HOLY FAMILY NURSING AND MIDWIFERY TRAINING COLLEGE,

BEREKUM

A CLIENT/FAMILY CENTERED MATERNITY CARE STUDY

ON

MADAM ALICE AGYEMANG

BY

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TABLE OF CONTENT

PREFACE

Midwifery is a very vital aspect of health care given to the pregnant women and their families. Client and Family centered maternity care study is a systematic, comprehensive and holistic approach used in rendering obstetric care to the expectant mother and her family as a whole throughout pregnancy, labour and puerperium. The case involves data collection, assessment, identification of problems, nursing diagnosis, planning; implementation and evaluation of the data that would help solve the individual's problems. The care also focuses on the mother's physical, emotional, spiritual, psychological and social needs to help attain maximum standard of care. The family centered maternity care study also gives the student midwife an opportunity to use her knowledge and skills acquired both practically and theoretically during her period of training to care for a pregnant woman throughout pregnancy, labour and puerperium. Moreover, the family centered care study helps the student midwife to use the new trend in midwifery like the partograph and nursing process in management of first stage of labour and to diagnose any complication during pregnancy. The nursing process provide framework for solving problems and making decisions in the management of the client and family in a systematic manner. The study also enables student midwife to educate the client and family and also promote cordial relationship between the student midwife, the mother and her family.

Furthermore, the study helps the student midwife to put into practice the concept of safe motherhood initiative which has being adapted to render quality maternity care through antenatal, labour and puerperium which will eventually reduce maternal and neonatal mortality. The family centered maternity care study is an academic exercise required by the Nursing and

Midwifery Council of Ghana so as to enable the student midwife to practice after completion of her training.

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INTRODUCTION

This Client and Family Centred Maternity care study was on Madam Alice Agyemang a 32years old, Gravida 3 Para 2 and her family who live at Wenchi in the Bono Region. Client was first met on 21st August, 2023 at 37 weeks of gestation and in good health. She went through pregnancy, labour and puerperium successfully and delivered a healthy Female baby on the 5th September, 2023. Mother together with her baby was discharged on the 6th September, 2023. To maintain confidentiality, she will be called Madam Alice throughout the study. The client was visited at home on several occasions and the entire family as well, was included in the care.

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

Chapter one deals with the particulars of the client that is her personal and social history, family history, medical history, surgical history, menstrual history, lifestyle and hobbies as well as her past and present obstetric histories.

Chapter two deals with the antenatal care of the client, a description of the first encounter with the client and home visit made to her. The nursing care plan used in providing care for the client, where problems were identified, objective set, then an implementation plan used in rendering services.

The third chapter gives report on the admission and management of the first to the fourth stage of labour, including the immediate and subsequent care of the baby and the nursing care plan.

Chapter four gives an account of the management of puerperium with emphasis on care of the mother and baby from day of delivery to the first seven days after delivery and second postnatal clinic visits.

The script also includes summary, conclusion, bibliography, appendix like laboratory investigations, antenatal records, pharmacology of drugs and signatories.

LITERATURE REVIEW

Pregnancy

Henderson (2009) stated that, pregnancy may be suspected by the woman based on the knowledge on her menstrual cycle, sexual activity and the signs and symptoms of pregnancy. They are; amenorrhea, nausea and vomiting, breast changes, enlargement of the uterus, frequent micturition, skin changes and quickening. These signs and symptoms of pregnancy may be considered as presumptive, probable, and positive. They become obvious to the woman as her pregnancy advances. Women may confirm their pregnancy using home pregnancy test. Confirmation of pregnancy may also be sought from the midwife or doctor. This is established by a detailed history and relevant clinic examination based on the signs and symptoms of pregnancy.

Weller (2014) defines pregnancy as being with child, the condition from conception to the expulsion of the fetus. During this period, a lot of physiological and psychological changes take place in the woman. This affects the entire system as a result of hormonal influence, some women suffer minor disorders like heart burns, constipation, waist pains, food cravings and others which most of these changes go away after delivery. If these are not treated early, they can lead to severe complications which could be life threatening, therefore, it is important for the pregnant woman to attend antenatal clinics as soon as she realizes she is pregnant, for supervision, observations, investigations, and examinations for early detection and treatment of any deviation from normal. During this period, the expectant mother needs special education, encouragement and care, in order to cope with these minor disorders. These educations are given at the antenatal clinics by the attending midwife. Antenatal care is a special care to promote a healthy mother and foetus. Focus antenatal is a special care given to a pregnant woman by the

attending midwife and an obstetrician, during pregnancy to ensure that, maternal and foetal health are normal. The aim of focus antenatal is to detect early and treat any abnormalities, prevent complications, promote health and educate mothers on complication readiness.

Oduro-Kwarteng (2012) defines pregnancy as having a developing embryo of fetus in the uterus as a result of the union of an ovum and spermatozoa. The normal duration of pregnancy is 280days (40wks or 9months and 7 days) counted from the first day of the last menstrual period.

Perry (2006), pregnancy is the period of physical and physiological preparation for child birth and parenthood. The expectant mother ideally should begin prenatal visit soon after the first missed menstrual period for early detection of complications and to ensure good health of the expectant mother and foetus. Normal pregnancy last for about fourty (40) weeks or two hundred and eighty (280) days and healthcare providers refer to early, middle and late pregnancy as trimesters. The first trimester last from week one (1) to thirteen (13) weeks and the second from fourteen (14) to twenty-six (26) weeks whereas the third trimester from twenty-seven (27) weeks to fourty (40) weeks. Any pregnancy that advances from thirty-eight (38) to forty (40) weeks is considered to be at term.

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

Labour

Perry (2006) Labour, purely in the physical sense, may be described as the process by which the foetus, placenta and membranes are expelled through the birth canal; however, labour is much more than a purely physical event. There are five factors which affects the process of labour and birth. These are the Passenger which is the fetus and placenta, Passageway which is the birth canal, Powers which is the contractions, Position of the mother and Psychological responds.The stages of labour are as follows; the first stage of labour begins with the onset of regular uterine contractions, effacement, dilatation of the cervix and progress in descent of the presenting part. The first stage of labour has been divided into three phases namely; the latent phase where there is more progress in effacement of the cervix and a little increase in descent. Active phase and transitional phase where there are more rapid dilation of the cervix and increase rate of the descent of the presenting part. The second stage of labour; this stage begins with full cervical dilation (10 centimeters) and complete effacement and ends with the baby's birth. The second stage takes an average of 20 minutes for multiparous women and 50 minutes for nulliparous women. The third stage of labour which lasts from the birth of the fetus until the placenta is delivered and there is arrest of haemorhage. The placenta normally separates with the third or fourth strong contractions after the infant has been born. The duration of the third stage may be as short as 3-5minute although up to 1 hour is considered within the normal limits. The fourth stage of labour last for 6 hours after delivery of the placenta. It is the period of immediate recovery when homeostasis is re-established. It is an important period of observation for complications such as bleeding.

Oduro-Kwarteng (2014), 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 foetus, cervical changes, increase in uncoordinated uterine contractions, rupture of membranes, bloody show or increased mucus discharge from the vagina, maternal perception of increased energy, gastrointestinal distress. 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. Physiologic adaptations during labour are required to support the unique demands imposed on both the woman giving birth and her foetus. Traditionally, the processes involved in labour and birth have been conceptualized as those that affect the power (uterus), the passenger (foetus) and the passage (pelvis). The term fourth stage of labour refers to six hours following placental expulsion and haemorrhage arrest.

Marie (2013), labour is a series of events that takes place in the genital organs in effort to expel the viable products of conception out of the womb through the vagina into the outer world. Labour is called normal if it fulfills the following criteria; Spontaneous in onset, with vertex presentation, without undue prolongation. Natural termination with minimal aids, without having any complication affecting the health of the mother and/ or the baby. The features of true labour signs are: Painful uterine contraction at regular intervals. ‘’Show’’. Progressive effacement and dilatation of the cervix. Formation of the bag of waters. The events of labour are divided into four stages; first, second, third and fourth stage. First stage starts from the onset of true labour pain and ends with full dilatation of the cervix. Its average duration is 6 hours in multipara. Second stage starts from full dilatation of the cervix and ends with expulsion of the foetus from

the birth canal. Third stage begins after the expulsion of foetus and ends with the expulsion of the placenta and membranes (afterbirth) and haemorrhage has been arrested. Average duration is about 15 minutes in both multi and primigravidae. Fourth stage is the stage of observation after the expulsion of the afterbirth. Four factors are significant in the process of labour; that is the pelvis, passenger, powers and psyche. These are known as the four P's.

Henderson (2009) stated that normal labour naturally follows a sequential pattern that involves painful regular uterine contractions stimulating progressive effacement and dilatation of the cervix and decent of the foetus through the pelvis, culminating in the spontaneous vaginal birth of the baby, followed by the expulsion of the placenta and membranes. The aims of midwifery care in xiii 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 women 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. Under emotional and psychological care, it is important for the midwife to have a good understanding of women'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. Throughout labour, there should be a free flow of information between the women and her partner and the midwife, particularly in relation to examinations and their findings. Being fully informed and involved in decision making helps the women 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

Littleton (2005), Normal labour is a sequence of events that occurs to expel the fetus, placenta and its membranes through the birth canal which starts with regular painful uterine contractions and dilation of the cervix. There are four stages of labour. The first stage comprising of the latent phase where the cervix takes eight hours to dilate from onset-3 centimeter and the active phase, where the cervix dilates one centimeter every hour from 4- 10 centimeter. The second stage begins when the cervix becomes fully dilated to complete delivery of the baby. The third stage is the complete expulsion of the placenta, membranes and the control of hemorrhage. The fourth stage is the period of six hours observation of both mother and the baby after the third stage is completed.

Puerperium

Myles (2008) states that, following the birth of the baby and expulsion of the placenta, the mother enters a period of physiological and psychological recuperation. Puerperium starts immediately after the delivery of the placenta and membranes continue for six weeks. The overall expectation is that by the six weeks after birth of the baby, all the body systems will have recovered from the effects of pregnancy and return to their non-pregnant state. Between exercise and healthy activity verse rest, relaxation and sleep, exploring each person's level of activity will encouraged in relation to appropriate exercise and by association, nutritional intake and rest or relaxation and sleep. Undertaken regular pelvic floor exercise is of benefit the woman's long term health.

Henderson (2009), the postnatal period or Puerperium is traditionally defined as the time from immediately after the end of the third stage until the reproductive organs have returned as nearly as possible to their pre gravid condition, a period estimated to be around 6-8 weeks. The 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 falling levels of progesterone affect the alimentary tract. The smooth muscle tone gradually improves throughout the body and symptoms of heartburn the women may have experienced should resolve. Constipation may however remain a common problem during the postnatal period.

Marie Elizabeth (2013) describes puerperium as the period following childbirth during which the body tissues, especially the pelvic organs revert back approximately to the pre-pregnant state both anatomically and physiologically. The period is divided into; Immediate –within 24 hours, early up to 7 days, remote –up to 6 weeks, immediately following delivery, the uterus becomes firmer and retracted with alternatively hardening and softening. At the end of 6 weeks, its

measurement is almost similar to that of the non-pregnant state and it weighs 60 grams. The lower uterine segment becomes thin, flabby and collapsed structure. The cervix contracts slowly; the external os admits to fingers for the few days but by the end of the first week, narrows down to admit the tip of a finger only. The external os never revert back to the nulliparous state.Soon after birth it takes a long time (4 to 8 days) for the vagina to involutes. The vaginal discharge for the first fortnight during puerperium is the lochia. The lochia originates from the uterine body, cervix and vagina. Depending upon the variation of the colour of the discharge it is named as: Lochia rubra (red) 1 -4 days, lochia serosa (yellowish or pink or pale brownish) 5- 9 days, lochia alba (pale white) 10 -15 days. The average amount of discharge, for the first 5-6 days is estimated to be 250 ml.

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. 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. 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. 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. The average amount of discharge for the xv first 5-6 days is estimated to be 250mls. Normal duration may extend up to 3 weeks. 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.

Marshall and Raynor (2014) puerperium starts immediately after the delivery of the placenta membrane and continues for six (6) weeks. In many cultures around the world, 40 days for recuperation is a time- honored practice. The general expectation is that by six weeks after birth xvi all the systems in a woman's body will have recovered sufficiently from the effects of the pregnancy and recovered to their non-pregnancy state.

WHY CLIENT WAS CHOSEN

Madam Alice was seen at Wenchi Health Center as a client on one of her usual antenatal visits to the clinic. Madam Alice was chosen as client because, during a health education, she reported very late to her normal antenatal clinic visits, she was asked the reason and she complained of waist pain which almost prevented her from coming. An opportunity was taken to explain the physiology behind it to her, she was as well reassured of relieve from waist pain after delivery.

Client was 37 weeks after glancing through her Antenatal card; decision was permission was sought from her to be taken as client for study which she accepted. Education was also made to her on the need to attend ANC. Introduction was made as a student from Holy Family Nursing and Midwifery training college, Berekum and was at the facility for practical experience.The midwife in- charge was also informed and she gave the go ahead.

CHAPTER ONE

CLIENT PARTICULARS

1.0 INTRODUCTION

This chapter deals with assessment of the client. It gives information about Madam Alice, the client used for the study, her social history, daily habits, and surgical, menstrual, obstetric and family histories. Information was acquired through observation, interview and antenatal care.

1.1 PERSONAL AND SOCIAL HISTORY

Madam Alice Agyemang is 32years old. She is Gravida3 Para2 (G3P2) and comes from Wenchi in the Bono Region of Ghana. She stays at Wenchi specifically Wenchi-Fie with her two children. She is 155cm tall, 61.5kg in weight and dark in complexion. She speaks English and Twi. She is a member of Heaven Gate Ministry Church at Wenchi-Fie. Her educational level is Senior High School. She is a food vendor. Her partner Mr. Oduro Amanfo Derrick comes from Wenchi and stays at Wenchi-Fie to be precise. He is a driver and a member of the Heaven Gate Ministry Church. Mr. Oduro is Madam Alice's next of kin. Madam Alice neither smokes nor drinks alcohol.

1.2 FAMILY HISTORY

Madam Alice comes from a family of five with 3 siblings, two females and one male including the mother and father. She is the second born of her parents. According to the client both parents (Mr. and Mrs. Agyei) are still alive and are natives of Wenchi. According to her there is no chronic or hereditary disease such Diabetes Mellitus, Hypertension, heart and sickle cell disease. There is no history of congenital abnormalities in the family but a history of multiple

pregnancies. They die a natural death.

1.3 MEDICAL HISTORY

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

1.4 SURGICAL HISTORY

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

1.5 MENSTRUAL HISTORY

Madam Alice had her menarche at age of sixteen (16**)** and stated that she bleeds moderately with no dysmenorrhea for six (6) days. She uses sanitary pad and changes it when soaked. Her Last Menstrual period was January 2023 but cannot remember the actual date and her expected date of delivery was calculated to be in September, 2023 and scan gave 4th September, 2023.

1.6 CLIENT'S LIFESTYLE AND HOBBIES

Madam Alice wakes-up around 6am and goes to bed around 9pm. She washes her face and brushes her teeth with toothbrush and toothpaste. She then sweeps her compound and baths her child. Client then takes her bath and prepares breakfast for the family, before she goes to work. Madam Alice closes from work around 4pm and goes back home and prepare supper for her family around 5pm. She eats thrice daily and empties her bowel at least once a day, she neither smokes cigarette nor takes in alcoholic drinks. On Saturdays client sweeps and cleans her

compound, her dirty clothes as well as that of her husband and her daughter washes and dries them in the sun. Alice's favorite food is Fufu with light soup. She enjoys conversing and uses her leisure time mostly to sleep. On Sundays client goes to church with her family and closes around 12:00pm. Client goes to the market every Thursday (which is a market day) to buy foodstuff in bulk and shops for the items that she would need in the upkeep of the house. She then comes home and prepares food for the family.

1.7 PAST OBSTETRIC HISTORY

Pregnancy: Madam Alice has three pregnancies with two births (G3P2). Her first pregnancy in 2013, second in 2018 and the third one in 2023. Client said she has never had complications in pregnancy such as anaemia, pregnancy induced hypertension (PIH), pre-eclampsia, diabetes in pregnancy, and vaginal bleeding but she experienced some minor disorders of pregnancy such as vomiting, frequency of micturition, backache and waist pains. Madam Alice attended antenatal care (ANC) regularly at Wenchi Health Center. Client had received the four doses of tetanus diphtheria injection in the previous pregnancies and she took all the doses of sulphadoxinepyrimethamine. Client was asked about her family planning method and she said she was using depo provera and her children are all in good health.

Labour: According to Madam Alice, she said all her babies were delivered per vaginum, perineum intact and they cried immediately after delivery but could not remember the duration of labour. Placenta and membranes were completely delivered with minimum blood loss. According to Madam Alice, she was discharged 24 hours after delivery at the ward.

Puerperium: Madam Alice said her puerperium was without any complication like puerperal infection or breast engorgement. The children had all their immunization against the childhood

disease and client practiced exclusive breastfeeding for six (6) months and initiated complementary feeding like porridge and water. However, babies were breastfed up to one and half year before weaning them completely. According to Madam Alice, she used Depo-Provera as her family planning method. Her children did not suffer any kind of sickness while growing up and were monitored at the child welfare clinic.

1.8 PRESENT OBSTETRICAL HISTORY

Madam Alice's first visit to the hospital was on 19th January, 2023 which she was 7weeks gestation. Client could not remember the date of her last menstrual period but could only remember the month which she said it was January 2023, therefore expected date of delivery was calculated as September 2023.The following vital signs and other assessment was checked and recorded as follows;

Temperature 36.5degrees Celsius, pulse 75 beat per minute, respiration 19 cycles per minutes, blood pressure 110/70 millimeters of mercury, weight 62 kilograms, height 155centimeters

Other laboratory investigations were done and recorded as follows;

Hemoglobin - 14.1 gram per deciliter, Sickling Test - Negative, Blood group - A, Rhesus factor - Positive, Hepatitis B - Negative, G6PD - No defect, PMTCT -120, Stool - No abnormality detected, Urine- Negative

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

Tablet folic Acid 5 milligrams daily for 30days, Tablet ferrous sulphate 200 milligrams daily for 30days , Tablet multivitamin 200 milligrams daily for 30days

She received third dose of Tetanus diphtheria immunization on 26th February 2023 which was confirmed in her antenatal book. She has taken four (4) doses of sulphadoxinepyrimethamine and was a regular attendant at ANC.

CHAPTER TWO

ANTENATAL CARE

2.0 INTRODUCTION

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

2.1 FIRST CONTACT WITH THE CLIENT

Madam Alice was first met on 21st August, 2023 at Wenchi Health Center around 03:00pm. During antenatal care, it was realized that client came to the facility looking exhausted, she complained of waist pains so the physiology behind it was explained to the client. An opportunity was taken to ask client her Gestational age and was confirmed in her antenatal book as 37weeks. Self -introduction was made as student midwife from Holy Family Nursing and Midwifery Training College, Berekum, who has been stationed there for seven weeks to write care study and would like to take her as a client. She was then introduced to the Midwife in-charge for her approval. Client vital signs and other assessment were checked and recorded as follow; temperature 36.3degree celcuis, pulse 80 bpm, respiration 20 cpm, blood pressure 120/80millimetres of mercury, weight 61.5kilograms, HB 13.7g/dl

A clean specimen bottle was given to client to void into it for urine test. It was explained to her that midstream urine was needed. After she had returned with the urine sample, hands were washed and dried with clean towel. Gloves were worn and urine reagent strip was dipped into the urine for about half a minute and the results were compared to the corresponding colour chart on the strip container. The result for both protein and glucose were negative, the urine was clear and

not offensive. Hands were washed with soap under running water and dried. Results were recorded in the antenatal book.

Madam Alice was encouraged to empty her bladder if she had the urge, after the procedure of physical examination from head to toe has been explained to her and her consent sought. Client was assisted unto a couch for the examination. Privacy was provided; hands were washed with soap under running water and dried.

HEAD-TO-TOE EXAMINATION

REQUIREMENT; Sterile cotton wool swab in a sterile gallipot with a lid, receiver for used cotton wool swabs, fetoscope, tape measure,a watch with a second hand,a pen and a client's folder

Head and neck: Standing at the right-hand side of the client, the hair was examined and it was neatly braided. Lice and dandruff were absent on the scalp. There was no edema and rashes on the face. The sclera was checked for jaundice and the conjunctiva for pallor but none was detected. The nose and the ears were examined for pain and discharge but none was present. The ears were in alignment with the eyes with no discharges. The lips were examined for dryness, pallor, sore and cracks but none was detected. Client was engaged in conversation and there was absence of halitosis, the gum was inspected for bleeding, sores, lesions which were neither pale nor coated. The neck was inspected and palpated for enlarged lymph nodes, thyroid glands and distended veins and enlarged thyroid gland but none was detected.

Breast examination: The breast was exposed and inspected for size, shape; signs of

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

Extremities: The upper extremities were examined for equality and alignment with the body but both were equal. The hands and fingers were also examined for dirt and grown nails, oedema, pallor of palm and nail bed and all these were absent. Capillary refill of the finger nails were checked by pressing the nail bed and releasing it and the result was good. Client was therefore congratulated and encouraged to continue with her cleanliness. The lower extremities were examined for size and equality, varicose veins and oedema as well as leg cramps, tenderness in the calf muscle but no abnormalities was detected.

Back: Client was assisted to turn her back for inspection and upon inspection and palpation of the sacral region no lesion, rashes or oedema was detected. There was no costovertebra angle tenderness.

Abdominal Examination and palpation

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

Inspection: The shape of the abdomen was ovoid, medium in size and there was presence of linear nigra but no striae gravidarium. The abdomen was inspected for scars from previous deliveries and there was none detected**.**

There was no evidence of foetal movement.

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

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

Lateral Palpation: On lateral palpation, hands were placed on each side of the uterus, midway between the symphysis pubis and the fundus, the uterus was stabilized with one hand and examined with the other and palpated the entire area from the abdominal midline to the lateral side and from the symphysis pubis to the fundus in a rotatory manner. A smooth curve was felt which indicated the back at the right side of the abdomen, the process was then repeated on the left side of the abdomen and an irregular mass and movement were felt which indicated the

limbs. This helps to locate where to place the fethoscope to listen to the foetal heart sound. The position was therefore right occipitoanterior.

Pelvic Palpation: It is used to identify the presentation, which is the part of the foetus lying in the lower pole of the uterus and over the pelvic brim. This examination was done facing Madam Alice's feet. She was asked to flex the knee slightly and helped to relax by guiding her to breathe out slowly. Both hands were used in the process. One hand is placed on the either side of the presentation and pressure is applied with the other hand. Accordingly, a hard mass was felt at the lower pole indicating the head of the foetus. The lie was longitudinal and presentation was cephalic.

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

Auscultation; A fetoscope was rubbed in the palms to make it warm and was placed at the area where the back was located to listen to the fetal heartbeat. Whiles listening to the heart beat, one hand was placed at the maternal radial pulse to ensure that it is not the maternal pulse being listened to. As soon as the maternal pulse was heard, client hand was left. The fetal heart rate was checked for one minute noting the volume and rhythm and was recorded as 138 beat per minute. From the above abdominal examination, lie was longitudinal, Descent was $5/5^{th}$ and presentation was cephalic.

Vulva examination: Permission was sought to inspect the vulva and it was granted. A pillow was placed under her head and she was draped to provide privacy and modesty. Hands were washed with soap and clean running water and dried with clean towel. Sterile gloves were worn on both hands and the vulva and perineum were examined for abnormal discharges, rashes,

genital wart, ulcers, scars and varicose vein. The labia majora was examined for same size and shape, redness, swelling and tenderness and nothing abnormal was detected. The client was asked to lie laterally and sit up before getting out of the couch

All findings were recorded in client's antenatal book and communicated to her. All items were decontaminated appropriately. The gloves were removed and discarded. Hands were washed with soap under running water and dried with clean towel and all findings recorded in her antennal record book. Client was asked of any complains and questions. Client complains of waist pain. She was educated that, the pain was due to the weight of the gravid uterus. She was asked not to lift heavy objects and avoid prolonged standing. She was encouraged to sit on seats with back rest. Client took the fifth dose of sulphadoxinepyrimethamine and was given routine drugs but was asked to take the Folic Acid two days after because sulphadoxinepyrimethamine counteracts the actions of Folic Acid. The routine drugs given to client were;

Tablet ferrous sulphate 1daily for 2 weeks , Tablet Folic Acid 1 daily for 2 weeks, Tablet multivitamin 1daily for 30 days

Client was encouraged to take her drugs as prescribed and was asked to report to the clinic if any abnormality was observed. Education was given on birth preparedness and complication readiness. She was also informed on home visits which she agreed. Her phone number with directions to her house was taken. Appointment for home visit was scheduled for on 24th August, 2023. All activities carried out and findings were recorded and reported. Permission was sought from the Midwife-in-charge to accompany client to her house and it was granted.

2.2 FIRST ANTENATAL HOME VISIT

First home visit to Madam Alice's house was on the 24th August, 2023 at 4:00pm. The main aim was to know where she lives, check how she was coping with pregnancy, meet members of her family observe her physical environment, listen to her complains and address the needs of her family. The journey was made by an okada because the client's house is quite far from the clinic per directions given by her. It is located at Wenchifie just behind the police station.

A seat was offered, quick assessment was made on the environment before sitting down, a cup of water was offered after which interaction with client started. Introduction was made to the family. She was very glad for the visit. Her daughters were around on a play ground with their friends. Client was there with her mother preparing food for the family. Client lived in a compound house with her children and other neighbours. Client stated that she goes to throw her rubbish at the back of her house and was educated on the need to throw the rubbish at the refuse dump as it can cause cholera, malaria and among others and to allow her first child who is a female to help her in cleaning the back of the house. The compound was very neat, all weeds cleared and their bathroom and toilet are located outside the house which was also clean. Madam Alice fetches water from a pipe which is located in her house.

The position of the windows was good with a net for proper ventilation. Layette was brought for inspection and it was complete. She was congratulated for purchasing all the items and was educated on birth preparedness and complication readiness plan such us finding a blood donor, adding money to the layette, a taxi driver, add her National Health Insurance card, ANC card and among others. Client was educated on the signs of labour and the progress of labour .Then she complained of difficulty emptying her bowels. Client was encouraged to take enough water, eat

fruits like oranges, water melon and any fruit of her choice to help prevent constipation. She was again encouraged to keep up on her environmental hygiene. She was informed of the next visit, permission was sought to leave, she was very grateful. She was thanked for her cooperation and willingness to heed to the advice.

2.3 SECOND ANTENATAL HOME VISIT

The second home visit was made on Monday 29th August, 2023 at 4:30pm. Madam Alice was paid a visit, a hospitable welcome was given by client. Client's husband was met, they were all happy after exchange of pleasantries, she complained of heart burns. Client was educated on the low intake of fatty and spicy foods; she was thought to use more pillows to prop herself. Client was reassured and the physiological change in pregnancy was explained to her that, they will subside and disappear after delivery. She also complained of feeling fatigue. We then discussed about postpartum family planning and her husband said they were interested in .She was educated on the danger signs of pregnancy which were severe headache, blurred vision, vaginal bleeding, and severe vomiting, and advised that she should report immediately to the facility if she experiences any of them. She was educated on the true signs of labour which includes the appearance of show and painful rhythmic regular uterine contractions. Client was told to also report to the facility as soon as she notices these signs. She was thanked for her cooperation and was reminded of her next antenatal care visit and permission was sought to leave.

2.4 SECOND VISIT TO THE CLINIC

On 28th August, 2023, Madam Alice visited the clinic at 9:00am. She was offered a chair and welcomed. An enquiry was made about her heartburns which she said it has resolved. She was asked about the signs of true labour to know if she recalls the education on the previous visit which she said she was coping and frequent urination at night had reduced, and also, she

repeated the education on the rhythmic painful uterine contractions and the appearance of show and was congratulated. Client was examined from head to toe and no abnormality was detected. Vital signs and other assessment are as follows:

Temperature 36.1 degree Celsius, pulse 78beats per minute, respiration 22cycles per minute, blood pressure 130/80 millimeters of mercury, weight 69.5kilograms, SFH 38centimeters, descent $5/5^{th}$, fetal heart rate 147 beats per minute.

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

2.5 SUBSEQUENT VISIT TO THE CLINIC

Madam Alice visited the hospital on 2^{nd} September, 2023. She was welcomed and given a chair to sit. An enquiry was made about her health and that of the family and she said they are all doing well.

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

Temperature 36.3 degree Celsius, pulse 83 beats per minute, respiration 18 cycles per minute, blood pressure 120/70 millimeters of mercury, weight 69.2kilograms,SFH 42centimeters ,descent $5/5^{th}$, fetal heart rate 150 beats per minute

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

2.6 ANTENATAL CARE PLAN

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

Problems identified during antenatal care

1. Waist pains
2. Fatigue
3. Heartburns
4. Constipation

Short term objectives

1 Client's waist pain will reduce and be coped with throughout the pregnancy.

2. Client's fatigue will be reduced and cope with it throughout pregnancy.

3. Client's heartburns will be reduced and coped with throughout the pregnancy.

4. Client will be able to empty her bowel at least once within 48hours.

Long term objectives

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

ANTENATAL CARE PLAN

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES	NURSING ORDERS	NURSING INTERVENTIONS	DATE/ TIM	EVALUATION	SIGN
21/8/23 3:00pm	Waist pain related to the effects of pregnancy hormones on the musculoskeletal system	Madam Alice's waist pain will reduce and be coped with throughout pregnancy as evidenced by client verbalizing.	1. Reassure client. 2. Encourage client to have enough rest. 3. Encourage client to wear low heel shoes. 4. Teach client the body mechanics. 5. Serve prescribed analgesic such as paracetamol.	1. Client was reassured. 2. Client had enough rest. 3. Client agreed to wear low heel shoes. 4. Client should squat when picking items from the floor. 5. Paracetamol 1g was served.	4/9/23 10:00pm	Goal fully met. Client told midwife the intensity of waist pain is no more.	

DATE/ TIME	NURSING DIAGNOSIS	OBJECTIVE/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
26/8/23 4:00pm	Fatigue related to weight of the growing foetus and stress from work	Madam Alice's fatigue will reduce and be coped with throughout pregnancy as evidenced by client verbalizing.	1. Reassure client. 2. Encourage family members to help with household chores. 3. Teach client energy conservation techniques such as sitting rather than squatting or standing whiles working. 4. Encourage client to rest in-between activities.	1. Reassure client. 2. Family members assisted in household chores. 3. Client was seen sitting rather than squatting or standing whiles working. 4. Client rested for at least 30minutes during daily activities.	4/9/23 10:00pm	Goal fully met. Client verbalized ability to cope with weight of product of conception and reduced stress of work.	

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES	NURSING ORDERS	NURSING INTERVENTIONS	DATE/ TIME	EVALUATION	SIGN
29/8/23 4:30pm	Heart burns related to effect of hormones causing relaxation of the cardiac sphincter during pregnancy	Client's heartburns will be reduced and be coped with till the end of pregnancy as evidenced by client verbalizing.	1. Reassure client. 2. Educate client on the physiology of heart burns. 3. Encourage client to reduce the intake of oily and spicy food. 4. Encourage client to delay going to bed after eating. 5. Encourage client to prop up in bed.	1. Client was reassured. 2. The physiology was explained to client. 3. Client reduced intake of oily and spicy food. 4. Client spent 2hours before going to bed after meals. 5. Client propped up in bed.	4/9/23 10:00pm	Goal partially met. Madam Lydia told midwife her heartburns has reduced.	

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES	NURSING ORDERS	NURSING INTERVENTIONS	DATE/ TIM	EVALUATION	SIGN
24/8/23 4:00pm	Constipation related to hormonal activities on smooth muscles of the intestine during pregnancy.	Client will be able to empty her bowel at least once within 48hours as evidenced by client verbalizing.	1. Reassure client. 2. Educate client on the intake of food rich in fiber and roughages. 3. Encourage client to take 500mls of water every day. 4. Encourage the client to engage in tolerable exercises such as walking.	1. Client was reassured. 2. Client took food rich in fiber and roughages. 3. Client drank 500mls of water per day. 4. Client understood the health benefits of exercising and engages herself in walking.	26/8/23 4:00pm	Goal fully met. Madam Lydia told midwife she was able to empty her bowels	

CHAPTER THREE LABOUR

3.0 INTRODUCTION

This chapter talks about labour, admission and management of the various stages of labour, the immediate care of the new-born, examination of the new-born and care plans drawn for the management of the problems encountered during this period.

3.1 ADMISSION AND MANAGEMENT OF FIRST STAGE OF LABOUR

On the 5th September, 2023, Madam Alice arrived at the labour ward at 3:30pm accompanied by her mother with a history of lower abdominal pain and having seen a bloody mucoid discharge. Rapport was established and they were offered a seat. Before examination, the antenatal care record book was collected and read through quickly. Client's appearance indicated that she was having labour pains. She was taken to the delivery room and her mother was given a chair to sit outside at the visitors lounge and was reassured that her daughter is in the hands of competent student midwife as well as the staff midwife as the supervisor.

At the delivery room, client was oriented and wash room shown to her, she was offered a bed and reassured of a successful birth outcome. Procedures to be done were explained to client and her consent was given. According to Madam Alice, labour pains started about two hours, thirty minutes ago when she called on phone and she was told to arrive at the facility immediately.

Her vital signs were checked and recorded as follows; Temperature 36.2 C, pulse rate 87 beats per minute, respiration 20cpm, blood Pressure 110/60mmHg

Client was served with a bedpan to empty her bladder and a specimen bottle for mid-stream urine. The mid-stream urine taken tested negative for protein and glucose using the urine reagent strip. The amount of urine produced was 150mls. She was assisted unto the couch; after changing to gown, hands were washed and dried with a clean dry towel.

Client was examined from head to toe and no abnormalities were detected. Inspection: Client abdomen was ovoid in shape and medium in size. Striae gravidarium, linear nigra and foetal movement were present but no scar was found. On palpation, the abdomen was palpated, symphysio fundal height was 37cm, and gestational age was 39weeks+2 days the lie was longitudinal, presentation was cephalic and descent was 3/5th palpable abdominally. Contraction was 3 in 10minutes lasting thirty (30) seconds. The foetal heart rate was 140beat per minute with good volume and regular in rhythm.

Vaginal examination;

Requirement; Two sterile gallipots, with each containing cotton and savlon**, r**eceiver for collecting used swap**, s**terile gloves**,** perineal pad

Permission was sought to continue with vaginal examination. Client was asked to lie in a lithotomy position and flex her knees. Hands were washed with soap and water and dried with clean towel, a pair of sterile glove was worn. On inspection, there was no scar, rashes, warts, varicose vein or sores. Five(5) cotton swabs were used for the examination. The dominant hand was used to pick the cotton wool swab and dipped into savlon lotion. Swab was dropped from the dominant hand into the non-dominant hand per stroke. Labia majora was wiped from anterior to posterior and the used swab was discarded into the receiver.

Labia minora was also wiped from anterior to posterior and used swab was also disposed into the receiver. The vestibule was parted using the non-dominant, a swab in the dominant hand was used to wipe the vestibule from anterior to posterior and disposed into the receiver. Client permission was sought and the middle finger of the dominant hand was inserted into the vagina by firmly pressing downwards. The index finger was also inserted and this cause relaxation of vagina walls and muscles. The vagina felt warm and moist, cervix was soft and thin, effaced and cervical dilatation was 4cm with the presenting part well applied to the cervix with intact membranes and no moulding, ischial spines were blunt and promontory was not reached at 12cm and there was an evidence of show. The midwife in-charge also confirmed the findings. She was cleaned and a pad was applied to the perineum. The gloved hands were immersed in 0.5% chlorine solution and was removed by inverting them inside out and disposed off into a plastic container. Hands were washed with soap and water and dried with a clean towel. She was helped to lie on her left side to get out of bed. Dilatation board was used to explain how far she had gone with labour. She was advised on deep breathing exercises as she complained of lower abdominal pains. She was also encouraged to ambulate and to empty her bladder when she feels the edge to improve decent and contraction.

Findings were communicated to her and encouraged to ask questions. The tray was discarded, hands were washed under running water with soap, dried with a clean dry towel and all information gathered was recorded on a partograph sheet around 3:00 am.

3.2 PREPARATION FOR BIRTH

In preparing for birth, a helper was identified, that was skilled and unskilled helpers. The skilled helper was the Midwife-In-Charge who would supervise labour and delivery as well as the care

of the baby and mother. A second skilled helper happened to be the client's mother. The client's mother who accompanied her to the facility would be assisted in times of need. Emergency plan was reviewed, which includes communicating with the physician assistant to be alert and attend to any emergency when called upon .The contact numbers of the referral hospital were active when checked as well as the ambulance.

Madam Alice was informed that after delivery baby would be placed on her chest for skin to skin contact for one hour of which she responded positively. She was asked to wash her hands, chest and abdomen to prepare for skin to skin care prior to the second stage of labour. The area for delivery was also prepared. Client was told that, the windows and doors will be closed, curtains were drawn down and fan will be turned off when delivery is eminent to provide warmth for the baby and also privacy. Hands were washed thoroughly with soap and water to prevent the spread of infection. The resuscitation table was checked, cleaned and all equipment and instrument were assembled and tested for their function.

The equipment to help babies breathe was assembled in the area for ventilation and their functions tested especially the ventilation bag and mask. Madam Alice's hands and abdomen would be washed prior to second stage. The delivery trolley was set and the entire instruments needed for the delivery were assembled, a cot was prepared for the baby.

There was monitoring of maternal pulse, respiration, contractions and fetal heart rate at every 30 minutes. The temperature, blood pressure, decent and vaginal examination were done 4 hourly and results were plotted on the partograph.

MANAGEMENT OF FIRST STAGE OF LABOUR

On observation client was anxious. Contractions were becoming frequent and strong. Client was encouraged to do deep breathing exercise when contractions comes and not to push when she has not been asked to prevent edematous cervix. Client was reassured of normal labour with a healthy baby without any complications after delivery. She was educated not to reuse pad when it falls. Client was complaining of waist pains and the sacral region was massaged to relieve the pain and she was encouraged that the pain will stop after delivery. Bedpan was provided for her to empty the bladder frequently to enhance effective contractions and descent of the foetal head since full bladder could slow down the progress of labour. Client was educated on the importance of changing the perineal pad when soiled and not to be touching the perineal area. She was encouraged to ambulate whiles her mother was informed about the progress of labour.

At 7:30 pm, client's vital signs were checked and recorded as follows: Temperature 36.9C, pulse 80bpm, respiration 20cpm, blood Pressure 110/70mmHg, descent was 1/5th above the pelvic brim, foetal heart rate was 142 beat per minute with good volume, contractions were 4:10, 5:10 and 4:10 lasting 40 seconds and 45 seconds respectively

She passed 100ml of urine and sample was tested for protein and glucose, which was negative. The vagina was warm and moist, the cervix was 8 centimetres (cm) dilated and well applied to the presenting part with membranes still intact. There was no moulding (0). Hands were washed with soap under running water and dried with a clean dry towel. All findings were plotted on the partograph. The delivery trolley which contains the following items was made ready: Top Shelf Delivery pack containing; Four clean towels, Two artery forceps, Two dissecting forceps, Two gallipot (with one containing cotton swabs soaked in savlon solution and the other containing

gauze), One cord scissor, Receiver, Episiotomy set, Cord clump, Pair of sterile gloves, 10 units of oxytocin, Two cot sheet, Vitamin k injection.

Lower Shelf; A jug for measuring the amount of blood loss, Receiver for placenta, Container with syringes and needles, Fethoscope, Antiseptic lotion (savlon), Sterile gloves, Extra perineal pad,

Small cup containing water and bulb syringe, Cord clamp, Bed pan, Identification band ,Examination gloves, Mackintosh, Cot sheets, Drum containing gauze and cotton wool, Cheatle forceps in its container. At 10:40 am, membranes ruptured artificially and liquor was clear.

Vaginal examination done to rule out cord prolapse, moulding was two (++), the cervical os was also fully dilated that is 10cm and descent was 0/5th. The Midwife in- charge was informed about the progress of labour and also asked to confirm the findings and she said Madam Alice's cervix was fully dilated. Findings were recorded on the partograph sheet and client was informed of full dilatation of the cervix. Madam Alice was reminded again that the baby would be delivered onto her abdomen for skin to skin contact as well as to establish bonding. This marked the beginning of the second stage.

3.3 MANAGEMENT OF THE SECOND STAGE OF LABOUR

Client was asked to assume any comfortable position she wished and client selected the lithotomy position after demonstrating the various types as explained during the first stage of labour. She was assisted to assume the lithotomy position with a pillow supporting the back and her legs well supported on the bed. After putting on the protective clothing, hands were washed thoroughly with soap and water and dried with a clean sterile towel. The already prepared

delivery trolley containing the needed items was pulled nearer to the delivery bedside and the sterile towel covering the top shelf of the trolley removed.

The vulva was cleaned with savlon solution as well as the upper thighs. Client's abdomen and thighs were draped with a sterile dry towel. A pad was put to the perineum to prevent faecal matter from contaminating the delivery field and she was asked to push with contractions. She was again encouraged to rest in between contractions and adheres to instructions at this stage. She was supported emotionally and physically throughout delivery. Client complained of frequent micturition and was reassured the physiology behind the frequency of micturition was explained to her.

As the head advanced, flexion was maintained with two fingers placed on the head to allow the smallest diameter of the fetal head to distend the vulva. This was done to prevent perineal tear. Client was encouraged to rest if there were no contractions and was reminded that the baby will be delivered onto her abdomen. When the head crowned, client complained of fatigue and she was asked, to breathe through her mouth and she was asked to give only small pushes with contractions. By extension of the fetal head which is one of the movements used by the fetus as it passes through the birth canal, the sinciput, face and mentum swept the perineum and the head was born. The baby's eyes, mouth and nose were wiped off gently with sterile gauze as well and the airway was cleared with a penguin. The neck was felt for cord around neck but there was none detected. Restitution was followed by external rotation of the head, which indicated internal rotation of the shoulders that the shoulders were in anterior posterior diameter of the outlet. The palms were placed on each side of the baby's head and she was asked to push gently. The anterior shoulder was delivered by downwards traction and posterior shoulder by upwards traction. With lateral flexion the baby was delivered onto mother's abdomen as the midwife in

charge noted the time as 9:50pm. The baby cried soon after delivery. Liquor was wiped off the baby; the wet sheet was changed and replaced by a dry one to prevent heat loss. A healthy baby girl was delivered and sex confirmed by the mother. The baby was placed on mother's abdomen for skin to skin contact. First minute Apgar score was 8/10. She was congratulated for her effort and co-operation.

3.4 IMMEDIATE CARE OF THE BABY AT BIRTH

Immediately the head was delivered, sterile gauze was used to clean baby's face, eyes, mouth and nose. The baby was delivered onto the mother's abdomen. Thorough cleaning of the baby was done quickly as possible to prevent heat loss and hypothermia. The baby was kept warmly wiping off the liquor thoroughly and was covered with a clean dry cot sheet on the mother's chest. The baby was suctioned to ensure the airway was clear and prevent aspiration, the baby cried immediately. The Apgar score at the end of the first minute of birth was quickly assessed as 8/10.

The cord was then measured 2 fingers beneath the baby's abdomen and clamped with the cord clamp and measuring 2 finger breaths above the cord, the cord was cut with sterile scissors covered with sterile gauze to avoid splashing of blood. The baby was made warm by covering it with a warm dry sheet and was left on the mother's abdomen and skin to skin to prevent heat loss. Identification band was placed on the baby's wrist with the mother's name, sex, date and time of delivery and breastfeeding was initiated. The condition of the baby was very good as she was actively crying and responding to stimuli.

3.5 MANAGEMENT OF THE THIRD STAGE OF LABOUR

Client still in the lithotomy position, the procedure was explained to her. Abdomen was palpated to exclude undiagnosed twin and there was none. Ten (10) units of oxytocin was given intramuscularly on the right thigh by the midwife in charge one minute after delivery to aid in the contraction of the uterus and separation of placenta, the cord was clamped near the perineum with the artery forceps with a receiver placed in between the mothers thighs to receive the placenta.

Controlled cord traction was used in the delivery of the placenta. The cord was re-clamped closer to her perineum. The non -dominant hand was placed on the fundus and as soon as there was contraction, one hand was placed above client's pubic bone and the other hand held the clamped cord. The cord was re-clamped and waited for strong uterine contractions. The non-dominant hand was turned with the palm facing the client abdomen and counter pressure was applied to avoid inversion of the uterus and with controlled cord traction, when the uterus contracted, the cord was downwardly and steadily pulled to deliver the placenta. This procedure was repeated until placenta became visible at the vulva. The dominant and non-dominant hands were used to receive the placenta and gently twisted till membranes were teased out.

The placenta and its membranes were delivered at 9:57pm. The placenta was placed in the palms and quick examination was done to detect any retained product of conception but none was detected. It was then placed in a receiver to be properly examined in the sluice room. The uterus was massaged immediately after the delivery of the placenta to aid uterine contraction, arresting hemorrhage as well as expelling clots. Gauze was wrapped around the index and middle fingers to inspect the cervix, vagina and perineum to exclude tears and lacerations. The cervix and the vaginal wall were inspected using the clockwise method and the perineum was intact. There

were no tears found in the cervix, the vaginal wall, the vulva nor the perineum. She was cleaned and sterile pad was applied. Madam Alice was made comfortable in bed with baby still on the abdomen and covered with dry cloth. She was encouraged to empty her bladder whenever she had the urge for the uterus to contract well and she was also taught how to massage the uterus herself and report any changes quickly. She was congratulated for the effort made.

All findings were recorded on the partograph.

3.6 EXAMINATION OF THE PLACENTA AND MEMBRANES

Under a good source of light and on a flat surface, a thorough inspection of the placenta and membranes is done in order to ensure that no part of it is being retained during delivery. The placenta was dipped in 0.5% chlorine and removed immediately. The cord was of normal size and the cut edge of the umbilical cord had two arteries and one vein surrounded by Wharton's jelly. The cord insertion was central. The placenta was held by the cord with the membranes hanging. The membranes were checked for completeness by spreading out hand inside the membranes and it was intact. The placenta was put on a flat surface and was examined; the amnion was peeled from the chorion up to the umbilical cord to permit full visualization of the chorion. The fetal surface was shiny and bluish grey. The maternal surface was dark red in colour. The branches of the cord vessels were seen radiating on its surface. The placenta was placed in the palm with the maternal surface facing upward. The lobes were intact with no infarcts or extra lobes nor edematous. The placenta was placed in 0.5% chlorine solution in the sluice room for decontamination and discarded in the placenta pit.

The delivery instruments and equipment used were soaked in 0.5% chlorine solution, gloves were removed and hands were washed. After 10 minutes, instruments were removed with utility gloves, washed in soapy water and rinsed in clean water and was then air dried and packed for

sterilization. Measured blood loss was 150 milliliters. All findings were recorded on the labour ward sheet, delivery book and summary of delivery in the antenatal booklet. The partograph was then completed.

3.7 MANAGEMENT OF THE FOURTH STAGE OF LABOUR

Client and her baby were transferred into the lying in ward after putting the baby skin to skin for an hour. Monitoring of client and baby continued strictly for six (6) hours after a successful completion of the third stage of labour. During this stage, the mother and the baby were assessed every 15 minutes for 2 hours, 30 minutes for an hour and one hourly for three (3) hours and recorded on the post-delivery observation chart and it fell within the normal ranges.

The uterus was massaged to enhance contractions. Blood clots were expelled and blood loss was 150 milliliters and the Symphysio- fundal height was 18 centimetres. At the end of the 6 hours monitoring, all findings were recorded in the post-delivery chart. Lochia was red in colour (rubra), moderate in quantity. Madam Alice was educated on the need to micturate frequently and changing of perineal pads when soaked. Also how to fix baby to breast was demonstrated to client. Education on importance of exclusive breastfeeding for the first 6 months and importance of feeding the baby on demand was given to her . She was also encouraged to wash hands thoroughly with soap and water before breastfeeding and after changing perineal pad. Client's mother was allowed to see her and she was served with porridge and bread to restore energy. General condition of client was good after delivery.

3.8 PREVENTION OF DISEASES IN THE NEWBORN

After the birth of the head, the eyes were cleaned from the inner canthus to outer canthus. Care was given to the eye to prevent eye infection where chloramphenicol eye drop was instilled on each of the eye. Vitamin K injection was given to prevent bleeding.

Cord was also dressed with methylated spirit to prevent any infection and to keep the cord dry at all times. Infection prevention techniques such as washing of hands before and after touching the baby were also ensured to prevent any cross infection. Mother was also educated on the need to use only methylated spirit given to her to dress the cord and to avoid application of herbs, other creams and cow dung on the cord to prevent infection of the cord. No bleeding was noticed. Hands were washed with soap under running water and dried with a clean dry towel afterwards.

3.9 EXAMINATION OF THE NEWBORN

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

Head and neck; The head was examined for shape and size, widened sutures, bulging/depressed fontanelles, edematous swelling, caput succedaneum, microcephaly, anencephaly and hydrocephaly but none was detected. The middle and the index finger were used to run through the head to feel for widened sutures and were absent. A tape measure was used to encircle its head starting from the occipital protuberance to the supra orbital ridges to measure the head circumference and it was 35 centimeters. The ears were examined for size, shape, patency, softness of the cartilage; the eyes were in alignment with the ears. The eyes were examined for the presence of eye ball and redness of the eyes, jaundice on the sclera and any abnormal discharges. The nose was examined for shape, discharges, size, patency, and deviated septum.

The mouth was examined for false teeth, tongue tie, cleft lip and palate by using the little finger to feel for palate for any sub mucous cleft and no abnormality was detected. Rooting, suckling and swallowing reflexes were present; the neck for congenital goiter, but no abnormality was detected.

Chest and Abdomen; On the chest, respiratory movement was normal (34 cycles per minute), nipples were in alignment and breast had no mass. The abdomen was examined for shape and size, enlarge spleen and liver, bleeding from the umbilical cord and abnormalities such as omphalocele and gastroschisis and among others were absent. All findings were normal.

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

Lower Extremities; The lower extremities were inspected for equality, clubbed feet, extra/loss digits, talipes. Congenital hip dislocation was also checked using ortholani's test and it was absent.

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

Genitalia and Anus; The vulva was well formed, urethra and anal orifices were patent and there were no abnormalities noticed. Baby passed meconium and urinated soon after birth indicating the patency of the anus and urethra. Baby's weight was 3.0 kilogram; measurements of the head circumference (33), length of baby (50) were done. Gloves were removed and disposed aseptically before washing and drying hands. Findings were documented and communicated to

client. The baby was warmly wrapped in with a clean dry sheet and placed beside her mother. Mother was asked to observe the baby continuously and report any abnormality.

3.10 SUMMARY OF LABOUR AND DELIVERY

Client had a spontaneous vaginal delivery to a live female baby on 5th September,2023, at 9:50pm with birth weight 3.0kg with APGAR score 8/10 and 9/10. Placenta and membranes were completely delivered at 9:57pm by controlled cord traction. Estimated blood loss was 150mls. Condition of mother and baby was satisfactory and they were made comfortable in bed.

CONDITION OF BABY AT BIRTH

After birth, baby was wrapped with warm cot sheet and was sent to mother side to start breastfeeding and her general condition was satisfactory. The following findings were obtained and recorded as;

Temperature 36.8 degree Celsius, apex heart rate 128 beat per minute, respiration 40 cycles per minute, baby's weight 3.0 kilogram, head circumference 32 centimeters, length 47 centimeters, general condition of baby very good, meconium passed, urine passed, and sex female.

3.11 CONDITION OF MOTHER AFTER BIRTH

Client was made comfortable in bed and was helped to fix baby to the breast. Uterus was well contracted and her condition was good. Client's initial vital signs were checked and recorded as well as other examinations done as; Temperature 36.2 degree Celsius, pulse 78 beats per minute, respiration 20 cycles per minute, blood pressure 110/60 milliliters of mercury, symphysio-fundal height 17 centimetres, blood loss 150 milliliters

3.12 CARE PLAN DURING LABOUR

Problems Identified During Labour:

1. Lower abdominal pain

2. Anxiety

3. Fatigue

4. Frequent micturition

SHORT TERM OBJECTIVES

1. Client will cope with lower abdominal pains throughout labour

2. Client will be relieved of anxiety within 30 minutes after delivery

3. Client will be relieved of fatigue within 48 hours after delivery.

4. Client will be able to cope with frequency of micturition throughout labour.

LONG TERM OBJECTIVES

Madam Alice will go through all the stages of labour and puerperium successfully without any complication to both mother and baby

LABOUR CARE PLAN

DATE/ TIME	NURSING DIAGNOSIS	OBJECTIVES/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTIONS	DATE / TIME	EVALUATION	SIGN
4/9/23 3:30pm	Lower abdominal pains related to painful uterine contractions secondary to descent of fetal head	Client will cope with lower abdominal pains during labour as evidenced by; client verbalizing.	1. Reassure client. 2. Encourage client to practice deep breathing exercise. 3. Explain the physiology of pain to her. 4. Encourage client to empty her bladder frequently. 5. Encourage client to perform mild exercise.	1. Client was reassured. 2. Deep breathing exercise was performed by client. 3. Physiology of pain was explained to her. 4. Client was encouraged to empty her bladder frequently. 5. Client performed mild exercise.	4/9/23 6:00pm	Goal fully met. Client indicated that she can cope with pain	

LABOUR CARE PLAN

DATE/TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES	NURSING ORDERS	NURSING INTERVENTIONS	DATE/ TIME	EVALUATION	SIGN
5/9/23 9:20pm	Anxiety related to unknown outcome of labour.	Client will be relieved of anxiety within 30minutes after delivery as evidenced by Client verbalizing.	1. Reassure client. 2. Establish and maintain good interpersonal relationship with client. 3. Explain to client about the progress of labour and clarify all misconception. 4. Encourage deep breathing exercise. 5. Encourage client to ask questions and answer them tactfully.	1. Client was reassured. 2. Good interpersonal relationship with client was established and maintained. 3. Progress of labour and clarifications of all misconception was explained to client. 4. Deep breathing exercise was performed by client. 5. Client was allowed to ask questions and express her worries and explanations were given accordingly.	5/9/23 9:50pm	Goal fully met. Client verbalized she feels no more anxious.	

DATE/TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES	NURSING ORDERS	NURSING INTERVENTIONS	DATE/ TIME	EVALUATION	SIGN
4/9/23 9:00am	Fatigue related to stress of labour.	Client will be relieved of fatigue within 24 hours after delivery as evidenced by client verbalizing.	1. Reassure client. 2. Encourage client to rest in between uterine contractions. 3. Encourage client to practice deep breathing exercise. 4. Serve client with beverages. 5. Encourage client to take in foods containing carbohydrate.	1. Client was reassured. 2. Client rested in between uterine contractions. 3. Deep breathing exercise was done. 4. Client was served with malt. 5. Client took in foods containing carbohydrates.	6/9/23 9:00am	Goal fully met. Client states that she is no more tired after delivery.	

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES	NURSING ORDERS	NURSING INTERVENTIONS	DATE/TIME	EVALUATION	SIGN
5/9/23 11:00am	Frequency of micturition related to pressure of the presenting part on the bladder.	Client will be coped with frequent micturition till the end of labour as evidenced by client verbalizing.	1. Reassure client. 2. Explain the physiology of frequency of micturition to client. 3. Encourage client to urinate whenever she has the urge to help. 4. Provide bedpan within her reach. 5. Educate client on the importance of micturition.	1. Client was reassured. 2. The physiology of frequency of micturition was explained to client. 3. Client was encouraged to urinate whenever she has the urge. 4. Bedpan was provided within her reach. 5. Client was educated on the importance of frequency of micturition.	5/9/23 10:00pm	Goal fully met. Client verbalizing reduction in frequency of micturition	

CHAPTER FOUR

4.0 INTRODUCTION

This chapter deals with the care given to the mother and the baby after delivery, baby's first bath, subsequent care of the baby, first day post-delivery care, post-delivery home visits, preparation towards discharge, post natal review, care plan drawn for the management of the problems encountered during this period.

4.1 DAY OF DELIVERY

After delivery of the placenta and membranes, Madam Alice and her baby were transferred to the lying-in ward at 1:30am after postpartum check when her condition and that of the baby was stable. She was given bread and porridge to eat for energy. She was encouraged to empty her bladder frequently to avoid postpartum hemorrhage as well as breastfeeding baby frequently to help the uterus to contract. The vital signs were monitored for every 15 minutes for the first 2 hours, every 30 minutes for the next 1 hour and hourly for the last three hours. Her vital signs were checked and recorded as follows: Temperature 36.4 degree Celsius, Pulse 78 beats per minute, Respiration 20 cycles per minute, Blood pressure 110/60 mmHg, Her Symphysio- fundal height measured 17 centimetres. The uterus was checked for involution and the perineum was also checked for any active bleeding at this time. Lochia was bright red in colour (rubra) and the flow was normal. Client was encouraged to change perineal pad frequently when soiled to avoid infection as well as wash her hands with soap and water after changing the pad. She was taught

how to massage the uterus by rubbing the palm on the fundus to help in the involution of the uterus and arrest hemorrhage. She was also educated on exclusive breastfeeding for 6 months and on demand as this would help the baby to grow well. Client was also taught to perform pelvic floor muscles and abdominal exercises to strengthen the muscles and also to aid involution. Head to toe examination was done on the mother and no abnormality was detected. She complained of fatigue and was encouraged to have enough rest. Later, she was assisted to the bathroom to take her bath. She felt good and refreshed after bathing.

4.2 SUBSEQUENT CARE OF THE BABY

After six (6) hours of observation, baby was given warm bath and her cord dressed with methylated spirit and cotton wool swabs. Head to toe examination was also done and no abnormality was detected. The baby was wrapped in a warm dry sheet to maintain body temperature and he was also placed beside his mother to breastfeed. The mother was advised not to apply anything at the injection site. The vital signs and other measurements were taken and recorded as follows: Temperature 36.1 degree Celsius, Apex beat 124 beats per minute, Respiration 40 cycles per minute, Weight 3.0 kilograms, Length 47 centimetres, Head circumference 32 centimetres. All findings were communicated to Madam Alice and recorded.

BABY BATH AND CORD DRESSING REQUIREMENTS

Soap, Sponge, Surgical gloves, Cream/powder, Sterile cotton wool swabs and gauze in a galipot, Towels, 1 big towel and 3 small towels, Cot sheets 2, Plastic apron, A clean baby dress, cap and

socks, 2 jugs containing hot, and cold water each, Two receptacles for used water and dirty linens.

Procedure

All procedures were explained to the mother and she consented. She was also asked to observe how the procedure was done. A plastic apron was worn. The hands were washed with soap and water under running water and dried with a clean dry towel. Both cold water and hot water were missed together and the temperature of the water was checked using the elbow where client also confirmed. Examination gloves were worn and the baby was taken from his mother. The baby was put on a flat surface and the mother was given a seat to observe the procedure. The baby was undressed and quick observation was made before baby was wrapped with a cot sheet. Her eyes were cleaned with cotton wool swab soaked in sterile water from the inner canthus to the outer canthus of each eye using separate cotton wool swabs. Her face was cleaned with a damp face towel and dried. The nape of the neck was supported with one hand. The baby's ears were plugged with the middle finger and thumb to prevent water from entering into the ears. The head was washed with soapy sponge, the baby was lifted off the flat surface with the body resting in the elbow and still supporting the nape, the washed head was rinsed with clean water and was then dried. The baby was placed on the flat surface with the body been exposed. The neck, arms and front of trunk were bathed paying attention to the skin folds. The back was turned with one arm supporting the chest and the other hand bathing the back down to the feet, paying attention to the skin folds. The baby's body was supported firmly and was immersed into the warm water

with the head supported above the level of the water. The body was rinsed thoroughly. The baby was removed from the water onto the working surface and was covered with clean dry cot sheet. The wet cot sheet was removed and a clean dry towel was used to dry the baby paying attention to skin folds. Baby oil was smeared on the body and the baby was dressed up. The gloves were removed and hands were washed with soap under running water and dried with a clean dry towel. Cord Dressing Sterile gloves were worn and the cord was exposed and was inspected for bleeding and looseness but there was none. Five (5) cotton wool swabs were soak in methylated spirit. The tip of the cord was held with sterile cotton wool swab, the base of the cord was then cleaned with separate cotton wool swab. The whole cord was cleaned from the base upwards and lastly the tip was also cleaned with separate cotton wool swab. The cord was left exposed to air dry. Gloves were removed and Hands were washed with soap under running water and dried with a clean dry towel. Baby was dressed and wrapped with clean dry cot sheet to maintain his temperature and was given to his mother. Client was thanked for her co-operation and she was accompanied to the bedside. Her things were packed and used items were discarded. The working surface and the instruments used were decontaminated with 0.5% chlorine solution for 10 minutes. Hands were washed with soap under running water and dried with a clean dry towel. Findings were communicated to the mother and were documented. The mother was encouraged not to touch or apply anything to the cord. She was taught and encouraged only to dress the cord with clean cotton wool swabs and methylated spirit. She was also encouraged to breastfeed the baby anytime baby wants to feed and allow him to empty one breast completely before she takes the other.

4.3 FIRST DAY POST DELIVERY (DAY OF DISCHARGE)

6th September, 2023 happens to be the first day after delivery. Madam Alice and baby were in good health. She woke up around 6:30am and brushed her teeth. The baby was being breastfed and she was suckling well. Permission was sought later to examine the baby. Hands were washed with soap under running water and dried with a clean dry towel. On general examination, there was nothing abnormal detected. The baby was top and tailed, dressed and wrapped nicely in the presence of the mother and her husband. The cord was dressed with sterile cotton wool swabs soaked in methylated spirit. The baby passed urine and meconium which was normal. The mother was educated not to apply hot compress on the fontanelles with the intention that it is a wound and with the hot compress it would heal. It was explained to the family that the fontanelles would close by themselves. That is the anterior fontanelles will close by 18 months and the posterior fontanelles will also close by 6 weeks. Client was encouraged to keep the cord clean and to prevent using local herbs. She was also educated on the provision of warmth, maintaining temperature and prevention of infection. Vital signs and weight were checked and recorded as follows: Temperature 36.0 0c, Apex beat 132 bpm, Respiration 43cpm, Weight 2.95kg,

Mother's vital signs were checked and recorded as: Temperature 36.7 0 c, Pulse 76 bpm, Respiration 20cpm, Blood pressure 100/60mmHg.

Procedures to be done were explained to Madam Alice and she consented. Head to toe

examination was done and nothing abnormal was detected. Her breasts were lactating and nothing abnormal was observed. The vulva and perineal pad were inspected after permission was sought and lochia was red (Rubra), flow was small and not offensive. She was reminded on changing of perineal pad frequently especially when soiled to prevent ascending infection to the uterus. Client then complained of after pain. She was reassured and educated that it was as a result of involution of the uterus. She was then encouraged to practice good personal hygiene and do warm sit bath to help reduce the pain. On palpation, the uterus was well contracted and Symphysio- fundal height was 16 centimetres. Madam Alice took fufu with light soup as her breakfast. She was educated to practice exclusive breastfeeding on demand especially in the night. Every two to four hours or at least 8 to 12 times per day, the baby should be breastfed. Client was educated on the importance of breast milk to both mother and baby such as to aid in bonding as well as exclusive at night to serve as a family planning method. Education on proper personal and environmental hygiene to prevent infections was reinforced. Client was also encouraged to take in a balance diets. She was encouraged to take enough rest, perform postnatal exercises and ambulate to help her abdominal muscles and pelvic floor muscles gain their tone. She was also reminded on how to perform self-breast examination and educated on its importance.

The in-charge was informed about the procedures and findings, client and baby were reassessed for confirmation. She was informed of her discharge and was helped to pack her things. Routine drugs were prescribed according to the protocol of the facility. She was told to come for one

week postnatal care on the 14th September, 2023. She was informed about the continuity of care and that she would be visited at home for seven days to check on her condition and that of the baby. Her mother was encouraged to take good care of her and also provide her with physical, emotional, psychological and financial support. She was again educated on the prescribed drugs, its route, dosage and effects and encouraged to register the baby at the births and deaths registry. Client was asked if she had any other complaints or questions and she said no. She was discharged at 4:00pm on the 6th September, 2023.

4.4 FIRST DAY POST NATAL HOME VISIT (2ND DAY POST DELIVERY)

Madam Alice and her baby were visited on 7th September, 2023 in the evening at 5:00 pm. Both mother and baby looked healthy on arrival to their house. Greetings were exchanged with warm welcoming. She was informed of the procedures to be carried out. Hands were washed and dried. The baby was top and tailed after head to toe examination was done and no abnormality was detected. Baby passed meconium and urine during the procedure. The cord was also dressed with sterile cotton wool swabs and methylated spirit using aseptic technique; it was clean, dry and not offensive. The baby was dressed, wrapped and given to the client's mother. Madam Alice emptied her bladder and head to toe examination was done. The conjunctiva was examined and there was no pallor. The breasts were soft and lactating well. The uterus was well contracted and Symphysio fundal height was 14 centimetres. The perineum was clean, dry and intact, lochia was small, red and not offensive. Mother's vital signs were checked and recorded as follows Temperature; 36.5 0C, Pulse; 80bpm, Respiration; 20cpm, Blood pressure; 107/75mmHg

The baby's vital signs and weight were also recorded as follows: Temperature: 36.8 0C, Apex heart rate: 138bpm, Respiration: 46cpm, weight: 2.9kg. Baby was given to mother to breastfeed and baby was able to suckle well. Client was asked if she had any question or problem and she complained of not being able to sleep. She was reassured, encouraged to take naps in the afternoon and sleep whenever baby is asleep or whenever possible. Madam Alice was educated on danger signs of the newborn such as breathing difficulties, cyanosis, persistent vomiting, fever, crying weakly, refusal of baby to feed and yellowing of the palms of the hands and soles of the feet. Client and family were congratulated and permission was sought to leave. She was informed of the next home visit the next day.

4.5 SECOND DAY POST NATAL HOME VISIT (3RD DAY POST DELIVERY)

On 8th September, 2023 at 7:00 am and 5:00 pm, Madam Alice was visited twice to assess her and her baby. On observation, the general condition of the family was good. The procedures to be carried out were explained to her. The symphysio fundal height was 15centimeters. The perineum was inspected and it was clean, dry and intact with small bright red lochia which was not offensive. Her vital signs were checked and recorded as follows: temperature; 36.30C, pulse; 76bpm, Respiration: 18cpm, Blood pressure: 100/60mmHg. Evening: Temperature: 36.80C, pulse: 80bpm, Respiration; 20cpm, Blood pressure: 110/60mmHg. Permission was sought to top and tail and dress baby's cord but before that, head to toe. Baby was top and tailed and cord was dressed and left to dry. Baby was wrapped in a cot sheet and given to mother for breastfeeding. Baby's vital signs and weight were checked and recorded as follows: Morning: temperature:

36.80C, Apex heart beat: 130bpm, Respiration: 38cpm, weight: 2.9kg. Evening: Temperature; 36.90C, apex heart rate: 132bpm, Respiration: 40cpm, weight; 2.7kg.. During head to toe examination no abnormality was detected but on breast examination, client's breast was full on inspection and the breast was tender to touch on palpation. She was reassured and she was educated to breastfeed baby on demand to reduce the breast pain and can also lie on bed to breastfeed effectively. She was also educated on other positions that can be used during breastfeeding such as lying on her side. Client and family were thanked for their cooperation and permission was sought to leave and return the following day.

4.6 THIRD DAY POSTNATAL HOME VISIT (4TH DAY POST DELIVERY)

Madam Alice was visited at home twice to check on how she and the baby were faring on 9th September, 2023 at 7:00am and 5:00pm respectively. Greetings were exchanged and permission was sought to inspect her perineal pad. Her lochia was pink serosa and not offensive. Client said the lower abdominal pain has stopped when asked. Client complained of nappy rashes on the baby and she was encouraged to continuously change baby's diaper when soiled. And also use cotton diapers. She also said she was able to have enough sleep now. Head to toe examination was conducted and everything was normal. The uterus was firmly contracted and symphysio-fundal height measured 10 centimetres. Vital signs were checked and recorded as: Morning: Temperature; 36.50C, Pulse; 88bpm, Respiration; 18cpm, Blood pressure; 11/60mmHg. Evening: Temperature; 36.70C, Pulse; 78bpm, Respiration; 19cpm, Blood pressure; 110/60mmHg. Mother was asked to top and tail the baby under supervision which she did very

well with few lapses. Head to toe examination was done and everything was normal. Baby's cord was dressed with six cotton wool swabs and methylated spirit and left to dry. The cord was not offensive and the baby passed stools and urine in which stools were brownish yellow in colour. The baby's vital signs and weight were checked and recorded as follows: temperature: 36.50 c, Apex heart rate: 134bpm, Respiration: 48 46cpm, Weight: 2.85kg. Evening: Temperature: 36.80 c, Apex heart rate: 130bpm, Respiration: 47cpm, Weight: 2.85kg. Client was thanked for her cooperation and support. She was asked to take her routine drugs and permission was sought to leave.

4.7 FOURTH DAY POST NATAL HOME VISIT (5TH DAY POST DELIVERY)

Madam Alice was visited again on 10th September, 2023 at 7:00am. Mother, baby and family looked healthy on arrival. Client said she was relieved of her lower abdominal pain when she was asked about it. Head to toe examination of the baby was done and no abnormality was detected. Baby's cord was dressed with methylated spirit, it was dry and non- offensive and the stump was almost off. Head to toe examination was carried out on the mother and result was healthy afterwards. On palpation, the uterus was well contracted and the Symphysio- fundal height was 8centimetres, perineum was inspected for Lochia and the colour was pink (serosa) and the flow was small not offensive. The breast was lactating well. Her vital signs were checked and recorded as follows: Blood pressure: 110/ 60mmHg, Temperature: 37.10 c, Pulse: 76bpm, Respiration: 18cpm. The baby's vital signs and weight were checked and recorded as follows: Temperature: 36.8 0c, Apex heart beat: 130bpm, Respiration: 47cpm Weight: 2.8kg. Client was

asked of complaints and she responded she is doing very well. Mother was encouraged to ask questions. All findings were communicated to her and the necessary documentations were done. Client was thanked and permission was sought to leave

4.8 FIFTH DAY POST NATAL HOME VISIT (6TH DAY POST DELIVERY)

On the 11th September, 2023, Madam Alice was visited at 7:00am. Mother and baby looked healthy on arrival. Baby was bathed, head to toe examination was done and no abnormality was detected. The cord was off and the stump was dressed with cotton wool swab and methylated spirit, it was dry and not offensive. Madam Alice was also examined from head to toe and no abnormality was detected. On palpation, symphysio fundal height was 6cm. Perineum was clean and lochia was small and serosa in colour and not offensive when inspected. Madam Alice's vital signs were checked and recorded as: Blood pressure; 100/60mmHg, Temperature; 36.90 c, Pulse; 72bpm, Respiration; 21cpm. Baby's vital signs were checked and recorded as: Temperature; 36.80 c, Apex heart rate; 138bmp, Respiration; 40cpm Weight; 2.75kg. Baby was given to mother to breastfeed and baby's suckling was good. Mother was encouraged to continue with breastfeeding. Client was thanked and permission was sought to leave.

4.9 SIXTH DAY POSTNATAL HOME VISIT (7TH DAY POST DELIVERY)

On 12th September, 2023, Client and baby were visited at 5:00pm. Mother and baby looked happy on arrival and the whole family was doing well. Procedures to be done were explained to Madam Alice. Her permission was sought and she consented. Head to toe examination was done

for the baby and the mother and no abnormality was detected. Her symphysio fundal height was measured and it was 4cm. The perineal pad was inspected and lochia was pink (serosa) and the flow was small no foul smell. Her vital signs were checked and recorded as follows; Blood pressure; 110/70mmHg, Temperature; 36.50 c, Pulse; 78bpm, Respiration; 19cpm. The baby was top and tailed and the umbilical stump was cleaned with cotton wool swabs and methylated spirit. The cord stump was clean and dry with no offensive odor. The baby looked healthy and active. Her vital signs were checked and recorded as: Temperature; 36.50 c, Apex heart rate; 130bpm, Respiration; 38cpm, Weight; 2.75kg. Madam Alice was asked if she had any problem and she said no. Client was informed about the termination of visits on the seventh day and permission was sought to leave after a short interaction.

4.10 SEVENTH DAY POSTNATAL HOME VISIT (8TH DAY POST DELIVERY)

On the 13th September, 2023, at about 5:00pm, client was visited for the last time. Greetings were exchanged and a seat was offered. Baby and mother were doing well. Madam Alice's mother bathed the baby under supervision and she did it perfectly after head to toe examination was done on both mother and baby and no abnormality was detected. The baby passed urine and stools during the bath. The colour of the stool was bright-yellow. The uterus was no more palpable on palpation. The perineal pad was inspected and the lochia was scanty and brownish red in colour. The cord stump was dressed with six cotton wool swabs and methylated spirit by Madam Alice under supervision and she did it well. The cord stump was clean, dry and healed. Mother's vital signs were checked and recorded as follows: temperature: 36.1C, Pulse: 76bpm,

Respiration: 18cpm and Blood pressure: 110/60mmHg, Symphysio- fundal height: 3cm. The baby's vital signs were: temperature; 36.70C, apex heart beat: 134bpm, respiration; 40cpm and weight: 2.8kg. Madam Alice was encouraged to continue exclusive breastfeeding for six months, ensure personal and environmental hygiene as she always does. The importance of immunizing the baby against the preventable childhood diseases was also explained to her. She was reminded of her visit to the clinic on the following day. Madam Alice and her family expressed their heartfelt gratitude. They were thanked for their cooperation and also making the work easier. Permission was sought to leave.

4.11 FIRST POST NATAL VISIT TO THE CLINIC

On 14th September, 2023, Madam Alice and her baby came to the Clinic at 8:00 am. They were welcomed and offered a seat. Client and baby were looking healthy and they were nicely dressed in all white. The purpose of this visit was to maintain the physical, and medical wellbeing of mother and baby and also to do further investigations to know the state of health of both mother and baby. Client was asked how she and her family were doing and she said they were fine.

General observations were made on her mood and attitude towards baby and all were okay. All procedures to be carried out were explained to her and her consent was sought. She was asked to empty her bladder and a sample of urine was taken to test for glucose and protein and all tested negative. Her vital signs and haemoglobin level were checked and recorded as: Temperature: 36.30C, pulse: 72bpm, Respiration: 18cpm, Blood pressure; 100/60mmHg and **Hemoglobin;**

12.8g/dl. Privacy was provided and Madam Alice was helped to undress and lie on the examination bed. Hands were washed with soap under running water and dried with a clean dry towel. Head to toe examination was done on her. On the head, the hair was very neat, well combed and clipped with white ribbon and free from lice and dirt. The conjunctiva was pink; there were no discharges from the eyes, nose and ears. There was no abnormality detected in the mouth and there was the absence of enlarged lymph nodes around the neck. The breast was lactating well; there were no sore or cracked nipple and breast engorgement. The abdomen was firm; there was no tenderness, no scars, enlarged liver or spleen on examination. The uterus was not palpable. There was no oedema, varicosities and tenderness in the calf muscle. The perineum was intact and there was no offensive vaginal discharge. The lochia was small and the colour was alba. She was thanked for her cooperation and helped to dress up. The baby was also examined from head to toe and no abnormality was detected. The umbilical stump was inspected and it was healed. The baby looked healthy and active. The baby's vital signs were checked and recorded as follows: Temperature: 36.60 c, Apex heart rate: 138bpm, Respiration: 38cpm, Weight: 2.85kg. Mother was encouraged to ask questions but she said there was none. Client was educated on exclusive breastfeeding and the importance of attending child welfare clinic. All findings were recorded and communicated to client.

4.12 TERMINATION OF CARE

Explanation was given to Madam Alice on the need to be handed over to the midwife in-charge for continuity of care on 14th September, 2023, at 11:30 am. Explanation was made to her that

our programme had ended on the 14th September, 2023, but client was reassured of midwife in-charge's competency. Client was accompanied to her house and a seat was offered. Client and her mother together with her partner were thanked for their cooperation; information provided throughout the study, they were reminded to register the baby at birth and death registry. Also, to complete baby's immunization schedule and permission was sought to leave.

4.12 CARE PLAN DURING PUERPERIUM

Problems Identified

1. Fatigue

2. After pain

3. Insomnia

4. Skin rashes on baby

SHORT TERM OBJECTIVES

1. Client will be relieved of fatigue within 24hours.

2. Client's after pain will reduce within 48 hours.

3. Client will be able to sleep for 3 hours during the day within 24 hours

4. Client's baby will be relieved of skin rashes within 72 hours

LONG TERM OBJECTIVES

Madam Alice and her baby will have a safe and normal puerperium without any complications.

TABLE 3: PUEPERIUM CARE PLAN

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
5/09/2023 At 8:00am	Fatigue related to stress from labour.	Client will be relieved of fatigue within 24 hours as evidenced by client verbalizing.	1. Reassure mother. 2. Encourage client to sleep in the day when the baby is asleep. 3. Encourage client's relatives to assist in the caring of the baby. 4. Encourage client to have rest. 5. Encourage client to assume a comfortable position.	1. Mother was reassured. 2. Client was encouraged to sleep in the day when baby is asleep. 3. Client relatives were encouraged to assist in caring for the baby. 4. Client was encouraged to have rest. 5. Client was encouraged to assume a comfortable position.	6/9/2023 At 8:00am	Goal fully met. Client reported that, she is no more tired.	

TABLE 3: PUEPERIUM CARE PLAN

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVE/OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
6/9/23 7:00am	After pain related to involution of the uterus.	Client's after pain will reduce within 48 hours as evidenced by Client verbalizing.	1. Reassure client. 2. Explain the physiology of after pain to the client. 3. Advice client to breastfeed on demand. 4. Encourage client to empty her bladder frequently. 5. Administer prescribed analgesic to reduce client after pain.	1. Client was reassured. 2. Physiology of after pain was explained to the client. 3. Client breastfed baby at least eight times a day. 4. Client emptied her bladder frequently whenever she has the urge to. 5. Prescribed analgesic was administered to reduce client after pain.	8/9/23 6:30am	Goals fully met. Client stated that her after pain is no more.	

TABLE 3: PUEPERIUM CARE PLAN CONT'D

DATE/TIME	NURSING DIAGNOSIS	NURSING OBJECTIVE/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
7/9/23 05:00PM	Insomnia related to demand of feeding of baby at night.	Madam Alice will be able to sleep for 3 hours during the day in 24 hours as evidenced by client reporting.	1. Reassure client. 2. Encourage family support. 3. Encourage client to limit her time spent with visitors. 4. Encourage client to sleep in a noise free environment. 5. Encourage client to sleep whenever baby sleeps.	1. Client was reassured. 2. Family support was encouraged. 3. Time spent on visitors was limited for client to have enough rest. 4. Client was able to sleep well in a noise free environment. 5. Client was encouraged to sleep whenever baby sleeps.	8/9/23 05:00Pm	Goal fully met. Client reported that she can now sleep.	

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVE/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
9/9/23 7:00am	Nappy rash related to prolonged use of diaper.	Baby's nappy rashes will disappear within 72 hours as evidenced by: Client verbalizing.	1. Reassure client. 2. Educate client on the need to change diaper when soiled. 3. Encourage client to use cotton diapers. 4. Encourage mother to use carbolic soaps when bathing baby.	1. Client was reassured. 2. Client changed diaper when soiled. 3. Cotton diapers were used on baby. 4. Mother used carbonic soaps when bathing baby.	12/9/23 7:00am	Goal fully met. Nurse observed nappy rashes on baby were no more.	

SUMMARY AND CONCLUSION

The Patient/Family Care Study has given an account of how the midwifery nursing process approach was used in nursing Madam Agyemang Alice throughout pregnancy and after birth. Client is a native of Wenchi in the Bono Region. A 32 years old gravida 3 para 2, who was an attendant at Wenchi Health Center for antenatal care, was chosen among the lot because she fell within the criteria for clients to be chosen for the care study. Friendship was then established to render effective care throughout pregnancy, labour and puerperium. Home visit were done and the minor problems that were encountered during the period of pregnancy, labour and puerperium were all managed using the nursing process. Her successful antenatal care, labour and puerperium were due to the early assessment and analysis of her problems, proper counselling and education. She had a spontaneous vaginal delivery to a live female child on the 5th of September, 2023 at 9:50pm without any complications.

The appropriate care was rendered to her and the baby. She was also educated appropriately. She had intensive puerperal care and all visits and examinations were carried out on her as required and hence she had a normal and safe puerperium. The baby also received all appropriate immunizations required at birth for the prevention of any diseases or complications. She was finally handed over to the midwife in charge for the continuity of care. There was proper and accurate documentation of all activities and procedures carried out on her and the baby for proper and easy reference.

The Client / Family Centered Care Study has enabled me to understand the unique essence of the case study and the midwifery profession as well as the managerial tool and step for managing any pregnant woman through antenatal, labour and puerperium and therefore sustained.

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APPENDIX 1

DATE	WEIGHT (KG)	BLOOD PRESSUE	URINEFOR PROTEIN/ SUGAR	GESTATIONAL AGEIN WEEKS	FUNDAL HEIGHT (CM)	PRESENTATION	DESCENTOF FETAL HEAD	FETAL HEART RATE(FH)	TREATMENT GIVEN	COMPLAIN	SIGN
19/1/23	62 kg	110/70mmHg	Negative / Negative	7weeks	-	-	-	-	Routine drugs	No complain	
19/3/23	61.5kg	100/60mmHg	Negative / Negative	14weeks	-	-	-	-	Routine drugs	No complain	
07/05/23	63.kg	90/60mmHg	Negative / Negative	21weeks	20cm	-	-	-	Routine drugs	No complain	
18/7/23	59kg	100/60mmHg	Negative / Negative	31weeks+ 2d	35cm	-	-	135bpm	Routine drugs	Feels well	
25/7/23	61kg	114/72mmHg	Negative / Negative	32weeks+ 2d	35cm	-	-	140bpm	Routine drugs	Waist pain	

DATE	WEIGHT (KG)	BLOOD PRESSUR	URINE FOR PROTEIN/ SUGAR	GESTATIONAL AGEIN WEEKS	FUNDAL HEIGHT (CM)	PRESENTATION	DESCENT OF FETAL HEAD	FETAL HEART RATE (FH)	TREATMENT GIVEN	COMPLAIN	SIGN
01/08/23	60kg	100/70mmHg	Negative / Negative	33weeks + 2d	35cm	Cephalic	$5/5^{th}$	140bpm	Routine drugs	Feels well	
03/08/23	62kg	110/68mmHg	Negative / Negative	35weeks+3d	37cm	Cephalic	$5/5^{th}$	140bpm	Routine drugs	Feels well	
21/08/23	63kg	126/73mmHg	Negative / Negative	37Weeks+4d	35cm	Cephalic	5/5	138bpm	Continue treatment	Healthy	
28/08/23	69.5	130/80mmHg	Negative /Negative	38Weeks+4d	38cm	Cephalic	5/5	140bpm	Continue treatment	Healthy	
02/09/23	69.2	120/70mmHg	Negative/ Negative	38Weeks + 4d	38cm	Cephalic	5/5	138bpm	Routine drugs	Healthy	

APPENDIX II: COMPLETED DIAGNOSTIC INVESTIGATIONS

ANTENATAL

DATE	SPECIMEN	INVESTIGATION	NORMAL VALUES	FINDINGS	REMARKS
19/01/2023	Blood	Hemoglobin	12g/dl-16g/dl	14.1g/dl	Normal
		Rhesus level	Negative	Negative	Normal
		Sickling status	A, B, AB, and O	A	Normal
		Grouping factor	Positive and Negative	Positive	Normal
		HIV status	None reactive	Negative	Normal
	Urine	VDRL	None reactive	Non-defect	Normal
		Hepatitis status	Negative	Negative	Normal
		G6PD status	None reactive	Non-defect	Normal
		Sugar	Negative	Negative	Normal
		Protein	Negative	Negative	Normal

COMPLETE DIAGNOSTIC INVESTIGATION

DATE	SPECIMEN	INVESTIGATION	NORMAL VALUES	FINDINGS	REMARKS
19/01/23	Urine	Sugar Protein Hemoglobin level	Negative Negative 12g/dl-16g/dl	Negative Negative 14.1g/dl	Normal Normal
19/03/23	Urine	Sugar Protein	Negative Negative	Negative Negative	Normal Normal
07/05/23	Urine	Sugar Protein	Negative Negative	Negative Negative	Normal Normal
18/07/23	Urine Blood	Sugar Protein Hemoglobin Level	Negative Negative 12g/dl-16g/dl	Negative Negative 12.8g/dl	Normal Normal Normal
25/07/23	Urine	Sugar Protein	Negative Negative	Negative Negative	Normal Normal
01/08/23	Urine	Sugar Protein	Negative Negative	Negative Negative	Normal Normal
13/08/23	1 Urine	Sugar Protein	Negative Negative	Negative Negative	Normal

DATE	SPECIMEN	INVESTIGATION	NORMAL VALUES	FINDINGS	REMARKS
21/08/23	Urine	Sugar	Negative	Negative	Normal
		Protein	Negative	Negative	Normal
	Blood	Hemoglobin	12g/dl-16g/dl	13.7g/dl	Normal
28/08/23	Urine	Sugar	Negative	Negative	Normal
		Protein	Negative	Negative	Normal
	Blood	Hemoglobin	12g/dl-16g/dl	13.8g/dl	Normal
02/09/23	Urine	Sugar	Negative	Negative	Normal
		Protein	Negative	Negative	Normal
	Blood	Hemoglobin	12g/dl-16g/dl	14.2g/dl	Normal

APPENDIX III

PHARMACOLOGICAL DRUGS FOR MOTHER

NAME OF DRUG	CLASSIFICATION	DOSAGE	ROUTE	USE AND ACTION	ACTUAL EFFECT	SIDE EFFECT	SIDE EFFECT EXPERIENCED
Tablet multivitamin	Vitamin preparation	200 milligram once daily	Orally	Increased appetite and helps in the formation of red blood cells.	Increased appetite	Gastrointestinal disturbances	No side effect observed.
Tablet folic acid	Haematinics	5 milligram once daily	Orally	Proper formation and functioning of red blood cell.	Hemoglobin Level increase	Nausea and vomiting	No side effect observed
Tablet Ferrous sulphate	Iron supplement	200 milligrams once daily	Orally	Helps in the formation of hemoglobin and red blood cells	Increased hemoglobin level	Gastrointestinal disturbances. Dark stools.	Dark stools

Tablet Metronidazole	Antibiotic	400 mg 3 times daily	Orally	Fights against bacterial infection	Fights against bacterial infection	Stomach pain, dizziness, dry mouth, cough, sore tongue	No side effect observed
Tablet Paracetamol	Analgesic and anti- Pyretic	1 gram 3 times daily	Orally	Relieve pain and Reduce body temperature	Pain relieved	Prolonged use may cause liver damage.	No side effect ob
Capsule Amoxicillin	Antibiotic	500mg 3 times daily	Orally	Fights against bacterial infection	Bacterial infection prevented	Nausea, stomach pain, diarrhea, vomiting	No side effect ob

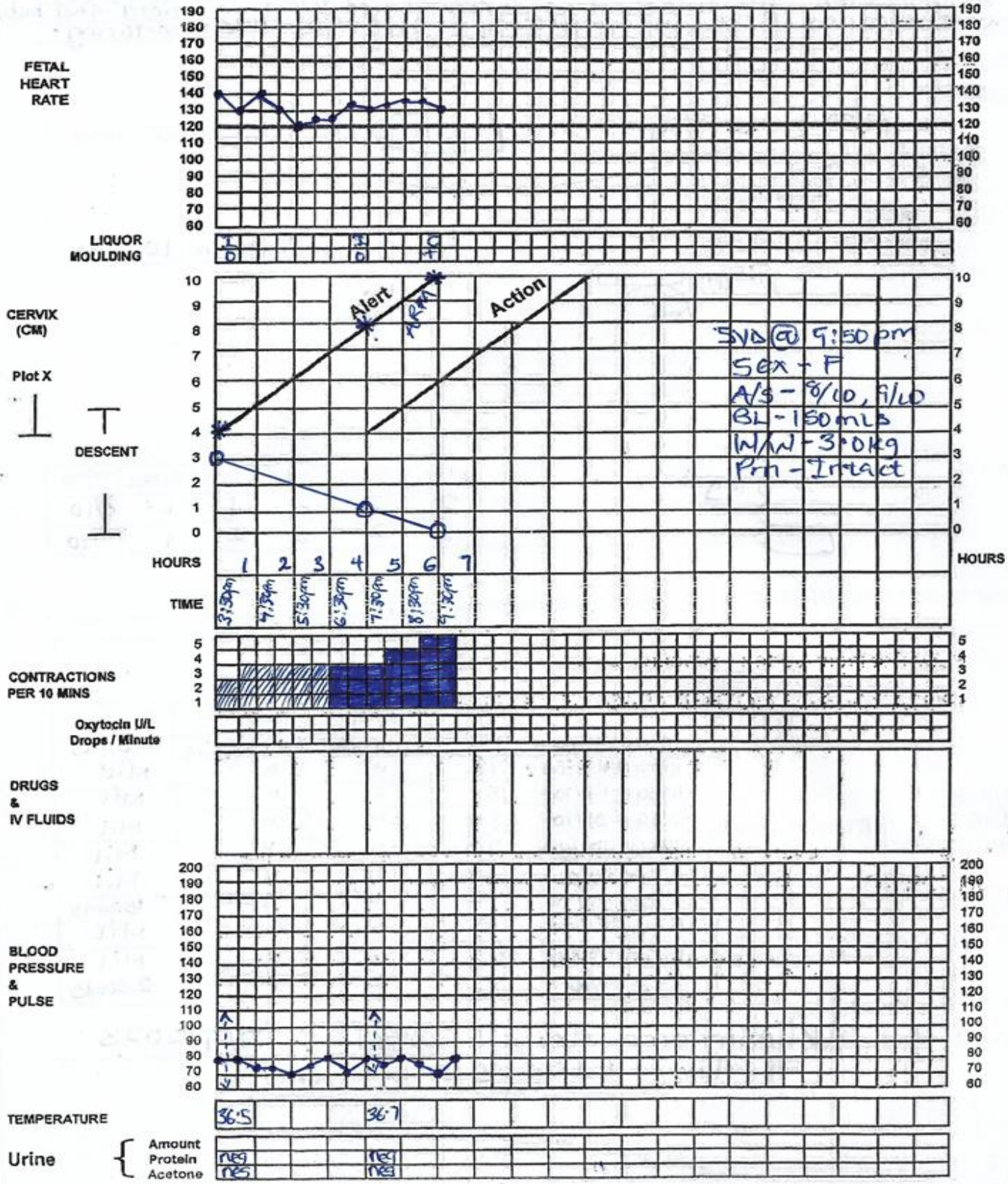
Tablet Sulphadoxinepyrimethamine	Antimalarial and Malaria prophylaxis	3 tablets stat at 16weeks and repeated at a 4 week interval at delivery.	Orally	Treatment and prevention of malaria	Malaria prevented	Itching Nausea Dizziness Headache	No side effect observed.
Tetanus Injection	Anti-tetanus	0.5 milligrams	Subcutaneously	Provides immunity against Tetanus disease.	Tetanus prevented	Fever Chills Urticarial rash	Pain at the site.
Injection oxytocin	Oxytocin drug	10 units	Intramuscularly	Stimulates uterine contraction	Uterine contractions stimulated	Nausea and Vomiting	No side effects observed.

PHARMACOLOGICAL DRUGS FOR BABY

NAME OF DRUG	CLASSIFICATION	DOSAGE	ROUTE	USE AND ACTION	ACTUAL EFFECT	SIDE EFFECT	SIDE EFFECT EXPERIENCED
Injection vitamin k	Coagulant (Group K Vitamins)	1.0mg	Intramuscular	Production Prothrombin which aids in clotting.	No bleeding	Risk of haemolysis in people with G6PD deficiency.	No side effects observed.
Chloramphenicol eye drop	Antibiotic	2 drops	Instillation	To prevent eye infection.	Eye infection was prevented.	Transient stinging	No side effect observed.
Oral polio vaccine	Antigen vaccine	2 drops	Orally	Production of antibodies to prevent poliomyelitis	Under observation	Diarrhea Fever	No side effects observed.
Capsule vitamin A	Group A vitamin supplement	200,000 units for 2 days	Orally	Growth, development and proper sight	Normal vision and healthy skin.	Vomiting	No side effect observed.
Injection Bacillus Calmette Guerin (BCG)	Antigen vaccine	0.05 milligrams	Intradermal injection	Production of antibodies against tuberculosis	Under observation	Blister formation and fever	Blister observed

WHO Modified Partograph

Registration No. 686/23 Name (Last, First) Agyemang Alice Age 32yrs
Date 5/9/2023 Parity/Gravida 3 / 2 LMP – EDD 4/9/23 Gestation (wks) 39+2
ROM (Time, Date) 10:40am Labour Durable (Hrs) 6hrs Facility/Clinic Name Wenchi Health Center



LABOR NOTES

Client G3P2 with gestational age of 39+2 wks came to the facility accompanied by mother per ambulation, she had spontaneous vaginal delivery at 9:50pm to a live female baby with APGAR score 8/10, 9/10. IM oxytocin 10 unit was given to her with one minute after delivery, fundus palpated to rule out second twin. Third stage completed successfully. Vitamin K was administered, eye care and cord dressing done. Head to toe examination was done and no abnormalities detected. Client and baby were cleaned and put comfortably to bed under close monitoring.

Please circle or write responses.

DELIVERY

DATE: 5/9/2023 TIME: 9:50pm METHOD: (Spontaneous) / Vacuum Extraction / C/S / Other

PERINEUM: (Intact) / Episiotomy / Laceration

ANESTHESIA: (None) / Local / General

THIRD STAGE

Active Management: Yes / No Medication: Time 9:52pm Type/Dose Oxytocin - 10 units

PLACENTA: TIME: 9:57pm (Complete) / Incomplete

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

BABY

Weight: 3.0kg

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	10:00pm	110/60mm	72	Contracted	No excessive bleeding	200mls
	10:15pm	115/80mm	78	"	"	Nil
	10:30pm	120/70mm	81	"	"	Nil
	10:45pm	105/70mm	84	"	"	Nil
	11:00pm	100/60mm	76	"	"	Nil
	11:15pm	110/60mm	89	"	"	Nil
	11:30pm	120/70mm	72	"	"	150mls
	11:45pm	118/70mm	75	"	"	Nil
Every 30 minutes For 1 hour	12:15pm	120/80mm	83	"	"	Nil
	12:45pm	110/60mm	88	"	"	250mls

Birth Attendant Azheampoma Abigail assisted by Ahema Blessing (Senior midwife) Date 5/9/2023

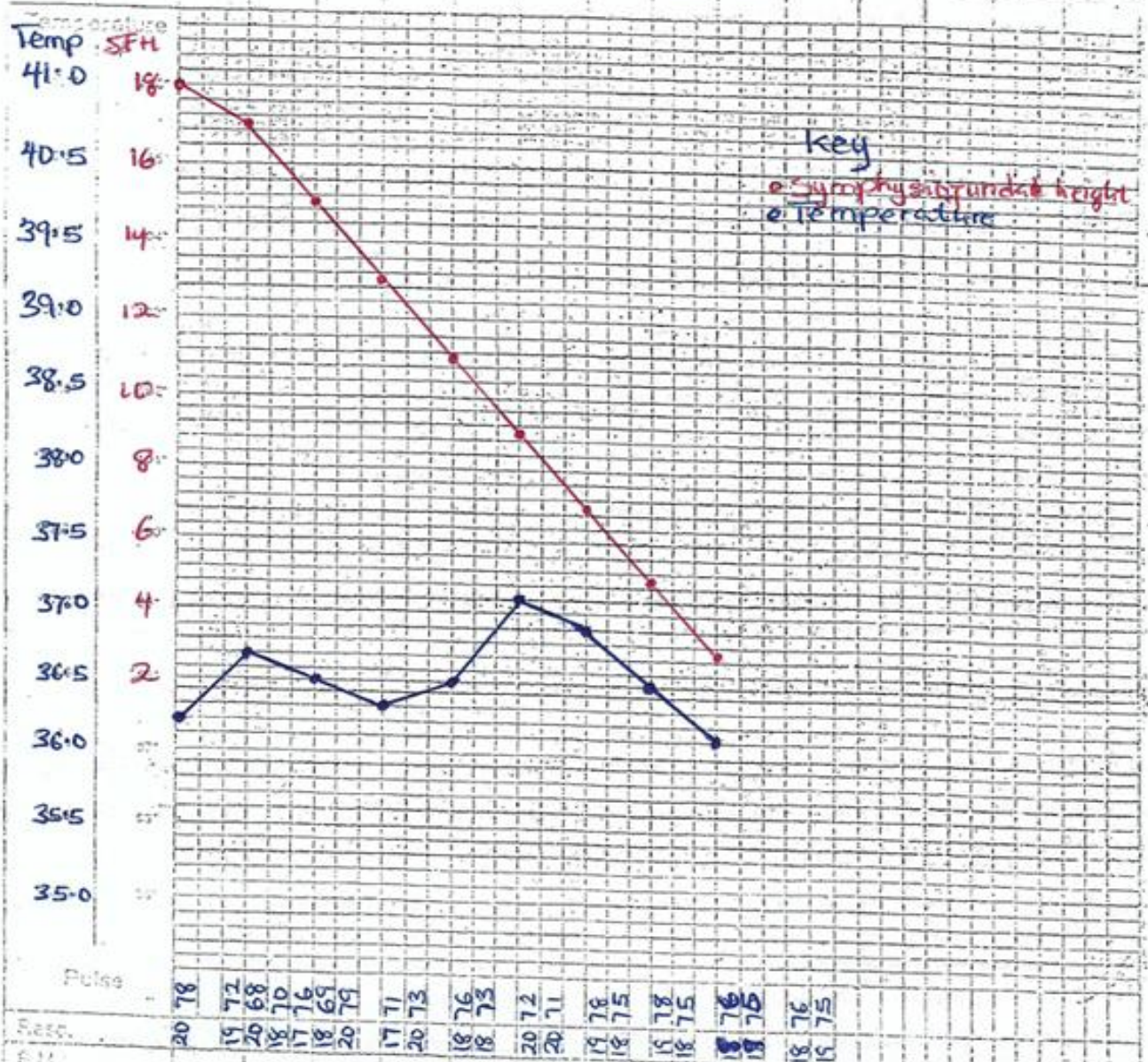
MATERNITY CHART

NAME: Agyemang Alice

AGE: 32 years WARD: Lying in

IP NO.: 686/23 BED NO.: 4

Date		5/9/23	6/9/23	7/9/23	8/9/23	9/9/23	10/9/23	11/9/23	12/9/23	13/9/23
Days in Hospital		D0	D1	D2	D3	D4	D5	D6	D7	D8
SFH		18	17	15	13	11	9	7	5	3
Hour	am		7:00	8:00	7:00	8:00	9:00	5:00	9:30	8:30
	Pm	8:00	5:00	4:00	5:00	4:00	4:50	4:00	3:30	4:00



Pulse		78	72	68	70	76	69	79	71	73
Resp.		20	19	20	18	17	18	20	17	20
B.M.										
Urine		Passed	Passed	Passed	Passed	Passed	Passed	Passed	Passed	Passed
B.P.	AM		100/60	101/75	100/60	110/60	110/60	100/60	110/70	110/70
	PM	110/60	110/70	110/80	110/60	100/60	110/85	100/70	112/65	110/60

Pulse		76	73	72	71	78	75	78	75	76	75	76	75
Resp.		18	18	20	20	19	18	15	18	18	18	18	15

NEW BORN EXAMINATION FORM

Name: Baby Agyemang Alice Date of Assessment: 5/9/23 Time: 9:57pm
Date of Birth: 5/9/2023 Time of Birth: 9:50pm Sex: ☐ M ☑ F Age at time of Assessment (days/hrs) _____
Astational Age ☐ 39+2 ☐ Mode of Delivery: ☑ Vaginal Assisted Vaginal C-Section
APGAR: 1min 9/10 5min ☐ 9/10 Birth Weight: ☐ 3.0 kg ☐ Lenght: 47 cm Head Circumference: 32 cm
Temperature at time of Assessment: 36.1 °C Urine passed: Yes No Meconium passed: Yes No
Name of Assessor (Midwife/Doctor): Acheampong Abigail

1. Respiration
Rate_____
- ☐ 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: _____
- ☐ Normal (100-160)
- ☐ <100 *
- ☐ >160*

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

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

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

22. Limbs
- ☑ Normal
- ☐ Abnormal_____

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

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

24. Anus
- ☑ Patent
- ☐ Imperforate*

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

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

*May indicate severe disease that requires urgent referral

Diagnoses (if known)_____

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 Agyemang Alice Date of Assessment: 5/9/2023 Time: 4:00pm
Date of Birth: 5/9/2023 Time of Birth: 9:30pm Sex: ☐ M ☑ F Age at time of Assessment (days/hrs) _____
Astational Age ☐ ☐ Mode of Delivery: ☑ Vaginal Assisted Vaginal C-Section
APGAR: 1min 9/☐ 5min ☐ 9/10 Birth Weight: ☐ 3·0kg ☐ Length: 47 cm Head Circumference: 32 cm
Temperature at time of Assessment: 36·7 °C Urine passed: Yes No Meconium passed: Yes No
Name of Assessor (Midwife/Doctor): Acheampoma Abigail

1. Respiration
Rate_____
☐ 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: _____
☑ Normal (100-160)
☐ <100 *
☐ >160*

19. Femoral pulse
☑ Present
☐ Not palpable*

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

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

22. Limbs
☑ Normal
☐ Abnormal_____

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

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

24. Anus
☑ Patent
☐ Imperforate*

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

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

***May indicate severe disease that requires urgent referral**
Diagnoses (if known)_____

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

NEW BORN CHART

Name: Baby Agyemang Alice ..... No: ..... Birth Weight: 3.0 kg

Sex: Female ..... Mother's No: 686/23 ..... Length: 47cm

Nature of Delivery: Spontaneous vaginal delivery ..... Diagnosis: Term baby

Date of Birth: 5/9/2023 ..... Time: 9:50pm ..... Date of Discharge: 6/9/2023

Date	5/9/23		6/9/23		7/9/23		8/9/23		9/9/23		10/9/23		11/9/23		12/9/23		13/9/23					
No. of Days	D0		D1		D2		D3		D4		D5		D6		D7		D8					
Weight	3.0kg		2.95kg		2.90kg		2.85kg		2.8kg		2.75kg		2.75kg		2.8kg		2.85kg					
Temperature	AM	PM 36.1°C	AM 36.0°C	PM	AM	PM 36.8°C	AM 36.8°	PM 36.9°C	AM 36.5°C	PM 36.8°C	AM 36.8°C	PM	AM 36.8°C	PM	AM	PM 36.5°C	AM	PM 36.7°C	AM	PM	AM	PM
Stools		Passed	Passed			Passed	Passed	Passed	Passed	Passed	Passed		Passed			Passed		Passed				
Urine		Passed	Passed			Passed	Passed	Passed	Passed	Passed	Passed		Passed			Passed		Passed				
Remarks	Trunk, Limbs, Abdomen, Neck — No abnormalities detected.																					

TEMPERATURE CHART

NAME: Baby Agyemang Alice
Newborn
O.: 686/23 WARD: Lying in
BED NO.: 4

Date	5/4/23	6/4/23	7/4/23	8/4/23	9/4/23	10/4/23	11/4/23	12/4/23	13/4/23
Days in Hospital	DOO	D1	D2	D3	D4	D5	D6	D7	D8
Wt: P.O.	3·0	2·95	2·9	2·85	2·80	2·75	2·75	2·80	2·85
Hour		36·6	36·7	36·5	36·5	36·6	36·8	36·8	36·5
	36·1	36·5	36·8	36·9	36·8	36·7			

Temperature

C | F

40 | 104
39 | 102.2
38 | 100.4
37 | 98.6
36 | 96.8
35 | 95

Pulse

124								
132	138	130	134	130	138	130	134	
133	138	132	120		136	132	143	
40	43	40	38	46	47	46	38	40
	45	48	40	47		42	40	35
Passed	Passed	Passed	Passed	Passed	Passed	Passed	Passed	Passed

SIGNATORIES

THE STUDENT

NAME: ACHEAMPOMA ABIGAIL

SIGNATURE: .....

DATE: 7th June, 2024

THE MIDWIFE IN CHARGE

NAME: MRS. BLESSING AHEMA

SIGNATURE .....

DATE: 7th June, 2024

THE SUPERVISOR

NAME: MS. MARTHA KYEREMAA

SIGNATURE: .....

DATE: 07/06/2024

THE PRINCIPAL

NAME: MS. MONICA NKRUMAH

SIGNATURE: .....

PRINCIPAL
HOLY FAMILY NURSING AND
MIDWIFERY TRAINING COLLEGE
BEREKUM

DATE: 07/06/2024