HOLY FAMILY NURSING AND MIDWIFERY TRAINING COLLEGE

BEREKUM

A CLIENT/ FAMILY CENTERED MATERNITY CARE STUDY

ON

MADAM VIDA NTIAWINE

BY

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PREFACE

Client/family centered maternity care study is the systematic way of administering midwifery care to a pregnant woman and her family throughout pregnancy, labour and puerperium.

The family centered maternity care is mainly based on total nursing care in which the physical, psychological, spiritual, social and rehabilitative aspect of the client is consider ed. It includes the expectant mother, her family and the community in preparing towards the impending arrival of the new family member.

The client/family centered maternity care study also help the student midwife to use new trends in midwifery like the partograph which have been tested and recommended by World Health Organization (WHO) in the management of the first stage of labour. And the Active Management of Third Stage of Labour (AMSTL) also introduce to limit the occurrences of postpartum hemorrhage.

The care study offers the student midwife the opportunity to put the knowledge and skills acquire during training into practice, being culturally sensitive. It also enables her to detect problem and need of the mother and her family. Also, the family centered maternity care study helps to reduce maternal and neonatal morbidity and mortality. The client and family centered maternity care study is compiled into a document in partial fulfillment for the award registered midwifery certificate by the Nursing and Midwifery Council of Ghana.

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Finally, my sincere thanks go to the authors if the various book used as references, without them, there would not have been enough information for my care study.

INTRODUCTION

In line with the safe motherhood initiative, the client and family centered maternity care study have been made a requirement in the partial fulfillment for the award of diploma in registered midwifery by the Nursing and Midwifery Council of Ghana. This care is rendered to an expectant mother, her family and community at large. It includes antenatal care, intrapartum and postpartum care. The study also uses the new trend in midwifery practice such as the use of Focus Antenatal care service, partograph, practice of active management of the third stage of labour, essential care of the new born, exclusive breastfeeding, postnatal visit and immunizations the eligibility criteria include (1) a woman with good past obstetrical history (2) Woman has undergone SVD at least once (3) Woman not in the risk group example: teenager and also not a grand multiparous.

The client chosen for this study is Madam Vida 23 years old $G2P1^{A}$ Who hail from Totain in the Northern Region of Ghana. This care study document is in four chapters,

Chapter one gives detailed information about client particulars such as social, family, obstetric, medical and surgical histories. Chapter two outline the antenatal care rendered to Madam Vida throughout her pregnancy. Chapter three concerns the care given to the client during labour and it`s management. And Chapter four is about management of client during puerperium. A care plan was drawn for identified problems and management given with the use of nursing process at the end of all the chapters except chapter one. Summary and conclusion, bibliography, signatories as well as various appendices for example; antenatal records, laboratory records postnatal and pharmacology of drugs are all included.

LITERATURE REVIEW

PREGNANCY

Tiran (2008) define pregnancy as a form conception to delivery of the fetus; normal duration is two hundred and eight days (280 days, 40 weeks or nine months and seven days), counted from conception to delivery. Kings (2014) state that, the prenatal period covers the time from the first day of the last normal menstrual period to the start of labour, which marks the beginning of the intrapartum period.

Henderson (2009) states that, pregnancy may be suspected by the woman base on her knowledge of her menstrual cycle, sexual activity and the signs of pregnancy. Women may confirm their pregnancy using home pregnancy test.

Henderson (2009) further stated that, confirmation of pregnancy may also be sought from the midwife or doctor. This is established by a detail history and relevant clinical examination based on the signs and symptoms of pregnancy. The signs and symptoms of pregnancy are; amenorrhea, breast changes, nausea, and vomiting, increase frequency of micturition, enlargement of the uterus, skin changes and quickening. These signs will become obvious to the woman in sequential stages. The signs and symptoms of pregnancy may be considered as presumptive, probable and positive.

King (2014) also state that, the prenatal period is divided into trimesters, first trimester is considered to be weeks 1 to 12 (12weeks) because organogenesis is completed at the end of twelve weeks and the risk of spontaneous abortion is significantly reduced at time. Historically, the second trimester was considered to be weeks 13 to 28 because prior to the introduction of modern neonatal intensive care technique 28 weeks was limit of viability. The third trimester

extend from weeks 28 to 40. The term` post-date` or` post term ` is typically used to describe a pregnancy beyond forty weeks (40).

According to King (2014), pregnancy is a time of profound anatomic and physiologic change in a woman`s body. In addition to the reproduction organs all maternal physiologic system makes adaptations needed to support the developing fetus and at the same time, maintain maternal homeostasis. Pregnancy last approximately two hundred and sixty, six days (266 days) or thirty, eight weeks (38 weeks) from ovulation.

Konar (2013) also added that, during pregnancy, there is 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.

Konar (2013) further stated that, there is enormous growth of the fetus during pregnancy. The uterus which in non-pregnant state weighs about 60g with a cavity of 5-10ml and measure about 7.5cm in length, at term, weighs 900-1000gm and measure 35 in length. The capacity is increased by 500-1000 times and changes occur in all part of the uterus. There is increase in growth and enlargement of the body of the uterus. Not only the individual muscle fibers increase in length and breadth but there is limited addition of new muscle fibers. These occur under the influence of the hormones; oestrogen and progestron limited to the first half pregnancy pronounced up to twelve weeks (12). Three (3) distinct layers of muscle fibers are evidenced; outer longitudinal, inner-circular and intermediate. Normal anteverted position is exaggerated up to eight (8 weeks). Thus, the enlarged uterus may lie on the bladder rendering it incapable of filling, clinically evident by

frequent micturition. Afterwards, becomes erect; the long axis of the uterus conforms more or less to the axis of the inlet.

Fraser & Cooper (2009) also added that uterine blood flow in pregnancy supplies the myometrium, endometrium and placenta, with the latter receiving nearly 90% of the total uterine

blood flow near term.

Konar (2013) states that, there is marked congestion with hypertrophy of the muscle and elastic tissues of the wall. In late pregnancy, the bladder mucosa becomes oedematous due to venous and lymphatic obstruction especially in primigravida following early engagement. Increased frequency of micturition is noticed at 6-8 weeks of pregnancy which subsides after 12 weeks. It may be due to resetting of osmoregulation causing increased water intake and polyuria. 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.

According to Konar (2013), 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 oesophagus 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.

According to Ghana Health Service (2008), the number of times a client needs to be seen during pregnancy may vary. For the uncomplicated pregnancy it is recommended that at least four ANC visits should be made according to the following schedule.

 First visit: From onset of pregnancy up to sixteen weeks (16) gestation.

 Second visit: from the 24th to 28th week of pregnancy.

 Third visit: at 32nd week of pregnancy.

 Fourth visit: at 36th week.

LABOUR

Henderson (2009) states that normal labour naturally follows a sequential pattern that involves painful regular uterine contractions stimulating progressive effacement and dilatation of the cervix and descent of the fetus through the pelvis, culminating in the spontaneous vaginal birth of the baby, followed by the expulsion of the placenta and membranes.

King (2014) also states that, labour is the process by which childbirth occurs, requiring uterine contractions of sufficient frequency, duration, and intensity to cause demonstrable effacement and dilatation of cervix.

Marshall & Raynor (2014) also added that, labour, purely in the physical sense, may be 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.

Marshall & Raynor (2014) further states that, human pregnancy is considered to last approximately 40 weeks, with labour usually occurring between 17- and 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.

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

Konar (2013) also states that, conventionally, events of labour are divided into three stages:

 First stage starts from the onset of true labour pains and ends with full dilatation of the cervix. It is in other words, the 'cervical stage' of labour. Its average duration is twelve hours (12) in primigravida and six hours (6) in multipara.

 Second stage starts from the full dilatation of the cervix (not from the rupture of the membranes) and ends with expulsion of the foetus from the birth canal. It has got two (2) phases thus the propulsive phase starts from full dilatation up to the descent of the presenting part to the pelvic floor and the expulsion phase is distinguished by maternal bearing down efforts and ends with delivery of the baby. Its average duration is two hours (2) in primigravida and thirty minutes (30) in multipara.

 Third stage begins after expulsion of the foetus and ends with expulsion of the placenta and membranes (after-births). Its average duration is about fifteen minute (15) in both primigravida

and multipara. The duration is, however, reduced to five minutes (5) in active management.

 Fourth stage is the stage of observation for at least one hour (1) after expulsion of the after births. During this period, general condition of the patient and the behavior of the uterus are to be carefully monitored.

King (2014) added that the term fourth stage of labour refers to the first postpartum hour following placental expulsion.

According to Marshall & Raynor (2014), the onset of labour is process, not an event; therefore, it is very difficult to identify exactly when the painless (sometimes painful) contractions of pre labour develop into the progressive rhythmic contractions of established labour. Diagnosing the onset of labour is extremely important, since it is on the basis of this finding that decisions are made that will affect the intrapartum care and support subsequently provided.

King (2014) also states that, the onset of labour is classically defined as the occurrence of regular painful contraction that promotes dilation of the cervix. Contractions that occur at regular intervals with increasing frequency, duration, and intensity are the hallmark of labour. The onset of spontaneous labour cannot be reliably predicted, although many pregnant women experience premonitory signs or symptoms of impending labour. Common signs and symptoms suggestive of physiologic progress towards labour include descent of the fetus, cervical changes, increase in uncoordinated uterine contractions, rupture membranes, bloody show or increased mucus discharge from the vagina, maternal perception of increased energy, gastrointestinal distress. King (2014) also states that, physiologic adaptations during labour are required to support the unique demands imposed on both the woman giving birth and her fetus. Traditionally, the processes involved in labour and birth have been conceptualized as those that affect the power (uterus), the passenger (fetus), and the passage (pelvis).

According to Henderson (2009), the aims of midwifery care in labour are to achieve a safe labour and birth for mother and baby, and a pleasurable, fulfilling experience of child birth for the mother and her partner. In order to give woman-centered care, the midwife should:

 Assess the needs and expectations of each individual woman regarding labour and birth.

 Plan care with each woman in labour that is tailored to meet her specific needs and expectations.

 Put the care plan into practice, and

 Evaluate the care given to measure its effectiveness

Henderson (2009) also states that under emotional and psychological care, it is important for the midwife to have a good understanding of a woman's feelings in labour. Attitudes and reactions to childbirth vary considerably and are influenced by differing social, cultural and religious factors. Many women anticipate labour with mixed feelings of fear and excitement.

Henderson (2009) further states that, throughout labour, there should be a free flow of information between the woman and her partner and the midwife, particularly in relation to examinations and their findings. Being fully informed and involve in decision-making helps the woman to retain a sense of autonomy and control. The midwife should be aware that not all individuals may feel sufficiently secure or able to express fear or anxiety during labour.

Konar (2013) further states that under bladder care; patient is encouraged to pass urine by herself as full bladder often inhibits uterine contraction and may lead to infection. If the woman cannot go to the toilet, she is given a bed pan. Privacy must be maintained and comfort must be ensured. If the patent fails to pass urine especially in late first stage, catheterization is to be done with strict aseptic precautions.

Marshall & Raynor (2014) also states the following under bath or shower: Immersion in a warm bath or birthing pool can be an effective form of pain relief for laboring women that facilitates increased mobility with no increased incidence of adverse outcome for the woman or fetus. This

midwife should invite the woman who is mobile to have a bath or shower whenever she wishes during labour

According to Konar (2013), under rest and ambulation; if the membranes are intact, the patient is allowed to walk about. This attitude prevents vena cava compression and encourages descent of the head. Ambulation can reduce the duration of labour, need of analgesia and improves maternal comfort. If, however, labour is monitored electronically of analgesic drug (epidural analgesia) is given, she should be in bed.

According to Konar (2013), assessment of progress of labour and partograph recording are also done. Partographs are tools that allow labour progress to be graphically recorded and visually assessed. They aid in the early detection of abnormal labour progress and are credited by some for decreasing rates of prolonged labour, oxytocin use, caesarean sections and intrapartum morbidity/mortality as compared to usual care. Use of the partograph is initiated during presumed active labour.

According to Marshall & Raynor (2014), active management of the third stage of labour (AMTSL): An active management policy usually includes the routine prophylactic administration of a uterotonic agent, either intravenously, intramuscularly or (occasionally) orally, as a precautionary measure aimed at reducing the risk of post-partum haemorrhage.

It is applied regardless of the assessed obstetric risk status of the woman, and is usually undertaken in conjunction with clamping of the umbilical cord shortly after birth of the birth and delivery of the placenta by the use of controlled cord traction.

PUERPERIUM

According to Henderson (2009), the postnatal period or puerperium is traditionally defined as the time from immediately after the end of labour until the reproductive organs have returned as nearly as possible to their pre gravid condition, a period estimated to be around 6-8 weeks. Konar (2013) also states that, puerperium is the period following child birth in which the body tissues, especially the pelvic organs revert back approximately to the pre-pregnant state both anatomically and physiologically.

During puerperium the following physiological changes take place in all women as the body returns to its pre-pregnant state:

 Involution of the uterus and other soft parts of the genital tract. Commencement of lactation.

 Physiological changes in other systems of the body. It is important that the midwife is familiar with these to ensure that appropriate care and advice are given.

According to Konar (2013), involution is the process whereby the genital organs revert back approximately to the state as they were before pregnancy. The woman is termed as puerperal. Konar (2013) further states that, puerperium begins as soon as the placenta is expelled and lasts for approximately 6 weeks when the uterus becomes regressed almost to the non-pregnant size. The period is arbitrarily divided into; immediate – within 24 hours; early – up to 7 days and remote – up to 6 weeks.

Henderson (2009) also states, the secretion of prolactin from the anterior pituitary gland initiates lactation. Once lactation commences, it is maintained by the baby suckling. This provides the natural stimulus for the release of prolactin.

Konar (2013) states that, lochia is the vaginal discharge for the first fortnight during puerperium. The discharge originates from the uterine body, cervix and vagina. Depending upon the variation of the colour of the discharge, it is named as:

- Lochia rubra: red, 1-4 days
- Lochia serosa: 5-9 days, the colour is yellowish or pink or pale brownish.
- Lochia alba: 10-15 days, pale white

Konar (2013) also added that, the average amount of discharge for the first 5-6 days is estimated to be 250ml. Normal duration may extend up to 3 weeks.

Henderson (2009) states that changes in the urinary tract include a marked diuresis after delivery which lasts for 2-3 days. This is due to the reduction in blood volume occurring in the immediate postnatal period. The dilatation of the urinary tract, which occurs in pregnancy due to increased vascular volume, resolves and the renal organs gradually return to their pre gravid state.

Fraser & Cooper (2009) also states that, regardless of whether women are breastfeeding, they may experience tightening, and enlargement of their breasts towards the 3rd or 4th day hormonal influences encourage the breasts to produce milk. For women who are breastfeeding the general advice is to feed the baby and avoid excessive handling of the breasts. Simple analgesics may be required to reduce the discomfort.

Henderson (2009) further states that, the falling progesterone levels affect the alimentary tract. The smooth muscle tone gradually improves throughout the body, and symptoms of heartburn the woman may have experienced should resolve. Constipation may however remain a common problem during the postnatal period. Fraser & Cooper (2009) further states that it has been

traditional to associate after pains with multiparity and breastfeeding. However, women experience after pains regardless of whether they have had previous pregnancies and when they are not breastfeeding. Management of after pains is by an appropriate analgesic.

WHY CLIENT WAS CHOSEN

Madam Vida was formally chosen as client for the client family centered care study on 19th May, 2022 at Dormaa West District Hospital at 10:00am when she has come for her usual antenatal care. Madam Vida was seen eating without washing her hands. When approached kindly, she confessed she had not really done anything with her hands. She was taught on the importance of ensuring clean hands before and after eating. After which she was very grateful. Upon establishing rapport with her, Client was asked of her gestational age which she said, she was 36weeks, so her permission was sought to be used as client for care study. She demanded to know what goes into it and so a detailed explanation was given to her and she agreed.

CHAPTER ONE

1.0 INTRODUCTION

This chapter gives detailed information concerning the client's social history, daily habits, medical, surgical, menstrual, obstetric and family histories. Information was acquired through observation, interview and antenatal records.

1.1 PERSONAL HISTORY

Mrs. Vida Gravida 2 Para1 is a 23year old woman from Totain in the Northern Region of Ghana. She lives at Nkrankwanta with her husband and kid. Madam Vida is dark in complexion, 160cm tall and 58kg. Client speaks Twi and Dagare with formal education up to junior high school. She is a seamstress. Client is married to Mr. Abudu who also hails from Burkina. Mr. Abudu is an Electrician. Client and husband are both Muslims. She said her next of kin is her husband, Mr. Abudu. Client said she does not smoke nor take alcohol.

1.3 FAMILY HISTORY

Madam Vida is the first born of Mr. and Mrs. Issah. Her parents are both farmers and stay at Nkrankwanta. She is the elderly child of five siblings of which four are females and one male.

There is no known history of heart disease, sickle cell disease, diabetes mellitus, liver cirrhosis, epilepsy, mental illness and congenital abnormalities. She also said that, her family has no history of multiple pregnancy. She said her self and the family seek medical treatment and prays whenever they are not feeling well. In her family death occurs naturally according to client.

1.4 MEDICAL HISTORY

Madam. Vida has no known history of hypertension, heart disease, sickle cell disease, diabetes, jaundice, respiratory disease, epilepsy or mental illness. Client has never been admitted to a hospital except the time she got into labour and has no known allergy for food or drugs.

1.5 MENSTRUAL HISTORY

Madam Vida has a regular menstrual cycle of 28 days. And said she had her menarche when she was 18 years old. Client has seven days duration of menses which flows moderately on all days and has no dysmenorrhea. Client said she changes her pad twice daily indicating client has normal flow. According to client, her last menstrual period was in September, 2021 but she does not remember the exact date.

1.6 HOBBIES AND LIFESTYLE

Madam Vida is a principled woman who goes about her days in a similar trend each day. Client wakes up at 6:00am and says her daily morning prayers, goes through her daily domestic chores such as sweeping her room and compound and sees to other household chores if any. Client then takes her bath and grooms herself getting ready to go to her shop. According to Madam Vida, akpele with okro soup is her favorite food which she usually takes as supper. Client's breakfast is usually porridge made from corn dough with bread. Client goes to bed around 9 pm after the family had finished watching television to entertain them.

1.7 PAST OBSTETRIC HISTORY

PREGNANCY

Madam Vida has 2 pregnancies with 1 birth (G2P1A). The interval between her pregnancies is 3 years and it was without any complications such as pregnancy induced hypertension (PIH), antepartum haemorrhage and hyperemesis gravidarum. Client attended antenatal care (ANC) regularly during her previous pregnancy at a maternity home at Nkrankwanta and

LABOUR

According to client, with her previous child she delivered per vaginum spontaneously with perineum intact at Nkrankwanta Ceci's maternity home but could not remember the duration of labour. Baby cried immediately after delivery. Placenta and membranes were completely delivered with minimum blood loss. According to Madam Vida, she was discharged twenty-four hours after delivery at the ward.

PUERPERIUM

Client explained that her baby was very healthy throughout the post- partum period with normal weights. Client breastfed her baby for six months and started complementary feeds, such as porridge and mashed yam with egg. However, the baby was breastfed up to one and half year before weaning her completely. The growth of the child was monitored at the child welfare clinic, he was healthy and baby received immunization against all the childhood preventable diseases. She added that she was supported by her parents and husband physically and financially. Finally, she used combined oral contraceptive as her family planning method

1.7 PRESENT OBSTETRIC HISTORY

Madam Vida G2P1 alive visited the antenatal clinic for the first time on 12th November, 2021 with the gestational age of 9weeks 5days.Client could not remember the date of her last menstrual period but could only remember the month which she said was in September 2021. Her expected date of delivery was to be in the month of June during her first visit and that of scan was 20th June,2022. During her first antenatal visit, vital signs checked, physical examination was done and laboratory investigations were also done and the results recorded as follows;

Temperature	36.7 degree Celsius
Pulse	78bpm
Weigh.	58kg
Height	164cm
Blood pressure	110/69mmhg
Respiratory rate	22cpm
Hb	11.0g/dl
Sickling	Negative (-)
Blood group	O
Rhesus factor	Positive (+)
Urine for pregnancy test	Positive (+)
HIV	Negative (-)
Hep B	Negative (–)

VDRL	Non-reactive
Protein in urine	Negative (–)
Glucose in urine	Negative (-)
G6PD	No Defect

Physical examination from head to toe revealed no abnormalities. On palpation, there were no palpable lumps or masses in her breasts, her spleen was non palpable, uterus was not palpable. On inspection her abdomen was of a normal shape with no scars on the skin with no presence of straie gravidarum. Her gestational age was 9 weeks 5days to be specific. The following drugs were administered to her without any complains.

1.Tablet folic acid - 5mg daily for 30days

3. Tab multivitamins - 200mg daily x 30days

Looking at the records in her antenatal book, she has been a regular as she has been honouring all appointments as at the time she was met.

CHAPTER TWO

ANTENATAL CARE

2.1 INTRODUCTION

This chapter talks about the first contact with client, first and second home visits, her subsequent visits to the clinic, problems identified care plan drawn for the resolution of problems.

2.2 FIRST CONTACT WITH CLIENT

The first contact with Madam Vida was 10:25am on 19th May, 2022 at Dormaa West District Hospital, Nkrankwanta. Client was in her 36th week of gestation and was attending her 8th antenatal visit. Madam Vida was seen eating without washing her hands. She was then approached and served with soap and water in a bowl to wash her hands. She was told to always wash her hands with soap and water before and after eating and also educated on the need to practice good personal hygiene. Self-introduction was made as a student midwife from Holy Family Nursing and Midwifery Training College, Berekum, who has been stationed there to pick a client with some specification to write a care study and would like to take her as a client. Her antenatal booklet was taken and her previous antenatal record was noted. Client wholeheartedly agreed and she was glad for that. All procedures to be carried on her were explained to her understanding and she agreed. Client was encouraged to ask questions when necessary and also thanked her for her cooperation. Some investigations taken as well as her vital signs were recorded as follows.

Temperature - 36.0 degree Celsius

Pulse - 74 beats per minute

Respiratory rate - 21 cycles per minute

Weight - 65kilogram

GENERAL PHYSICAL EXAMINATION

A tray comprising of the following items;

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

Head examination: Client's hair was examined for cleanliness, lice, dandruff, ringworm, alopecia or any other scalp infection and no abnormality was detected. Client was commended for keeping the hair clean and encouraged to keep it up. The face was inspected for edema, rashes and nothing abnormal was detected. Her eyes were also inspected for pallor of the conjunctiva, yellowish or jaundice of the sclera but no abnormality was detected. The ears were also inspected for discharges and alignment with the eyes and nothing abnormal was detected. The mouth was inspected for dryness, cracks and infections of the lips. The gums and tongue for pallor, sores, and lesions and the teeth for decay but no abnormalities were detected. She was encouraged to brush her teeth two times daily and rinse her mouth after each meal. The neck was palpated for enlarged thyroid gland, distended neck veins and enlarged lymph nodes and nothing abnormal was detected.

Breast examination: Both breasts were exposed to check for size, shape and condition of the skin. On examination, both breasts were almost equal in size. One breast was then covered and she was asked to put the hand to be examined under her head. The breast was palpated systematically in a circular manner using the inner aspect of the fingers and client was taught self- examination of the breast, then nipples were squeezed gently, swabbed to check for abnormal odour or discharge and

everything was normal and no lymph nodes and lumps detected. Client was encouraged on the need to perform self-breast examination regularly as it helps in early detection of any abnormality. Client was encouraged to wear well- fitting braziers to support the breast and enhance comfort.

Extremities: The upper and lower extremities were checked for tingling sensations, tightness of fingers on making a fist with the hand, edema, palms and nails were checked for pallor, capillary refill, no extra digits. then tenderness in the calf muscles, varicose veins and but there were no abnormalities were noted.

Abdominal examination

Inspection: The abdomen was inspected and there was no scar as an indication of previous operation or falls or burns. There was however the presence of linea nigra and straie gravidarum. The shape and size of the uterus was globular and medium respectively and foetal movements were obvious.

Symphysio-fundal height; Palms were rubbed together to generate warmth in other to prevent stimulation contraction. The xiphisternum and upper boarder of the symphysis pubis were located. The zero mark of the measuring tape was placed on the fundus and extended along the contour of the abdomen along the midline to the upper boarder of the symphysis pubis and it measured 37cm and her gestational week was 36.

Fundal palpation; Upon facing the head end of the woman. Palms were rubbed together to generate warmth in order to avoid inducing contraction. The palms were placed on either side of the fundus for fundal palpation. The fingers were curved around the fundus to determine what lies in the upper pole. A soft mass was felt there which indicated the buttocks. The fundus has grown to the level of the xiphisternum.

Lateral palpation; on lateral palpation still facing the woman, the palms were place on each side, with one hand stabilizing one side of the maternal uterus, the other hand was moved gently in a rotational manner where the fetal leg were palpated at the right side. This was repeated at the other side and the fetal back was felt with the left side. The position of the fetus therefore was occipito-anterior.

Pelvic palpation; on pelvic palpation, position was changed to the feet of the client as pelvic palpation was done. Madam. Vida was asked to bend her knees and also to breathe in and out slowly and the palms were placed just below the level of the umbilicus with the fingers directed towards the symphysis pubis and the thumb almost meeting. On palpation hard mass was felt indicating the head of the foetus.

Descent; the anterior shoulder was located during palpation, upon locating the symphysis pubis with the ulna boarder just above the symphysis and anterior shoulder. Five fingers occupied the space indicating descent of $5/5^{th}$.

Auscultation; on auscultation, the foetal stethoscope (fetoscope) was warmed by rubbing it on the palms. The foetoscope was placed at the area where the back was located to listen to the fetal heart rate 145.

Health education was given on the need of eating nutritious diet, taking food in bits which would maintain her health. She was encouraged to report any abnormalities detected to the clinic very early and was reminded of the next visit to the health center. The intention of visiting her house was made known to her and directions to her house was given as phone numbers were exchanged and appointment was also booked to visit her in her house. A date which was scheduled for the home visit was on 22nd May 2022.

Her medications were served as follows;

Tab folic acid 5mg 1dly x 14days

Tab ferrous sulphate 200mg 1dly x 14days.

Tab multivitamins 200mg daily x 30days

She was encouraged to take the drugs as prescribed and reminded again of the next visit to the health center. She was thanked for the cooperation, escorted and bid good bye.

2.3 FIRST ANTENATAL HOME VISIT

The first visit to Madam Vida's house was on 22nd May, 2022, at 04:30pm as scheduled. The main aim of the visit was to observe the environment, source of water, light, ventilation number of people she shares her room with, where she disposed her refuse and her interpersonal relationship with her family members and neighbours. Not forgetting how she's fairing and give client the necessary health education on problems that would be encountered. Client's house is about 10 minutes' drive from the health facility.

Madam Vida was called on phone and direction to her house was repeated. On arrival Warm welcome and seat was offered. A quick assessment was made on the environment before sitting down. Water was offered and gratitude was expressed. Client lives with her husband and her kid.

The house is built with block with a pink painting and less ventilation for the room. The source of light supply to the house is electricity, the bathroom is outside the house and the refuse damp and toilet was fifty meters away from the house. Client curtains were neat but there was no mosquito net hanging on the bed and client was asked the reason for not using it, client explained that she feels hot and irritated when using it. Madam Vida was educated on the effect of malaria

on her and the unborn child. Client was advised to hang it in the shade early in the morning to prevent the irritation and remove all hanged cloth and put them in a bag. The client had a cordial relationship with her neighbours

Opportunity was made to ask her about her health and Madam Vida said she was coping with the stress of pregnancy but complained of backache, constipation and heart burns. She was educated to use the pillow anytime she sits to support her back. Client was educated to reduce spicy and oil foods and should avoid sleeping immediately after eaten. She was educated to eat more fibre foods, fruits and drink more fluids to prevent constipation. Client was educated on birth preparedness and complication readiness such as a driver who will transport her to the hospital when in labour, blood donor and was asked if her things were ready such as her cot sheet, baby's dress, pad, toilet roll, mackintosh and antiseptic soap and taught of signs of true labour. Client was encouraged to take her routine drugs as prescribed. Client was then reminded of her next visit to the health center and promises to see her again. In the absence of questions, Madam Vida was thanked for the nice reception and permission and asked to leave at 6pm.

2.4 SUBSEQUENT VISIT TO THE CLINIC

On the 25th of May 2022, madam Vida visited the clinic since she was booked to come to the clinic in one-week time. She was warmly welcomed and a seat was offered to her. She was asked how she was faring and Client said she was fine. Madam Vida was asked of her previous complains and She confess that she is now coping with the backache and she can now move her bowel freely.

Her vital signs and other observations were checked and recorded as follows;

Temperature - 36.2

BP - 110/60

HB - 11.0g/dL

Pulse - 78bpm

Respiration - 18cpm

Urine sugar - negative

Weights – 67kg

Client was encouraged to continue taking her routine medications as prescribed. She was educated on the true labour signs as the discharge of show and strong regular and painful uterine contractions. Client was told to report to the facility when she noticed any of the signs or any abnormality. Madam Vida was asked about the preparations she has made towards delivery and she explained that she bought all the things needed for delivery and said she has 6 cot sheet, baby's dress, cap and socks, mackintosh, cloth, pad, Dettol and some others. Client was congratulated on the preparation she had made towards delivery. Client was asked if there is anything bothering her mind and any complaint but she said, there was none. Appointment for the next home visit was booked to be 29th May, 2022 at 12:00pm and Madam Vida was bid farewell as she was escorted to the entrance of the facility.

2.5 SECOND ANTENATAL HOME VISIT

On 29th May, 2022 at 12: 00pm, the second home visit to Madam Vida's house was honoured as promised. The main objective for the visit was to know how far Madam Vida was coping with her term pregnancy and her preparation madam towards her delivery. On reaching home, the client

gave a smiling welcome and a seat was offered. Client was asked how she was faring she and the whole family; she said they were all doing well and that the kid had gone to school. Client said she was fine but of late she is unable to sleep. Client complain of loss of appetite Client was educated on the physiological changes that goes on in the body during pregnancy and also encouraged to take a warmth bath before bed, if possible, take warm milo too. Client was educated on mouth care before eaten and after going to bed to boost her appetite. Client was asked about the mosquito net and she said she has been sleeping under it. The opportunity was used to inspect her packed items in a suitcase once again to ensure it is still complete and it was complete. The client was thanked for her co-operation and was reminded of her next antenatal care visit and permission was sought to leave. Client saw me off and bid me goodbye.

2.6 ANTENATAL CARE PLAN

ACTUAL PROBLEM

1. 22/05/2022 Client complain of backache.
2. 22/05/2022 Constipation.
3. 22/05/2022 Heart burns.
4. 29/05/2022 Loss of appetite.
5. 29/05/2022 Sleeplessness.

SHORT TERM OBJECTIVES

1. Client backache will reduce within 24 hours.

2. Client will have free bowel within 48 hours.

3. Client will be reduced of heart burns within 24 hours.

4. Client will regain her appetite within 24 hours.

5. Client will be able to sleep for at least 2 hours during the day time and 6 hours at night within 24 hours.

LONG TERM OBJECTIVES

Madam Vida will go through pregnancy, labour and puerperium successfully without any complication to the mother and fetus.

ANTENATAL CARE PLAN

Date/Time	Nursing Diagnosis	Nursing Objectives/out come criteria	Nursing Orders	Nursing Intervention	Date/Time	Evaluation	Sign
22/05/2o 22 @ 10:00am	Backache related to exaggerated lumbar curvature during pregnancy.	Client will have reduced episodes of backache within 24 hours as evidenced by; Client verbalizing that her pain is reduced.	1. Reassure client 2. Educate client on the physiology of backache in pregnancy. 3. Advice client to have enough rest. 4. Educate client to support her back with pillow when sleeping or sitting. 5. Serve her prescribed analgesics.	1. Client was reassured. 2. Client was educated that pain was as a result of the effect of the hormones progesterone and relaxin which relaxes the pelvic ligaments and muscles. 3. Client was advised to have enough rest. 4. Client was educated to support her back with pillow when sleeping or sitting. 5. Prescribed paracetamol 1g was served tid.	23/05/2022 @ 10:00am	Goal fully met as client reported to the midwife that her back pains has reduced.	KA

ANTENATAL CARE PLAN

Date /Time	Nursing Diagnosis	Nursing Objectives/out come criteria	Nursing Orders	Nursing Intervention	Date/ Time	Evaluation	Sign
22/05/2022 @ 4:30pm	Constipation related to increase progesterone level in the blood which causes relaxation of the smooth muscles of the colon there by causing decreased motility of the gut.	Madam sharifa will have free bowel within 48 hours as evidence by Madam Sharifa verbalizing that she has been able to empty her bowel freely.	1. Reassure client 2. Explain the physiology of constipation to her. 3. Educate client to eat enough roughage like vegetables and fruits. 4. Encourage client to take more of fluids. 5. Encourage her to respond to the urge of emptying the bowel to avoid reabsorption of water from the stools.	1. Client was reassured that she will empty her bowels freely. 2. Client was educated that it was due to the effect of progesterone on her GIT. 3. Client was advised to eat enough roughage like fruits and vegetables. 4. Client was encouraged to take at least 2000mls of fluids everyday which is equivalent to four sachets of pure water. 5.Client was encouraged to respond to the urge of emptying her bowel to avoid reabsorption of water from the stools.	24/05/2022 @ 4:30pm	Goal fully met as client said she moved her bowel freely.	KA

ANTENATAL CARE PLAN

Date /Time	Nursing Diagnosis	Nursing Objectives/ outcome criteria	Nursing Orders	Nursing Intervention	Date/ Time	Evaluation	Sign
22/05/2022 4:30pm	Heart burns related to the relaxation of the cardiac sphincter of the stomach with reflux of acidic contents of the stomach into the lower oesophagus.	Client will cope with reduced episodes of heartburns within 24 hours as evidence by: Client verbalizing that the intensity of heart burns has reduced.	1. Reassure client. 2. Educate client on the causes of heart burns. 3. Encourage client not to go to bed immediately after meals. 4. Educate client to elevate the head end of the bed when sleeping. 5. Encourage client to eat less spicy foods.	1. Client was reassured that the intensity of heart burns would reduce. 2. Client was educated that it was due to regurgitation of gastric content due to relaxation of the cardiac sphincter. 3. Client was encouraged to go to bed at least 30 minutes after meals. 4. Client was educated to use more pillows when sleeping to elevate the head end of the bed. 5. Client was encouraged to eat less spicy foods.	23/05/2022 @ 4:30pm	Goal fully met as the intensity of heartburns reduced.	KA

ANTENATAL CARE PLAN

DATE/ TIME	NURSING DIGNOSIS	NURSING OBJECTIVES/OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALU-ATION	SIGN
29/05/2022 at 12:00pm	loss of appetite related hormonal changes during pregnancy.	Madam Vida will be able to eat two-thirds of her served meals within 24 hours as evidenced by; 1.Client verbalizing that she can eat very well. 2. The midwife observing that there has been an increase in client's weight on the next antenatal visit	1. Reassure client that loss of appetite can be managed. 2. Educate the client to ensure good oral hygiene 3. plan meals with client 4. Serve client's food attractively. 5. Encourage client to take her routine drugs as prescribed.	1.Client was assured that loss of appetite can be managed 2. Client was educated on proper oral hygiene by brushing twice daily. 3. Meal was planned with the client. 4. client's food was served attractively. 5. Client was encouraged to take her routine drugs as prescribed especially vitamin B Complex.	30/05/2022 at 12:00pm	Goal fully met as evidenced by client verbalizing that she can eat well.	KA

ANTENATAL CARE PLAN

DATE/ TIME	NURSING DIGNOSIS	NURSING OBJECTIVES/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALU-ATION	SIGN
29/05/2022 @ 12:00 pm	Interrupted sleep pattern related to frequency of micturition	Client will be able to sleep for at least 2 hours within the day time and 6 hours continuous sleep at night within 24 hours as evidenced by; 1. Client verbalizing that she was able to sleep for 6 hours during the night and 2 hours during the day. 2. By midwife observing that client looked refreshed.	1. Reassure client. 2.Explain the physiology of frequency of micturition to the client. 3. Encourage the client to take warm bath at night to facilitate sleep. 4. Encourage client to urinate before going to bed. 5.Advice client on intake of fluids containing natural diuretics.	1. Client was reassured. 2. Client educated that the condition was as a result of pressure from enlarged uterus pressing on the bladder. 3. Client was encouraged to take warm bath before going to bed. 4. Client was encouraged to urinate before going to bed. 5.Client was advised on intake of fluids like tea and warm milk.	30/05/ 2022 @ 12:00 pm	Goal fully met as client was able to sleep 2 hours in the day and 6 hours in the night.	**KA**

CHAPTER THREE

LABOUR

3.0 INTRODUCTION

This chapter talks about labour and involves management of the first stage of labour, management of second stage of labour, immediate care of the baby at birth, management of third stage of labour, examination of the placenta and membranes and management of fourth stage of labour.

3.1 ADMISSION AND MANAGEMENT OF FIRST STAGE OF LABOUR

Madam Vida arrived at the labour ward at 08:00pm on 31st May, 2022 accompanied by her husband with a history of lower abdominal pain and waist pain. Rapport was established and they were offered a seat. Before examination, the antenatal care record book was collected and read through quickly, history of labour was taken from client and client said labour pains started 2 hours ago which was around 6:00pm. Client said membranes had not ruptured nor was she bleeding but she could feel foetal movement and has seen the appearance of show. Enquiries were made to know if client took any medicine or concoction but she answered no. Client disclosed that she had not eaten and so her husband was asked to get porridge with koose to take. Client was reassured that she is in the hands of a competent student midwife as well as the staff midwife as a supervisor and made comfortable in bed.

Her vital signs were checked and recorded as follows;

Temperature – 36.5 degree Celsius

Pulse – 86beat per minute

Respiration – 22cycle per minute

Blood Pressure – 110/60millimeters of mercury

Explanation of procedure for physical examination from head to toe was given, consent was sought from client and she agreed so privacy was provided. Client was asked to empty her bladder which was 150mls clear umber urine, Midstream urine was tested for protein, sugar and acetone and findings were negative for both. Client was assisted to undress and helped unto the examination couch. Hands were washed with soap and water dried and warmed. Client was examined under the supervision of the midwife in-charge with no abnormalities detected. On abdominal inspection, abdomen was globular in shape, presence of straie gravidarum and linea nigra but no previous surgical scar observed. Symphysio fundal height was 38cm with gestation of 37 weeks 2 days. The fundus was palpated to identify the presenting part which was the buttocks. Lateral palpation revealed the fetal back at the left side and fetal limbs at the right side, the lie was longitudinal, position was left occipito anterior, presentation was cephalic, descent of the foetal head was three fifth (4/5) palpated above the pelvic brim. On auscultation fetal heart rate for one minute was read as 144bpm with regular rhythm and good volume. The uterine contraction was 2 in 10minute all lasting between 18seconds, and 19seconds respectively.

Permission was sought to perform vaginal examination which she agreed. Client was then assisted to lie on a lithotomy position with the legs parted. On inspection of the vulva, there was no scar, rashes, warts, varicose vein or sores. Five cotton swabs were soaked in savlon solution and it was used to clean the vulva, majora was cleaned using 1 to clean each side of the labia majora, 1 for each side of the labia minora and one for the vestibule. On vagina examination the vagina felt warm, moist and slippery the cervix was effaced, soft and thin and well applied to the presenting part. The cervical dilation was 2cm with intact membranes; the sacral promontory could not be reached; the presenting part was cephalic and the sacrum was well curved. The ischia spines were

blunt and sutures just touching each other. Client was cleaned and new perinea pad was applied. The gloved hand was removed and hand hygiene was performed and all findings were explained to Madam Vida was asked to ambulate and empty her bladder when she feels the urge to, to help in the descent of the foetal head. Client was encouraged to ask questions. All findings were documented and recorded on the observation chart. She was made comfortable and thanked for her corporation.

3.2 PREPARATION BEFORE BIRTH

A helper was identified, both skilled and unskilled helpers. The skilled helper was the midwife in-charge of the facility and the unskilled helper was client's husband. Client's husband is to her doula, provide emotional support and also to run errands in case client is in need of food or blood donation. Then the emergency plan was reviewed; thus, a taxi driver was informed to be alert in case of emergency.

PREPARATION OF AREA OF DELIVERY

The delivery room was made clean and warm by drawing the curtains closer and down, lights were switch on, and touch light was also made ready in an event of light off. Hands were washed with soap and water and dried with clean towel. The client was also assisted to wash her hands, chest and abdomen with clean water and soap and dried with clean towel to prepare for skin-to-skin contact. Delivery set was available waiting to be set at appropriate time. Oxytocin and other emergency drugs like oxytocin, magnesium sulphate was also made available.

PREPARATION OF RESUSCITATION AREA

Resuscitation area was made ready by switching on the radiant heat bulb to keep the place warm, all equipment such as ventilation bag and mask, stethoscope needed to help baby breath were assembled and tested for their function.

The delivery trolley was set and the entire instrument needed for the delivery were assembled.

3.6 MANAGEMENT OF FIRST STAGE

The foetal heart rate and maternal pulse were checked every 30 minutes, temperature every 2 hours, blood pressure, descent as well as vaginal examination were done 4 hourly and the results plotted on the observation sheet until client was 4cm.

Madam. Vida was reassured that in no time she will be due and so she was encouraged to do her best when she was asked to bear down.

At 12:30am, contractions were 3 in 10minutes lasting for 38 seconds. Fetal heart rate 130bpm. Client was due for the next vaginal examination that revealed that the vagina was warm and moist, cervical dilation was 4cm, cervix was thin soft and elastic with membranes still intact and moulding of one plus (+) which indicates that parietal bones were in apposition. Other examination reveal descent to be $3/5^{th}$, Maternal pulse was 92bpm, blood pressure 120/70mmHg and temperature 36.9C whilst urine measured 140mls with protein and acetone being negative. Client was anxious related to unknown outcome of delivery. She was told that she was in competent hands and that she will have a safe delivery and made comfortable. The delivery trolley was cleaned and a sterile delivery pack with other clean items were made available on both top and bottom shelf.

TOP SHELF CONTAINED STERILE ITEMS AS FOLLOWS

- Artery forceps
- Drape
- Cord scissors
- Gallipot with sterile cotton wool swabs
- Episiotomy scissors
- Receiver for placenta

3.5 LOWER SHELF CONTAINED

- Cheatle forceps and its container
- Identification band
- Cot sheets
- An oxytocin drugs
- Container with syringes and needles
- Fetoscope
- Local anesthesia
- Antiseptic lotion
- Measuring jug for measuring blood loss
- Disposable gloves
- Catheter and drainage bag
- Mackintosh
- Sterile gloves
- Cord clamp

- Receiver for used swabs
- Perinea pad
- Bowl of water with bulb syringe, Bedpan and Clock.

At 4:00am, Client complained of labour pains and that she had the urge to pass stools and to bear down. Client was reassured that it was due to the decent of the foetal head and that it will resolve after delivery. Client also complained of fatigue, impaired discomfort, thirst and dry throat. She was served with malt and encouraged to lie in the left lateral position to relieve her of the fatigue. She was encouraged to take sips of water to quench her thirst to keep her mouth and throat wet. Client was encouraged to do deep breathing exercise. Foetal heart rate, contractions and maternal pulse was checked every 30 minutes. Cervical dilatation, decent and blood pressure was checked every four hours and findings recorded on the partograph. Contractions were becoming frequent and strong. Client was encouraged to breathe through her mouth and not to push when she does not have the urge to. Client was assigned to a comfortable position (lithotomy). Hand hygiene was performed, sterile gloves were worn and vaginal examination was conducted. On vaginal examination at 4:30am, her cervix was 10cm dilated as membranes spontaneously ruptured whiles removing the examining fingers with clear amniotic fluid and moulding two plus, whilst urine was measured 120mls with protein and acetone negative.

3.7 MANAGEMENT OF THE SECOND STAGE OF LABOUR

Client was assisted into the lithotomy position as she preferred. Client head was also supported with a pillow. Client hands and abdomen were washed with soap and water, dried with a clean towel. The second stage was explained to her and she was encouraged to push with each contraction and breathe through the mouth when the contraction wears off. Protective clothing such as rubber, apron, boots and a scarf were worn. Hand hygiene was done. The trolley was pushed near the delivery bed at the right side of the client. Client was reassured to allay anxiety. A perinea pad was placed to the anus to prevent fecal matter from contaminating the delivery field hence infecting the baby. All observation was confirmed by the midwife in-charge

Client complained of tiredness which was explained to her that it is related to increased energy demand during labour which will be resolved after delivery. Progress of labour was communicated to her and reassured. The middle finger of the right hand was placed on the advancing head to prevent impulsive crowning of the head so that the smallest diameter of the head distends the perineum. When the head crowned, she was asked to stop pushing and pant to prevent impulsive push. The head was delivered by holding the parietal eminences, the face and chin to sweep slowly over the perineum to be delivered. The baby's eyes were cleaned with sterile gauze from the inner canthus to the outer canthus to prevent infection using one swab for each eye.

The mouth and nose were also wiped gently with sterile gauze. Cord around neck was looked for but there was none. Restitution took place followed by external rotation of the head indicating that the head is in the anterior posterior diameter of the pelvic outlet. The hands were placed on the sides of the baby's head over the ears and with gentle downward traction towards the mother's abdomen exactly 4:40am, a live female infant who cried lustily was delivered. Client was congratulated for her good maternal effort and cooperation.

3.8 IMMEDIATE CARE OF THE BABY

Immediately the head was delivered, the eyes were cleaned with sterile gauze. The baby cried immediately after birth. Mouth and nose were cleaned the to prevent aspiration of secretions. Baby was dried thoroughly with a cot sheet paying attention to the skin folds and replaced with a dry one. The umbilical cord was clamped 3cm away from the baby's abdomen and about 2cm from the first clamp. The umbilical cord was covered with gauze and cut in between the clamps with a pair of sterile scissors to avoid splashing of blood from the cord. The baby was separated from the mother and skin- to- skin care of mother and baby was performed for an hour. Breastfeeding was initiated during skin-to-skin care. An identification band comprising of mother's name, baby's sex, time and date of delivery was placed on baby's wrist to differentiate her from other babies. The baby was assessed according to the APGAR score at the first and fifth minute after birth.

The first minute APGAR score was recorded as following,

Appearance /colour	-	2
Pulse	-	2
Grimace	-	1
Activity/muscle tone	-	1
Respiration	-	2
TOTAL	-	8/10

The fifth minute APGAR was also recorded as

Appearance	-	2
Pulse	-	2
Grimace	-	1
Activity	-	2
Respiration	-	2
TOTAL	-	9/10

The baby was left for skin-to-skin contact on mother's chest providing warmth and also promoting bonding for 1 hour. The mother was asked to hold the baby on her abdomen as management of the third stage began.

3.9 MANAGEMENT OF THE THIRD STAGE OF LABOUR

Client still in the lithotomy position, a gentle palpation was done on the uterus to exclude undiagnosed fetus but there was none. Ten (10) units of oxytocin was given intramuscularly on the thigh within one minute of delivery of the baby. The cord was reclamped closer to the mother's vulva with a receiver placed in between the mother's thighs to receive the placenta. The clamped cord was held with the dominant hand whiles the non-dominant hand was placed on the fundus of the uterus to feel for contractions. When a uterine contraction was felt, the non-dominant hand was placed on the lower abdomen in the supra pubic area just above the symphysis pubis and counter traction applied to support the uterus to prevent uterine inversion whiles controlled cord traction was used in delivering the placenta until it was visible at the introitus. The non-dominant hand was released and both hands were used in receiving the placenta in a teasing manner till fully delivered.

The placenta was quickly examined and no missing lobes were identified. The placenta was then placed into a receiver for further examination. The placenta including the membranes was completely expelled at 4:50am.

The uterus was massaged immediately after the delivery of the placenta to aid uterine contraction, arresting hemorrhage as well as expelling clots. Consent was sought from client that her cervix, vagina, perineum and vulva would be examined. A good light source was directed to the perineum. Two sterile gauzes were wrapped round the index and middle fingers of both hands for inspection all-round the walls of the genital tract. The vagina and cervix were inspected thoroughly but there were no tears. Afterwards, the perineum was also examined and they were intact. The vulva, perineum and upper thigh were cleaned and a clean perineal pad was applied.

Client was wiped off blood and a clean perinea pad was applied to make her comfortable. She was congratulated and her baby was shown to her and she confirmed the sex of the baby. Blood loss estimated was approximately 180mls. Instruments used was decontaminated in 0.5% chlorine solution for ten minutes after which the instruments were washed and sterilized. She was encouraged to urinate frequently whenever she had she urge to, so that the uterus can be well contracted to prevent post- partum hemorrhage.

3.10. EXAMINATION OF THE PLACENTA AND MEMBRANES

A thorough inspection of the placenta and membranes is done in order to ensure that no part of it being retained in the uterus during its delivery. The cord was of normal size and the cut edge of the umbilical cord had two arteries and one vein surrounded by Wharton's jelly. The cord insertion was central. The foetal surface was shiny and bluish grey. The branches of the cord vessels were seen radiating on its surface but not beyond the edge of the placenta. The placenta was placed on a flat surface with the maternal surface facing upward. The cotyledons were intact with no infarcts

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

3.10.1 MANAGEMENT OF FOURTH STAGE OF LABOUR

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

Post- delivery vital signs were checked and recorded as follows;

Mother

Temperature 36.5 degree Celsius

Blood pressure 110/70mmhg

Respiratory rate 20cpm

Pulse 82bpm

Baby

Temperature 36.7degree Celsius

Respiratory rate 40cpm

Heart rate 138bpm

Madam Vida was asked to empty her bladder frequently in order to help contractions of the uterus. She was educated on how breastfeeding enhances the release of oxytocin which would improve uterine contractions, drainage of lochia, control of haemorrhage and also suppress the gonadal pituitary axis and subsequently prevent unwanted pregnancy

The uterus was well contracted with the symphysio fundal height 14cm. Her perineal pad was inspected for amount and colour of lochia. On inspection, the lochia was bright red, small blood loss and not offensive. Client was encouraged to change her pad frequently when it's soaked and to wash her hands before handling the baby. She was given porridge with bread after which she continued breast feeding. Baby was put to breast and the mother was reminded again on the importance of exclusive breastfeeding and to also breastfeed on demand.

3.10.3 EXAMINATION OF THE NEW BORN

The procedure was explained vividly to the client, examination gloves were worn and the baby was examined head to toe to detect any deviation from normal. Baby was put on a flat surface, Baby was exposed and the general condition, respiration and skin colour was noted and covered again to be examined from head to toe.

On examination of the head, the sutures and fontanels were examined with no abnormality detected. There was no laceration on the scalp and no caput succedaneum as well. The head circumference was measured and it was 33 cm. The pinna of the ears was well formed and there were no discharges from the ear. The eyes were in alignment with the ears. There was no pallor of the conjunctiva or jaundice on the sclera. The nose was well formed with septum dividing it. Nose was patent with no discharges. The mouth was examined for the presence of false teeth, cleft palate and tongue tie but there was none. Rooting, suckling and swallowing reflexes were present. There was no enlargement of lymph nodes, rigidity, congenital goiter and swelling of the neck.

On breast examination, there was no engorgement of the breast. The nipple was at the center of the areolar. There was no exomphalos, distention of the abdomen, enlarged spleen or liver as well as bleeding of the cord. There were three blood vessels that run through the cord which indicated two arterial cord vessels and a cord vein. The spine was examined with the baby lying in prone position. The back was palpated for swellings, spinal bifida or a missing vertebra, meningomyelocele but there was none. The skin was examined for skin colour, vernix caseosa, and lanugo, peeling of the skin, rashes and birth mark. There were no abnormalities with some amount of vernix caseosa. The upper extremities were equal with no extra digits. There were palmer creases and no webbed fingers. Grasping and Moro reflexes were present.

The lower extremities were also equal without an extra digit. Both legs were examined with no talipes and congenital dislocation of the hip. Knee flexes were normal.

On inspection of the genitalia, the vulva is well form with no discharges and there were no abnormalities noticed. Baby passed meconium and urinated soon after birth confirming the patency of the anus and urethra.

PREVENTION OF DISEASES

Baby Akua Ntiawine was given vitamin K1 to prevent bleeding. Tetracycline eye drop instilled on the eyes to combat infections. Again, two drops of polio ‘O’ was given by mouth and injection BCG 0.05ml was administered intradermal to prevent polio and tuberculosis. Client was also educated not to apply anything on the injection site. In all no abnormality was detected. Gloves were removed and disposed of according infection prevention protocol proper hand washing was performed and dried with a clean towel. Baby was given to his mother. All findings were

communicated to the mother and recorded. Madam. Vida was thanked. The baby's vital signs and weight were checked were recorded as follows;

Temperature	36 .7 ºC
Apex beat	138 bpm
Respiration	40 cpm
Weight	2.9 kg

She was also told that the baby may have swelling at the site of injection which would subside. Baby was wrapped in clean dry sheet and put to breast.

3.10. SUMMARY OF LABOUR

Madam. Vida had a spontaneous vaginal delivery to a live female baby on 1st June ,2022 at4:40am with birth weight 2.9kg with APGAR score 8/10 and 9/10. Placenta and membranes were completely delivered at 4:50am by controlled cord traction. Estimated blood loss was 180mls. Condition of mother and baby was satisfactory and they were made comfortable in bed.

3.10 DURATION OF THE STAGES OF LABOUR

1st stage	-	8 hours 30 minutes
2nd stage	-	10 minutes
3rd stage	-	10 minutes
Total	-	8 hours 50 minutes

3.10.5 LABOUR CARE PLAN

ACTUAL PROBLEMS IDENTIFIED

1. 31/5/2022 client complain of lower abdominal and waist pains.

2. 01/5/2022 Anxiety related to unknown outcome of labour.

3. 01/6/2022 Impaired discomfort.

4. 01/6/2022 Thirst and dry throat.

5. 01/6/2022 Fatique.

SHORT TREM OBJECTIVES

1.Madam Vida will cope with lower abdominal and waist pain within 2 hours.

2.Client Anxiety will resolve within 30 minutes.

3.Client will relive of discomfort within 1 hour.

4.Client Thirst and dry throat will resolve within 10 minutes.

5.Madam Vida will be relieved of fatique within 1 hour.

LONG TERM OBJECTIVES

Madam Vida will go through labour and delivery successfully without complications to both client and baby.

LABOUR CARE PLAN

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES/OUT COME CRITERIA	NURSING ORDERS	NURSING INTERVENTIONS	DATE/ TIME	EVALUATION	SIGN
31/5/2022 @ 9:00pm	Lower abdominal and waist pain related to strong uterine contractions.	Client will cope with lower abdominal and waist pains within 2 hours as evidenced by client verbalizing that she is coping and midwife observing that client no longer complain.	1. Explain the physiology of labour pains to her. 2. Reassure client that labour will soon end. 3. Put client in a comfortable position. 4. Encourage client to perform breathing and relaxation exercises. 5. Provide diversional therapy 6. Perform sacral massage for client.	1. The physiology of labour pains was explained to client. 2. Client was reassured that labour would soon end. 3. Client was put in the left lateral position. 4.Client was encouraged to perform breathing and relaxation exercises. 5. Client was engaged in a conversation. 6. Client's sacral region was massaged by her support person.	31/05/22 1 1:00pm	Goal fully met as client said she was coping.	KA

LABOUR CARE PLAN

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTIONS	DATE/ TIME	EVALUATION	SIGN
01/05/2022 @ 12:30am.	Anxiety related to unknown outcome of labour.	Clients' anxiety will resolve within 30 minutes as evidence by client verbalizing that she is no longer anxious.	1. Reassure client. 2. Explain every procedure to be carried to client. 3. Allow her to ask questions and answer her. 4. Update client with progress of labour. 5. Allow support person to be with her.	1. Client was reassured that labour will end safely. 2. Procedures like checking of vital signs, vaginal examination was explained to client. 3. Client was allowed to ask questions and answers were given to her. 4. Client was updated about progress of labour using the dilatation board after V/E. 5. Client husband was allowed to be with her and massage her sacral region during contractions.	01/05/22 @ 1:00am.	Goal fully met as client said she was no longer anxious.	KA

LABOUR CARE PLAN

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE AND TIME	EVALUATION	SIGN
01/06/22 @ 4:00am	Impaired discomfort related to insufficient body control as evidenced by client discontent with situation.	Client comfort will be restored within1 hour as evidenced by; 1.Client readiness to adhere to comfort measures. 2. Midwife observing client adhere to comfort techniques.	1.Reassure client. 2. Encourage client to perform breathing and relaxation exercise. 3. Engage client in diversional therapy. 4.Massage client sacral region. 5.Encourage client to ambulate around	1.client was reassured that she is in safe hands. 2. Client was encouraged to perform breathing and relaxation exercise. 3. Client was engaged in diversional therapy. 4.sacral massage was done by client support person to relieve the pain. 5.Client was encouraged to ambulate around clinic corridor	01/06/22 @ 5:00am	Goal fully met s client cope with activities.	KA

LABOUR CARE PLAN

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVE	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
01/6/2022 @ @4:00am	Thirst and dry throat related to the process of labour.	Clients' thirst and dry throat will resolve within 10 minutes as evidenced by client verbalizing; she is no longer thirsty.	1. Reassure client. 2. Explain the process of labour to client. 3. Support client to perform deep breathing exercise. 4. Give client sips of water. 5. Serve client with fluid diet.	1. Client was reassured those measures will be put in place to relieve her off the thirst and dry throat. 2. Process of labour was explained to client. 3. Client was supported to perform deep breathing exercise during contraction. 4. Client was given sips of water and ice to suck. 5. Client was served with cold milo drink.	01/6/2022 @ 4:10am	Goal fully met as evidenced by client verbalizing, she does not feel thirsty and dry throat.	KA

LABOUR CARE PLAN

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES	NURSING ORDERS	NURSING INTERVENTIONS	DATE/TIME	EVALUATION	SIGN
01/06/2022 @ 4:30am	Fatigue related to stress of labour	Client will be relieved of fatigue within 1hour delivery as evidenced by the client verbalizing that she is relieved and Midwife visualizing that client is refreshed and pushing effectively.	1.Reassure client that she will be relieve of fatigue. 2. Encourage client to continue with the relaxation techniques. 3. Encourage client to do deep breathing exercise during contraction. 4.Encourage client to take sips of fluids at regular interval. 5.Encourage client to assume a comfortable position.	1.Client was reassured that she will regain her energy very soon. 2. Client was encouraged with the relaxation technique. 3. Client was encouraged to do deep breathing exercise during contraction. 4.Client was encouraged to sips of water throughout the labour process. 5.Client was encouraged to assume left lateral position.	01/06/ 2022 @ 5:30am	Goal fully met as client verbalizing; she had been relieved of tiredness.	KA

CHAPTER FOUR

PUERPERIUM

4.1 DAY OF DELIVERY

Madam Vida and baby were transferred to the lying-in ward after six hours of close monitoring when their conditions were satisfactory. Client's immediate post-delivery vital signs were recorded as;

Temperature 36.5 ºC

Blood pressure 110/70mmhg

Respiration 20cpm

Pulse 82bpm

Head to toe examination of the mother was done after the procedure was explained to her for approval. The breasts were not really lactating, then on palpation the uterus was well contracted and the symphysio fundal height measured 14cm just below the umbilicus. The lochia was red in colour with moderate flow

Client was encouraged to take in adequate fluid and eat a well balance diet to help repair worn out tissue. she was served with a cup of beverage.

4.2 FIRST DAY POSTNATAL (Day of discharged)

First baby bath and examination

The next day, Madam Vida was informed about the need for the baby to be bathed and she responded positively. Client was asked to watch closely how to bath baby and practice same at home. Requirements needed for the procedure were gathered and are as follows;

4.3 TOP SHELF CONTAINED

- Chlohyxidine
- Sterile cotton wool swabs and gauze in a galipot
- Sterile water in a galipot

4.4 BOTTOM SHELF CONTAINED

- Baby's towel and baby's diapers
- Baby's dress
- Surgical gloves
- Cot sheet to wrap the baby
- Baby's sponge
- Soap in a soap dish
- Disposable gloves
- Jug of hot water
- Jug of cold water
- A bowl for mixing water
- Kidney dish for used gauze and swab
- A receptacle for used water

- Mackintosh apron

The procedure was explained to the mother on how to bath the baby and all items to be used were assembled. Plastic apron was worn. Cold and hot water were mixed and temperature tested with elbow. Hands were washed with soap and water and dried and gloves worn. Baby was placed on a protected flat surface and undressed after which she was wrapped with a cot sheet. Baby was not over exposed to prevent hypothermia. Eyes were cleaned with soaked cotton wool from inner canthus out and then the face was clean with damp face towel and dried. The nape of baby's neck was supported with one hand protecting the ears with the middle finger and the thumb.

Baby's head was washed with soapy sponge still supporting the nape and the body resting in the crook of the elbow with head lifted to the edge of the basin. Soap was rinsed off the head and dried. Baby was placed back on protected flat surface and exposed. Arms and front of the trunk were washed paying attention to skin folds. Baby's back was turned with one arm supporting the chest with the hand holding the distal arm of the baby. The back was washed down to the feet paying attention to the skin folds. Baby was firmly supported and rinsed thoroughly from the trunk to the limbs. Baby was placed on flat surface and covered with a clean big towel. He was wiped with a small towel to dry, paying attention to skin folds. Baby was smeared with pomade and dressed leaving the umbilical cord exposed for dressing and the hair combed neatly.

CORD DRESSING

The cord was dressed with chlorhexidine and baby was wrapped in a towel to keep her warm. Hands were thoroughly washed again and under running water and dried in a clean towel. Sterile gloves were worn and the cord was exposed. The cord was inspected for bleeding but there was none. The tip of the cord clamp was held with the non-dominant hand and the cord was dressed aseptically with chlorhexidine from top to down and exposed to dry. Baby was dressed, wrapped

and given to mother to breastfeed. The waste materials were discarded according to infection prevention protocol. Gloves were removed and discarded. Hands were washed with soap and water before handling the baby.

Education on how to position herself when breastfeeding and how to put the baby to breast were demonstrated and she did it perfectly and also encouraged to exclusively breastfeed for six months and on demand. Mother was educated on minor disorders in puerperium such as breast problem (breast engorgement and mastitis) and skin rashes on the baby. She was asked to report to the clinic especially if the problem was not resolved and also signs of engorgement were noticed. Client was also encouraged to change her pad when wet to avoid the risk of infections, educated on proper personal hygiene, report any excess bleeding, urinate frequently to enhance firm contraction of the uterus and also prevent post- partum hemorrhage.

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

Temperature	36.3ºC
Pulse	79bpm
Respiration	20 cpm
Blood Pressure	100/60mmHg
Symphysio-fundal height	14cm

The baby's vital signs checked were recorded as follows:

Temperature	36.0ºC
Respiration	38cpm

Pulse beat	140bpm
Head circumference	33cm
Full length	48cm
Weight	2.9kg

All findings were communicated to Madam Vida and all documentations were done.

Client was reassured and explained that the suckling will help in the release of oxytocin, to cause uterine contractions and expulsion of milk so she should continue to breastfeed the baby and it would subside with time. A discussion on how to care for the baby to prevent infection was done. Client was also advised to eat food rich in iron, protein, fiber, vitamins and also to take adequate fluid, all these would help to increase her hemoglobin level and promote enough breast milk production and prevention of constipation.

Prescribed drugs given are as follows;

Folic acid 5mg 1dly x 30 days

Tab ferrous sulphate 200mg 1dly x 30 days

Tab multivite 200mg 1 dly x30 days

Tab Paracetamol 1gram tid x 3 days

Capsule Amoxicillin 500mg tid x 7days

The dosage and time for taking the drugs were explained to her. She was helped to pack her belongings. She was congratulated for her cooperation and informed of the discharge, because she was insured, she had no bills to settle. She was also counselled to register the baby with the NHIS

when three months old so she could be a beneficiary. She was finally accompanied to the roadside and bid goodbye.

4.4 SECOND DAY POST DELIVERY/ FIRST POST-NATAL HOME VISIT

Madam Vida was visited on 2nd June, 2022. The aim was to assess their general conditions and to detect early conditions that could be harmful. She was met at her house. The procedure for the examination of both mother and baby was explained to her. Having washed hands with soap and water and drying them with a towel, Client was asked to lie on her bed for head-to-toe examination. Client complained of after pains. On general examination, nothing abnormal was observed. But breasts were still not lactating well and she was encouraged to continue breastfeeding as that will stimulate milk production. The uterus was well contracted and lochia was rubra when examined.

Vital signs were also checked and recorded as follows;

MOTHER

OBSERVATION	**MORNING**	**EVENING**
Temperature	36.5 ^{0}C	36.7 ^{0}C
Pulse	72 bpm	76 bpm
Respiration	20 cpm	21 cpm
Blood pressure	110/70millimeters of mercury	110/60 mmHg
Symphysio-fundal height	12 centimeters	12cm
Lochia	Rubra and not offensive	Rubra and not offensive
Condition of the uterus	Contracted	Contracted
Breast	Not really lactating	Lactating

BABY

OBSERVATION	MORNING	EVENING
Temperature	36.7 ^{0}C	36.8 ^{0}C
Apex beat	126 bpm	130 bpm
Respiratory	36 cpm	38 cpm
Weight	2.8 kg	2.8kg
Cord condition	Fresh and clean with no smell	Fresh and clean with no smell
Stool colour	Yellow	Yellow
Suckling	Good	Good

The baby was kept warm and given to mother to breastfeed, Client was encouraged to make sure the baby empties one breast before giving the other breast to prevent engorgement and to make sure the baby takes adequate breast milk. Madam Vida was educated on maintenance of the baby's personal hygiene and always keep the baby's warm especially during cold weather to prevent hypothermia. Cord dressing was done and Client was also educated to avoid the application of herbs and any other substance on the umbilical cord except chlorhexidine. All findings were documented and explained to client. Permission was sought to leave and it was granted. Client was assured of the subsequent visits at home.

4.4 SECOND POST-NATAL HOME VISIT

On 3rd June 2022, Madam Vida and the family were visited for the second time. Client's whole family was looking healthy on arrival around 8:45am, a warm reception and a seat was offered. Client was asked of her previous complain and she verbalized that she is relieved of the after pain. Head to toe examination was done and no abnormalities were detected. Madam Vida complained of breast engorgement and education was given to her to continue breastfeeding. Client confirmed

that baby had passed meconium and urine. Client was educated to allow the baby to empty one breast before offer the other one and apply warm compress on the engorged breast.

Head to toe examination was performed on the new born and no abnormality was present. Documentation for both mother and baby for morning and evening are as follows;

MOTHER

OBSERVATION	**MORNING**	**EVENING**
Temperature	36.6^{0}C	37.2 ^{0}C
Pulse	78 bpm	80 bpm
Respiration	22 cpm	23 cpm
Blood pressure	110/70 mmHg	120/70 mmHg
Symphysio-fundal height	10 cm	10 cm
Lochia	Rubra	Rubra
Condition of the uterus	Contracted	Contracted
Breast	Lactating	Lactating

BABY

OBSERVATION	**MORNING**	**EVENING**
Temperature	36.8 ^{0}C	36.5 ^{0}C
Apex beat	134 bpm	140 bpm
Respiratory	38 cpm	36 cpm
Weight	2.7 kilograms	2.7kg
Suckling	Good	Good
Stool colour	Yellow	Yellow
Condition of cord	Drying	Drying

Madam Vida was educated to continue with her personal hygiene, take in nutritious diet and to continue practicing the exclusive breast feeding.

4.5 FOURTH DAY POSTNATAL/ THIRD POST-NATAL HOME VISIT

On the 4th June, 2022 Madam Vida was visited around 8:35am. The environment was neatly kept, she verbalized that the engorged breast has reduced. Client complain of sleeping disturbances and backache. Head to toe exanimation was done on both mother and baby and no abnormalities were found. Client was educated to rest the back against a wall or backrest when sitting and ensure rest and sleep when baby is asleep. The baby passed urine and stool while it was top and tailed. She was educated to check and change baby's diapers quickly when soiled. Both mother and baby's assessment are as follows

MOTHER

OBSERVATION	**MORNING**	**EVENING**
Temperature	36.7 ^{0}C	37.2 ^{0}C
Pulse	72 bpm	74 bpm
Respiration	18 cpm	20 cpm
Blood pressure	120/80 mmHg	110/80 mmHg
Symphysio-fundal height	8 cm	8cm
Lochia	Scanty Serosa and not offensive	Scanty Serosa and not offensive
Condition of the uterus	Contracted	Contracted
Breast	Lactating	Lactating

BABY

OBSERVATION	MORNING	EVENING
Temperature	37.0^0C	$36.7\ ^0$C
Apex beat	128 bpm	140 bpm
Respiratory	38 cpm	36 cpm
Weight	2.7 kilograms	2.7kg
Suckling	Good	Good
Stool colour	Yellow	Yellow
Cord condition	Shrinked	Shrinked

FOURTH POST-NATAL HOME VISIT

Client and her baby were visited on the 5th June, 2022, at 8:00 am. Mother and baby's general conditions were good according to her. Permission was sought for the examination to be carried out and nothing abnormal was detected. Her perineal pad was inspected and lochia was serosa with moderate flow and odourless. The perineum and vulva were clean and the symphysio fundal height was taken. She lacks knowledge in family planning and she was educated on the various methods. The baby was bathed with warm water and the stump of the cord was dressed with chlohyxidine and wrapped in a cot sheet.

Vital signs checked were also recorded as follows:

MOTHER

OBSERVATION	**MORNING**
Temperature	36.4 ^{0}C
Pulse	70 bpm
Respiration	19 cpm
Blood pressure	110/70 mmHg
Symphysiofundal height	6 cm

BABY

OBSERVATION	**MORNING**
Temperature	36.9 ^{0}C
Apex beat	120 bpm
Respiratory	34 cpm
Weight	2.8kg
Suckling	Good
Stool colour	Yellow
Condition of cord	Cord was off and clean

Findings were communicated to her; she was then asked if she had any complains or concern but there was none. She breastfed baby till she slept. She was educated on proper and regular hand washing before changing of pad when soiled to prevent infection. She was encouraged to wash underwear and dry them in the sun and not in the room. She was advised to change pad regularly when wet and was educated on vulva toileting.

4.7 FIFTH POST-NATAL HOME VISIT

On the 6th June, 2022, around 8:00am, Madam Vida and the entire family were visited, the baby was doing well. The routine examination was carried out on both the mother and baby from head to toe and there were no abnormalities detected. The mother was made to bath the baby under my supervision and kept warm in a cot sheet. The umbilical stump was inspected and the cord was dressed and dry. The mother's assessment is as follows;

MOTHER

OBSERVATION	**MORNING**
Temperature	36.8 ^{0}C
Pulse	82 bpm
Respiration	19 cpm
Blood pressure	110/70 mmHg
Symphysiofundal height	4 cm

BABY

OBSERVATION	**MORNING**
Temperature	37.1 ^{0}C
Apex beat	120 bpm
Respiratory	40 cpm
Weight	2.9kilograms
Suckling	Good
Stool colour	Yellow
Stump	Clean and dry

4.8 SIXTH POST-NATAL HOME VISIT

On the 7th June, 2022 around 9:00am, Madam Vida was visited, the baby as well as the family were doing well. Routine examination was carried out on both the mother and baby from head to toe and there was no abnormality detected on any of them. The perinea pad was inspected the lochia was pink (serosa) with no odour.

The baby was bathed with warm water and kept in a cot sheet. The umbilical cord was dressed well with chlorhexidine. Baby passed urine and stool. Observations made on both mother and baby were also recorded as follows:

MOTHER

OBSERVATION	**MORNING**
Temperature	36.5 ^{0}C
Pulse	80 bpm
Respiration	20 cpm
Blood pressure	120/80 mmHg
Symphysiofundal height	2cm

BABY

OBSERVATION	**MORNING**
Temperature	37.3^{0}C
Apex beat	122 bpm
Respiratory	34 cpm
Weight	3.0kg
Suckling	Good
Stool colour	Yellow
Cord stump	Dressed with chlohyxidine

She was congratulated for her effort during this day. She was then reminded of her last official home visit which is 8th of June,2022

4.9 SEVENTH POST-NATAL HOME VISIT

Madam Vida was visited on the 8th of June, 2022 at 8:30 am as usual. Client's friend was present. After the usual chat, hands were washed and examination was done in client's room. Head to toe examination was carried out on both mother and baby and no abnormalities were found. The stump was healing so well as it was being dressed.

The vital signs of the baby are as follows;

BABY

OBSERVATION	**MORNING**
Temperature	36.6^0C
Apex heart beat	130bpm
Respiration	36cpm
Weight	3.1kg

MOTHER

OBSERVATION	**MORNING**
Temperature	36.1^0C
Pulse	78bpm
Respiration	18cpm
Blood pressure	120/80
Symphysiofundal height	Non palpable above pelvic brim.

Her lochia was serosa and without any offensive odour, client was educated on the care of the baby to prevent infection and also advised to continue with postnatal exercise. Client was asked about the complains made the previous visit, that is fatigue and loss of appetite and client said it was better, client was encouraged to report any abnormality in her condition and that of the baby for management. She was then reminded of the first postnatal visits to the facility and permission was sought to leave. Client and her family were thanked for their support and co-operation throughout the visits, this they responded with friendly smiles and they said, "You rather need to be thanked".

4.10. FIRST POSTNATAL VISIT TO THE CLINIC

Madam Vida and her baby arrived at the hospital for postnatal care on the 8th June, 2022 accompanied by her mother. Client was neatly dressed and looked cheerful. They were welcomed and given a comfortable seat.

Health educations on nutrition, immunization against preventable childhood diseases and family planning as well as care of the baby was given. Client was asked about her condition and that of the baby and she said they were doing well.

Client said her baby was able to feed well and always sleeps well. Madam Vida also confirmed that the baby passed urine and stools regularly.

Permission was sought from Madam Vida to examine the baby generally. She granted the permission and the procedure was explained to her.

The baby was taken, undressed and then wrapped with a clean cot sheet and placed on a flat surface for the examination in the presence of the mother. Baby's weight was 3.4kg. There were no Skin rashes detected on the baby moreover, there were no discharges from the eyes, nose and ears. No discoloration of the mucus membranes, palms, eyes, conjunctiva and feet was observed during

inspection. Baby's abdomen was not distended and the umbilical stump was almost healed. The baby's vital signs were checked and recorded as follows;

Temperature - 36.6^0 C

Apex beat - 130 bpm

Respiration - 42 cpm

Weight - 3.1kg

The baby was neatly wrapped before she was given back to the client's mother. The findings were communicated to the mother and thanked her for the care rendered.

The following were vital signs obtained

Temperature - 36.6 ^{0}C

Pulse - 82 bpm

Respiration - 20 cpm

Blood pressure - 110/70 mmHg

Permission was sought from Madam Vida to examine her from head to toe. The procedure was explained and she was asked to empty her bladder and a sample of her urine was taken and tested for glucose and protein and all tested negative. Privacy was provided, hands were washed and dried and examination was commenced.

On inspection, it was observed that the conjunctiva of the eyes was not pale, the nose was not discharge and breasts were soft with no cracks or sore on the nipples. There was also no abdominal tenderness and the symphysio-fundal height was not palpable above the pelvic brim and she was

encouraged to do abdominal exercise. There was no drainage of lochia on inspection. Madam Vida was advised to complete all immunization scheduled.

Client was reminded of her second postnatal visit to the clinic. Baby was registered at the Births and Deaths Registry and client was handed over to the public health nurse for continuity of care. Madam Vida and her entire family were thanked for their co-operation and for helping to make the study a success.

TERMINATION OF CARE

On 8th June, 2022, it was explained to Madam Vida and her family that, the official days for the home visits has come to an end since the period of study was over. She was handed over to the midwife in charge for the continuity of care. It was made known to her that update on her will be received from the midwife in-charge and she will be called if the need arises for any information, and she gladly said she will be available anytime needed. She and her entire family were thanked for availing themselves and helping me to achieve this study. Madam Vida expressed her gratitude for the care given to her. She and the family were bid farewell.

4.11 SECOND POST-NATAL VISIT TO THE CLINIC

According to the midwife in charge, on the 15th June. 2022. Madam Vida came to the clinic for six weeks visit. They were warmly welcome and they all looked very healthy. General examination was conducted on the client from head to toe revealed no abnormality. Again, all investigations and examinations on mother and baby were within normal ranges and baby weighed 5.8kgs.

Speculum examination revealed no bruises on the cervix but showed slit-like appearance. She had not resumed her menses when asked. She was educated on the need to start a family planning method to prevent unwanted pregnancy.

Madam Vida and her baby were handed over to the child welfare clinic and family planning unit for the six weeks' immunization against diphtheria, pertussis, tetanus, haemophilus influenza and hepatitis B.

She was finally referred to the public health nurse for continuity of care but report to the facility anytime she encounters any health-related problem. She was thanked for her co-operation and understanding as reported by the midwife in-charge.

4.12 NURSING CARE PLAN DURING PUERPERIUM

PROBLEMS IDENTIFIED

1. 02/06/2022 After pain.
2. 03/06/2022 Breast engorgement.
3. 04/06/2022 Sleeping disturbances.
4. 04/06/2022 Backache.
5. 05/06/2022 Lack of knowledge on family planning methods.

SHORT TERM OBJECTIVES

1. Client after pain will reduce within 24 hours.
2. Client breast engorgement will reduce within 24 hours.
3. Client will have at least six hours sleep within 24 hours.
4. Client backache will reduce within 24 hours.
5. Client will gain adequate knowledge on family planning method within 2 hours.

LONG TERM OBJECTIVES

Mother and baby will get a safe puerperium without any complication.

NURSING CARE PLAN

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
02/06/2022 @ 8:30 am	Acute lower abdominal pains related to contraction of the uterus.	Client will be relieved of lower abdominal pain within 24 hours as evidenced by: Client verbalizing that pain in the lower abdomen has subside.	1. Reassure client that this can be treated. 2. Explain to the client the reason behind the pain to allay anxiety 3. Encourage client to void frequently. 4. Encourage client to assume comfortable position. 5. Serve analgesics to relieve the pain.	1. Client was reassured that she will be relieve soon. 2.It was explained to the client that it is a normal physiology which helps to arrest hemorrhage. 3. Client voids frequently to relieve pressure from the uterus. 4. Client was encouraged to assume prone position. 5. Client was served with paracetamol 1g to reduce the pain.	03/06/2022 @ 8:30 am	Goal was fully met as evidenced by client verbalizing that pain has subsided.	KA

NURSING CARE PLAN

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
03/06/22 @ 8:45 am	Engorgement of breast related to poor feeding pattern	Client's breast engorgement will reduce within 24 hours as evidenced by client verbalizing that the pain has reduced	1. Reassure client to allay anxiety 2. Explain the cause of the engorgement of breast to client. 3. Assist client to position and fix baby well to breast. 4. Encourage client to breastfeed baby on demand 5. Encourage client to empties one breast completely before offering another one.	1. Client was reassured to ally anxiety 2. The cause of breast engorgement was explained to her. 3. Client was assisted to position and fix baby well to breast. 4. Client was encouraged to breastfeed baby on demand 5. Client was encouraged to ensure complete emptying of one breast before offering another one.	04/06/22 @ 8:45 am	Goal was fully met as client verbalized a reduction of breast engorgement.	kA

NURSING CARE PLAN

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/TME	EVALUATION	SIGN
04/06/2022 @ 8:35 am	Sleep disturbance related to crying of the baby at night.	Client will be able to understand and cope with the parenting responsibility within 24 hours as evidenced by client verbalizing that she can have adequate sleep during the night.	1. Reassure client that it is temporal and it shall be well. 2.Encourage client on various breastfeeding position. 3. Educate the client to ensure baby is filled and comfortable. 4. Encourage client to sleep during the day. 5. Encourage family support in the care of the baby.	1. Client was reassured that; with time it shall come to pass. 2. Client was encouraged on various types of positioning when breastfeeding. 3. Client was breastfeeding baby well and changing dippers before sleeping. 4.Client was educated to sleep during the day as her baby is asleep in the day. 5. Client involved support person in the care of the baby.	05/0/2022 @ 8:35 am	Goal was fully met as evidenced by client verbalizing that she can cope with the activities of the new born.	KA

NURSING CARE PLAN

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES /OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
04/06/2022 @ 8:35 am	Backache related to poor feeding and sitting position	Client backache will reduce within 24 hours as evidenced by client verbalizing a reduction of pain.	1. Reassure client. 2. Explain the causes of the backache to client. 3. Educate client on the proper use of body mechanics and good posture. 4. Educate client to assume correct position during breastfeeding 5. Educate client not to bend down during household chores.	1. Client was reassured that pain will resolve 2. The causes of the backache were explained to client. 3. Client was educated on the proper use of body mechanics and good posturing. 4. Client was educated to straight with back supported when feeding baby. 5. Client was educated to bend from knees during household chores.	05/06/2022 @ 8:35 am	Goal was fully met as client verbalized a reduced of backache.	KA

NURSING CARE PLAN

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
05/06/2022 @ 08:00 am	Knowledge deficit on family planning methods related to inadequate information.	Client will gain adequate knowledge on family planning methods within 2 hours as evidenced by client verbalizing that she will make a choice.	1. Reassure client. 2. Educate client on family planning method. 3. Introduce client to different types of family planning methods and help her choose one. 4. Encourage client to practice family planning method. 5. Encourage client to ask questions.	1. Client was reassured 2. Client was educated on family planning method during the puerperium 3. Client was introduced to the different types of family planning methods and was helped to choose one. 4. Client was encouraged to practice family planning method. 5. Client was encouraged to ask questions.	05/06/2022 @ 10:00am	Goal was fully met as evidenced by client willingness to choose a method.	KA

SUMMARY AND CONCLUSION

This client and family centered maternity care study was rendered to Madam Vida who comes from Totain in the Northern region but lives at Nkrankwanta, in the Bono Region. A 23-year-old Gravida 2, Para 1^{A} who was a regular attendant at Dormaa West District Hospital Nkrankwanta for antenatal care. I first met my client at the Antenatal clinic on the 19th May, 2022, when she was 36 weeks pregnant. Various observations and examination including laboratory investigations were carried out to aid in the progress of pregnancy. Friendship was then established to render effective care throughout pregnancy, labour and puerperium. Minor problems that were encountered during the period of pregnancy, labour and puerperium were all managed using the nursing process.

She went through some minor disorders which were managed successfully. Madam Vida's labour and delivery were carefully managed without any complications and she delivered an alive 2.9 kg female infant on the 1st of June, 2022, at Dormaa West District Hospital Nkrankwanta.

She went through puerperium successfully where both mother and baby were finally handed over to the Public Health Nurse at Dormaa West District Hospital Nkrankwanta on the 8th June, 2022 for continuity of care

This family centered maternity care given to Madam Vida has enabled me to gain much experience about the importance of proper client management during pregnancy, labour and puerperium.

It has also helped me to improve my skills as a student midwife in planning, interviewing, implementing, setting objectives and evaluating them to solve client's problem identified.

In the end, I will be able to give quality care to every woman who comes under my care.

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APPENDIX I

DATE	WEIGHT (KG)	BLOOD PRESSURE	URINE FOR PROTEIN/ SUGAR	GESTATIONAL AGE IN WEEKS	FUNDAL HEIGHT (CM)	PRESENT A-TION	DESCENT OF FETAL HEAD	FETAL HEART RATE (FH)	TREATMENT GIVEN	COMPLAIN	SIGN
12/11/21	58kg	100/70mmHg	negative/ negative	9weeks 5 days	Early cycis	-	-	+	Folic Acid	No complaints	RA
10/12/21	59kg	100/60mmHg	negative/ negative	13weeks 5days	Early cycis	-	-	-	Folic Acid	No complaints	PK
07/01/22	60kg	110/60mmHg	negative/ negative	18weeks	22cm			FMT	Routine drugs.	Feels well	LA
04/02/22	61kg	113/60mmHg	negative/ negative	21weeks 5days	23cm	Variable	5/5	143bpm	Routine drugs.	Complaints of waist pains.	LO

MOTHER'S ANTENATAL

DATE	WEIGHT (KG)	BLOOD PRESSURE	URINE FOR PROTEIN/ SUGAR	GESTATIONAL AGE IN WEEKS	FUNDAL HEIGHT (CM)	PRESENTA-TION	DESCENT OF FETAL HEAD	FETAL HEART RATE (FH)	TREAT-MENT GIVEN	COMPLAIN	SIGN
03/03/22	62kg	110/70mmHg	negative/ negative	25weeks 4days	26cm	Cephalic	5/5th	151bpm	Routine drugs.	No complaints	
24/03/22	65kg	110/65mmHg	negative/ negative	28weeks 4days	29cm	Cephalic	5/5th	147bpm	Routine drugs	No complaint	KP
21/04/22	66kg	110/60mmHg	negative/ negative	32weeks 4days	33cm	Cephalic	5/5th	148bpm	Routine drugs	No complaints	KP
19/05/22	65kg	110/60mmHg	negative/ negative	36weeks 4days	36cm	Cephalic	5/5th	145bpm	Routine drugs	Dizziness	KA
25/05/22	67kg	100/70mmHg	trace/ negative	37weeks 3days	38cm	Cephalic	5/5th	154bpm	Routine drugs	Healthy	KA

ITN Given – 12/11/2021

TETANUS IMMUNIZATION	PREVIOUS TT		TD 1 Yes TD 2 and TD 3		No	
	CURRENT TT 4th dose		Date 12/11/2021		Date	
INTERMITTENT PREVENTIVE TREATMENT (IPT)FOR Malaria	1ST dose SP* 3 tabs (Directly Observed Therapy) 07/01/2022	Gestation age In weeks 18weeks	2nd dose (1 month after 1st dose (Directly Observed Therapy) 04/02/2022	Gestation age In weeks 20weeks 5days	3rd dose (1 month after 2nd dose (Directly Observed Therapy)03/03/2022	Gestational age in weeks 25weeks 4days
	4th dose 3 tabs (Direct observed therapy)21/04/22	Gestation age in weeks 32weeks4days	5th dose 3 tabs (Direct Observed Therapy)19/05/2022	Gestation age in weeks 36weeks 4days		

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

APPENDIX II

COMPLETE DIAGNOSTIC INVESTIGATIONS

DATE	SPECIMEN	IVESTIGATION	NORMAL VALUES	FINDINGS	REMARKS
12/11/2021	1. Blood	Haemoglobin level	12g/dl-16g/dl	11.0g/dl	Low
		Sickling status	Negative	Negative	Normal
		Grouping and Rhesus	A, B, AB, and O	O	Normal
		factor	Positive and negative	Positive	Normal
		HIV status	None reactive	Negative	Normal
		VDRL	None reactive	Non-defect	Normal
		Hepatitis status	Negative	Negative	Normal
		G6PD status	None reactive	Non-defect	Normal
	2. Urine	Sugar	Negative	Negative	Normal
		Protein	Negative	Negative	Normal
10/12/2021	1. Urine	Sugar	Negative	Negative	Normal
		Protein	Negative	Negative	Normal
07/01/2022	1.Urine	Sugar	Negative	Negative	Normal
	Blood	Protein	Negative	Trace	Not Normal
		Haemoglobin level	13.0g/dl-16g/dl	11.2g/dl	Low
04/02/2022	1.Urine	Sugar	Negative	Negative	Normal
		Protein	Negative	Negative	Normal
03/03/2022	1.Urine	Sugar	Negative	Negative	Normal

		Protein	Negative	Negative	Normal
24/03/2022	1.Urine	Sugar Protein	Negative Negative	Negative Negative 12.0g/dl	Normal Normal
21/04/2022	1.Urine	Sugar Protein	Negative Negative	Negative Negative	Normal Normal
09/05/2022	1.Urine 2. Blood	Sugar Protein Haemoglobin level	Negative Negative 12g/dl-16g/dl	Negative Negative 11.2g/dl	Normal Normal Low
25/05/2022	1.Urine	Sugar Protein	Negative Negative	Negative Trace 11.6g/dl	Normal Not Normal

APPENDIX III

PHARMACOLOGY OF DRUGS USED (MOTHER)

NAME OF DRUGS	CLASSIFICATION	DOSAGE	ROUTE OF ADMINISTRATION	ACTION & USE	ACTUAL EFFECTS	SIDE EFFECT OF DRUGS	SIDE EFFECT EXPERIENCED
Tablet folic acid	Haematinics	5 milligrams once daily	Orally	Proper formation and functioning of red blood cell.	Haemoglobin level increase	Nausea and vomiting	None
Tablet multivitamin	Vitamin preparation	200 milligrams twice daily	Orally	Increased appetite. Helps in the formation of red blood cell	Increase appetite.	Gastro intestinal disturbances	None
Tablet ferrous sulphate	Iron supplement	200 milligrams 2 twice	Orally	Help in formation of haemoglobin and red blood	Haemoglobin level increased	Gastrointestinal disturbance	Dark stool

PHARMACOLOGY OF DRUGS USED CONTINUED (MOTHER)

NAME OF DRUGS	CLASSIFICATION	DOSAGE	ROUTE OF ADMINISTRATION	ACTION & USE	ACTUAL EFFECTS	SIDE EFFECT OF DRUGS	SIDE EFFECT EXPERIENCED
Tablet sulphadoxin epyrimetha mine	Anti-malaria and prophylaxis	3 doses stat from 16 weeks or after quickening and the remaining doses within 4 weeks interval until she delivers.	Orally	Treatment and prevention of malaria	Malaria prevention	Itching, nausea, dizziness, headache	None
Injection Tetanol	anti-tetanus	0.5 milligrams	Subcutaneously	Helps in the prevention of tetanus	Client protected against tetanus	slight fever and chills	None

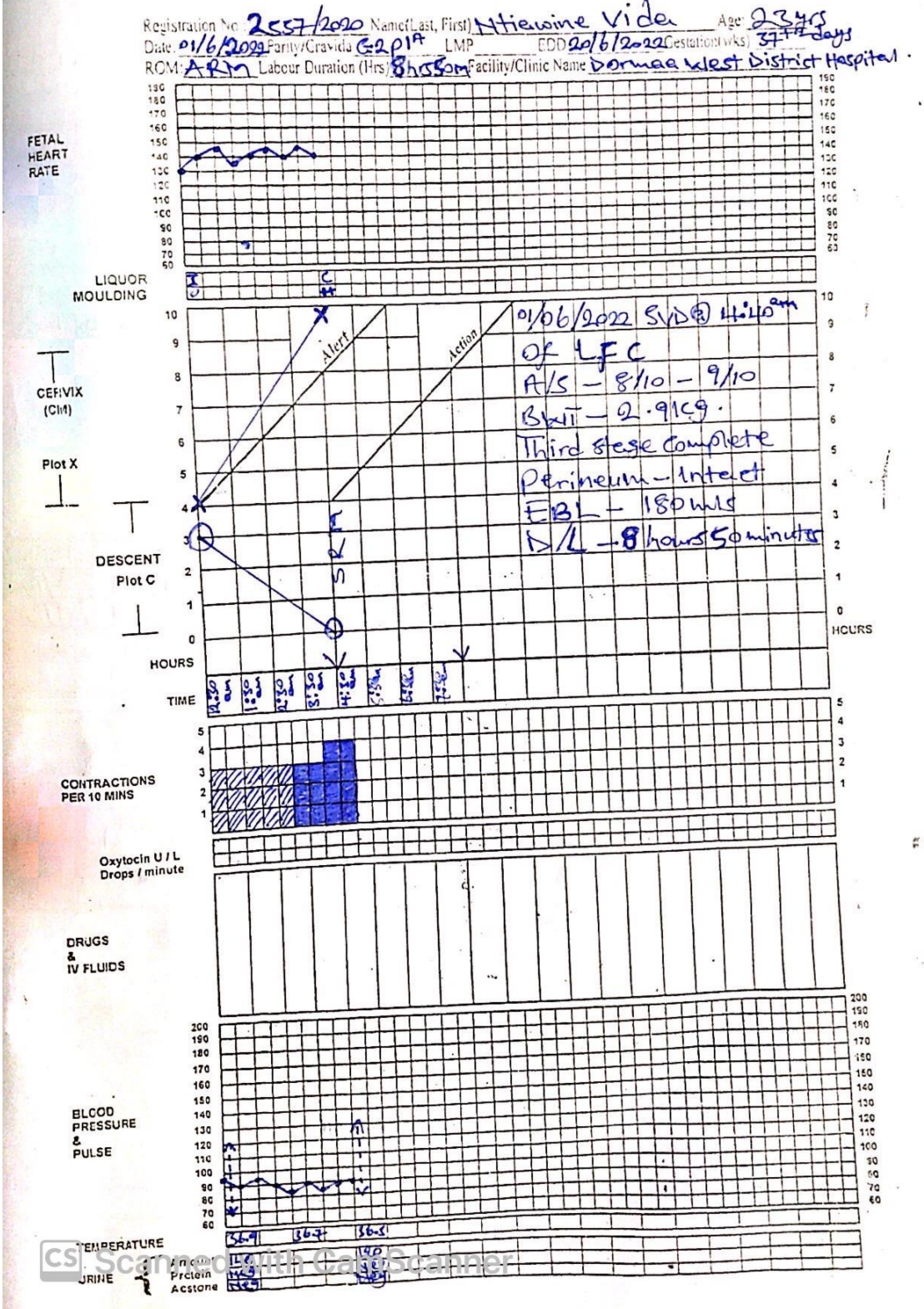
PHARMACOLOGY OF DRUGS USED CONTINUED (MOTHER)

NAME OF DRUGS	CLASSIFICATION	DOSAGE	ROUTE OF ADMINISTRATION	ACTION & USE	ACTUAL EFFECTS	SIDE EFFECT OF DRUGS	SIDE EFFECT EXPERIENCED
Injection oxytocin	Oxytocic drug	10 units	Intramuscularly	Stimulate uterine contractions	Client had good uterine contractions and bleeding was controlled	Nausea and vomiting	None
Capsule vitamin A	Group A vitamin supplement	200,000 units for 2 days	Orally	Growth development, immaturity and proper sight	Normal vision and healthy skin	Vomiting	None

PHARMACOLOGY OF DRUGS USED (BABY)

NAME OF DRUGS	CLASSIFICATION	DOSAGE	ROUTE OF ADMINISTRATION	ACTION & USE	ACTUAL EFFECTS	SIDE EFFECT OF DRUGS	SIDE EFFECT EXPERIENCED
Vitamin K	Group K vitamins (coagulant)	1.0mg	Intramuscular	Production of prothrombin which aids in clotting	No bleeding	None	None
Tetracycline eye drop	Antibiotics	2 drops	Instillation	To prevent infection	Infection of the eye was prevented	None	None
Poliomyelitis	Antigen vaccine	2 drops	Orally	Production of antibodies	Baby is under observation	There may be diarrhea	None
Injection Bacillus Calmette Guerin	Antigen vaccine	0.5 Milligrams	Intradermal	Production of antibodies for prevention of tuberculosis	Baby is under observation	Blister formation	None

WHO Modified Partograph



LABOR NOTES

Client was admitted at the facility @ 5:00pm with a complaint of labour pains. Labour progress well and had spontenous vaginal delivery to alive female infant with a birth weight of 2.9kg, head circumference of 33cm, full lenght of 45cm. Third stage was actively managed and completed. Estimated blood loss was 180mls. Baby's Apgar was 8/10 and 9/10 for the first and fifth minutes respectively.

Please circle or write responses.

DELIVERY

DATE: 01/06/2022 TIME: 4:40am METHOD: (Spontaneous) / Vacuum Extraction / C/S / Other

PERINEUM: (Intact) / Episiotomy / Laceration

ANESTHESIA: (None) / Local / General

THIRD STAGE

Active Management: (Yes) / No ·Medication: Time 4:41am Type/Dose 10 unit of oxytocin

PLACENTA: TIME 4:50am (Complete) / Incomplete

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

BABY

Weight: 2.9kg

Sex: Male / (Female)

Baby Position: (Vertex) / Breech / Other

APGAR

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

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

FOURTH STAGE MONITORING

Frequency	Time	B/P.	Pulse	Fundus	Bleeding	Bladder
Every 15 minutes first 2 hours	6:15am	120/60	80	1L Cm	180ml5	120ml5
	6:30am	120/70	82	Contracted	"	
	6:45am	112/66	86	Contracted	"	
	7:00am	110/70	90	Contracted	"	
	7:15am	118/72	88	Contracted	"	"
	7:30am	100/70	89	Contracted	"	"
	7:45am	110/75	84	Contracted	"	"
	8:00am	122/82	78	Contracted	"	"
Every 30 minutes For 1 hour	8:30am	100/68	80	Contracted	"	"
	9:00am	130/82	92	Contracted	"	"

Birth Attendant: Abigail Konadu (SRN) Supervised by Isabella Morino Midwife in-charge Date 01/06/2022

NEW BORN EXAMINATION FORM

Name: Baby Akua Ntiawine Date of Assessment: 01/06/2022 Time: _____

Date of Birth: 01/06/2022 Time of Birth: 4:14am Sex: ☐ M ☑ F Age at time of Assessment (days/hrs) _____

Astational Age 37+2days ☐ Mode of Delivery: ☑ Vaginal Assisted Vaginal C-Section

APGAR: 1min 8/10 5min ☐ 9/10 Birth Weight: ☐ ____ kg ☐ Length: 48 cm Head Circumference: 33 cm

Temperature at time of Assessment: 36.7°C °C Urine passed: (Yes) No Meconium passed: (Yes) No

Name of Assessor (Midwife/Doctor): _____

1. Respiration
Rate 40
☐ Rate < 30 b/m *
☐ Rate < 60 b/m *
☑ 30-60 b/m
☐ Retractions *
☐ Grunting *
☐ Stridor *

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

3. Tone
☑ Normal
☐ Floppy *
☐ Increased *

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

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

6. Cry
☑ Normal
☐ Shrill *
☐ Absent *

7. Suck
☑ Good
☐ Weak
☐ Absent

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

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

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

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

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

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

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

16. Clavicle
☑ Normal
☐ Swelling/Fracture

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

18. Heart rate
Rate: 138 bpm
☑ Normal (100-160)
☐ <100 *
☐ >160*

19. Femoral pulse
☑ Present
☐ Not palpable*

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

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

22. Limbs
☑ Normal
☐ Abnormal _____

23. Genitalia
Male Genitalia
☐ Normal
☐ Undescended testes
☐ Abnormal meatus
☐ Hernia
☐ Other: _____

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

24. Anus
☐ Patent
☐ Imperforate*

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

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

*May indicate severe disease that requires urgent referral.

Diagnoses (if known) Healthy 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 Akua Ntiamoah Date of Assessment: 02/06/2022 Time: 10:

Date of Birth: 01/06/2022 Time of Birth: 4.40am Sex: ☐ M ☑ F Age at time of Assessment (days/hrs)

Astational Age: 37 + 2 days ☐ Mode of Delivery: ☑ Vaginal Assisted Vaginal C-Section

APGAR: 1min 8/10 5min ☐ 9/10 Birth Weight: 2.9 kg ☐ Length: 48 cm Head Circumference: 33 cm

Temperature at time of Assessment: 36.7 °C Urine passed: (Yes) No Meconium passed: (Yes)

Name of Assessor (Midwife/Doctor):

1. Respiration
Rate 38
☐ Rate < 30 b/m *
☐ Rate < 60 b/m *
☑ 30-60 b/m
☐ Retractions *
☐ Grunting *
☐ Stridor *

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

3. Tone
☑ Normal
☐ Floppy *
☐ Increased *

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

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

6. Cry
☑ Normal
☐ Shrill *
☐ Absent *

7. Suck
☑ Good
☐ Weak
☐ Absent

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

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

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

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

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

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

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

16. Clavicle
☑ Normal
☐ Swelling/Fracture

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

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

19. Femoral pulse
☑ Present
☐ Not palpable*

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

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

22. Limbs
☑ Normal
☐ Abnormal

23. Genitalia
Male Genitalia
☐ Normal
☐ Undescended testes
☐ Abnormal meatus
☐ Hernia
☐ Other:

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

24. Anus
☑ Patent
☐ Imperforate*

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

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

***May indicate severe disease that requires urgent referral**

Diagnoses (if known)

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

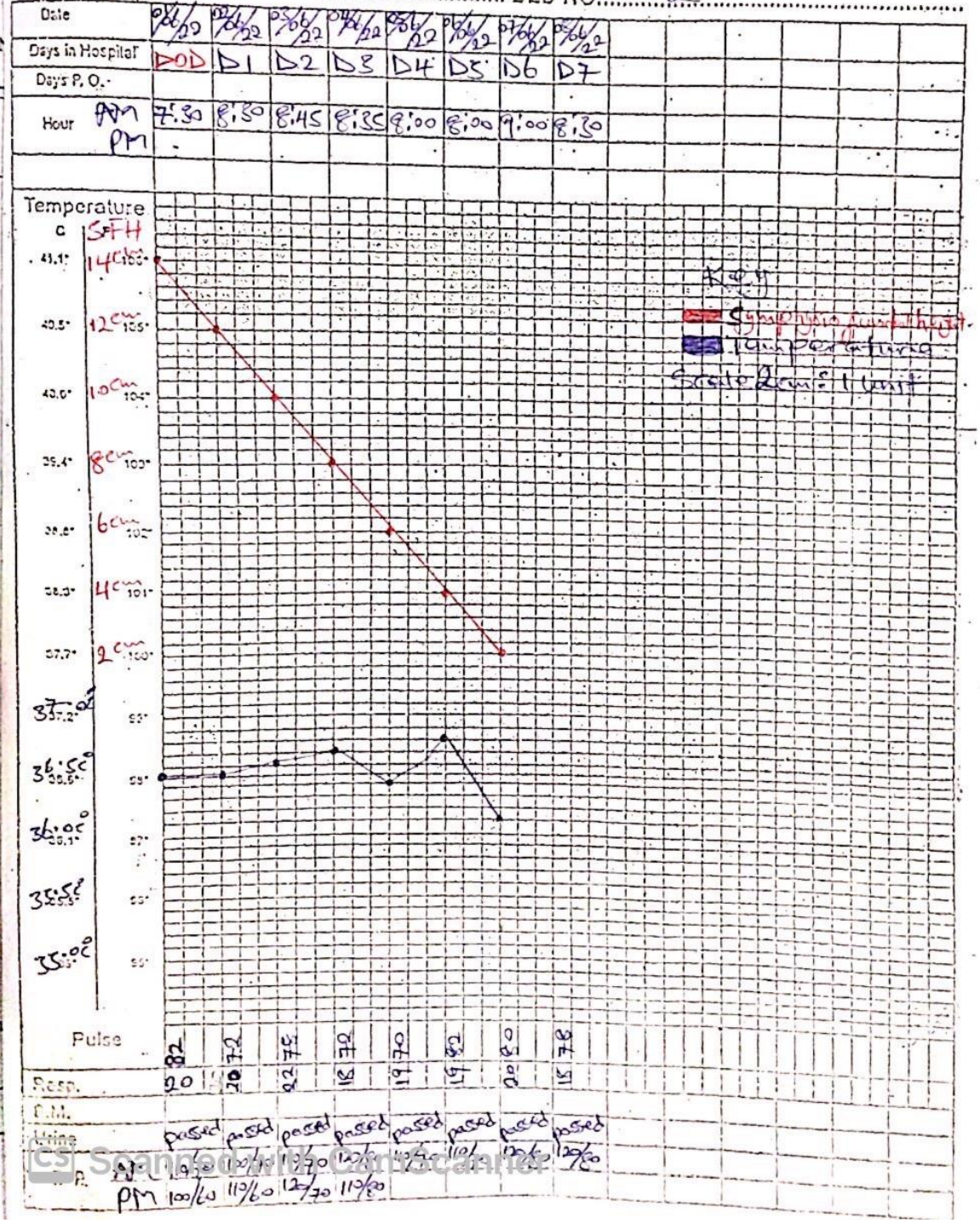
Plan: [ ] Routine Care [ ] Problem. Continue supportive in-patient care [ ] Urgent Referral / Advanced Care [ ] Discharge

MATERNITY CHART

NAME: Vida Ntiawine

AGE: 23 years. WARD: Maternity

IP NO.: BED NO.: 2

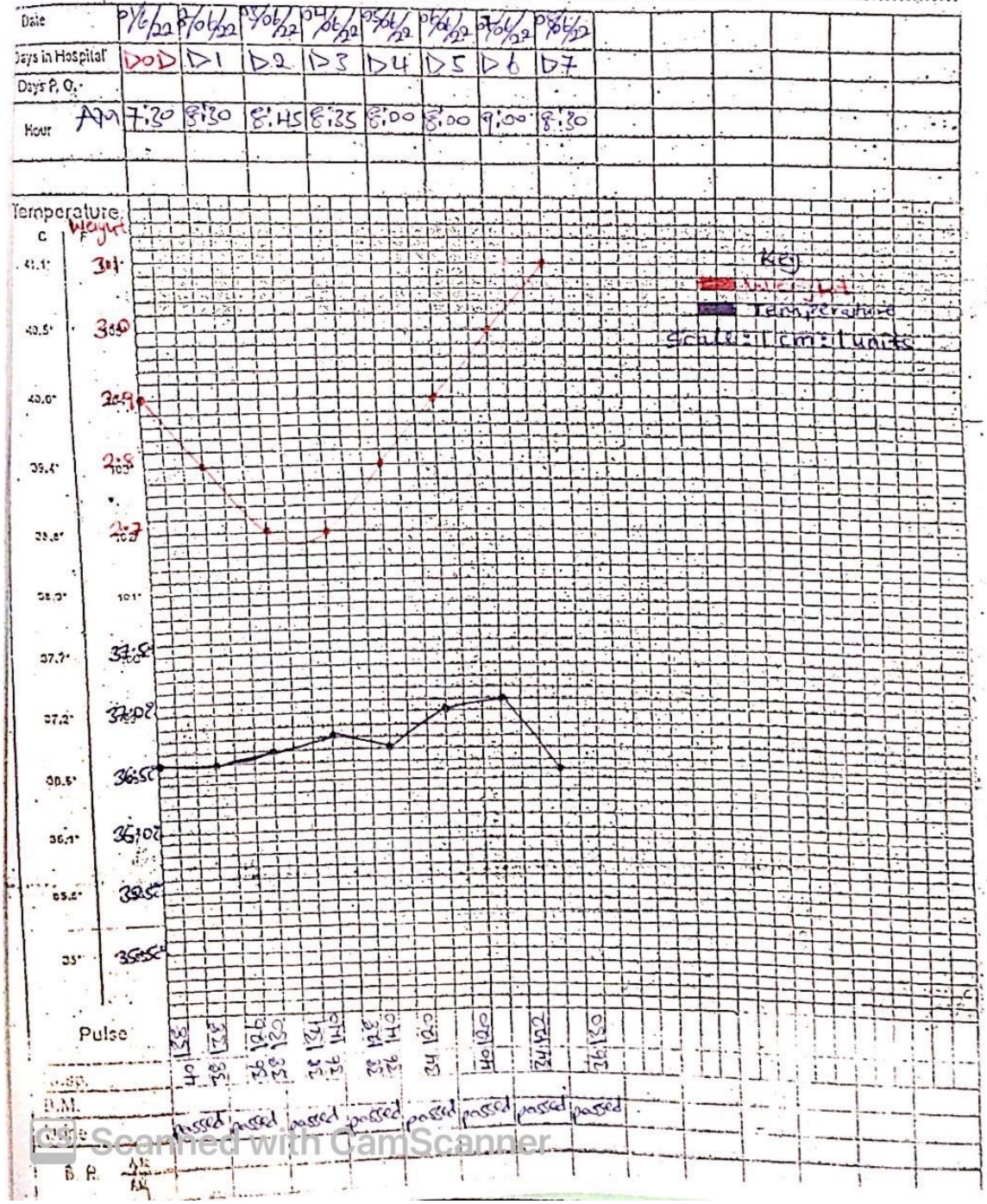


TEMPERATURE CHART

ME: Baby Alcua Ntiawine

E: ..... WARD: .....

NO.: ..... BED NO.: .....



NEW BORN CHART

Name: Baby Akua Ntiawine No: Birth Weight: 2.9kg

Sex: Mother's No: 2557/2020 Length: 48.5cm

Nature of Delivery: Spontenous Vaginal Delivery Diagnosis:

Date of Birth: 01/06/2022 Time: 4:40am Date of Discharge: 08/06/2022

Date	01/06/2022		02/06/2022		03/06/2022		04/06/2022		05/06/2022		06/06/2022		07/06/2022		08/06/2022									
No. of Days	D0D		D1		D2		D3		D4		D5		D6		D7									
Weight	2.9kg		2.8kg		2.7kg		2.7kg		2.8kg		2.9kg		3.0kg		3.1kg									
	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM
Temperature	36.7°C	36.0°C	36.7°C	36.8°C	36.8°C	36.5°C	37.0°C	36.7°C	36.9°C		37.1°C		37.3°C		36.6°C									
Stools	passed	passed	passed	passed	passed	passed	passed	passed	passed		passed		passed		passed									
Urine	passed	passed	passed	passed	passed	passed	passed	passed	passed		passed		passed		passed									
Remarks	Head Neck Trunk Limbs Genitalia — NO Abnormalities Detected																							

SIGNATORIES

CANDIDATE NAME

NAME: ABIGAIL KONADU

SIGNATURE: .....

DATE: 30/09/2022

THE MIDWIFE IN- CHARGE

NAME: MS. CONTANCE YEBOAH

SIGNATURE: .....

DATE: 01/10/2022

SUPERVISOR

NAME: MS. ERNESTINA MENSAH

SIGNATURE: .....

DATE: 07/10/2022

THE PRINCIPAL

NAME: MS. MONICA NKRUMAH

SIGNATURE: .....

DATE: 14/10/2022