Normal
31/12/2022	Urine	Sugar and Protein	Negative	Negative	Normal
10/03/2022	Urine	Sugar and Protein	Negative	Negative	Normal
	Blood	Haemoglobin level	11-16g/dl	11.5g/dl	Normal

07/04/2022	Urine	Sugar and Protein	Negative	Negative	Normal
09/05/2022	Urine Blood	Sugar and Protein Haemoglobin level	Negative 11-16g/dl	Negative 12.6g/dl	Normal Normal

17/05/2022	Urine	Sugar and Protein	Negative	Negative	Normal
24/05/2022	Urine	Sugar and Protein	Negative	Negative	Normal

APPENDIX II

PHARMACOLOGY OF DRUGS FOR THE MOTHER

NAME OF DRUG	CLASSIFICA - TION	DOSAGE	ROUTE	ACTION AND USES	ACTUAL EFFECT	SIDE EFFECT	SIDE EFFECT EXPERIENCED
Tablet multivitamin	Vitamin Preparation	200 milligram once daily	Oral	Helps in formation of red blood cells and increase Appetite	Increase appetite	Gastrointestinal disturbance	None
Tablet folic acid	Vitamin preparation	5 milligram once daily	Oral	Helps in formation of red blood cells and prevent neural tube defect.	Increase haemoglobin Level	Nausea and vomiting	None
Tablet ferrous Sulphate	Hematinics	200 milligram	Oral	Helps in formation of red blood cells	Increase haemoglobin level.	Gastrointestinal disturbance	Dark stools
Tablet Sulphadoxine Pyrimethamine	Anti-malaria (prophylaxis)	3 tablets start at 16weeks/ after quickening and other 6 doses 4 weeks interval.	Oral	Treatment and prevention of malaria.	Malaria was prevented	Nausea, itching, weakness, insomnia and headache	Nausea
Tablet paracetamol	Analgesic and antipyretic	100 milligram 3 times daily for 3 days	Oral	Helps to reduce high bodytemperature and pain	Pain was reduced	Liver damage	None
Injection Oxytocin	Oxytocic drug	10 units	Intramus Cular	Stimulate contractions	Client had contractions	Vomiting and Pressure	None

PHARMACOLOGY OF DRUGS FOR BABY

NAME OF DRUG	CLASSIFICATION	DOSAGE	ROUTE	ACTION AND USES	ACTUAL EFFECT	SIDE EFFECT	SIDE EFFECT EXPERIENCED
Vitamin k1	Coagulant	1ml	Intramuscular	Production of prothrombin to prevent haemorrhage	Prevention of haemorragic diseases of the new born	None	None
Tetracycline eye drop	Anti-bacterial	2 drops	Instillation into the eye	To prevent infection of the eye	Prevention of eye infection	None	None
Oral polio vaccine	Antigen	2 drops	Oral	To stimulate the body to produce antibodies against poliomyelitis	Prevention of poliomyelitis in children	There may be diarrhea	None
Bacillus calmette Guriene (BCG)	Antigen	0.05	Intradermal	To stimulate the body to produce antibodies against tuberculosis	Prevention of tuberculosis	Blister formation at the injection site.	Blister formation
Penta 1	Antigen	0.5 mls	Intramuscular	To stimulate the body to produce antibodies against diphtheria, hepatitis B, tetanus, pertusis and haemophilus influenza B	Prevention of diphtheria, hepatitis B, tetanus, pertusis and haemophilus influenza B	Fever	Fever

Pneumococcal 1	Antigen	0.5 mls	Intramuscular	To stimulate the body to produce antibodies against pneumonia	Prevention of pneumonia	None	None
Rota virus 1	Antigen	1.5 mls	Intramuscular	To stimulate the body to produce antibodies against Rota virus	Prevention of diarrhea	None	None

APPENDIX III

ANTENATAL CHART RECORD

DATE	TEMPERATURE (^{0}C)	WEIGHT (kg)	BLOOD PRESSURE (mmHg)	URINE/ PROTEIN AND SUGAR	GESTATION AGE IN WEEKS	FUN-DAL HEIGHT (cm)	PRESENTATION	DES-CENT	FOETAL HEART RATE (BPM)	COMP-LAINT	TREAT-MENT	REM-ARKS
30/12/21	36.2	55	80/40	Negative	18	20	_	_	_	No complain	Tablet (Multivitamin, Folic acid, Ferrous sulphate	Healthy
27/01/22	36.5	56	100/60	Trace/Negative	22	20	_	_	positive	No complain	Tablet (Multivitamin, Folic acid, Ferrous sulphate, sulphadoxine pyrimethamine)	Healthy

10/03/22	37.0	57	100/60	Negative	28	28	cephalic	_	128	No complaints	Tab (Multivitamin, Folic acid, Ferrous sulphate,suiphad0xine pyremethamine r , Paracetamol)	Healthy
07/04/22	37.1	58	90/40	Negative	32	32	cephalic	_	130bpm	Cough, headache	Tablet (Multivitamin, Folic acid, Ferrous	Healthy

											sulphate, tab sulphadoxine prymethamine) capsules Amoxicillin	
09/05/22	36.1	58	100/50	Negative	36	36	cephalic	5/5th	1361beat per minute	No complaints	Tablet(folic acid, ferrous sulphate, multivitamin, tab sulphadoxine prymethamine)	Healthy

17/05/22	36.6	59	100/60	Negative	37	37	cephalic	5/5th	142beat per minutes	General body pains, itching vulva	Tablet(folic acid, ferrous sulphate, multivitamin, tab sulphadoxine prymethamine,	Well
24/05/22	36.8	60	100/50	Negative	38	38	Cephalic	5/5th	139beat per minutes	No complaints	Tablet(folic acid, ferrous sulphate, multivitamin,	Healthy

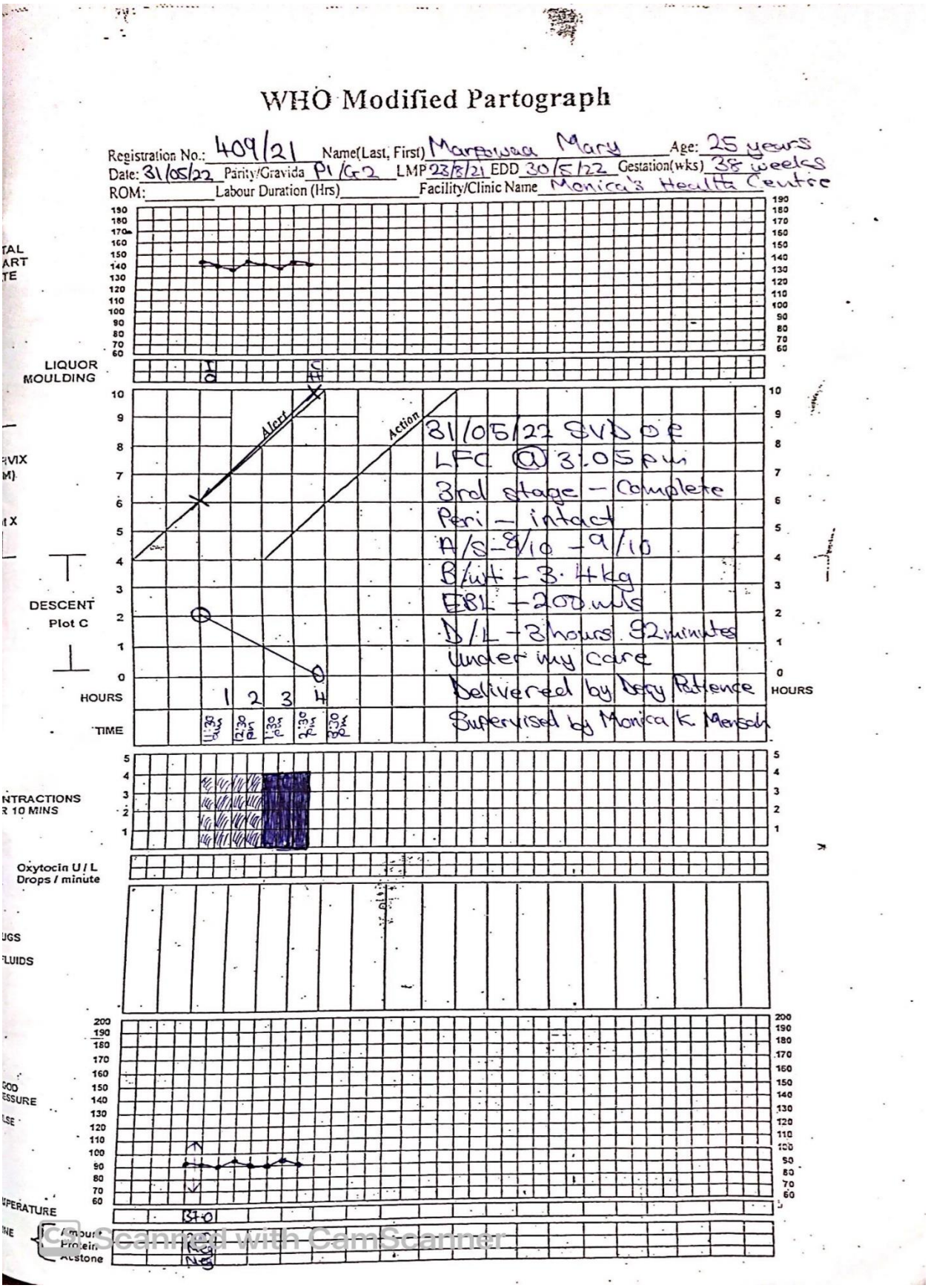
*NB: Sulphadoxine – Pyrimethamine (SP) should be given to pregnant women between 16 weeks (after quickening and 36 weeks)

27/01/2022 1st dose of SP was taken at 22 weeks.

10/03/2022 2nd dose of SP was taken at 28 weeks.

07/04/2022 3rd dose of SP was taken at 32 weeks

09/05/2022 4th dose of SP was taken at 36 weeks


WHO Modified Partograph
Registration No.: 409/21 Name(Last, First) Marfowaa Mary Age: 25 years
Date: 31/05/22 Parity/Gravida P1/G2 LMP 23/8/21 EDD 30/5/22 Gestation(wks) 38 weeks
ROM: Labour Duration (Hrs) Facility/Clinic Name Monica's Health Centre
LIQUOR
MOULDING
DESCENT
Plot C
HOURS
TIME
Alert
Action
31/05/22 SVD OF
LFC @ 3.05pm
3rd stage - Complete
Peri - intact
A/S - 8/10 - 9/10
B/wt - 3.4kg
EBL - 200mls
D/L - 3hours 32minutes
Under my care
Delivered by Mary Patience
Supervised by Monica K. Mensah
NTRACTIONS
R 10 MINS
Oxytocin U/L
Drops / minute
UGS
LUIDS
GOD
ESSURE
PERATURE
Protein
Acetone
Scanned with CamScanner

LABOR NOTES

Client G2P1 at 38weeks reported to the clinic with the comp
of labour pains. She progressed Successfully and had Spontaneous
Vaginal delivery to a live Female Child with an Apgar Score of
8/10, 9/10, Estimated Blood loss was 200mls. Active manggemen
of the 3rd Stage of labour complete, Both mother and baby are
doing well and they were made comfortable in bed.

Please circle or write responses.

DELIVERY

DATE: 31/05/22 TIME: 3:05pm METHOD: (Spontaneous) / Vacuum Extraction / C/S / Other

PERINEUM: (Intact) / Episiotomy / Laceration

ANESTHESIA: (None) / Local / General

THIRD STAGE

Active Management: (Yes) / No . Medication: Time 3:06pm Type/Dose Oxytocin /10un

PLACENTA: TIME: 3:08pm (Complete) / Incomplete

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

BABY

Weight: 3.4kg

Sex: Male / Female

Baby Position: Vertex / Breech / Other

APGAR

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

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

FOURTH STAGE MONITORING

Frequency	Time	B/P.	Pulse	Fundus	Bleeding	Bladder
Every 15 minutes first 2 hours	3:45pm	120/80	80	1.7cm	200mls	100 mls
	4:05pm	110/70	79	2		
	4:20pm	110/60	79	2		Emptied
	4:35pm	110/70	78	2		
	4:50pm	110/60	80	1	1	
	5:05pm	110/60	79	2	3	Emptied
	5:20pm	100/70	78			
	5:35pm	104/70	79	3	0	Emptied
Every 30 minutes For 1 hour	6:05pm	120/70	79	3	0	
	6:35pm	110/60	80	3	00	Emptied

Birth Attendant Mercy Patience, supervised by Monica K. Mensah Date 31/05/2022

LSS 4th Edition external review draft - © ACNM (to be published 2008)

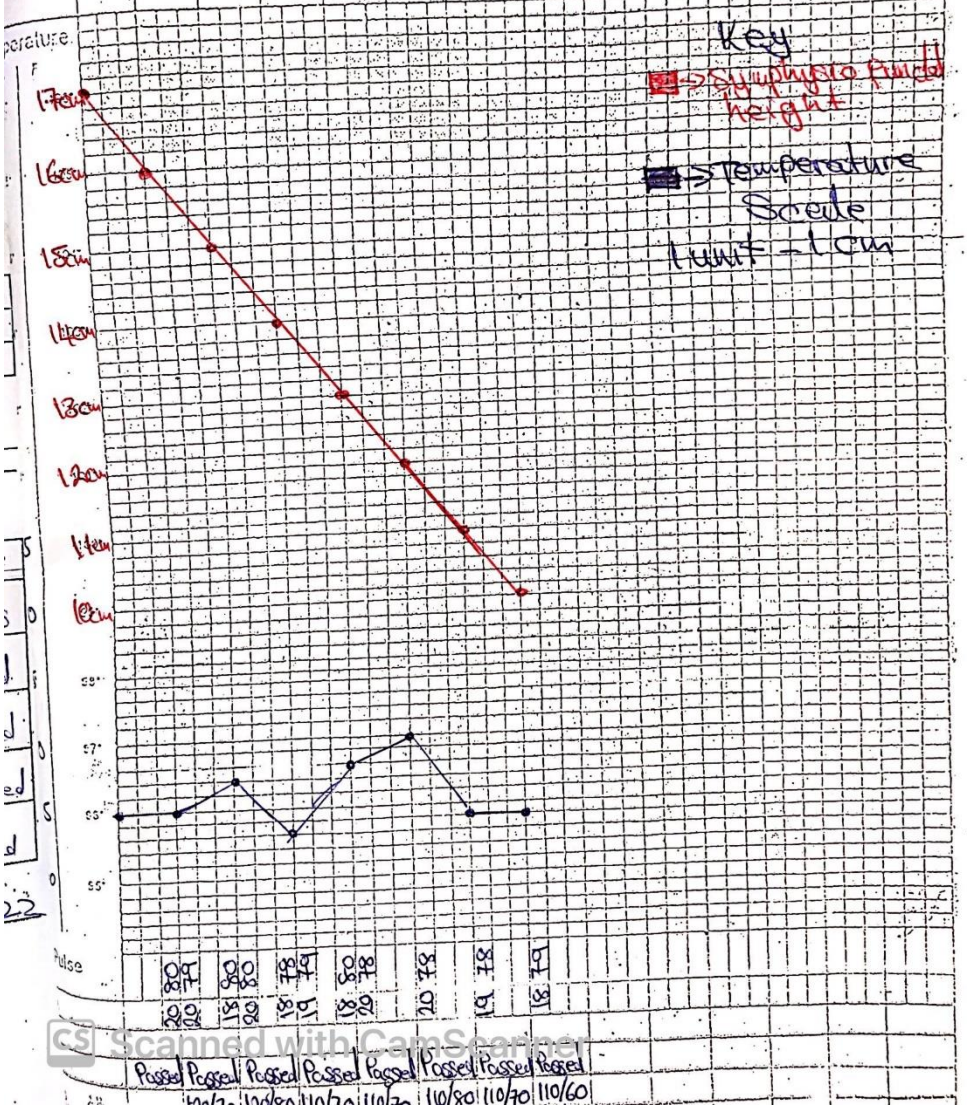
MATERNITY CHART

Mary Mareowa

25 years WARD: Lying-in

409/21 BED NO.:

	31/5/22	1/6/22	2/6/22	3/6/22	4/6/22	5/6/22	6/6/22	7/6/22
Hospital	DOA	D1	D2	D3	D4	D5	D6	D7
P.O.								
AM		6:15	7:30	6:32	6:10	7:40	7:30	5:31
PM	3:05	5:31	5:29	5:30				



TEMPERATURE CHART

E. Baby Abena Marfowaa

Newborn WARD: Lying in

O.: BED NO.:

Date	31/5/22	1/6/22	2/6/22	3/6/22	4/6/22	5/6/22	6/6/22	7/6/22
ys in Hospital	DOD	D1	D2	D3	D4	D5	D6	D7
ays P. O.								
Hour AM		6:15	7:30	6:32	6:10	7:40	7:30	5:31
PM	3:05	5:31	5:29	5:30				

Key

⇒ Weight

⇒ Temperature

Scale

1cm = 1unit

Temperature

C F

3.6kg

3.5kg

3.4kg

3.3kg

3.2kg

3.1kg

100

99

98

97

96

95

Pulse

PR 136	PR 132	PR 140	PR 136	PR 130	PR 132	PR 130	PR 142
RR 36	RR 42	RR 40	RR 40	RR 42	RR 40	RR 38	RR 40

Passed | Passed | Passed | Passed | Passed | Passed | Passed | Passed

NEWBORN EXAMINATION FORM

aby Abena Marfowaa — Date of Assessment: 31/5/22 — Time: 4:05 Pm

th 31/5/22 Time of Birth: 3:04pm Sex: ☐M ☑F — Age at time of Assessment(days/hrs): 1 hour

l Age: 38+0 Mode of Delivery: ☑Vaginal ☐Assisted Vaginal ☐C-Section

min 8/10 ☐ 5min 9/10 ☐ Birth Weight: ☐ 3.4 Kg ☐ Length: 51 Cm — Head Circumference: 33 Cm

re at time of Assessment: 36.8 °C Urine passed: (Yes) No Meconium passed: (Yes) No

ssessor (Midwife/Doctor): Dery Patience

piration

6 bpm
30 b/m*
60 b/m*
/m
ons*
g*

Movement

neous symmetric
ent
d/Absent
ent in > 1 limb
ement*

ed*

ir

over
dy but blue
eet
over*
e*

rd

lining pus

y

7. Suck
☑Good
☐Weak
☐Absent*

8. Head swelling
☐Caput succedaneum
☐Cephalhaematoma
☐Subgalcal hemorrhage
☐No swelling

9. Sutures
☑Normal
☐Overlapping
☐Fused
☐Widely separated*

10. Fontanelle
☑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

14. Neck
☑Normal
☐Swelling
☐Webbed
☐Other:

15. Clavicle
☑Normal
☐Swelling/Fracture

16. Chest
☑Normal (shape/movement)
☐Abnormal

17. Heart rate
Rate: 141 bpm
☑Normal (100-160)
☐<100*
☐>160*

18. Femoral pulse
☑Present
☐Not palpable*

19. Abdomen
☑Normal
☐Distended*
☐Scaphoid*
☐Abdominal defect*
☐Masses:
☐Other:

20. Black (spine)
☑Normal
☐Abnormal Swelling*
☐Hairy patch over spine
☐Abnormal dimple
☐Abnormal curvature

21. Limbs
☑Normal
☐Abnormal

22. Genitalia Male Genitalia
☐Normal
☐Undescended tests
☐Abnormal meatus
☐Hernia
☐Other:

23. Female Genitalia
☑Normal
☐Pistula (meconium/urine through abnormal opening in vagina)*
☐Large clitoris
☐Other:

24. Anus
☑Patent
☐Imperforate*

25. Resuscitation provided
☑None
☐Suction/Stimulation
☐Bag and mask
☐Endotracheal Tube
☐Ventilator/CPAP

26. Service provided
☑Vitamin K given
☑Eye care provided
☑Cord care provided
☑Breastfeeding initiated
☑Breastfeeding established
☑BCG ☑Polio Immunization
☐Antibiotics in mother
☐Antenatal corticosteroids

Healthy Term baby

[ ] With a Problem [ ] Danger Signs [ ] <2000g [ ] severe jaundice

NEWBORN EXAMINATION FORM

e: Baby Abena Marfowaa Date of Assessment: 1/6/22 Time: 3:05 pm
of Birth 31/5/22 Time of Birth: 3:05pm Sex: ☐M ☑F Age at time of Assessment(days/hrs): 24 hours
ational Age: 38+0 Mode of Delivery: ☑Vaginal ☐Assisted Vaginal ☐C-Section
AR: 1 min 8/10 ☐ 5min 9/10 ☐ Birth Weight: ☐ 3.4 Kg ☐ Length 51 Cm Head Circumference 35 Cm
perature at time of Assessment: 37.1 °C Urine passed: (Yes) No Meconium passed: (Yes) No
e of Assessor (Midwife/Doctor): Dery Patience

Respiration
- e 46 cpm
- ate < 30 b/m*
- ate > 60 b/m*
- -60 b/m
- etractions*
- runt ng*
- tridor*

Activity Movement
- pontaneous symmetric movement
- Reduced/Absent movement in > 1 limb
- No movement*

Tone
- Normal
- Floppy*
- ncreased*

Colour
- ink all over
- Pink body but blue hands/feet
- Blue all over*
- Pale*
- Jaundice*

5. Cord
- Normal
- Red draining pus
- Bleeding

6 Cry
- Normal
- Short*
- Absent*

7. Suck
- ☑ Good
- ☐ Weak
- ☐ Absent*

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

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

10. Fontanelle
- ☑ 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:

14. Neck
- ☑ Normal
- ☐ Swelling
- ☐ Webbed
- ☐ Other:

15. Clavicle
- ☑ Normal
- ☐ Swelling/Fracture

16. Chest
- ☑ Normal (shape/movement)
- ☐ Abnormal

17. Heart rate
Rate 142 bpm
- ☑ Normal (100-160)
- ☐ <100*
- ☐ >160*

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

19. Abdomen
- ☑ Normal
- ☐ Distended*
- ☐ Scaphoid*
- ☐ Abdominal defect*
- ☐ Masses:
- ☐ Other:

20. Black (spine)
- ☑ Normal
- ☐ Abnormal Swelling*
- ☐ Hairy patch over spine
- ☐ Abnormal dimple
- ☐ Abnormal curvature

21. Limbs
- ☑ Normal
- ☐ Abnormal

22. Genitalia Male Genitalia
- ☐ Normal
- ☐ Undescended tests
- ☐ Abnormal meatus
- ☐ Hernia
- ☐ Other:

23. Female Genitalia
- ☑ Normal
- ☐ Pistula (meconium/urine through abnormal opening in vagina)*
- ☐ Large clitoris
- ☐ Other:

24. Anus
- ☑ Patent
- ☐ Imperforate*

25. Resuscitation provided
- ☑ None
- ☐ Suction/Stimulation
- ☐ Bag and mask
- ☐ Endotracheal Tube
- ☐ Ventilator/CPAP

26. Service provided
- ☐ Vitamin K given
- ☐ Eye care provided
- ☑ Cord care provided
- ☐ Breastfeeding initiated
- ☑ Breastfeeding established
- ☐ BCG ☐ Polio Immunization
- ☐ Antibiotics in mother
- ☐ Antenatal corticosteroids

...disease that requires urgent referral
...known) Healthy Term baby
...overall assessment) ☑ Normal ☐ Baby ... ☐ Danger Sign/<1800g [ ] severe Jaundice
... [ ] Problem ... Referral Advanced

Name: Baby Abena Marfowaa No: Birth Weight: 3.4kg

Sex: Female Mother's No: 409/21 Length: 51 c.m

Nature of Delivery: Spontaneous Vaginal Delivery Diagnosis:

Date of Birth: 31/05/2022 Time: 3:05pm Date of Discharge: 01/06/2022

Date	31/5/22		1/6/22		2/6/22		3/6/22		4/6/22		5/6/22		6/6/22		7/6/22							
No. of Days	DOD		D1		D2		D3		D4		D5		D6		D7							
Weight	3.4kg		3.3kg		3.2kg		3.2kg		3.3kg		3.4kg		3.5kg		3.6kg							
Temperature	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM
		36.8°C	37.1°C	37.1°C	36.8°C	36.8°C	37.0°C	36.8°C	36.8°C		37.1°C		36.4°C		36.8°C							
Stools		Passed	Passed	Passed	Passed	Passed	Passed	Passed	Passed		Passed		Passed		Passed							
Urine		Passed	Passed	Passed	Passed	Passed	Passed	Passed	Passed		Passed		Passed		Passed							

Remarks

Head
Neck
Trunk
Limbs
Genitalia

No abnormalities detected.

SIGNATORIES

THE STUDENT

NAME: DERY PATIENCE

SIGNATURE.....

DATE.....11/10/2022.....

THE MIDWIFE IN-CHARGE

NAME: MS. MONICA KONTOH MENSAH

SIGNATURE.....

DATE.....08/09/2022.....

THE SUPERVISOR

NAME: MS. ERNESTINA MENSAH

SIGNATURE.....

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

THE PRINCIPAL

NAME: MONICA NKRUMAH

SIGNATURE:.....

DATE:....12/10/2022..... ACADEMIC CO-ORDINATOR-NURSING HOLY FAMILY NURSING & MIDWIFERY TRAINING COLLEGE, BEREKUM