

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

A CLIENT AND FAMILY CENTERED MATERNITY CARE STUDY ON

MADAM ADUBIA BENEDICTA

BY

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**A CLIENT/FAMILY CENTERED MATERNITY CARE STUDY
SUBMITTED TO THE NURSING AND MIDWIFERY COUNCIL OF
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LICENSE TO PRACTICE AS A PROFESSIONAL MIDWIFE
(DIPLOMA)**

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PREFACE

A family centered maternity care is the care and supervision given to the expectant mother and family throughout pregnancy, labour and puerperium.

It is based on a thoughtful understanding of the woman as a unique individual with peculiar needs which must be met within the context of the client's family. The care is extended to the members of the client's family as well as the community in which she lives.

Family centered maternity care gives each family member the education and support the family needs to welcome the new baby.

It helps to utilize all the skills and knowledge acquired from the various subjects taught in school to give care to meet the peculiar needs of the pregnant woman and her family.

The care study also serves as a partial fulfillment of an academic requirement of the Nursing and Midwifery Council of Ghana to license a student midwife to practice upon completion of course.

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INTRODUCTION

Family centered maternity care study involves rendering holistic obstetric care to a specific client and her family from the first contact during antenatal period through to labour and puerperium. The care study was conducted on Madam Benedicta Adubia, 22 years old woman who is gravid 2 para 1 alive at the time of the study. She comes from Biadan in the Bono region.

The interaction with her started on the 8th December, 2022 during her 6th visit to the facility and she was 37+2 weeks pregnant. She had a spontaneous vaginal delivery to a baby boy on 19th December, 2022. Care was rendered to her during pregnancy thus her antenatal visits through to labour and puerperium. Interactions with her ended eight days after delivery. The client was healthy throughout the beginning to end of the end of my interactions with her.

The study is divided into four (4) sections based on chapters as follows:

Chapter one (1) consists of client's social history, medical, surgical, past obstetrical, present obstetrical, family menstrual history and habits of daily living.

Chapter two (2) consists of care delivered in the antenatal period. The chapter ends within care plan which outlines care given based on the nursing process.

Chapter three (3) narrative of the care given during the first, second and third stages of labour. It ends with a care plan.

Chapter four (4) explains the care provided during puerperium. It consists of daily visits to the client and family. The chapter also explains client's visit to the family for postnatal care. It also ends with a care plan.

This script also contains literature review, summary and conclusion to the whole study. It contains signatories which makes the work genuine.

LITERATURE REVIEW

Pregnancy

King (2014) states that, the prenatal period covers the time from the first day of the last menstrual period to the start of true labour, which marks the beginning of the intrapartum period. Prenatal period is divided into three (3) trimesters, the first trimester is 1 to 12 weeks because organogenesis is completed at 12 weeks. And the risk for spontaneous abortion is significantly reduced at this time. Second trimester is from 13 to 28 weeks, third trimester extends from 28 to 40 weeks. The term post-date is typically used to describe a pregnancy beyond 40 weeks.

Marshall & Raynor, (2014) pregnancy starts from the time conception is confirmed until the beginning of labour and also the midwife facilitates woman-centered care by providing her with accessible and relevant information to help her make an informed choice throughout pregnancy. The aim of antenatal care is to monitor the progress of pregnancy optimize maternal and fetal health. To achieve this, the midwife critically evaluates the physical, psychological and sociological effects of pregnancy on the woman and her family.

Konar (2013) pregnancy is the progressive anatomical, physiological and biochemical change not only confined to genital organs but also to all systems of the body. This is principally a phenomenon of maternal adaption to the increasing demand of the growing fetus. Unless understood, this physiological adaptation to normal pregnancy can be misinterpreted as pathological there is enormous growth of the fetus during pregnancy. In late pregnancy, frequency of micturition once more reappears due to pressure on the bladder as the presenting part descends down the pelvis. Stress incontinence may be observed in late pregnancy due to urethral sphincter weakness. The gums become congested and spongy and may bleed to touch. Muscle tone and motility of the entire gastrointestinal tract are diminished due to high progesterone level. Cardiac sphincter is relaxed and regurgitation of acid gastric content into esophagus may produce chemical esophagitis and heart burn. There is diminished gastric secretion and delay emptying time of stomach. Risk of peptic ulcer

disease is reduced. A tonicity of the gut leads to constipation while diminished peristalsis facilitates more absorption of food materials.

Labour

According to Tiran (2015), normal labour occurs spontaneously after 37 weeks gestation with vertex presentation of a single fetus, completed within 24 hours without maternal and fetal trauma; physiology depends on interaction between uterus, maternal pelvis and fetus.

Marshall & Raynor, (2014) stated that labour in physical sense is described as the process by which the fetus, placenta and membranes are expelled through the birth canal. However, labour is much more than a purely physical event. What happens during labour can affect the relationship between the mother and baby and can influence the likelihood and or experience of future pregnancies. Pregnancy is considered to last approximately 40 weeks, with labour usually occurring between 17 to 42 weeks gestation. Complex physiological and psychological changes occur during the last few weeks of pregnancy and also during the onset of labour that prepare the woman for the process of labour and birth. Four stages of labour are described, the first, second, third stage and fourth but this is a rather pedantic view, as labour is obviously a continuous process.

Konar (2013) states that, labour is the process by which the fetus, placenta and membranes are expelled through the birth canal. The events of labour are divided into four stages; First stage starts from the onset of true labour pains and ends with full dilation of the cervix. It is in other words the “cervical stage” of labour. Its average duration is 12 hours in primigravida and 6 hours in multipara. second stage starts from full dilation of the cervix (not from rupture of membranes) and ends with the expulsion of the fetus from the birth canal. It mostly lasts up to 30 minutes in multiparous and 60 minutes in nulliparous women. Third stage begins after the delivery of the fetus and ends with the expulsion of the placenta and membranes. The average duration is about 15 minutes in both primigravida and multipara. Fourth stage is observation of the woman for at least 1 hour after

expulsion of product of conception. During this period, general condition of the patient and the behaviour of the uterus are carefully monitored.

Puerperium

Marie Elizabeth (2013) puerperium as the period following childbirth during which the body tissues, especially the pelvic organs revert back approximately to the pre-pregnant state both anatomically and physiologically. The period is divided into;

1. Immediate –within 24 hours
2. Early- up to 7 days
3. Remote –up to 6 weeks
4. Immediately following delivery, the uterus becomes firmer and retracted with alternating hardening and softening. At the end of 6 weeks, its measurement is almost similar to that of the non-pregnant state and it weighs 60 grams. The lower uterine segment becomes thin, flabby and collapsed structure. The cervix contracts slowly; the external os admits to fingers for the few days but by the end of the first week, narrows down to admit the tip of a finger only. The external os never revert back to the nulliparous state. During puerperium the number of muscle fibres is not decreased but there is substantial reduction in the myometrial cell size. The arteries are constricted by contraction of its wall and thickening of the intima followed by thrombosis. New blood cells grow in the thrombi. Soon after birth it takes a long time (4 to 8 days) for the vagina to involute. The vaginal discharge for the first fortnight during puerperium is the lochia. The lochia originates from the uterine body, cervix and vagina. Depending upon the variation of the colour of the discharge it is named as:

1. Lochia rubra (red) 1 -4 days.
2. Lochia serosa (yellowish or pink or pale brownish) 5- 9 days.
3. Lochia alba (pale white) 10 -15 days.

4. The average amount of discharge, for the first 5-6 days is estimated to be 250 ml.

Puerperium is defined as the time from the delivery of the placenta through the placenta through the first few weeks after the delivery. **(E.M. Symonds, 2021)**. This period is usually 6 weeks in duration. The uterus involutes, traumatized areas of the genital tract heals and lochia drainage changes and ceases. The midwife renders the care needed towards prevention of complications such as puerperal infection, postpartum haemorrhage and others. The puerperal is also educated on how to fix baby to breast and breastfeed, etc. Some of the minor disorders of puerperium are backache, after pain, retention of urine, constipation, breast engorgement, etc. To help the puerperal woman attain these goals, the midwives care should be based on principles of promoting the physical wellbeing of both mother and baby. By promoting the development of the good mother child relationship, supporting and strengthening the mother's confidence in herself. Enabling her to fulfill her role as a mother in her personal, family and cultural situation. From the above, it can be deduced that, puerperium is the management of the mother and baby to exclude puerperal sepsis, other complications and establishment of lactation.

WHY CLIENT WAS CHOSEN

Madam Adubia was chosen as my client for the client/ family centered maternity care study on the 8th December, 2022. She reported to the facility very early. During the health session, she was not paying attention and was holding her head. She was approached and she complained of having a headache, she was assured and the physiology of the pain was explained to her that, it was due to the stress of pregnancy. After going through her antenatal booklet, she was qualified to be used for the study. An introduction was made as a student midwife from Holy Family NMTC, Berekum, who is on clinical practice and the interest to select her for the study. She agreed and was thanked for her understanding and cooperation. The midwife in-charge was informed about the selection of madam Adubia for the care study which she agreed.

CHAPTER ONE

CLIENT PARTICULARS

1.0 INTRODUCTION

This chapter provides detailed information about client social history, family history, medical history, surgical history, past and present obstetric history and also client lifestyle and the community as a whole. The various information helps the health worker to render the most appropriate care to the client.

1.1 PERSONAL/ SOCIAL HISTORY

Madam Adubia gravida two para one alive, who comes from Biadan in Bono region and stays there with her husband and child. She is twenty-two years old. She is dark in complexion, with height 165cm and weight 53kg. She was born in 1st December, 1999. She speaks English, bono and Twi. She completed her junior high school at Catholic J.H.S at Dormaa Ahenkro. She is also a S.H.S graduate. She is a trader. She and her family are all devoted Christians who attends Methodist church. Mr. Azuma is the husband of madam Adubia. He comes from Dormaa Ahenkro in Bono region. The husband's occupation is a graphic designer. He is a S.H.S graduate. Her next of kin is her husband. She does not engage in smoking and alcoholism.

1.2 SURGICAL HISTORY

Madam Adubia has never undergone any surgical procedure since she was born. Also, she has never been involved in an accident that might have affected her spine, pelvic bone or any other reproductive organs.

1.3 FAMILY HISTORY

Madam Adubia mentioned that, there is no history of hereditary diseases such as hypertension, diabetes, asthma, sickle cell anemia, epilepsy or mental illness in her or that of her husband's family. Also, there is no history of multiple pregnancies in both families. She is the third born

out of four children, one male and the rest are females all alive and in good health. Mr. and Mrs. Amoah are the parents of the client. Client's mother is alive but the father is late. He died of a car accident. The economic status of the client's family is financially stable.

1.4 MEDICAL HISTORY

Madam Adubia said she has no history of heart disease, asthma, hypertension, diabetes, respiratory disease and sickle cell. She is not allergic to any food and drugs. Also, she is not on any medications except for drugs given to her on antenatal visit.

1.5 MENSTRUAL HISTORY

According to Madam Adubia, she had her menarche at the age of sixteen (16) years. She has a regular menstrual cycle and bleeds for five days with slight lower abdominal and back pains for the first two days. She complained of having mittelschmerz during ovulation.

1.6 CLIENT LIFESTYLE AND HOBBIES

Madam Adubia usually wakes up as early as 5:30am and goes to bed at around 8:30pm. She cleans the environment and other house chores with the support of her husband and child. She bathes her child and prepares her for school. She brushes her teeth and takes her bath. She prepares breakfast for her family which is usually porridge with bread. She goes to work and goes to pick her child from school before coming home after closing from work. She prepares supper which are usually ampesi, rice, banku or sometimes konkonte. Her favorite food is rice ball (emotuo) and palm nut soup. She empties her bowel once a day and bath twice a day. She does the laundry and cleaning of the house on Saturdays. She goes to church on Sundays with her kid and husband. She usually watches television on her leisure time.

1.7 PAST OBSTETRIC HISTORY

Pregnancy

Madam Adubia, G2P1, carried her previous pregnancy till full term without any complication. She has no history of previous abortion either spontaneous or induced. She had her first pregnancy in

2019 making the interval between the first pregnancy and this current pregnancy three years. According to her, she had no history of pregnancy induced hypertension, antepartum haemorrhage, diabetes in pregnancy and anaemia. She also experienced minor disorders like waist pains, heart burns and leg cramps which was explained to her as normal physiology in pregnancy more especially in early pregnancy and will resolve as pregnancy advances. She was given her first and second tetanus diphtheria injection according to her antenatal book and her five doses of sulphadoxine pyrimethamine in her first pregnancy. She was a regular attendant at the antenatal clinic. Records for laboratory investigations were all good. She tested negative for HIV and syphilis

Labour

According to client, labour started spontaneously so there was no induction or augmentation of labour. She said her child was delivered spontaneously per vaginum without any complications like prolong second stage of labour or maternal distress. Also, she had no history of retained placenta or postpartum hemorrhage. According to her, her baby cried immediately after delivery and was in good condition. Client said she had a female as her first child and her weight at birth was 2.8kg. The estimated blood loss for the first pregnancy was 200 milliliters. She had no complication after delivery, no abnormality or congenital malformation such as cleft lip, cleft palate or extra digit were found on baby. She was discharged on the next day after delivery.

Puerperium

Madam Adubia passed through puerperium safely without any complications such postpartum haemorrhage or puerperal sepsis. Her baby was able suck well within the first one hour after birth. She practiced exclusive breastfeeding for six months and weaned the child at the age of two. The child was immunized against BCG, Polio, measles, yellow fever and the others. She practiced natural family planning. She attended her postnatal visits as scheduled.

1.8 PRESENT OBSTETRIC HISTORY

Madam Adubia, G2P1 alive visited the maternity home on 11th June 2022 when she was 20+2 weeks in gestation. She could not remember the date of her last menstrual period but could only remember the month which was in March, 2022 hence her expected date of delivery (EDD) was calculated as 24th December, 2022 for the first ultrasound scan and 27th December, 2022 for her second ultrasound scan. Vital information was taken and recorded during her first visit. Vital signs and laboratory investigation were checked and recorded as follows;

Temperature - 36.5 degrees celsius

Pulse - 94 beats per minutes

Blood Pressure - 120/84 millimeters of mercury

Weight - 53.5 kilograms

Height - 165 centimeters

Respiration - 24 beats per minutes

The following laboratory investigation were also conducted and recorded as;

Haemoglobin - 11.0g/dl

Sickling test - Negative

Blood group - A

Rhesus factor - Positive

Syphilis (VDRL) - Non-reactive

HIV /AIDS - Negative

Hepatitis B - Negative

G6PD - No defect

Stool R/E - Normal

Urine (glucose and protein) - Negative

Physical examination was done and recorded with no abnormalities detected. She was given her third dose of Tetanus Diphtheria (TD) injection since she had already taken her first and second doses in her previous pregnancy. She had no complains and was served with the following routine drugs;

Tablet folic acid - 5 milligrams daily for 30 days

Tablet multivitamins - 200 milligrams daily for 30 days.

Tablet Fersolate - 200 milligrams daily for 30 days

Laboratory investigation and ultrasound scan requested were carried out with no abnormalities recorded. She was served with her first dose of sulphadoxine pyrimethamine under direct observation since she was 20 weeks pregnant and it was repeated at 4 weeks interval. All findings were recorded in her ANC card.

CHAPTER TWO

ANTENATAL CARE

2.0 INTRODUCTION

This chapter contains information about first contact with client, antenatal home visits, and subsequent visit to the clinic. It also contains care plans drawn to help meet the needs of the client and help solve the problems detected during the period of her antenatal care.

2.1 FIRST CONTACT WITH CLIENT

Madam Adubia was met on 8th November, 2022 on her 6th antenatal visit. She was 37+2 weeks in gestation on one of her scheduled antenatal visits. She was welcomed and offered a seat. She was chosen as my client because during the health session, she was not paying attention and holding her head. So, I approach her and asked her about the reason why she was not paying attention and she complained of having a headache. So, she was in a hurry to go home and rest, because she took a day off from work. A look through her antenatal book indicated that she was suitable for the care study. Introduction of self was made to her as a student midwife from Holy Family Nursing and Midwifery Training College, Berekum. She was told about the intention to take her as my client for the care study. She accepted and all questions and doubts were answered and cleared. She was then introduced to the midwife in charge for her approval which she did. Client was thanked for her cooperation. Her vital signs were checked and recorded as;

Temperature - 36.5⁰C

Pulse - 86 bpm

Respiration - 23 bpm

Blood pressure - 110/79mmHg

Weight - 58kg

Laboratory investigations carried out showed the following;

Hemoglobin	-	11.8 g/dL
G6PD	-	No defect
HIV	-	Negative

Urine Testing

Client was given a specimen bottle to provide a midstream urine to test for protein and glucose by the use of a urine reagent strip. The quantity, colour, smell and sediment were noted. Urine was amber in colour. Urine tested negative for protein and glucose and there was no offensive smell.

General Head to Toe Examination

Client was asked to go to the examination room where privacy was provided. Permission was sought and granted to conduct the procedure. She was helped to undress and changed into a gown and assisted onto the examination bed. She was told to lie on her left side before lying supine and was encouraged to do that anytime she comes for antenatal care and even at home. Hands were washed under running water with soap and dried with clean towel and rubbed together to keep them warm. On general inspection, the client looked neat and healthy. Client was examined under the supervision of the midwife in-charge.

Head and neck examination

Standing at the right-hand side of the client, the hair was checked for dandruff, breakages and cleanliness. Client was encouraged to always keep her hair clean. Face was checked for oedema, chloasma, pallor, puffiness and none was detected. Her eyes were checked for jaundice, anaemia or conjunctiva. Ears and nose were then checked for any discharges and pain but there was none present. Ears were in alignment with the eyes. Mouth was inspected for cracked lip, halitosis,

tongue for pallor and sore which were absent. The neck was palpated for distended veins, enlarged lymph nodes but all was good.

Breast examination

Breast examination procedure was explained to her and permission was granted. Breast was exposed and inspected for size, shape and signs of pregnancy and any abnormalities such as retracted, inverted or flat nipples and none was detected. She was asked to place the arm of the part to be examined under the head. The inner finger was used to palpate the breast starting from the axilla in a circular motion for tenderness and enlargement of lymph nodes. Nipples were squeezed gently for fluid with a cotton wool for any discharge. The same procedure was performed on the other breast. Client was taught about self-breast examination, care and encouraged to wear a well-fitting bra to support the breast and enhance comfort.

Extremities

Client's upper extremities were inspected for oedema of the hand, pallor of the palms and the finger nails and the nail bed were checked for capillary refill and pallor and no abnormality was detected. Arms were checked for equal length and everything was normal. The lower extremities were checked for oedema, varicose veins, size and equality, extra or missing digits and tenderness in the calf but none was detected. She was encouraged to avoid prolonged standing and should rest her legs on a stool when sitting down to prevent swelling of the feet.

The back

The back was also inspected for oedema at the sacral region and the condition of the skin. There was no oedema at the areas inspected and the condition of the skin was good.

Abdominal Examination

Permission was sought to expose her abdomen for inspection and was granted. She was asked if she would like to empty her bladder and she said no. With hands already warmed, she was

asked to relax her abdominal muscles, lie comfortably on the bed with her arms by her side. Items used were showed to her to allay fears. A quick inspection was done on the abdomen without touching. The abdomen was ovoid in shape, firm and with no scars but striae gravidarum and linea nigra were present. She was asked if she has felt any fetal movement today and she said yes.

Measurement of Symphysis-Fundal Height, the upper border of the uterus was palpated to locate the fundus. The zero-part of the tape measure was placed on the fundus and was extended along the midline of the abdomen to the upper border of the symphysis pubis. The measurement was recorded as 37cm.

Fundal palpation, facing the head of the client, both hands were placed on the sides of the fundus. The fingers were curled around the upper border of the uterus and a gentle pressure was applied to determine what part lies in the fundus. Soft, firm with indefinite outlines was felt which indicates the buttocks.

On Lateral Palpation, hands were placed on each side of the uterus at the level of the umbilicus. The uterus was stabilized with one hand and examined with the other hand and palpated the entire area in a rotary manner. A smooth continuous curve was felt which indicated the back was at the right side of the abdomen. The left side of the abdomen was also palpated with the other hand while stabilizing the right side. An irregular movement and mass were felt which indicated the limbs. The position was therefore right occipito anterior.

Pelvic Palpation, this palpation is done to identify the presentation and descent of the fetus. Client's feet were faced and she was asked to flex the knees slightly to relax the abdominal muscles and breath through her mouth slowly. The palms were placed on either side of the uterus just below the umbilicus and the fingers held together pointing towards the symphysis

pubis. A hard, round and smooth mass was felt at the lower pole of the uterus indicating the head and that it was a cephalic presentation and the lie was longitudinal.

Descent, two fingers were placed over the anterior shoulders and it was below the umbilicus. The upper boarder of the symphysis pubis was located and the right ulna was placed just above the symphysis pubis and the palm extended to the anterior shoulder. Five fingers were accommodated indicating descent is 5/5th

On auscultation, the fetoscope was warmed by rubbing it in the palm and placed on the right side of the abdomen where the fetal back was located at a right angle to the abdomen. The fetal heart was listened by auscultation without touching the fetoscope. The fetal heart rate was counted for one minute using a second-hand watch and compared to the maternal pulse. It was one hundred and thirty-four 134 beats per minutes with a regular rhythm.

Vulva examination, permission was sought from the client and she agreed. Hands were washed with soap under clean running water and dried with clean towel. Examination gloves were worn. She was asked to bend her knees and separate her legs. The vulva and the perineum were examined for lesions, abnormal discharge, rashes, varicose veins and any scars (FGM). Nothing abnormal was detected. She was thanked for her cooperation and helped to lie on her side, sit up and get off bed and redressed. Gloves were removed and hands were washed properly under running water with soap and dried with clean towel. Findings were communicated to her and recorded into her antenatal book. Client was encouraged to have enough rest and sleep and also perform exercises such as kegel's exercise which strengthens the pelvic muscles and make delivery easy. Client was also encouraged to take her drugs as she was told. Health education was given on birth preparedness and complication readiness plan and danger signs of pregnancy. The following drugs were given to her;

Tablet multivitamin - 200mg once daily for 30 days.

Tablet folic acid -5mg daily for 30 days

Tablet ferrous sulphate - 200mg once daily for 30 days

Client complained of constipation and it was explained to her that it was because of the relaxation of the smooth muscle of the intestine. She was advised to take in more fluids, fruits and roughages. She also complained of headaches which were explained to her that it was because of stress. She was given analgesics and asked to rest and sleep well. Client was informed of her next antenatal visit which was 15th December, 2022 since she was 37 weeks. A schedule for home visit was planned and phone numbers were exchanged and client address was taken. Client was advised to not hesitate to visit the maternity home if any problem concerning her health and pregnancy arises.

2.2 FIRST ANTENATAL HOME VISIT

The first visit to Madam Adubia's house was on the 10th December, 2022 at exactly 4:30pm. The aim of the visit was to observe client's environment, meet the family and establish rapport with them and the neighbors and assess her condition. They welcomed me and she introduced me to her family. A quick assessment of the environment was done before a seat was offered. A glass of water was offered which was accepted. Permission was sought to involve husband in the conversation and was accepted. Madam Adubia and her family lives in a compound house with three neighbors. The house was built with cement blocks and roofed with aluminum roofing sheets. The house was painted in golden colour. Their house contained one bedroom, a kitchen, a hall, bathroom and toilet and a corridor. Their source of water was a pipe borne in the house and source of light is electricity but uses torch whenever there is light out. The rooms were well ventilated and her things well arranged. She, her husband and child sleep in the same bedroom. They slept under intermittent treated mosquito net. The room has two windows which could be opened for ventilation. The family has a waste bin into which they put their waste and

later emptied at the refused dump every morning. They store the water in a plastic container covered with a lid for use in case of shortage of water. Health education was given to the client and her family on birth preparedness and complication readiness plan, infection prevention and good nutrition even though she knew them. Client had the telephone number of a taxi driver who will bring her to the facility incase her husband is not around when she was due, and support person who is her mother. She was asked how she is faring now since she gave a complain of constipation the last time she came for antenatal visit and she said she could free her bowels now. Client was asked to bring her delivery items for inspection and it was complete and intact. She has a cordial relationship with her family and co-tenants and also members staying around the house. She attends social gatherings concerning her family and society always.

2.3 SUBSEQUENT VISIT TO THE CLINIC

On 15th December, 2022, Madam Adubia visited the maternity home at 9:45am as scheduled, which was the 2nd contact with her at the clinic but her sixth(6th) visit to the clinic. She was warmly welcomed and offered a seat and asked about her condition and she confirmed she was doing well.

Client's vital signs and weight was checked and recorded as follows;

Temperature	36.5 degree Celsius
Pulse	80 beat per minute
Respiration	22 beats per minute
Weight	59 kilograms
Blood pressure	110/88 millimeters of mercury.

Hemoglobin level was checked and recorded as 12.4grams per deciliter. Client was asked to empty her bladder to promote comfort during physical examination and sample of the urine was tested for

protein and glucose which tested negative. Hand washing was done with soap under running water and dried with a clean dry towel before head-to-toe examination was done. Privacy was provided and she was assisted unto the examination bed in a dorsal position after undressing. On physical examination, everything was normal, the abdomen was globular in shape with fetal movement present. On palpation, the buttocks occupied the fundus, the back was at the right side of the uterus. The head was at the lower pole of the uterus. The symphysio-fundal height was thirty-seven and gestation was 38 weeks. The lie and position were longitudinal and right occipito-anterior position with descent 5/5th above the pelvic brim. Presentation was cephalic.

On auscultation, the fetal heart rate was 138 beats per minutes. She was asked to lie on her side and assisted to get out of the bed to redress. Hands were washed and findings were communicated to her and recorded into her antenatal book. She was asked if she had any complains and she said she had been experiencing backache and heartburns. She was reassured and her symptoms were explained to her that, the backache its due to relaxation of the ligament by the activity of the hormones, relaxin and progesterone. She was educated to wear low heeled shoes, adapt a good posture and avoid straining herself.

With the heartburns, it is due to progesterone relaxing the cardiac sphincter of the stomach and also the pressure of the enlarging uterus resulting in regurgitation of gastric acid into the oesophagus. She was educated to eat less spicy and fatty food.

Client was also asked to come back in a week time for review that was 22th December, 2022. She was thanked for her cooperation.

2.4 SECOND ANTENATAL HOME VISIT

The second home visit was on 17th December, 2022 at 3:30pm. The family gave me a warm reception. My purpose of the visit was to find out how the family is fairing and how she is coping with the last complains of heartburns and backache, and she said they have reduced. She was reassured and encouraged to keep it up. Education on danger signs such as vaginal bleeding, excessive vomiting,

severe abdominal pains and headache were all to be reported immediately to the clinic if she notices any of these signs. She was again asked if her sister and the driver was available if anything were to happen and her husband was not around and she said yes. She was encouraged to keep all her delivery items packed in a bag along with her health insurance and antenatal book because she could be due at any time. She was also educated on labour signs which are show, regular painful rhythmic uterine contractions and the others. She complained of lower abdominal pains which was due to the growing uterus and descent of the head. She was advised on good posture and having a sacral massage by the husband. She was thanked, reminded of the next visit to the clinic on the 22th December, 2022 and bid farewell.

2.5 ANTENATAL CARE PLAN

Problems Identified during Antenatal

- 08/11/20- constipation
- 08/12/20- headache
- 15/12/20- backache
- 15/12/20- heartburns
- 17/12/20- lower abdominal pains

Short Term Objectives

- Client will be able to empty bowels at least once a day within 24 hours.
- Client's headache will resolve within 2 hours.
- Client will be able to cope with backache within 12 hours.
- Client's heartburns will reduce within 12 hours.
- Client's lower abdominal pains will reduce within 24 hours.

Long Term Objectives

Madam Adubia will pass through pregnancy safely without any complication.

TABLE 1: NURSING CARE PLAN DURING ANTENATAL CARE

Date/ Time	Nursing Diagnosis	Nursing Objectives/Outcome Criteria	Nursing orders	Nursing Intervention	Date/time	Evaluation	Sign
08/12/2022 10:00am	Constipation related to inadequate intake of roughages and fluids.	Client will be relieved from constipation within 24 hours as evidenced by client verbalizing that she can empty her bowels at least once a day.	1. Reassure client to allay fears and anxiety. 2. Encourage client to take in adequate fluids, fruits and vegetables. 3. Encourage client to free bowels when the urge is felt. 4. Educate client on mild exercises. 5. Encourage client to empty bladder regularly.	1. Client was reassured to allay fear and anxiety because she is in competent hands. 2. Client was encouraged to take in more fruits, fluids and roughages. 3. Client was encouraged to empty bowels when the urge is felt. 4. Client was educated on some mild exercises like kegel's exercise. 5. She was encouraged to empty bladder regularly.	09/12/2022 10:00am	Goal fully met as evidence by client was able to free her bowels once daily.	BAA

TABLE 2: CARE PLAN DURING ANTENATAL CARE

Date/ Time	Nursing Diagnosis	Nursing Objectives/Outcome Criteria	Nursing orders	Nursing Intervention	Date/time	Evaluation	Sign
08/12/2022 10:00am	Headache related to stress of pregnancy.	Client's headache will resolve within 2 hours as evidenced by client verbalizing that the pain has resolved.	1.Reassure client that headache will resolve. 2.Explain cause of headache to client. 3.Educate client to have enough rest and sleep. 4.Encourage client to drink adequate amount of water. 5.Administer prescribed analgesics.	1.Client was reassured that headache will resolve. 2.Client was told it was due to stress of pregnancy. 3.Client was educated to have at least two hours rest during the day and six hours at night. 4.Client was encouraged to drink at least 8 glasses of water every day. 5.Tab paracetamol 1g was served as prescribed.	08/12/2022 12:00pm	Goal fully met as evidence by client saying her headache has resolved.	BAA

TABLE 3: CARE PLAN DURING ANTENATAL CARE

Date/ Time	Nursing Diagnosis	Nursing Objectives/Outcome Criteria	Nursing orders	Nursing Intervention	Date/time	Evaluation	Sign
15/12/2022 10:00am	Backache related to relaxation of the ligaments of the pelvis.	Client's backache will reduce within 12 hours as evidenced by client verbalizing that her backache has reduced.	1.Reassure client that backache will reduce. 2.Explain the physiology of backache to client. 3.Educate client to avoid lifting heavy objects. 4. Encourage client to sit in an upright position and support back with pillow when sitting and sleeping. 5. Serve her prescribed analgesics.	1.Client was reassured that backache will reduce. 2.Physiology of backache was explained to her. 3.Client was educated to avoid lifting of heavy objects. 4.Client was advised to have enough rest and sleep on a firm mattress. 5.She was served with prescribed analgesics.	15/12/2022 10:00pm	Goal fully met as evidence by client saying she can sit for a longer period.	BAA

TABLE 4: CARE PLAN DURING ANTENATAL CARE

Date/ Time	Nursing Diagnosis	Nursing Objectives/Outcome Criteria	Nursing orders	Nursing Intervention	Date/time	Evaluation	Sign
17/12/2022 4:00pm	Heartburns related to relaxation of the cardiac sphincter by progesterone.	Client will be to cope with heartburns within 6hours as evidenced by client verbalizing that her chest pains has reduced.	1. Provide emotional support to client. 2. Explain the cause of heartburns to the client. 3. Advise client to take in less spicy food. 4. Educate client to eat in bits and early before time. 5. Advise client not to go to bed immediately after eating.	1. Emotional support was provided to her that she will be relieved of the heartburns. 2. The cause of heartburns was explained to client. 3. Client was advised to take in less spicy food. 4. Client was educated to eat in eat in bits and early before bed time to reduce heartburns. 5. Client was advised to go to bed at least 2 hours after meals.	17/12/2022 10:00pm	Goal fully met as evidence by client saying that her burning sensation has reduced.	BAA

TABLE 5: CARE PLAN DURING ANTENATAL CARE

Date/ Time	Nursing Diagnosis	Nursing Objectives/Outcome Criteria	Nursing orders	Nursing Intervention	Date/time	Evaluation	Sign
17/12/2022 at 4:00 pm	Lower abdominal pains related to engagement of the head.	Client's lower abdominal pain will reduce within 24 hours as evidenced by client verbalizing that she feels slight pain in her lower abdomen making her comfortable.	1.Reassure client that pain will reduce. 2.Explain the cause of lower abdominal pain in the late pregnancy to client. 3. Advise client to avoid prolong sitting. 4. Encourage client to have adequate rest and sleep. 5. Serve prescribed analgesics to client.	1.Client was reassured that pain will reduce . 2.The cause was explained to her that it was due to the engagement of the fetal head in the pelvis. 3.Client was advised to avoid prolong sitting and to take short walk to subsidies pain. 4.She was also encouraged to have adequate rest and sleep. 5.Client was served with prescribed analgesics.	18/12/2022 at 4:00pm	Goal fully met as evidence by client reporting that she feels slight pain in her lower abdomen making her comfortable.	BAA

CHAPTER THREE

LABOUR

3.0 INTRODUCTION

This chapter describes the management of labour and immediate care of the new born, examination of the new born and the care plan drawn for the management of the problems encountered during this period.

3.1 ADMISSION AND MANAGEMENT OF FIRST STAGE OF LABOUR

On 19th December 2022, Madam Adubia and her mother reported to the maternity home at 7:10am. She was welcomed and offered a seat. Her antenatal book was looked through and her present history of labour was taken and recorded. She gave a history of labour pains which started at dawn. She was asked if she has taken in any food before coming and she said she had eaten porridge with bread. She was encouraged to do deep breathing exercise and avoid pushing during uterine contraction to prevent exhaustion and the cervix from becoming oedematous. Her delivery items were collected and labelled and she was taken to the maternity room and admitted on a well laid bed and made comfortable after helping her change into a light dress with cloth wrapped around her. All procedures to be carried out were explained to her and her consent was sought. At 7:30am, her vital signs were checked and recorded as follows:

Vital Sign	Value
Temperature	36.7 degree Celsius
Pulse	82 beats per minutes
Respiration	22 cycles per minutes
Blood Pressure	124/80 millimeters of mercury

A specimen bottle was given to client for the midstream urine collection for urine examination and a bed pan was also served. The amount of urine produced was 110mls. A urine reagent strip was used to test for glucose, acetone and protein and the results were negative. The colour of the urine was amber, clear and not offensive. Hands were washed with soap under clean running and soap water and dried with clean dry towel. Privacy was ensured. Client was help to lie on her back and head to toe general examination was conducted but no abnormality was detected.

On abdominal examination, client was asked to empty her bladder. Client's abdomen was ovoid in shape and medium in size. Striae gravidarum, linea nigra and fetal movement were present but no scar was found. The abdomen was palpated, symphysio fundal height was 38cm, and gestational age was 38+6weeks, the lie was longitudinal, presentation was cephalic, and descent was 3/5th palpable abdominally. Contraction was 3 in 10 minutes lasting for 36 seconds. On auscultation, the fetal heart rate was 135 beats per minute with good volume and regular in rhythm.

On vaginal examination, a sterile prepared tray for vaginal examination was brought to the bed side and the procedure was explained to her consent sought. Hands were washed with soap under running water and dried with a clean towel, sterile gloves were worn for vaginal examination. She was asked to assume a lithotomy position and to flex her knees. The vulva which was neatly shaved was inspected for scars, sores, warts, edema, abnormal discharge but none was present.

Sterile cotton wool swabs were used to swab the vulva soaked in savlon solution. The soaked cotton wool swab was picked with the right hand into the left hand and labia majora, labia minora and the vestibule were wiped from anterior to posterior per one stroke each. After swabbing the vulva, the vagina was entered with the right middle finger and then followed by the index finger. The vagina was warm and moist, the cervix was soft, thin and the presenting part well applied to the cervix. The membranes were intact, cervical dilatation was five (5)

centimeters with no moulding. Presentation was cephalic, promontory of sacrum was not reached. The sacrum was well curved, ischial spines were blunt and pubic arch was wide. No blood was seen on the examining fingers and vaginal fluid was cleaned and odorless. Hands were removed and a fist was made and it fitted into the intertuberous diameter. Her perineum was cleaned and a perineal pad applied to the vulva. Client was covered with a cloth and made comfortable in bed. She was also encouraged to ambulate which will help her deliver early and to lie on her left side when she felt tired. She was also encouraged to empty her bladder frequently to enable the fetal head to descend and change pad when soiled. Client was then informed about the findings and were recorded.

3.2 PREPARATION FOR BIRTH

The midwife in-charge who was supervising the labour was chosen as a skilled helper. The mother of the client, the unskilled helper was told to be available in order to run errands when needed. The mother was asked to inform the taxi driver to be alert in case of emergency. The delivery room was cleaned and good source of light was ensured. Windows and doors were closed to provide privacy. A dry and flat surface was prepared to receive newborn. Resuscitation tray was checked, cleaned and all equipment and instrument were assembled and tested for their function. Client's hands and abdomen were washed and dried to prevent infection to the baby after delivery since the baby will be placed skin to skin on the mother's abdomen. The delivery pack and emergency drugs like oxytocin, cytotec and others were made available.

3.3 MANAGEMENT OF FIRST STAGE OF LABOUR

Client was put on partograph on admission when labour was established. Fetal heart rate, contractions and pulse were checked every 30 minutes and vaginal examination, descent, blood pressure, moulding and temperature was also checked every four hours. She was encouraged to take light nutritious diet and normal fluids in bits to prevent dehydration and to help her during the second stage of labour. She was also encouraged to adopt left lateral position whenever

lying down to aid blood supply to the foetus. Client was assisted into a comfortable position (lithotomy). Hand hygiene was performed, sterile gloves were worn and vaginal examination was conducted. At 10:30pm, client membranes ruptured spontaneously. Vaginal examination was done to exclude cord prolapse and to confirm dilatation of the cervix, client was 8cm dilated. Liquor was clear and moulding was (+) descent was 2/5th, contraction was 3 in 10 minutes lasting 45 seconds and fetal heart rate was 140 bpm. Blood pressure was 119/76mmHg, maternal pulse was 86bpm and temperature was 36.8⁰C. Urine was 100ml. findings were communicated to her and asked to ambulate but to lie on her left side when tired to prevent the uterus from pressuring on the inferior vena cava which can alter blood circulation to the fetus. She looked anxious and was asked the reason for that and she said that her labouring period is taking longer than in her first pregnancy, so she was worried. It was explained to her that every pregnancy has its own outcomes, so she shouldn't be worried and was reassured of safe delivery. She complained of waist pain which the physiology was explained to her and sacral massage given to her and taught to the relative to massage her to reduce the pain. She also complained of fatigue which the physiology was also explained to her that it was due to stress of labour. She was advised to take in something to recover her strength. Delivery trolley was cleaned delivery pack and resuscitation equipment were set up;

The top shelf:

- Cord scissors
- Cord clamp
- 2 artery forceps
- 2 cot sheets
- Injection tray containing oxytocin, vitamin K, syringe and needle and lidocaine
- Episiotomy set (2 dissecting forceps, suturing forceps, episiotomy scissors)
- Four (4) drapes

- Pair of sterile gloves
- 2 gallipots (one containing cotton swabs soaked in savlon solution and the other containing gauze)
- Receiver

Bottom shelf

- Measuring jag
- Placenta bowl
- Fetoscope
- Sucker in a bowl of water
- Bed pan
- Rubber mackintosh
- Rubber apron
- Extra sterile gloves.
- Perineal pads
- Antiseptic solution
- Examination gloves

At 12:30pm, client shouted she had the urge to pass stools, vaginal examination was done and the cervix was 10cm dilated. Liquor was clear and moulding was (++) descent was 0/5th, contractions was 4: 10 minutes lasting 50 seconds and fetal heart rate was 140bpm. Maternal pulse was 94bpm, temperature 37.0⁰C, blood pressure was 120/88. The perineum bulged and anus gaped. The midwife in-charge was asked to confirm it, which marked the second stage of labour. The first stage lasted for 5 hours.

3.4 MANAGEMENT OF SECOND STAGE OF LABOUR

Second stage of labour begins from full dilatation of cervix to the complete expulsion of the fetus. After carrying out vaginal examination, client was informed that she was due to deliver her baby. She was sent to the delivery room. She was asked if she felt the urge to empty her bladder and she said no. She was asked about the position she preferred to deliver her baby with and she assumed the lithotomy position. All windows were closed and fans were turned off. Protective clothing was then worn, that is plastic apron, boots and face masks. Delivery pack was opened and after which sterile gloves were worn. The vulva was cleaned with cotton wool balls soaked in savlon solution. She was draped with sterile sheets on both thighs, on the abdomen and under the buttocks to maintain a sterile field for the fetus. She was reminded that the baby would be delivered onto her abdomen and she agreed. With the second stage being confirmed by the last vaginal examination, she was asked to push with contractions and take a rest when the contractions wear off. To support the perineum and keep the delivery field clean from fecal contamination, a clean sanitary pad was applied to the anal orifice. The index and middle fingers of the right hand were placed on the fetal advancing head to aid flexion and to allow the smallest diameter of the fetal head to come out. Descent of the head advanced until the head crowned. With contractions crowning took place and the woman was asked to pant with contraction and not to raise her buttocks to prevent forceful delivery of the foetal head which can lead to perineal tear because she was found raising her buttocks. Extension of the head occurred in which sinciput, face and chins swept the perineum and the head was born. The eyes were cleaned immediately with sterile gauze, cleaning from the inner contour of the eyes outward using a swab at a time. The neck was felt for cord around it and there was none. Restitution occurred and external rotation of the head which indicates that internal rotation of the shoulders had occurred. The fetal head was held in both palms, each palm on the parietal bones and with little downward traction, the anterior shoulder was delivered. The posterior shoulder was also delivered with upwards traction as it was allowed to sweep the perineum and

with lateral flexion, the trunk and the rest of the body was delivered onto the mother's abdomen. The sex of the baby was noticed to be a female and the client was allowed to confirm it. The baby coughed and started crying out very loudly. The baby was left on the mother's chest to initiate bonding, breast feeding and to provide warmth. The baby was completely expelled at 12:55pm. She was congratulated for co-operation during the delivery process.

3.5 IMMEDIATE CARE OF THE BABY

Immediately the head was born, the eyes, mouth and nose were clean with sterile gauze and cotton wool swab. As soon as the whole body was delivered, the baby was dried off liquor to prevent heat loss through evaporation and clean with a warm clean cot sheet and put on mother's abdomen to ensure skin to skin contact. To establish breastfeeding and create bonding. The first minute APGAR score was 8/10. Cord clamping was delayed for 3 minutes before clamping. The umbilical cord was clamp 3cm away from the baby's abdomen and cut 2cm away from the first clamp. It was covered with a gauze to prevent blood from spilling. The cord was cut in between the two clamps using a cord scissors. A well labelled name tag was placed on baby's wrist for identification. The 5th minute APGAR score was 9/10. Baby's cap and socks were put on it. Baby's condition was very good.

The APGAR score was recorded as;

Apgar	First minute	Fifth minute	
Appearance	2	2	
Pulse	2	2	
Grimace	1	1	
Activity	1	2	
Respiration	2	2	

Total	8/10	9/10
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3.6 ACTIVE MANAGEMENT OF THIRD STAGE OF LABOUR

Third stage of labour deals with the total delivery of the placenta and membranes and control of hemorrhage. The abdomen was palpated to verify any undiagnosed second twin and there was none. 10 units of oxytocin was given intramuscularly at the thigh of the client to aid contraction of the uterus and control bleeding. Controlled cord traction was the method used in delivering the placenta in order to prevent retained placenta or products of conception. The cord was clamped closer to the perineum. A receiver was placed in between her thigh to receive the placenta and its membranes. The left palm was placed on the uterus to feel for contraction. It was repositioned to the supra pubic area when contraction was felt, control traction was applied on the cord in a downward motion to deliver the placenta in the direction of the curve of carus. Steady traction was maintained until the placenta was visible at the vulva. The placenta was cupped in both hands and the placenta was twisted to deliver the placenta and its membranes. The placenta and membranes were expelled completely at 1:05pm. The placenta was placed in the receiver after quick examination was done to know whether the membranes and lobes were intact. The blood loss was approximately 150mls. The uterus was rubbed to stimulate contraction and expel clots. Client was taught how to perform uterine massage and also educated on how the uterus should feel after massaging. The perineum, vulva, vagina and the cervix were swabbed and examined for tears and lacerations under a good source of light but there was no tear. A clean pad was then used to clean the liquor and the blood from her body. A clean perineal pad was also applied to the perineum and the client was asked to lie on her back and cross her legs so that any bleeding could easily be identified. She was thanked for her co-operation and efforts. She was informed to empty her bladder whenever she felt the urge in order to prevent bleeding. Finally, the placenta and membranes were sent to the sluice room to

be examined and discarded afterwards as per the protocol of the facility. Placenta and membranes were immersed in 0.5% chlorine solution for ten minutes to minimize the risk of infection during examination.

3.7 EXAMINATION OF THE PLACENTA AND MEMBRANES

After the client was made comfortable in bed, the placenta was examined thoroughly in the sluice room and was held by the cord with the membranes hanging and the membranes were examined for completeness and it was intact. The placenta was placed on a flat surface to examine both maternal surface and fetal surface. The fetal surface was shiny, smooth and grayish blue in colour. The amnion was peeled from the chorion up to the umbilical cord and was fully viewed. The maternal surface was dark red in colour, the lobes fitted together without any gap and edges also forming uniform circle at the maternal surface and this indicated there was no missing lobe, there were no white patches on the maternal surface, there was also no blood vessels radiating into the membranes which indicated absence of succenturiate lobe. The cord was situated at the center of the placenta with one vein and two arteries. There was no abnormality detected. The placenta was discarded after decontaminating it according to the protocol of the facility. The instruments and equipment used were soaked in 0.5% chlorine solution for ten minutes and washed, rinsed, dried and repacked for sterilization.

3.8 MANAGEMENT OF THE FOURTH STAGE OF LABOUR

The fourth stage of labour is a period of close observation of mother and baby for the first six hours after delivery of placenta, membranes and arresting haemorrhage to detect any deviation from normal. She was taken to the lying-in-ward after putting baby skin to skin for an hour. This stage includes prevention of disease, examination of the new born, management of the mother's condition and the baby.

Mother

Client`s vital signs as well as uterus and lochia were checked every 15 minutes for the first two hours, then 30 minutes for the third hour and hourly for the fourth, fifth and sixth hours post-delivery. Client`s vital signs were checked and recorded as follows;

Vital Signs	Value
Temperature	36.7 degree Celsius
Pulse	80 beats per minutes
Respiration	20 cycle per minute
Blood pressure	109/60 millimeters of mercury

Client was asked to empty her bladder for fundal height to be measured and she was further informed that, emptying her bladder would provide comfort and ensure accurate measurement. Afterwards, a new perineal pad was applied on her vulva. She was helped to lie down comfortably. The uterus was well contracted with symphysio fundal height measuring 15 centimeters. The lochia was red in color (rubra) and moderate in amount with no offensive odour. The baby was then put to breast to stimulate the release of oxytocin to aid in the contraction of the uterus and also to help in the passage of milk. Education was also given to her on the need to change her perineal pad frequently and any time it got soiled. She was encouraged to report any bleeding. She was further encouraged to eat any food of her choice. She ate kenkey with okra. Her relatives were allowed to visit mother and baby.

Baby

The baby was observed for colour, breathing, bleeding from the cord and warmth but no abnormality was detected.

Prevention of disease

This is done 90 minutes after delivery of the baby to prevent infections such as ophthalmic neonatorum, neonatal tetanus and hemorrhagic disease of the newborn. The baby's eyes were cleaned with sterile cotton wool swab with normal saline from the inner to the outer canthus. Two drops of Chloramphenicol eye drops were instilled on the baby's eye as prophylaxis for any eye infection. The baby was covered to provide warmth to prevent heat loss, vitamin K 1.0milligram was given intramuscularly on the thigh to prevent bleeding. Baby's skin was smeared with baby oil to provide warmth. Hands were washed and cord was dressed with methylated spirit. The baby was put to breast. She was further asked to report when she observes any bleeding, discharge and redness of the cord. Hands were washed with soap and water and dried with a clean towel.

3.9 EXAMINATION OF THE NEWBORN

The procedure was explained to madam Adubia. Hands were washed with soap and water and dried with a clean towel. Sterile gloves were worn and baby was undress on a clean, warm cot sheet. Baby's weight was 3.1 kilograms. Measurements of the baby were done and the head circumference 33 centimeters, length of the baby was 48 centimeters. Baby's vital signs were checked and recorded as follows;

Vital Sign	Value
Temperature	36.5degreeCelsius
Apex heartbeat	148 beats per minute
Respiration	36 cycles per minute

Examination gloves were worn and the baby was examined in the presence of the mother in a clean, warm environment, where nearby windows were closed. Baby was put on a covered flat surface and only the part to be examined was exposed. The general condition of baby was checked to be normal. The color was pink, chest was moving normally and the baby was active. A detailed head to toe examination was carried out to detect any abnormality. The head and scalp were normal with no caput succedaneum, bulging or sunken fontanelles. The eye balls were examined for jaundice, discharge and redness but no abnormality was found. The nose was inspected for size and shape and examined for deviated septum but the septum was normal. The nostrils were inspected for patency and discharges and the mucosa for color and polyps. No abnormality was detected. The mouth was examined by pressing the angle of the jaw which opened the mouth and the tongue, gum and palate were inspected and there was also no false tooth noticed. The palate was high arched, intact and the vulva centrally placed. There was no cleft palate or cleft lip, or tongue tie. The ears were inspected, the upper notch of the pinnae was at the same level with the eye. External auditory meatus was patent and the cartilage in the pinnae was checked for its softness. The shape and size were also noted and no abnormality was detected. The neck was inspected and palpated with no swelling such as congenital goiter, enlarged lymph node, rotation and flexion were good. The chest was examined, the respiratory movement was regular and the respiratory rate was 38cpm. The space between the nipples was noted and the nipples were in alignment. The abdomen was round with no bleeding from the umbilical cord. The cord was examined and there was one vein and two arteries. Hands and arms were inspected for symmetry, movement and paralysis, and the palm for the number of palmer creases. Shape and color of nail beds were inspected for reflexes (grasping, Moro) and they were normal. Hands were again examined for clubbing, extra or missing digits, nail growth and webbing and no abnormality was detected. The length and movement of the limbs were also noted. The digits were counted to be normal and separate to exclude webbing. The feet

were examined for any disability such as talips equinovarus. The lower limbs were also examined for congenital dislocation of the hip but no abnormality was detected. The spine was also examined with baby lying in prone position. The back was palpated for swelling, dimpling, hairy patches to exclude spinal bifida. In all, there was no abnormality detected. The genital area was examined and the vagina was inspected for patency and also any pseudo menstruation. The baby was classified as normal and routine care of the baby initiated. Gloves were removed and disposed aseptically before washing hands with soap under running water and dried with clean dry towel. The baby's skin was smeared with baby oil and wrapped. All findings were reported and recorded.

3.10 SUMMARY OF LABOUR AND DELIVERY

Date of delivery - 19th December, 2022

Time of delivery - 12:55pm

Type of delivery - spontaneous vaginal delivery

Time of placenta delivery - 1:05pm

Blood loss - 150mls

Drugs given - 10 units of oxytocin injection

Duration of labour

1st stage - 5 hours

2nd stage - 25 minutes

3rd stage - 10 minutes

Total - 5 hours 35 minutes

Condition of baby

Apgar score at first minute - 8/10

Apgar score at fifth minute - 9/10

Sex of baby - female

Weight - 3.1kg

Head circumference - 33cm

Full length - 48cm

Meconium - passed

Urine - passed

Condition - good

Condition of mother

Temperature - 36.7⁰C

Pulse - 80bpm

Respiration - 20bpm

Blood pressure - 109/60mmHg

Fundus - 15cm

Lochia - red(rubra)

Odour of lochia - non-offensive

Perineum - intact

Condition - good

Condition of placenta and membranes

Lobes and membranes - complete and healthy

Maternal surface - normal

Fetal surface - normal

Length - 45cm

Cord insertion - centrally

Cord vessels - three (2 arteries, 1 vein)

3.11 LABOUR CARE PLAN

PROBLEMS IDENTIFIED

On 19th December 2022, Madam Adubia complained of;

- Lower abdominal pains.
- Anxiety
- Waist pain
- Fatigue
- Potential for perineal tear.

SHORT TERM OBJECTIVES

- Client will be able cope with lower abdominal pain within 4hours.
- Client`s anxiety will resolve within 2 hours.
- Client`s waist pain will reduce within 2 hours.
- Client will regain her strength within 2 hours.
- Client will have an intact perineum after delivery.

LONG TERM OBJECTIVES

Client will go through labour and delivery successfully without any complications to mother and baby.

TABLE 1: LABOUR CARE PLAN

Date/Time	Nursing Diagnosis	Nursing Objectives/Outcome Criteria	Nursing Orders	Nursing Intervention	Date/Time	Evaluation	Sign
19/12/2022 7:30am	Lower abdominal pains related to uterine contractions.	Client will cope with lower abdominal pains throughout labour within as evidence by client verbalizing that she is coping with labour pains. Midwife observing that client expresses a relief from labour pains	1.Reassure her that labour will soon end. 2.Explain the physiology of labour pains to her. 3.Perform sacral massage for client. 4.Encourage client to do deep breathing exercise. 5.Provide diversional therapy.	1.Client was reassured that labour would soon end. 2.The physiology of labour pains was explained to her. 3.Client sacral region was massaged by her support person. 4. Client was encouraged to perform deep breathing exercise. 5. Client was stayed with and engaged in a conversation.	19/12/2022 1:00pm	Goal met as evidenced by client verbalizing that she was able to cope with the pain. Midwife observing that client expressed a relief from labour pains.	BAA

TABLE 2: LABOUR CARE PLAN

Date/ Time	Nursing Diagnosis	Nursing Objectives/Outcome Criteria	Nursing Orders	Nursing Interventions	Date/Time	Evaluation	Sign
19/12/2022 10:30am	Anxiety related to unknown outcome of labour.	Client will be relieved of anxiety within 2 hours as evidence by client verbalizing that her anxiety has reduced. Midwife observing that client is relaxed and looking cheerful.	1.Reassure client that anxiety is temporary. 2.Allow relatives to be with her. 3.Encourage client to ask questions and answer her tactfully. 4.Explain every procedure to be carried on client to her. 5.Update client with progress of labour.	1.Client was reassured that labour will end safe. 2.Client`s family was allowed to be with and accompany her. 3.Client was allowed to ask questions and answers were given tactfully. 4.Procedures like checking of vital signs, vaginal examination was explained to client. 5.Client was updated with progress of labour to calm client.	19/12/2022 12:30pm	Goal met as evidence by client verbalizing that anxiety has reduced to a manageable level. Midwife observing that she is relaxed.	BAA

TABLE 3

Date/Time	Nursing Diagnosis	Nursing Objectives/Outcome Criteria	Nursing Orders	Nursing Intervention	Date/Time	Evaluation	Sign
19/12/2022 11:30 am	Waist pains related to descent of fetal head.	Client's waist pain will reduce within 2 hours as evidenced by client verbalizing that she feels slight pain at the waist. Midwife observing that client waist pains is subsided.	1.Reassure client that waist pain is normal. 2.Explain the cause of the waist pain to the client. 3.Encourage client to assume any comfortable position to reduce waist pains. 4.Massage client's sacral region to ensure relaxation. 5.Encourage client to empty bladder.	1.Client was reassured that it's a normal physiology of labour. 2.The cause was explained to her that it was due to descent of the fetal head to gain understanding. 3.Client was encouraged to assume a comfortable position to reduce waist pain. 4.Sacral massage was done for client to ensure relaxation. 5. Client was encouraged to empty bladder to aid descent of fetal head.	19/12/2022 1:30pm	Goal fully met as evidenced by client verbalizing that the pain has reduced. Midwife observing that client waist pain has subsided.	BAA

TABLE 4: LABOUR CARE PLAN

Date/Time	Nursing Diagnosis	Nursing Objective/Outcome Criteria	Nursing Orders	Nursing Intervention	Date/Time	Evaluation	Sign
19/12/2022 12:00pm	Fatigue related to stress of labour.	Client will be relieved of fatigue within 1 hours as evidence by client verbalizing that she pushed effectively during the second stage.	1.Reassure client and explain the effect of exhaustion to her. 2.Encourage client to pant through contractions. 3.Educate client not to push before full dilation. 4.Assist client to assume a comfortable position. 5.Educate client to relax and rest between contractions.	1.Client was reassured and the effect of exhaustion was explained to her. 2.Client was encouraged to pant through contraction. 3.Client was educated not to push before full dilation of the cervix to prevent cervical tear. 4.Client was assisted to assume a comfortable position so she can rest. 5.Client was educated to relax and rest between contractions.	19/12/2022 1:00pm	Goal fully met as evidenced by client verbalizing that, she is no longer exhausted. Midwife observing that client shows signs of relieved and comfort.	BAA

TABLE 5: LABOUR CARE PLAN

Date/Time	Nursing Diagnosis	Nursing Objectives/Outcome	Nursing Orders	Nursing Intervention	Date/Time	Evaluation	Sign
19/12/2022 12:40pm	Risk of perineal tear related client lifting her buttocks in second stage of labour.	Client will have an intact perineum after delivery within 20 minutes as evidenced by the student midwife observing that the perineum is intact.	1.Reassure client to allay fears and anxiety. 2.Confirm full dilation of cervix before asking client to push. 3.Educate client on the dangers of lifting the buttocks. 4.Monitor progress and advancement of the foetal head. 5.Use skillful mechanisms and management of the second stage of labour to deliver baby.	1.Client was reassured to allay fears and anxiety. 2.Full dilation of the cervix was confirmed before client was asked to bear down. 3.The dangers of lifting the buttocks during second stage of labour was explained to her. 4.Progress and advancement of foetal head was monitored so as to prevent complications such as perineal tear. 5.All skillful mechanisms were employed to deliver the client.	19/12/2022 1:00pm	Goal fully met as evidenced by midwife visualizing an intact perineum after a successful delivery.	BAA

CHAPTER FOUR

PUERPERIUM

4.0 INTRODUCTION

This chapter entails the day of delivery, subsequent care of baby, home visits, and first visit to the clinic as well as care plan for problem identified.

4.1 DAY OF DELIVERY

Madam Adubia and her baby were transferred to the lying-in ward for close observation where she was given a comfortable bed to sleep on. Both mother and baby were kept warm to prevent heat loss by closing doors, windows and baby was well wrapped.

Her vital signs were checked and recorded as follows:

Temperature	36.5 degree Celsius
Pulse	80 beats per minute
Respiration	22 cycles per minutes
Blood pressure	117/68 millimeters of mercury

The vital signs were checked every 15 minutes for 2 hours and 30 minutes for 1 hour and hourly for the next 3 hours after which it was checked for every 4 hours. Perineum was inspected for lochia which was bright red (rubra) with small flows and no odour. Fundal height measured 15centimeters. She was served with porridge and bread by her mother.

4.2 SUBSEQUENT CARE OF BABY

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

BABY'S FIRST BATH AND CORD DRESSING

Requirements

1. Soap
2. Sponge
3. Cream/ powder
4. Sterile cotton in a gallipot
5. Basin
6. Towels (1 big towel and 3 small ones)
7. Cot sheets (2)
8. Apron
9. Gloves
10. A clean baby dress, cap and socks (if available)
11. Mackintosh
12. 2 jugs containing hot and cold water each
13. Two receptacles for used water and dirty linen
14. A receiver for used cotton wool swabs
15. Methylated spirit for cord dressing

Procedure

All windows and doors were closed, fans switched off and the lights switched on to make the room warm. Procedure was explained to Madam Adubia and was thanked for accepting. After gathering all items, plastic apron was worn and hand was washed with soap under running water and dried

with a clean towel. Examination gloves were worn, baby was put safe on a flat surface. The water was mixed and temperature of water was checked with the elbow. Baby was undressed and wrapped with a cot leaving the face. The general condition was observed and baby had a pink skin colour covered with vernix caseosa. Baby's eyes were cleaned with cotton wool swab soaked in clean water from the inner canthus out and then the face was cleaned with damp face towel and dried. The baby's neck was supported and the ears were plugged with the thumb and middle finger to prevent water from entering the ears. The hair was washed with soap and sponge in a circular manner, rinsed, dried and covered with a cleaned cap. The arms and front of the trunk was washed to the feet paying attention to the skin folds then turned and with one arm supporting the chest and the back was washed down to the feet paying attention to the skin folds. Baby's body was immersed in a bath of warmed water, with the head supported above the water and the body rinsed thoroughly. The baby was then placed on a flat surface covered with a bath towel. Small dried towel was used to dry baby, paying attention to the skin folds. Baby oil was applied on the skin, powdered and a diaper was put on the baby. Baby was dressed leaving the umbilical cord exposed for dressing and the hair combed neatly. Gloved hands were removed and discarded, hands were washed and dried with clean towel. Sterile gloves were then put on. Cord was inspected for loosed clamp and bleeding and there was none. Sterile cotton wool swabs and methylated spirit was used to dress the cord. One was used to hold the clamp and the cord was dressed aseptically with a cotton wool swab soaked in methylated spirit from the base upwards and left exposed. Hands were washed and dried. The baby was wrapped nicely to maintain temperature. Baby was dressed and wrapped nicely to prevent heat loss and the baby was given to the mother to breastfeed. Mother was asked to fix baby to breast by ensuring that she sat in a comfortable position, which meant that the baby should be fed for at least eight to twelve times a day and exclusively for six months. Mother was educated on breastfeeding problems such as cracked or sore nipples, breast

engorgement and mastitis. She was also advised to wash hands before and after handling baby. She was asked to report to the clinic especially if the problem was not resolved and also signs of engorgement were noticed. All findings were communicated to mother and recorded.

Vital signs of baby were checked and recorded as:

Apex heart beat	136 beats per minute
Temperature	36.5 degree Celsius
Respiration	41 cycles per minute
Weight	3.1 kilograms

4.3 FIRST DAY POST DELIVERY (DAY OF DISCHARGE)

On 20th December 2022 at 7am, client was checked at the lying-in ward. Greetings were exchanged and she was asked about how she and the baby are doing. She replied with a smile that, they are doing great except that she was had to wake up intermittently to breastfeed her baby. Her vital signs were then checked and recorded as follows:

Temperature	36.5 degree Celsius
Pulse	83 beats per minute
Blood pressure	120/69mmHg
Respiration	22 cycles per minute

Permission was sought for head-to-toe examination to be performed on her and was granted, and there was no abnormality detected. The breast was lactating well and the uterus was well contracted when palpated and measured with symphysio fundal height of 14cm. On inspection of the perineal pad, the lochia flow was small and the colour was red (rubra) with no odour. She was encouraged to ambulate to promote effective circulation and drainage of lochia. She took her baby after she

was served with warm porridge and a loaf of bread as breakfast. Baby was also examined with permission from the mother after hand washing was done with soap under running water and dried with clean towel. A thorough head to toe examination was performed on the baby again but no abnormality was detected. The cord was inspected for bleeding, odour and discharge but there was none. The baby was top and tailed and the cord dressed with methylated spirit. The baby was dressed nicely and wrapped in clean warm sheet. The baby`s vital signs were checked and recorded as follows:

Temperature	36.5 degree Celsius
Pulse	136 beats per minute
Respiration	41 cycles per minute
Weight	3.0kg
Stools	Meconium
Cord	Drying and no bleeding
Suckling	Good

Education on how to position herself when breastfeeding, importance of breastfeeding to both mother and baby and how to put the baby to breast were demonstrated to the client to enable her breastfeed well and prevent breast sore. She was asked to give a demonstration and she did it perfectly. Also, education on infection prevention measures, personal hygiene, good nutrition, adequate rest, postnatal exercises, use of insecticide treated nets (ITN), and care of the baby and household chores were taught to her. She was educated on the minor disorder in puerperium such as breast engorgement and skin rashes on the baby and told to report to the clinic whenever she sees

them. The baby was given polio oral vaccine and Bacillus Calmette Guerin (BCG) immunization before they were discharged home. Routine drugs were served as follows:

Tablet folic acid 5mg once daily for 7 days.

Tablet multivitamin 200mg once daily for 7 days

Tablet ferrous sulphate 200mg once daily for 7 days.

Tablet metronidazole 400mg tds x 5 days

She was also taught how to dress the cord and advised on the importance of keeping the baby's cord clean and dry, avoid the application of unprescribed medications on it. She was again educated on the importance of reporting to hospital anytime she notices danger signs like bleeding from the cord, offensive odour from the cord or high temperature of the baby. She was encouraged to sleep under treated mosquito net together with the baby to prevent malaria. She was further educated to breastfeed the baby on demand and also encouraged her friend and mother to help her take care of the baby. Client was encouraged to have adequate rest and sleep. The information about visits to her house to continue the care up to the seventh day was reinforced and they were seen off at 10:35am.

4.4 FIRST POSTNATAL HOME VISIT

On the 20th December 2022 at 4:50pm, Madam Adubia was visited in her house at Biadan. Greetings were exchanged and a warm welcome and seat was offered. She was asked about her health and that of her family and she responded that they are all well. Permission was sought from client to examine her and the baby which she agreed. After hand washing was done with soap under running water and dried. On examination, the symphysio fundal height was measured as 14cm with uterus well contracted. The perineal pad was checked and the colour of the lochia was

red with no foul smell and scanty in amount. Client complained of severe abdominal pains when the baby suckles. She was reassured and encouraged to perform postnatal exercises to strengthen the pelvic floor muscles and was encouraged to breastfeed the baby on demand, it helped in contraction thus involution of the uterus. There were no observed abnormalities. Her vital signs were checked and recorded as follows:

Temperature	36.3 degrees Celsius
Respiration	20 cycle per minute
Blood pressure	120/62 millimeters of mercury
Pulse	77 beat per minute
Breast	Lactating
Uterus	Contracted
Symphysio-fundal height	14 cm
Lochia	Rubra

The baby was examined from head to toe with no abnormalities detected. Permission was sought to bath the baby which was granted. The baby was top and tailed paying attention to the skin folds and procedure was done demonstrated to the client. The core was dressed with cotton soaked in methylated spirit. It was dry and clean. The baby's vital signs were checked and recorded as follows:

Temperature	36.4 degrees celsius
Respiration	43 cycle per minute
Pulse	139 beat per minute
Suckling	Good
Cord	Clean and dry

Skin Colour	Pink
Stool	Meconium
Weight	3.0kg

4.5 SECOND POSTNATAL HOME VISIT

On the 21th December, 2022, Madam Adubia was visited in her house in the morning and evening 8:55am and 4:50pm respectively. Greetings were exchanged and a warm welcome and seat were offered. She was asked about her health and that of her family and she responded that, they are all well. Permission was sought from client to examine her and her baby and she agreed. After hand washing was done with soap under running water and dried. Head to toe examination was carried out with no abnormality detected. The breasts were lactating well with symphysio fundal height measured as 13cm. The perineal pad was checked and the colour of the lochia was bright red with no foul smell and scanty in amount. There were no observed abnormalities. Her vital signs were checked and recorded as follows:

Mother	Morning	Evening
Temperature	36.6 degrees Celsius	36.6 degree celsius
Respiration	20 cycle per minute	24 cycle per minutes
Blood pressure	118/62 millimetres of mercury	116/78 millimeters of mercury
Pulse	78 beat per minute	81 beat per minute
Breast	Lactating	Lactating
Uterus	Contracted	Contracted
SFH	13 cm	13cm

Lochia	Rubra	Rubra
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The baby`s vital signs were as follows:

Baby	Morning	Evening
Respiration	42 cycle per minute	42 cycle per minute
Pulse	141 beat per minute	145 beats per minute
Temperature	36.2 ⁰ C	36.3 ⁰ C
Weight	2.9kg	2.9kg
Suckling	Good	Good
Cord	Clean and dry	Dry and clean
Skin Colour	Pink	Pink
Stool	Meconium	Meconium

The baby was top and tailed paying attention to the skin folds with permission sought from client. The cord was dressed with methylated spirit. After that baby was dressed nicely, wrapped in a warm clean sheet and was given to the mother to breastfeed. She was encouraged to continue the practice of exclusive breastfeeding not to put anything on the cord apart from the chlorhexidine and also wash hands before handling baby. She complained backache and she was reassured and also told to use proper body mechanics when breastfeeding. She was thanked and permission to leave was sought.

4.6 THIRD POSTNATAL HOME VISIT

On 22th December 2022, madam Adubia was visited in her house in the morning and evening at 8:30am and 5:30pm respectively. Greetings were exchanged and a warm welcome and seat was offered. She was asked about her health and that of her family and she responded that they are all well. Permission was sought from client to examine her and the baby, which she agreed. After hand washing was done with soap under running water and dried. The conjunctiva of was examined and there was no pallor, the breast was lactating, the uterus was well contracted with symphysio fundal height measured as 12cm. The perineal pad was checked and the colour of the lochia was red with no foul smell and scanty in amount. There were no observed abnormalities. Her vital signs were checked and recorded as follows:

Mother	Morning	Evening
Temperature	36.0 degrees Celsius	36.1 degree celsius
Respiration	22 cycle per minute	20 cycle per minute
Pulse	84 beat per minute	82 beat per minute
Blood pressure	108/72 millimeters of mercury	110/70 millimeters of mercury
Breast	Engorged	Engorged
Uterus	Contracted	Contracted
SFH	12cm	12cm
Lochia	Rubra	Rubra

The baby was examined from head to toe with no abnormalities detected. top and tailed paying attention to the skin folds. The cord was dressed with cotton wool swabs soaked in methylated

spirit. It was dry and clean. The baby had passed stools and urine. The baby's vital signs were as follows:

Baby	Morning	Evening
Temperature	36.4 degree Celsius	36.3 degree celsius
Respiration	44 cycle per minute	43 cycle per minute
Pulse	144 beat per minute	138 beat per minute
Weight	2.8kg	2.8kg
Suckling	Good	Good
Cord	Clean and dry	Dry and clean
Colour	Pink	Pink
Stool	Yellowish	Yellowish

After that baby was dressed nicely, wrapped in a warm clean sheet and was given to the mother to breastfeed. Education was given on prevention of infection. Client complained of engorged breast which she was encouraged to feed the baby on demand and also apply warm compresses to it. Permission was sought to leave

4.7 FOURTH POSTNATAL HOME VISIT

On the 23th December 2022 at 8:30am, Madam Adubia's family was paid another visit. Warm greetings were exchanged and her health and that of the family was asked and she said they were fine. Purpose of the visit was made known to her. Permission sought for head-to-toe examination which was granted and no abnormalities detected. Her breasts were lactating well. Her perineal pad was inspected for lochia and the flow was small, pink in colour (serosa) and was not offensive. Her symphysio fundal height measured was 11cm. Her vital signs were checked and recorded as:

Mother	Morning
Temperature	36.7 degree Celsius
Pulse	82 beat per minute
Respiration	21 cycle per minute
Blood Pressure	108/70 millimeters of mercury
Breast	Lactating
Uterus	Contracted
SFH	11cm
Lochia	Serosa

Baby was top and tailed paying attention to the skin folds and the general condition checked with no abnormality detected. The cord was dressed with methylated spirit. It looked dry and about to slough off. Baby had already passed stools and urine. Baby was nicely dressed and wrapped in a clean sheet and made comfortable in bed. Baby's vital signs were checked and recorded as:

Baby	Morning
Temperature	36.4 degree Celsius
Pulse	138 beat per minute
Respiration	44 cycle per minute
Weight	2.8kg
Suckling	Good
Cord	Shrinking
Colour	Pink
Stool	Yellowish

Client complained of sleep disturbances as a result of night feeding. She was reassured and educated on the various position to assume when breastfeeding. And she was informed of the next visit.

4.8 FIFTH POSTNATAL HOME VISIT

Client was visited on 24th December 2020 at 8:00am. On arrival, greetings were exchanged and she was asked about her health and that of the family and she responded that they were doing well. After the purpose of the visit was explained to client, her vital signs were checked and recorded as follows;

Mother	Morning
Temperature	36.8 degree Celsius
Pulse	79 beat per minute
Respiration	19 cycle per minute
Blood pressure	119/73millimeters of mercury
Breast	Lactating
Uterus	Contracted
SFH	10 cm
Lochia	Serosa

Her perineal pad was inspected and the lochia was pink (serosa) with scanty flow and not offensive. Her symphysio fundal height was 10 cm. The baby was top and tailed and the cord was dressed nicely. It looked very dry and it was reported that she passed yellowish stool. The baby was dressed and wrapped in a clean warm sheet and was given to the mother to breastfeed. Client was reminded of the practice of good personal hygiene. Baby`s vital signs were checked and recorded as follows:

Baby	Morning
Temperature	36.5 degree Celsius
Pulse	140 beat per minute
Respiration	38 cycle per minute
Weight	2.9kg
Suckling	Good
Cord	Off
Colour	Pink
Stool	Yellowish

She was asked of any problem and she said no. She was thanked and permission was sought to leave.

4.9 SIXTH POSTNATAL HOME VISIT

On 25th December 2020, client and family were visited again at 7:30am. Greetings were exchange and client health was asked and she responded that, they were doing well. Permission was then sought and daily routine examination was carried out on both mother and baby from head to toe and no abnormality was detected in any of them. Their condition was very good and both looked healthy. Lochia was inspected and the colour was creamy brown and scanty flow (Alba) with no foul odour. Symphysio-fundal height was 9cm and vital signs checked and recorded as follows:

Mother	Morning
Temperature	36.8 degree Celsius
Pulse	79 beat per minute

Respiration	19 cycle per minute
Blood pressure	120/76 millimetres of mercury
Breast	Lactating
Uterus	Contracted
SFH	9cm
Lochia	Alba

On examination of the baby, the cord was seen to have fallen off and the mother was educated on how to properly bath the baby. Baby`s vital signs were checked and recorded as follows:

Baby	
Temperature	36.5 degree Celsius
Pulse	136 beat per minute
Respiration	41 cycles per minute
Weight	3.0kg
Suckling	Yes
Cord	Off
Stool	Yellowish

She was asked if there was any problem but she said there was none. She was reassured and her mother was also encouraged to help in taking care of the baby. She was thanked and permission was sought to leave.

4.10 SEVENTH POSTNATAL HOME VISIT

On 26th December 2022, client and family were visited again. A warmly greetings were exchanged and the health of client and her family was inquired and positive response was given. Permission was then sought and routine examination was carried out on both mother and baby from head to toe and no abnormality was detected in any of them. Her perineal pad was inspected and lochia was creamy white (alba) but very little and not offensive. The symphysio fundal height was palpable. The baby`s bath was provided and stump was clean. The vital signs of mother were checked and recorded as follows;

Temperature	36.4 degree Celsius
Pulse	88 beat per minute
Respiration	21 cycles per minute
Blood pressure	112/60 millimetres of mercury
Breast	Lactating
Uterus	Contracted
SFH	8cm
Lochia	Alba

Baby`s vital signs checked and recorded as;

Temperature	36.3 degree Celsius
Pulse	135 beat per minute
Respiration	40 cycle per minute
Weight	3.1kg
Suckling	Good

Cord	Off
Colour	Pink
Stool	Not seen

Client was asked whether she had complaints and she complained of sore nipples. It was explained to her that it was because of certain creams, ointments, spray and soap that she used. Also because of improper positioning of the baby's mouth to breast. She was reassured and asked to apply drops of milk on the nipples and allow to air dry because this promotes healing. She was thanked and reminded of the postnatal visit which would be on the next day.

4.11 FIRST POSTNATAL VISIT TO THE CLINIC

Madam Adubia, her baby and her mother reported to the clinic on 27th December 2022 for the 7 to 10 days postnatal examination. She was welcomed and offered a seat. She was asked how they were faring and she responded that they were doing well. Procedures to be carried on her and the baby were explained and she agreed. She was given a specimen to take a midstream of her urine into it. The urine was tested for protein and glucose and it was negative. Her hemoglobin was checked and recorded as 10.9g/dl. Her vital signs were checked and recorded as follows:

Temperature	36.6 degree Celsius
Pulse	83 beat per minute
Respiration	19 cycle per minute
Blood pressure	115/81 millimetres of mercury

Privacy was provided and she was assisted to undress and lie on the bed for head-to-toe examination. Hands were washed and dried with clean towel. On examination, her hair was nicely braided and neatly kept. The eyes were inspected for pallor, jaundice and discharges, the nose and

ears were also inspected for discharges but nothing abnormal was detected. There were no swellings or lymph nodes around the neck. The breast was lactating well and was educated on breastfeeding the baby on demand to avoid breast engorgement. On abdominal examination, involution had taken place and symphysio-fundal height was 7cm. The extremities were free from edema, equal in size and no abnormalities detected. On vulva inspection, the lochia had stopped flowing and the vulva was neatly kept with no odour. She was assisted out of the bed and all finding communicated to her. The baby was also examined in the presence of the client and no abnormality was detected. The baby`s weight was 3.2kg. Baby`s vital signs were checked and recorded as follows:

Temperature	36.4degree Celsius
Pulse	142 beat per minute
Respiration	38 cycle per minute
Weight	3.2 kg

Findings on the baby were communicated to her and she was congratulated for taking good care of the baby and herself. She was educated on various family planning methods and the benefits of practicing family planning, when to resume sex and the need to feed the baby exclusively for six months. She was also educated on the need to attend child welfare clinic in order to monitor the growth of her baby, early detection of diseases to complete all the immunization. She was reminded of the importance of rest, eating nutritious diet, maintaining good personal hygiene, baby care, breastfeeding and breast care. Finally, she was handed over to the midwife in charge for the continuity of care. She and her entire family were congratulated and thanked for her cooperation and support throughout the writing of the care study. The midwife in-charge told Madam Adubia, her six weeks postnatal visit will be on the 3rd February, 2023.

4.12 TERMINATION OF CARE

Explanation was given to Madam Adubia on the need to be handed over to the midwife in-charge for continuity of care on the 27th December, 2022. Client was reassured of the midwife in-charge's competency. Client was reminded to continue and complete all the immunization. She and her mother were thanked for her cooperation.

4.13 SECOND POSTNATAL VISIT TO THE CLINIC

According to the midwife in-charge on 3rd February, 2023, Madam Adubia came to the clinic with her husband for her six weeks postnatal visit. They were warmly welcomed and they looked healthy. General examination was conducted after permission was sought. Her vital signs were checked and recorded as follows;

Temperature - 36.5degree celsius

Pulse - 79 beat per minute

Respiration - 20 cycle per minute

Blood pressure - 116/70mmhg

Madam Adubia was given a urine sample container to provide midstream urine to be sent to the laboratory for urine analysis to be performed. A sample of blood was also taken to the laboratory for hemoglobin level estimation. The results from the laboratory were as follows;

Hemoglobin level - 11.8g/dl

Urine protein - negative

Glucose - negative

The results were explained to her and recorded. Head to toe examination was done on her with no abnormalities were detected. She had not resumed her menses when she was asked. She was

educated on the need to start a family planning method to prevent unwanted pregnancy. All the methods of family planning were explained to her and she preferred the lactational amenorrhea method. The baby was examined from head to toe and no abnormalities were found. Baby's vital signs were checked and recorded as follows;

Temperature - 36.3degree celsius

Pulse - 24cpm

Respiration - 138bpm

Weight - 5.5kg

Madam Adubia and her baby was handed over to the child welfare clinic and family planning unit for the six weeks immunization against diphtheria, pertussis, tetanus, hemophilus influenza and hepatitis B. She was encouraged to ask questions but she had no complains. She was reminded on exclusive breastfeeding, rest and sleep, exercise and nutrition diet, which would help in lactation. She was finally referred to the public health nurse for continuity of care but to report to the facility anytime she encounters any health issues. She was thanked for her cooperation and understanding.

4.14 PUERPERIUM CARE PLAN

- 20/12/2022 After pains.
- 21/12/2022 Engorged breast.
- 22/12/2022 Backache.
- 23/12/2022 Sleep disturbances.
- 26/12/2022 Sore nipples.

Short Term Objectives

- Client after pains will stop within 6 hours.

- Client backache will stop within 6 hours.
- Client`s engorged breast will reduce within 48 hours.
- Client`s will be able to sleep at least 4 hours uninterrupted sleep at night.
- Client sore nipples will be treated within 24 hours.

Long Term Objectives

Client will go through puerperium successfully without any complication.

TABLE 1: THE NURSING CARE PLAN FOR MADAM ADUBIA

DATE& TIME	NURSING DIAGNOSIS	OBJECTIVES /OUTCOME CRITERIA	NURSING ORDERS	INTERVENTIONS	DATE& TIME	EVALUATION STATEMENT	SIGNATURE
20/12/2022 10:00pm	After pains related to uterine involution.	Client will be able to cope with after pain within 12 hours as evidenced by client verbalizing that she is no more in pains. Midwife observing that client shows signs of ease and comfort after pain.	1.Reassure client that the pain is manageable. 2.Educate client to gently massage the lower abdomen to help the uterus to contract 3.Encourage client to apply a warm towel on her lower abdomen. 4.Encourage the client to empty her bladder frequently. 5.Serve prescribed analgesics.	1.Client was reassured that the pain is manageable. 2.Client applied a gentle massage the lower abdomen which helped the uterus to contract. 3.Client was encouraged to apply a warm towel on her abdomen. 4.Client was encouraged to empty her bladder at least every two hours or whenever there is the urge. 5.Tab paracetamol 1gram tidx3 was given.	21/12/2022 10:00am	Goal fully achieved as evidenced by client verbalizing that the pain has stopped.	BAA

TABLE 2: THE NURSING CARE PLAN FOR MADAM ADUBIA

DATE& TIME	NURSING DIAGNOSIS	OBJECTIIVES /OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTIONS	DATE & TIME	EVALUATION	SIGNATURE
21/12/2022 8:00am	Backache related to poor posture during breastfeeding.	Client will be relieved of backache within 6 hours as evidence by the midwife observing that client sits comfortably and in a good posture while breastfeeding. Client verbalizing that she has been relieved of backache.	1.Explain the physiology of the backache to the client. 2.Educate client to on how to sit properly and fix baby to breast 3. Massage the back of client. 4.Encourage client to have enough rest to relieve pain 5.Serve prescribed analgesics.	1.The physiology of backache was explained to client that it was due to changes of musculoskeletal system that persist after delivery due to pregnancy hormone loosen. 2.Client was educated on how to sit properly and fix baby to breast to help relieve pain. 3.Client was given a massage at the back. 4.Client was encouraged to have enough rest after breastfeeding to relieve pain. 5.Prescribed analgesics was served.	21/12/2022 2:00pm	Goal was met as evidence by client verbalizing that she is relieved of backache. Midwife observing that client backache is subsided.	BAA

TABLE 3: THE NURSING CARE PLAN FOR MADAM ADUBIA

DATE & TIME	NURSING DIAGNOSIS	OBJECTIVES /OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTIONS	DATE & TIME	EVALUATION	SIGNATURE
22/12/2022 8:00am	Engorged breast related to incomplete emptying of the breast during breastfeeding.	Client will be free from breast engorgement within 48hours as evidence by client verbalizing that she does not feel pain in the breast again. Midwife observing that client engorged breast has reduced.	1.Reassure client that engorged breast will be relieved. 2.Educate client to feed baby on demand and frequently and for longer periods. 3.Educate the client on how to position baby correctly to breast. 4.Encourage the client to support breasts with a firm brassier. 5.Advise client to apply warm compress on the breast.	1.Client was reassured that breast engorgement will be relieved. 2.Client was educated to feed baby on demand, frequently and for a longer period. 3.Education was given on correct position of the baby to breast. 4.Client was encouraged to support breasts with a firm brassier. 5.Client was advised to apply warm compress on breast to promote easy flow of milk.	24/12/2022 8:00am	Goal fully met as evidenced by client verbalizing that she no longer feels pain in her breasts. Midwife observing that client breast feed baby with comfort.	BAA

TABLE 4: THE NURSING CARE PLAN FOR MADAM ADUBIA

DATE & TIME	NURSING DIAGNOSIS	OBJECTIVES /OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTIONS	DATE & TIME	EVALUATION	SIGNATURE
23/12/2022 4:00pm	Insomnia related to excessive crying of baby at night.	Client will have normal sleeping pattern within 24 hours as evidence by client verbalizing that she can sleep for at least 4 hours continuous at night and 2hours during the day.	1.Reassure client to allay fear and anxiety. 2.Encourage client to feed baby adequately before going to bed. 3.Educate client to assume a comfortable position for breastfeeding while lying down. 4.Encourage the client to sleep during the day when baby sleeps. 5.Advise client to change wet and soiled napkins frequently.	1.Client was reassured to allay anxiety and fear. 2.Client was encouraged to feed baby adequately before going to bed. 3.Client was educated to assume a comfortable position for breastfeeding while lying down. 4.Client was encouraged to sleep during the day when baby sleep to be able to provide the needs of the baby at night. 5. Client was advised to change wet and soiled napkin frequently to promote comfort ability.	24/12/2022 4:00pm	Goal fully met as client said that she can sleep for at least 4 hours at night without any interruption.	BAA

TABLE 5

DATE & TIME	NURSING DIAGNOSIS	OBJECTIVES /OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTIONS	DATE & TIME	EVALUATION	SIGNATURE
26/12/2022 4:00pm	Sore nipples related to improper positioning of baby's mouth to breast.	Client will be relieved of sore nipples within 24 hours as evidence by client confirming that she is relieved of the sore nipple.	1.Reassure client. 2.Educate client on how to attach baby to breast correctly. 3.Educate client to reduce or stop the application of any strong topical creams on the breasts. 4.Advise client to remove baby from breast by breaking suction first. 5.Encourage client to expose breast to air and sunlight for 15-30 minutes.	1.Client was reassured that it will be treated. 2.Client was educated on how to attach baby to breast correctly. 3.Client was educated to reduce the application of any strong topical cream, ointments and sprays because they can cause sore nipples. 4.Client was advised to remove baby from breast by breaking suction first. 5.Client was encouraged to expose breasts to air and sunlight for 15-30 minutes to reduce irritation.	27/12/2022 4:00pm	Goal was fully met as client verbalizing that she no longer feels pain in the nipples.	BAA

4.15 SUMMARY AND CONCLUSION

The family centered maternity care study was conducted on Madam Adubia, a 22years old gravida 2para 1 alive and her entire family. Care was given during antenatal; labour and puerperium periods and these processes were gone through successfully.

Client's first visit to the clinic was on 11/08/2022 when she was 20+2 weeks pregnant and attended the clinic till delivery and the first contact with her was on 8th December, 2022 when she was 37+2weeks pregnant.

She had spontaneous vaginal delivery of a life female child on the 19th December, 2022 without any complications and went through a normal and safe puerperium. She and her family were cooperative, supportive and acted towards any form of education given to them. Through home visits, a close monitoring was made throughout puerperium and education given on how to care for herself and the baby and they were later handed over to the midwife in charged for continuity of care.

To conclude, this care study has given me, the student midwife opportunity to put my theoretical knowledge into practice and has therefore boost the confidence level in me and has also help me to improve upon my ability in caring for other pregnant women whom I shall meet in the nearest future throughout pregnancy, labour and puerperium successfully.

I have learnt to care systematically for a pregnant woman and her family.

It has also broadened my knowledge on issues concerning pregnancy, labour and puerperium.

I have also learnt how to care for a pregnant woman in her own environment.

BIBLIOGRAPHY

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DATE	WEIGHT (KG)	BLOOD PRESSURE	URINE FOR PROTEIN/ SUGAR	GESTATIONAL AGE IN WEEKS	FUNDAL HEIGHT (CM)	PRESENTATION	DESCENT OF FETAL HEAD	FETAL HEART RATE (FH)	TREATMENT GIVEN	COMPLAIN	SIGN
11/08/2022	53.4kg	120/84mmHg	negative/ negative	20+2weeks	19 cm	-	-	Present	Routine drugs	No complains	Grace
15/09/2022	55.2kg	119/70mmHg	negative/ negative	25+2weeks	25cm	Cephalic	5/5 th	135bpm	Routine drugs	No complaints	Grace
20/10/2022	56kg	100/72mmHg	negative/ negative	30+2weeks	30cm	Cephalic	5/5 th	133bpm	Routine drugs.	No complaint	Grace
17/11/2022	56.9kg	122/80MmHg	negative/ negative	34+2weeks	34cm	Cephalic	5/5 th	138bpm	Routine drugs	No complaints	Grace
01/12/2022	57.5kg	112/76mmHg	negative/ negative	36+2weeks	36cm	Cephalic	5/5 th	133bpm	Routine Drugs	No complain	Grace
08/12/2022	58kg	110/79mmHg	negative/ negative	37+2weeks	37cm	Cephalic	5/5 th	134bpm	Routine Drugs	No complains	Grace
15/12/2022	59kg	110/88mmHg	negative/ negative	38+2weeks	37cm	Cephalic	5/5 th	138bpm	Routine Drugs	No complains	Grace

APPENDIX II

LABORATORY INVESTIGATION

DATE	SPECIMEN	INVESTIGATION	NORMAL RANGE	FINDINGS
11/08/2022	Blood	Groupings	A, B, AB, O	A
		Rhesus factor	Positive/ Negative	Positive
		Hemoglobin level (HB)	11-16g/dl	11.0g/dl
		Hepatitis B (HBsAg)	Negative	Negative
		Sickling	Negative	Negative
		VDRL (syphilis)	Non-reactive	Negative
		Glucose 6 phosphate dehydrogenase(G6PD)	No defect	Negative
		HIV Status	Negative	Negative
	Urine	Glucose/ Protein	Negative/ Negative	Negative/ Negative
	Stool	Worm infestation	Negative	Negative

15/09/2022	Urine	Protein/Glucose	Negative/negative	Negative
20/10/2022	Urine	Protein/Glucose	Negative/negative	Negative
17/11/2022	Urine	Protein/Glucose	Negative/negative	Negative
01/12/2022	Urine	Protein/ Glucose	Negative/negative	Negative
	Blood	Haemoglobin level	11-16g/dl	11.6g/dl
08/12/2022	Urine	Protein/Glucose	Negative/negative	Negative
	Blood	Haemoglobin level	11-16g/dl	11.8g/dl
15/12/2022	Urine	Protein/Glucose	Negative/Negative	Negative
	Blood	Haemoglobin level	11-16g/dl	12.4g/dl

APPENDIX III

PHARMACOLOGY OF DRUGS (MOTHER)

Name Of Drug	Classification	Dosage	Route Of Administration	Actions and Uses	Actual Effect	Side Effect	Side Effects Experienced
Tablet Ferrous Sulphate	Hematinic	200mg daily for 30 days	Oral	Helps in the formation of red blood cells. Used in the treatment of iron deficiency anemia.	Client's hemoglobin level increased.	Black stool, diarrhea and constipation	None observed
Tablet folic acid	Vitamin preparation	5mg daily	Oral	Helps in the formation of blood cell For DNA synthesis.	Increased client's hemoglobin level.	Nausea, vomiting, diarrhea and constipation	None observed

Tablet paracetamol	Analgesic	500mg tid x 5 days	Orally	To relieve headache and body pains	Client's headache and bodily pains have subsided	Liver damage	None observed
Tablet multivitamin	Vitamin preparation	5mg daily x 30 days	Oral	To promote appetite and helps in the formation of red blood cells	Client's appetite was improved	Gastrointestinal upset	None observed
Sulphadoxine pyrimethamine tablet	Antimalaria	500mg	Oral	Prevention of malaria	Prevents malaria in pregnancy	Vomiting, itching, nausea	None observed
Tablet albendazole	Anthelmintics	400mg	Oral	To kill worms		Overdose causes damage to liver and blood disorder.	None observed
Oxytocin injection	Uterotonic agent	10 units	Intramuscular	Increase uterine contraction and control bleeding	Client had good uterine contraction	Vomiting, uterine spasm and raised blood pressure	None observed

Injection Tetanus toxoid	Anti-tetanus vaccine	0.5mls	intramuscular	It stimulates the production of antitoxin	Client was protected against tetanus	Headache, seizures, hypotension, tachycardia, urticarial rash	None observed
Tablet metronidazole	Antibiotic	400mg tid x 5 days	Oral	Prevents infection	Client was protected against infection	Fatigue, lethargy, headache, irritability	None observed

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

LLIN Given – 22/02/2018

TETANUS IMMUNIZATION	PREVIOUS TT		TD 1: Yes		TD3: YES	
	CURRENT TT		TD 3: 11/08/2022		TD 4 and TD 5: Not yet	
INTERMITTENT PREVENTIVE TREATMENT (IPT)FOR Malaria	1 ST dose SP* 3 tabs (Directly Observed Therapy) 11/08/2022	Gestation age in weeks	2 nd dose (1 month after 1 st dose (Directly Observed Therapy) 15/09/2022	Gestation age in weeks	3 rd dose (1 month after 2 nd dose (Directly Observed Therapy) 20/10/2022	Gestational age in weeks
		20+2weeks		25+2weeks		30+2weeks

FOURTH DOSE	17/11/2022	34+2weeks
FIFTH DOSE	15/12/2022	38+2weeks

APPENDIX IV

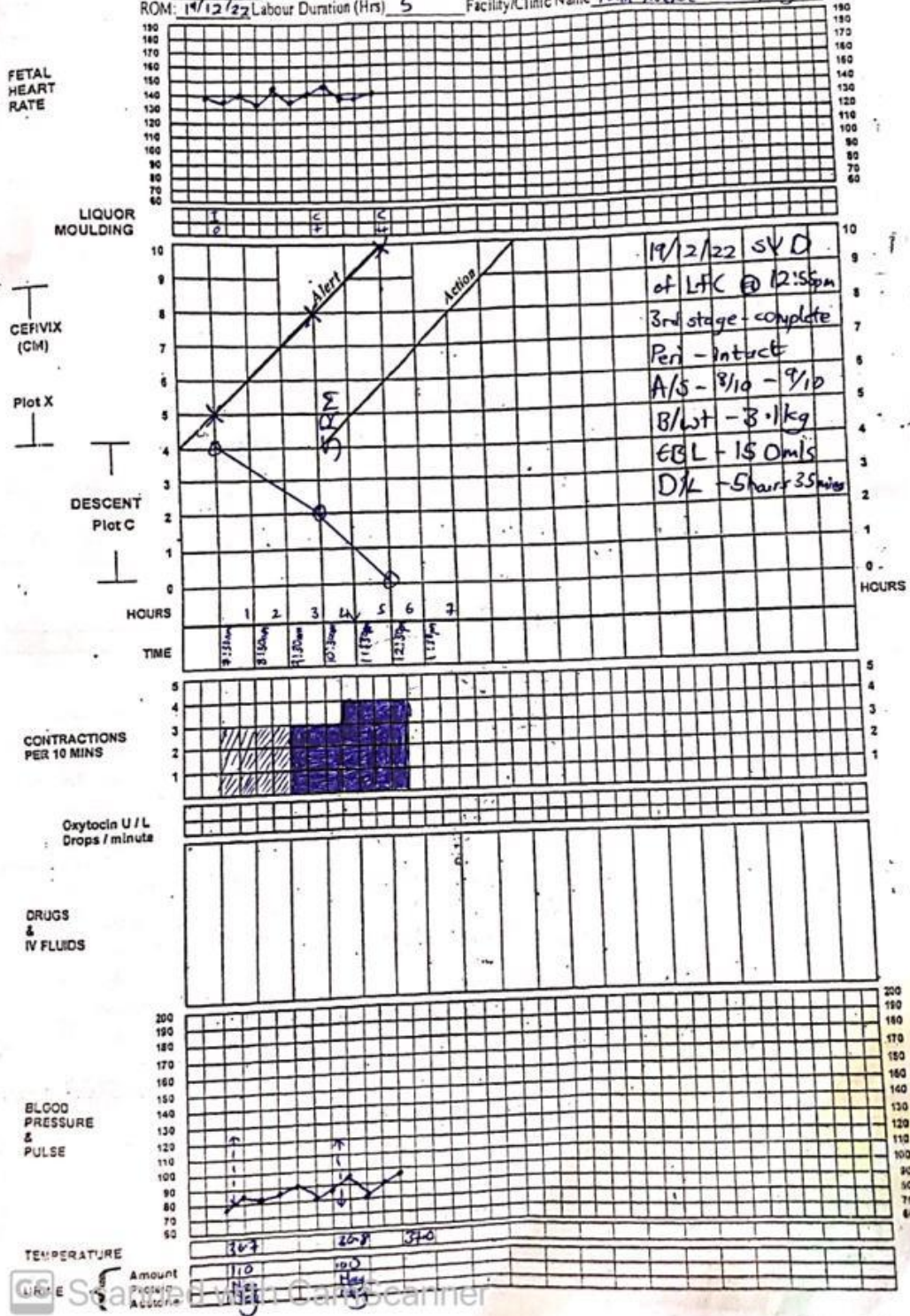
PHARMACOLOGY OF DRUGS (BABY)

Drugs	Classification	Dosage	Route	Actions and Uses	Actual Effect	Side Effect	Side Effects Experienced
Vitamin K	Coagulant	1.0ml	Intramuscular	Prevent hemolytic diseases	No bleeding	Risk of hemolysis in people with G6PD, rashes and brain damage	None observed
Chloramphenicol eye drop	Antibiotics	2 drops	Instillation	Prevent eye infection	Prevention of eye infection	none	None observed
Bacillus Calmette Guerin injection (BCG)	Antigen vaccine	0.05ml	Intradermal	Immunity against tuberculosis	Tuberculosis prevention	Mild fever, swelling of injection site and blister formation	Blister noticed

Polio O	Antigen vaccine	2 drops	Orally	Production of antibodies to prevent poliomyelitis	Under observation	Diarrhea, fever	None observed
Pneumococcal	Antigen	0.5ml	intramuscularly	Vaccinates neonates against pneumonia	Pneumonia prevention	Redness at the site of injection and fever	None observed
Rota virus vaccine	Antigen	1.5ml (2 drops)	Orally	prevention of gastroenteritis	Gastroenteritis prevention	None	None observed
Pentavalent vaccine	Antigen	0.5ml	Intramuscularly	Prevention of diphtheria, pertussis (whooping cough), tetanus, hepatitis B, haemophilus influenza type B	Prevention of childhood preventable diseases	Low grade fever	None observed

WHO Modified Partograph

Registration No.: 150/22 Name (Last, First) Adubia Benedicto Age: 22 years
Date: 19/12/22 Parity/Gravida 1/2 LMP - EDD 24/2/22 Gestation (wks) 35¹⁶
ROM: 19/12/22 Labour Duration (Hrs) 5 Facility/Clinic Name Palm Avenue Maternity Home



LABOR NOTES

Madam Adebisi G2P1 reported to the facility accompanied by mother and complained of lower abdominal pains. Client had SVD of live female baby. A/S - 8/10 and 9/10. Baby's weight was 3.1kg. Head circumference was 33cm. Length - 48cm. Placenta was delivered by controlled cord traction. Cord and eye care were done. Vitamin K injection was given. Breastfeeding was initiated. Monitoring of fourth stage on going.

Please circle or write responses.

DELIVERY

DATE: 11/12/22 TIME: 12:55pm METHOD: Spontaneous Vacuum Extraction / C/S / Other

PERINEUM: Intact Episiotomy / Laceration

ANESTHESIA: None Local / General

THIRD STAGE

Active Management: Yes / No Medication: Time 12:56pm Type/Dose 10 units of oxytocin.

PLACENTA: TIME: 1:05pm Complete Incomplete

Small (Less than 250 cc)

BLOOD LOSS AMOUNT:

Moderate (250-499 cc)

Large (more than 500 cc)

Significant for mother

APGAR

BABY

Weight: 3.1kg

Sex: Male / Female

Baby Position: Vertex Breech / Other

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

COMPLICATIONS OF MOTHER / BABY: None / Other:

FOURTH STAGE MONITORING

Frequency	Time	B/P	Pulse	Fundus	Bleeding	Bladder
Every 15 minutes first 2 hours	1:30pm	120/61	86 bpm	15cm	No active bleeding	150mls
	1:45pm	119/76	82 bpm	Well contracted	No active bleeding	
	2:00pm	121/70	74 bpm	Well contracted	No active bleeding	Nil
	2:15pm	115/55	78 bpm	Well contracted	No active bleeding	Nil
	2:30pm	110/77	81 bpm	Well contracted	No active bleeding	Nil
	2:45pm	121/83	90 bpm	Well contracted	No active bleeding	Nil
	3:00pm	120/78	77 bpm	Well contracted	No active bleeding	170mls
Every 30 minutes For 1 hour	3:15pm	117/70	84 bpm	Well contracted	No active bleeding	Nil
	3:45pm	121/76	92 bpm	Well contracted	No active bleeding	
	4:15pm	112/75	76 bpm	Well contracted	No active bleeding	Nil

Birth Attendant Bernice Asamoah - Ayemung (student midwife) assisted Date 19/12/22

by Madam Grace Mubwa (midwife in-charge)

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

MATERNITY CHART

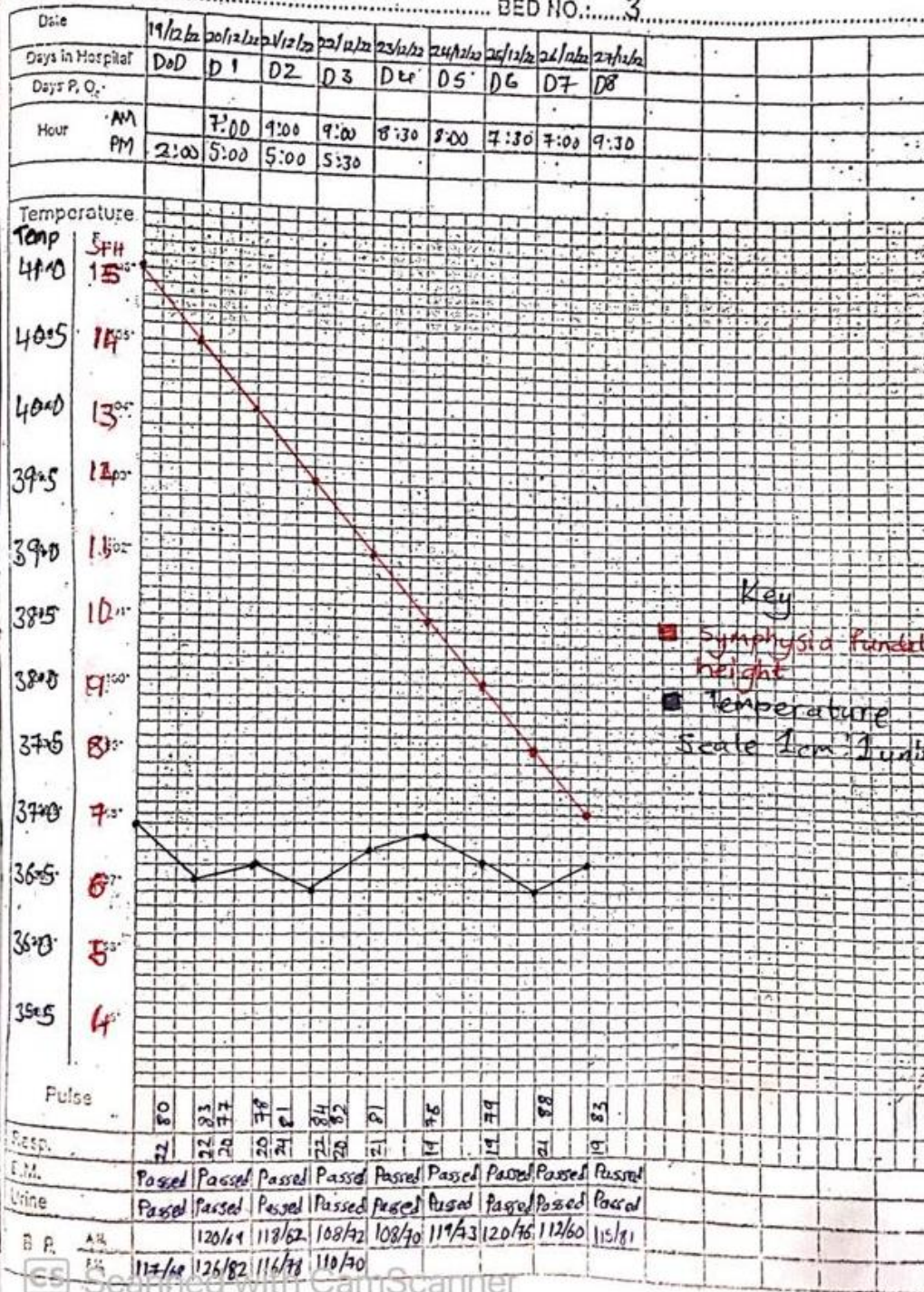
NAME: Benedicta Adubia

AGE: 22 years

P NO.: 150/22

WARD: Lying-In

BED NO.: 3



NEW BORN EXAMINATION FORM

Name: Baby Adeniyi Adubio Date of Assessment: 19/12/22 Time: 2:29pm
 Date of Birth: 19/12/22 Time of Birth: _____ Sex: ☐ M ☒ F Age at time of Assessment (days/hrs) 1hr 30m
 Gestational Age: 37+3 Mode of Delivery: ☐ Vaginal ☒ Assisted Vaginal ☐ C-Section
 APGAR: 1min 9 5min 10 Birth Weight: 3.1 kg Length: 48 cm Head Circumference: 32 cm
 Temperature at time of Assessment: 36.5 °C Urine passed: ☒ Yes ☐ No Meconium passed: ☒ Yes ☐ No
 Name of Assessor (Midwife/Doctor): Bernice Asamoah - Agyemang

1. Respiration Rate: <u>36bpm</u> ☒ Rate < 30 b/m * ☐ Rate < 60 b/m * ☐ 30-60 b/m ☐ Retractions * ☐ Grunting * ☐ Stridor * 2. Activity/Movement ☒ Spontaneous symmetric movements ☐ Reduced/Absent Movement in ≥ 1 limb * ☐ No Movement 3. Tone ☒ Normal ☐ Floppy * ☐ Increased * 4. Colour ☐ Pink all over ☐ Pink body but blue hands/feet ☐ Blue all over * ☐ Pale * ☐ Jaundiced * 5. Cord ☒ Normal ☐ Red, draining pus ☐ Bleeding 6. Cry ☒ Normal ☐ Shriill * ☐ Absent *	7. Suck ☒ Good ☐ Weak ☐ Absent 8. Head swelling ☐ Caput succedaneum ☐ Cephalhaematoma ☐ Subgaleal hemorrhage ☒ No swelling 9. Sutures ☒ Normal ☐ Overlapping ☐ Fused ☐ Widely Separated * 10. Fontanel ☒ Normal ☐ Sunken * ☐ Raised * ☐ Wide (>5cm) * 11. Eyes ☒ Normal ☐ Subconjunctival bleed ☐ White pupil or cornea ☐ Eye discharge ☐ Other _____ 12. Ears ☒ Normal (size / shape/position). ☐ Abnormal: _____ 13. Mouth ☒ Normal ☐ Cleft palate ☐ Cleft Lip ☐ Other: _____	15. Neck ☒ Normal ☐ Swelling ☐ Webbed ☐ Other: _____ 16. Clavicle ☒ Normal ☐ Swelling/Fracture 17. Chest ☒ Normal (Shape/movement) ☐ Abnormal _____ 18. Heart rate Rate: <u>140bpm</u> ☒ Normal (100-160) ☐ <100 * ☐ >160 * 19. Femoral pulse ☒ Present ☐ Not palpable * 20. Abdomen ☐ Normal ☐ Distended * ☐ Scaphoid * ☐ Abdominal defect * ☐ Moases: _____ ☐ Other _____ 21. Back (spine) ☒ Normal ☐ Abnormal Swelling * ☐ Hairly patch over spine ☐ Abnormal dimple ☐ Abnormal curvature	22. Limbs ☒ Normal ☐ Abnormal _____ 23. Genitalia Male Genitalia ☐ Normal ☐ Undescended testes ☐ Abnormal meatus ☐ Hernia ☐ Other: _____ Female Genitalia ☒ Normal ☐ Fistula (meconium/urine through abnormal opening in vagina) * ☐ Large clitoria * ☐ Other: _____ 24. Anus ☒ Patent ☐ Imperforate * 25. Resuscitation provided ☒ One ☐ Suction/stimulation ☐ Bag and mask ☐ Endotracheal Tube ☐ Ventilator/CPAP 26. Services provided ☒ Vitamin K1 given ☒ Eye care provided ☒ Cord care provided ☒ Breastfeeding initiated ☒ Breastfeeding established ☐ Immunization (BCG/Polio) ☐ BCG ☐ Polio Immunization ☐ Antibiotics in mother ☐ Antenatal corticosteroids
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*May indicate severe disease that requires urgent referral.

Diagnoses (if known) Term baby

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

NEW BORN EXAMINATION FORM

Name: Baby Adwoa Adubia Date of Assessment: 20/12/22 Time: 7:00am
 Date of Birth: 19/12/22 Time of Birth: 12:45pm Sex: ☐ M ☒ F Age at time of Assessment (days/hrs) 18 hrs
 Gestational Age 38 + 6 Mode of Delivery: ☒ Vaginal ☐ Assisted Vaginal ☐ C-Section
 APGAR: 1min 7 5min 10 Birth Weight: 3.0 kg ☐ Length 48 cm Head Circumference: 33 cm
 Temperature at time of Assessment: 36.4 °C Urine passed: ☒ Yes ☐ No Meconium passed: ☒ Yes ☐ No
 Name of Assessor (Midwife/Doctor): _____

1. Respiration Rate <u>41 cpm</u> ☒ Rate < 30 b/m* ☐ Rate < 60 b/m* ☐ 30-60 b/m ☐ Retractions* ☐ Grunting* ☐ Stridor* 2. Activity/Movement ☒ Spontaneous symmetric movements ☐ Reduced/Absent Movement in ≥ 1 limb* ☐ No Movement 3. Tone ☒ Normal ☐ Floppy* ☐ Increased* 4. Colour ☒ Pink all over ☐ Pink body but blue hands/feet ☐ Blue all over* ☐ Pale* ☐ Jaundiced* 5. Cord ☒ Normal ☐ Red, draining pus ☐ Bleeding 6. Cry ☒ Normal ☐ Shriill* ☐ Absent*	7. Suck ☒ Good ☐ Weak ☐ Absent 8. Head swelling ☐ Caput succedaneum ☐ Cephalhaematoma ☐ Subgaleal hemorrhage ☒ No swelling 9. Sutures ☒ Normal ☐ Overlapping ☐ Fused ☐ Widely Separated* 10. Fontanel ☒ Normal ☐ Sunken* ☐ Raised* ☐ Wide (>5cm)* 11. Eyes ☒ Normal ☐ Subconjunctival bleed ☐ White pupil or cornea ☐ Eye discharge ☐ Other 12. Ears ☒ Normal (size / shape/position). ☐ Abnormal: _____ 13. Mouth ☒ Normal ☐ Cleft palate ☐ Cleft Lip ☐ Other: _____	15. Neck ☒ Normal ☐ Swelling ☐ Webbed ☐ Other: _____ 16. Clavicle ☒ Normal ☐ Swelling/Fracture 17. Chest ☒ Normal (Shape/movement) ☐ Abnormal: _____ 18. Heart rate Rate: <u>140 bpm</u> ☒ Normal (100-160) ☐ <100* ☐ >160* 19. Femoral pulse ☒ Present ☐ Not palpable* 20. Abdomen ☒ Normal ☐ Distended* ☐ Scarphoid* ☐ Abdominal defect* ☐ Masses: _____ ☐ Other: _____ 21. Back (spine) ☒ Normal ☐ Abnormal Swelling* ☐ Hairly patch over spine ☐ Abnormal dimple ☐ Abnormal curvature	22. Limbs ☒ Normal ☐ Abnormal: _____ 23. Genitalia Male Genitalia ☐ Normal ☐ Undescended testes ☐ Abnormal meatus ☐ Hernia ☐ Other: _____ Female Genitalia ☒ Normal ☐ Fistula(meconium/urine through abnormal opening in vagina)* ☐ Large clitoria* ☐ Other: _____ 24. Anus ☒ Patent ☐ Imperforate* 25. Resuscitation provided ☐ One ☐ Suction/stimulation ☐ Bag and mask ☐ Endotracheal Tube ☐ Ventilator/CPAP 26. Services provided ☐ Vitamin K1 given ☐ Eye care provided ☒ Cord care provided ☐ Breastfeeding initiated ☐ Breastfeeding established ☒ Immunization (BCG/Polio) ☒ BCG ☒ Polio Immunization ☒ Antibiotics in mother ☐ Antenatal corticosteroids
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*May indicate severe disease that requires urgent referral.

Diagnoses (if known) Term baby

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

NEW BORN CHART

Name: Baby Adwoa Adubia No: Birth Weight: 3.1kg
Sex: female Mother's No: 150/22 Length: 48cm
Nature of Delivery: Spontaneous Vaginal Delivery Diagnosis: Term baby
Date of Birth: 19/12/22 Time: 12:55pm Date of Discharge: 20/12/22

Date	19/12/22	20/12/22	21/12/22	22/12/22	23/12/22	24/12/22	25/12/22	26/12/22	27/12/22		
No. of Days	D00	D1	D2	D3	D4	D5	D6	D7	D8		
Weight	3.1	3.0	2.9	2.8	2.8	2.9	3.0	3.1	3.2		
Temperature	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM
	36.3	36.5	36.4	36.2	36.3	36.0	36.1	36.4	36.5	36.3	36.4
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 Genitalia Limbs No abnormalities detected (NAD)										

TEMPERATURE CHART

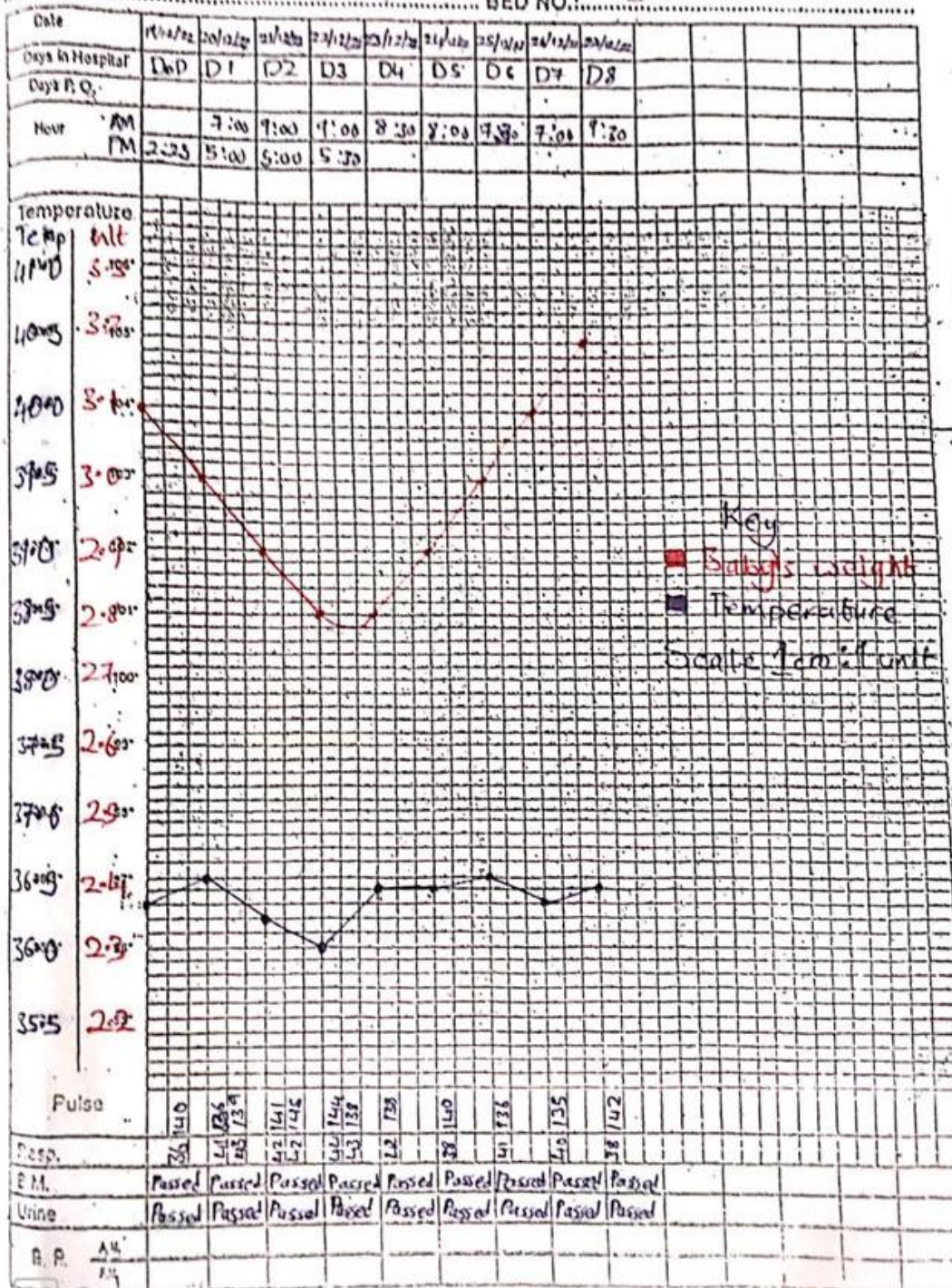
NAME: Baby Adwoa Adubia

AGE: Newborn

WARD: Lying-In

IP NO.:

BED NO.: 3



Scanned with CamScanner

SIGNATORIES

NAME OF CANDIDATE

NAME: ASAMOAH-AGYEMANG BERNICE

SIGNATURE: 

DATE: 20th June, 2023

NAME OF MIDWIFE IN-CHARGE (PALM AVENUE MATERNITY HOME)

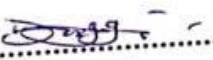
NAME: MS GRACE MAAKUU

SIGNATURE:  (f.m.)

DATE: 14/07/2023

NAME OF SUPERVISOR

NAME: MS DORCAS OSEI

SIGNATURE: 

DATE: 23/06/2023

NAME OF PRINCIPAL

NAME: MONICA NKRUMAH

SIGNATORIES:  (CR)

DATE: 14/07/2023

20. SENIOR ORDINATOR-NURSING
PALM AVENUE MATERNITY HOME
TRAINING COLLEGE, BERAKO