HOLY FAMILY NURSING AND MIDWIFERY TRAINING COLLEGE

BEREKUM

A CLIENT/FAMILY CENTERED MATERNITY CARE SITUDY ON

MADAM BARBARA AGYEIWAA ACHEMPONG

BY

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PREFACE

The Client/Family Centered Maternity care study is a systematic and a holistic obstetric nursing care rendered to a pregnant woman and her family throughout pregnancy, labour and puerperium so as to enhance quality health services and client satisfaction.

The Client/Family Centered Maternity care study enables the student midwife to put into practice her acquired knowledge in the classroom and to identify client's problem and also to use new trends in midwifery such as the use of a partograph which is recommended and tested by the World Health Organization (WHO) in order to manage client well during pregnancy, labour and puerperium. The Client/Family Centered Maternity care study enables the student midwife to put into practice the Safe Motherhood initiative which has been adopted in order to help reduce the maternal mortality among pregnant women to improve the quality of health care through antenatal, labour and puerperium.

Last but not the least, it helps the student midwife to gain knowledge in the changes that has brought about new management ideas and quality assurance in the various hospitals, clinics and maternity homes.

Lastly, The Client/Family Centered Maternity care study is a required study that every final year student of Registered Midwifery program is supposed to undertake to satisfy the Nursing and Midwifery Council to help contribute to the award of Registered Midwifery Certificate.

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INTRODUCTION

The Client/family Centered Maternity care study is a tool that enables the student midwife to put into practice the knowledge and skills acquired in the course of her study or training.

This Client/family Centered Maternity care study was carried out on Madam Barbara Agyeiwaa Achempong a 28year-old woman, gravida 2 para 1 during the period of pregnancy, labour and puerperium.

The interaction with her started on the 14th August, 2023. When she came for routine antenatal visit at Dormaa West District hospital which is located at Nkrankwanta in the Bono region. She was in her 37^{+2}days gestation. After an interaction for about 16 minutes, she was told about the intention to use her for a study which she gladly accepted. She was visited at home to know her family, assess her environment and the community in which she lives. She was given the required education, support and management throughout the study. Madam Barbara identified problems during pregnancy, labour and puerperium and were managed by the use of the nursing process. This care study also helped in identifying and giving treatment as well as provision of psychological and emotional support to the woman. She was also thought how to initiate breastfeeding and how to subsequently care for the baby. She went through pregnancy successfully and delivered a healthy baby girl on 30th August 2023 without any complications to both mother and baby. This study is grouped into four (4) chapters.

Chapter one talks about client's particulars and various histories.

Chapter two is about antenatal care and home visits made to client's house.

Chapter three talks about the care given to client during labour, delivery and its management.

Chapter four entails the care given to client during puerperium.

A care plan is drawn to identify problems and management given with the use of the nursing process at the end of each chapter.

Summary and conclusion, bibliography as well as various appendices like the antenatal records are also included.

LITERATURE REVIEW

PREGNANCY

Fraser & Cooper (2013) Pregnancy is the period when the fertilized ovum embeds in the maternal uterus until it is born thus the state of conception till the delivery of the foetus. The normal duration is 280 days or 40weeks counting from the last day of the menstrual period, she further states that uterine blood flow in pregnancy supplies the myometrium, endometrium and placenta, with the latter receiving nearly 90% of the total uterine blood flow near term. It further states that, the anatomical and physiological adaptations occurring throughout pregnancy affect virtually every body system. The timing and intensity of the changes vary between systems but all are designed to support foetal growth and development and prepare the mother for birth and motherhood. The uterus protects and supports the foetus, placenta and amniotic fluid. For most of the 40 weeks of pregnancy, the uterus expands to accommodate the growing foetus and remains relatively quiescent, yet at the time of labour it is able to contract regularly and forcibly to expel the foetus due to its unique properties of contractility and elasticity. She also says, the vagina also increases vascularity which results in the violet colour characteristic of Chadwick's sign. There is increased volume of vaginal secretions due to high level of oestrogen resulting in thick, white discharge known as leucorrhoea. Larger amount of glycogen is deposited in the vaginal epithelium due to high oestrogen availability. The glycogen is metabolized to lactic acid by the lactobacillus acidophilus, (Doderlein's bacillus), and this leads to increase vaginal acidity.

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 vomiting, heart burns, constipation, waist pains, nausea, ptyalism (excessive salivation), food craving and others which most of these changes

go away after delivery. Also, 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.

According to Perry (2013), pregnancy is the period of physical and physiological preparation for child birth and parenthood. According to him, 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. He also stated that 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 (2013) stated that five factors affect 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. He further identifies the stages of labour 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. He continued that, 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. He stated that 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. Lastly, 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 complication such as bleeding.

According to Oduro-Kwarteng (2012), normal labour occurs when the;

Foetus is born at term and alive

Presented by vertex

Process complete spontaneously by natural unaided effort of mother

Time does not exceed 12 hours when the woman enters active phase of labour

Baby is born without complications.

Marie (2013) defines labour as 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). 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.

Fraser & Cooper (2012) described labour as the process by which the foetus, placenta and membranes are expelled through the birth canal. It also explained that the first stage of labour can be divided into 3 stages namely:The latent phase which is prior to active phase of first stage of labour and may last for 6-8 hours in primigravida when the cervix dilates from 1cm to 3-4cm and the cervical canal shortens from 3cm long to less than 0.5 cm long.The active phase which is the time the cervix undergoes more rapid dilatation. This begins when the cervix is 3-4cm dilated and in the presence of rhythmic contractions, is completed when the cervix is fully dilated (10cm).The transitional phase which is the stage of labour when the cervix is from around 9cm dilated until it is fully dilated (or until the expulsive contractions of second stage are felt by the woman). There is often a brief lull in the intensity of uterine activity at this time. Henderson and Macdonald (2011) further stated that in order to provide woman-centered care during labour, the midwife should: asses the needs and expectations of each individual woman regarding labour and birth.Plan care with each woman in labour, tailored to meet her specific needs and expectations.Put the care plan into practice.Evaluate the care given to measure its effectiveness.She also stated that, labour is divided into four (4) stages, these are: first stage which deals with the onset of painful rhythmic uterine contractions and dilatation of the cervix. Second stage which deals with full dilation of the cervix and expulsion of the fetus. Third stage is the delivery of the placenta, membranes and the control of haemorrhage.The fourth stage is when the mother and baby are being monitored for the first six hours after delivery.

Littleton (2012), 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. Also gives a full description of the four stages of

labour. The first stage comprising of the latent phase where the cervix takes eight hours to dilate from 0-3 centimeter and the active phase, where the cervix dilates one centimeter every hour from 3- 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. According to the above definitions, it means labour is the process in which the fetus, the placenta and its membranes are expelled through the birth canal after 28 weeks of pregnancy

PUERPERIUM

Perry (2013) defined postpartum period as the interval between the birth of the newborn and the return of the maternal reproductive organs to their normal non pregnant state. He said that the term puerperium refers to the six weeks period elapsing between the termination of labour and the return of the reproductive organs to their normal condition. This includes both the progressive changes in the breast for lactation and involution of the internal reproductive organ. He also enumerates that, there are 3 types of lochia namely:lochia rubra: it is seen in the first 3 days and consists of blood, decidua and trophoblastic debris and may contain some small clots. It is bright red in colour. Lochia serosa: it is seen during the next 4-9 days. It consists of old blood serum, leucocytes and tissue debris. It is pinkish in colour. Lochia alba: it is seen after 10 days and consists of leucocytes, decidua, epithelial cells and cervical mucus. It is white in colour and continues for 10-14 days.

Fraser & Cooper (2012) states that, puerperium begins immediately after delivery of the placenta and membranes and continues for six (6) weeks. The expectation is that by 6th week after birth, all the systems affected by the pregnancy in the woman’s body would have recovered and returned to their non-pregnant state except the breast because of lactation. Myles also striked the difference between exercise and healthy activity verses rest, relaxation

and sleep. Exploring each person's level of activity will encourage advice in relation to appropriate exercise and by association, nutritional intake and rest or relaxation and sleep. Undertaking regular pelvic floor exercise is of benefit to the woman's long-term health.

According to Marie (2013) puerperium is 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 alternating hardening and softening. At the end of 6 weeks, its measurement is almost similar to that of the non-pregnant state and it weighs 60 gram. 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.

Oduro-Kwarteng (2012) defines puerperium as a period that starts immediately after delivery of the placenta up to 6-8 weeks. This period is characterised by a lot of physiological changes some of which may include the following

A) Lactation is well established
B) The reproductive organs return to their non- pregnant state
C) Other physiological changes which occur during pregnancy are reversed.
D) The foundations of the relationship between the infant and it's parents are laid.
E) The mother recovers from physical and emotional stresses of pregnancy and delivery and assumes responsibilities for the care and nature of the infant.

According to Littleton, (2012) puerperium last from delivery of the placenta to approximately 6 weeks afterward. The immediate postpartum period consists of the first 24 hours after

delivery. On palpation of the breast after delivery, breasts usually are enlarged, soft, warm and contain only a small amount of colostrum, the first milk. The nipples should be intact without redness, tenderness, cracks or blisters. Colostrum may be expressed. The breast may be engorged (enlargement and filling of the breast with milk), which may begin as a tingling sensation in her breast, 2 to 4 days after delivery. Also, with the uterus, immediately after delivery, it begins the process of involution or reduction in size. It generally takes 6 weeks for complete physiologic involution and for the reproductive system to be restored to its non-pregnant state. Sub involution or the failure of the uterus to return to a non-pregnant state, occurs when the process of involution is prolonged or stopped as a result of hemorrhage, infection or retained placental parts. Uterine involution involves the return of the uterus to a non-pregnant condition, diminishing in size and weight, and anatomic location back into the pelvis. The placental site usually is completely healed without scarring by 6 weeks postpartum. Immediately after delivery, the uterus weighs about 1000g. At the end of 6 weeks postpartum, the uterus weighs 50 to 100g. Littleton (2012) furthermore says that, with the fundus, immediately after delivery, the fundus usually can be located midline at the level of or one to two finger breadths below the umbilicus. The position of the fundus also should be noted because the broad and round ligaments were greatly stretched during pregnancy and become very lax after the loss of the enlarged uterus after delivery, the uterus is easily displaced (usually above the umbilicus) by an overfilled bladder. The displacement interferes with the uterus ability to contract after delivery resulting in uterine atony and hemorrhage. However, with lochia, is the usual uterine discharge of blood, mucus and tissue after childbirth. Lochia contains the sloughing of decidua's tissues, including erythrocytes, epithelia cells and bacteria. Lochia is assessed according to color, amount and change with activity and time. Lochia rubra is the term given to the discharge on the first 3 days after delivery. Lochia rubra is small to moderate in amount and has a bright-red color. Lochia

serosa, which occurs 4 to 10 days after delivery, is a watery, pink or brown tinged color, which is lighter in amount than is lochia rubra. Lochia serosa primarily contains serous fluid, leukocytes, erythrocytes and decidual tissues. Lochia Alba, a whitish yellow creamy discharge on days 10-17. Many women may have minimal discharge by day 14, however, it is not uncommon for lochia alba to last until 6 weeks postpartum. Lochia Alba consists of a mixture of leukocytes, decidual tissue and decreasing fluid content. Littleton (2005) again talked about the composition of breast milk which includes: Carbohydrate, protein, fat, sodium, potassium, calcium and iron. Breast milk is nutritionally superior to formula. Breast milk contains immunoglobulins, enzymes, and leukocytes to protect against infection. Breast milk is easily available at a perfect temperature and with no preparation. It also reduces the risk of bacterial contamination, and reduces the risk of allergies. Breastfeeding enhances mother-infant attachment and promotes the development of facial and jaw muscles. It is therefore important for mothers to practice exclusive breastfeeding. Furthermore, once the infant is born and taken to the assessment room, a complete head to toe physical assessment is done to determine the infant's health status. A general inspection is done first to identify abnormalities. The body is inspected for color and texture. The newborn's heart is auscultated for rate and rhythm. Sometimes suctioning is required to remove residual fluid from the infant's mouth. The axillary body temperature is taken. The newborn is weighed and the infant's head circumference is measured (frontal occipito circumference). The face is inspected for symmetry, birth marks, milia, and nevi over the forehead and eyelids. The mouth is inspected for natal teeth and abnormalities of the hard and soft palate, the tongue should be at midline. The genitalia is also inspected by palpating scrotum to check for descent of the testes if a male. Suckling reflex is sometimes demonstrated spontaneously during the examination.

WHY CLIENT WAS CHOSEN

Madam Barbara, G2P1 with 37^{+2} weeks gestation was chosen as a client for the client/family centered maternity care study on the 14th August, 2023 at Dormaa West District hospital Nkrankwanta in the Bono region, during her usual visit to the antenatal clinic in the morning. When her antenatal record was glanced through, she had a very good obstetrical history.

During the antenatal sessions, Madam Barbara complained of lower abdominal pain and persistent waist pains. She was encouraged and reassured that her condition would be managed. Client was also a regular antenatal attendant and presumably, her labour will be uneventful. An opportunity was then taken for introduction as a student midwife from the Holy Family Nursing and Midwifery Training College, Berekum on District midwifery practice and she was informed that she would be taken as a client for the study and she would be monitored during pregnancy, labour and puerperium and she agreed. She was thanked for her understanding and co-operation.

The Midwife In-Charge was informed and permission was granted. She gave the direction to her house, phone numbers were exchanged and client was promised to be visited at home.

CHAPTER ONE

CLIENTS PARTICULARS

1.0 INTRODUCTION

This chapter gives a detailed about how information was obtained through comprehensive history taking which consist of personal and social history, family history, medical history, surgical history, menstrual history, lifestyles and hobbies, past and present obstetrical history.

1.1 PERSONAL AND SOCIAL HISTORY

Madam Barbara G2P1 and 28 years of age is a native and reside at Nkrankwanta in the Bono Region of Ghana. She stays with her husband and her child. She is dark in complexion, weighed 62 kilogram and 163 centimeters tall at booking. She is a Christian by religion. According to client she had her formal education up to Senior High School. She has a husband by name Mr. Sah Edward who is a teacher and also a Christian. Client is a seamstress and speaks Bono Twi and English. She mentioned her lovely son as her next of kin.

1.2 FAMILY HISTORY

According to client God blessed her parents with four children and she is the second born among the four. She said all are females and her father's name is Mr. Achempong Andrews and her mother's name is Mrs Ama Konadu who are both farmers and natives of Nkrankwanta and added that both parents are alive. According to client, her family has no history of hereditary diseases like; hypertension, leprosy, epilepsy, sickle cell disease, diabetes, heart or liver diseases and mental illness. She said there is no history of any congenital abnormalities like cleft palate or cleft lip, hydrocephalus, spinal bifida and imperforated anus in her family. And also said there is no multiple gestation.

Client added that all people who die in their family dies naturally to the best of her knowledge.

1.3 MEDICAL HISTORY

According to client, she has no known medical disease such as Hypertension, Heart disease, Sickle Cell Disease, Diabetes, Epilepsy, HIV infection, Respiratory disease, Tuberculosis, Mental illness, Asthma and others. She said she has no known allergies to any drug or food taken and she visits the antenatal clinic with the use of the National Health Insurance Scheme (NHIS).

1.4 SURGICAL HISTORY

According to client, she has never undergone any surgical operation and has never sustained any injury or any accident that can cause injury to the spine and pelvis. She has no history neither has she donated blood nor has she been transfused before. According to her, she wasn't given any episiotomy during her previous delivery.

1.5 MENSTRUAL HISTORY

Madam Barbara had her menarche at the age of 14. Her regular menstrual cycle is 28 days which flows moderately for five days. She uses sanitary pad during the flow and changes it two times daily. She has no history of dysmenorrhea and uses only the natural method of family planning. According to her, she cannot remember her last menstrual period and her expected date of delivery was 2nd September, 2023 (According to scan).

1.6 LIFESTYLES AND HOBBIES

Madam Barbara wakes up around 5:00am every day. Once she is awake, she washes her face and brushes her teeth with tooth paste and tooth brush. She then sweeps her compound and empties her dustbin. She also empties her bowel two times a day when she feels the urge to.

She mostly washes her utensils in the evening after supper. She prepares breakfast and eat with her family. Client takes her bath twice daily. She eats three times a day with her favorite food being fufu with palm nut soup. Client does her washing on Saturdays but do wash on weekdays sometimes when the need arises. On Sundays, she goes to church with her family. She is sociable and neither smokes nor takes in alcohol. She also scrubs her bathroom and toilet every Saturday.

Madam Barbara has a cordial relationship with her relatives as well as the people in her neighborhood.

1.7 PAST OBSTETRICAL HISTORY

Pregnancy

Madam Barbara G2P1 went through her pregnancies successfully without any complication. She carried her first pregnancy to term. According to her, she only experienced headache, leg cramps during her previous pregnancy which she reported to the clinic and they were explained to her as a normal physiological change in pregnancy which would resolve as pregnancy progresses. She also said she has never had any spontaneous or induced abortion and still birth in her life. She has never suffered any pregnancy induced condition like gestational diabetes and pregnancy induce hypertension (pre-eclampsia). Client also visited antenatal clinic for at least seven (7) times during her previous pregnancy and received all doses of sulphadoxine pyrimethamine and two doses of tetanus diphtheria in the first pregnancy and one in second pregnancy making three in all.

Labour

Client delivered her child spontaneously per vagina at the hospital. She further stated that the duration for her labour did not exceed 18 hours. Client said her child was delivered at

Dormaa West District hospital Nkrankwanta. Her placenta was delivered completely with no retained product of conception. She also said she has never had any perineal tear neither was she given episiotomy during her previous delivery. Client added that she had never experienced post-partum haemorrhage and said her estimated blood loss for her previous delivery was small.

Puerperium

According to client, she stated that her child was active at birth and no birth abnormalities were detected. Client said her first child was a male and weighed 3.0kg at birth. She started breastfeeding him within the first hour after birth. She practiced exclusive breastfeeding for 6months and then added complementary feeds after the 6months for one and half year. Her child was fully immunized against all the vaccine preventable diseases which include polio, measles, diphtheria, whooping cough, tetanus and among others according to schedules. Health conditions of child and mother during puerperium was satisfactory. In relation to family planning, she uses the natural family planning method. She also stated that her family and husband supported her in taking care of her baby and some of the household chores.

1.8 PRESENT OBSTETRICAL HISTORY

Madam Barbara, G2P1 began her antenatal clinic attendance on 4th March, 2023 at Dormaa West hospital Nkrankwanta at 14 weeks gestation and her history was taken by the midwife in charge. Client said she doesn't remember her last menstrual period and her expected date of delivery was 2nd September, 2023(According to scan). She was given an ANC card and was sent for laboratory test. The results of the laboratory investigations that were carried out on her are as follows;

Hemoglobin	12.5 g/dl
Sickling test	Negative
Blood group	A
Rhesus factor	Positive
Urine for protein and sugar	Negative
PMTCT	Non-reactive
VDRL	Non-reactive
Hepatitis B	Negative
HIV status	Negative
G6PD	Negative
Stool test	No abnormality detected

Vital signs were checked and recorded as follows:

Temperature	36.1^0C
Pulse	92 bpm
Respiration	21 cpm
Blood Pressure	115/70 mmHg
Height	163cm
Weight	62kg

Records on Madam Barbara antenatal card indicated that she was examined from head to toe and no abnormality was detected. On palpation, the uterus was palpable and she was 14 weeks of gestation, the symphysio-fundal height was 12cm, there was no descent and foetal movement were present. Client was educated on danger signs of pregnancy. She gave no complaint and the following routine drugs were given;

Tablet Folic Acid	5 milligrams daily for 30 days
Tablet Ferrous Sulphate	200 milligrams daily for 30 days

Client was encouraged to take her drugs as ordered. Since booking client has been regular attendant and all findings detected no complications before client was met. (9/11/22)

CHAPTER TWO

ANTENATAL CARE

2.0 INTRODUCTION

This chapter is about the antenatal care given to the client. This includes the first contact with the client, subsequent visit to the clinic, home visits during antenatal period and the care plans drawn to solve any problem faced by the client.

2.1 FIRST CONTACT WITH THE CLIENT

The first contact with Madam Barbara was on the 14th August, 2023 when she was coming for her routine antenatal follow up at Dormaa West District hospital Nkrankwanta with $37+^{2}$ weeks gestation. Clients were educated on prevention of malaria and birth preparedness and complication readiness during pregnancy and she contributed so much during the discussion. During the antenatal session, client complained of lower abdominal pain and persistent waist pain. She was encouraged and reassured that, her condition would be managed. When it got to her turn, she came into the consulting room with her antenatal card which was collected and glanced through. An opportunity was taken and an introduction was made to her as a student midwife from Holy Family Nursing and Midwifery Training College Berekum, and an interest was expressed for client to be taken for care study which she accepted. She was encouraged not to hesitate in giving out any needed information about her problems. Her antenatal card was glanced through and her vital signs were checked and recorded as;

Temperature	36 .0^{0}C
Pulse	86 bpm
Respiration rate	20 cpm
Blood Pressure	115/70 mmHg

Weight	62kg

The results of the various laboratory investigations done were as follows

Haemoglobin	13.0grams per decilitre
Malaria Parasite	Negative

She was later sent to the palpation room for various examination to be conducted on her. Permission was sought from her to perform head to toe examination in which she consented. All the necessary requirements needed for the examination were gathered and sent to the examination room. Privacy was provided by closing the windows and shutting of the door and client was asked to empty her bladder and was assisted to undress. She sat on the couch and lied laterally. Client then assumed a supine position. Hands were washed under running water with soap and dried with clean towel.

Head to toe examination

Head to toe examination was performed on client. The hair was inspected for the presence of dandruff, lice, and infections of the scalp and none of these was seen. Client was encouraged to continue to keep her hair clean and neat always. There was no edema, or rashes on the face during examination. The ears were examined for discharges and checked if it's in alignment with the contour of the eyes. The eyes were checked for pallor and discharges. The nose was checked for discharges, the lips for cracks, pallor, dryness, sore and lesions but none was detected. The mouth was also inspected for inflammation of the gum, sore of the mouth and tooth decay but none was seen. The neck was inspected and palpated for enlarged lymph nodes, thyroid gland and distended vein or pain but none was detected.

Breast examination

Her breasts were exposed and inspected for the size and shape. The nipples for retraction, inversion or dirt but no abnormality was detected. The left breast was examined while client's left hand was placed under the head and the right hand was also placed under the head during examination of the right breast. The breasts were palpated systematically in a circular manner using the inner aspect of the fingers for any lumps and axillary lymph nodes but no abnormalities detected. She was taught how to perform self-breast examination. The nipples were squeezed gently for discharges and cleaned with swabs but no abnormality was detected. The nipples were prominent and centrally situated. She was encouraged to examine her breasts regularly and report any abnormalities earlier to the clinic.

Extremities

The upper extremity was inspected and she was asked if she feels any tingling and tightness of the fingers on making fist. The hands and fingers were also inspected for oedema, pallor of palms, nail beds and capillary refill but no deviation from the normal was detected. Symmetry of the hands were checked of which no abnormality was detected.

The lower extremities were also inspected for edema, varicose veins, calf tenderness but none was identified and they were of equal length and size.

Back

Client was asked to lie in the lateral position for the back to be examined. At the back, there was no tenderness at the costovertebral angle, scoliosis, oedema of the sacral region and also of the surrounding skin was noted and no abnormalities were identified.

Abdominal Examination

Inspection- There was no scar indicating previous operations. The abdomen was ovoid in shape, medium in size and fetal movement was seen. There was however the presence of linea nigra and striae gravidarum on her abdomen.

Measurement of symphysio-fundal height; the zero end of the measuring tape was placed on the fundus and the tape was extended along the midline to upper boarder of the symphysis pubis and the symphysio-fundal height measured 36 centimeters.

Fundal palpation – facing the head of Madam Barbara, palms were rubbed together and the fundus was palpated with both palms on either side of the fundus. The fingers curved around the top of the fundus to determine what lies in the fundus. A soft mass was felt and that indicated the buttocks.

Lateral palpation; on palpation, the right hand was used to stabilize one side of the maternal uterus, and the left hand was moved gently in a rotatory manner on the other side of the uterus where the fetal limbs (rough part) were palpated at the right side. This was repeated at the other side and the fetal back (smooth part) was felt at the left side.

Descent: Location of the anterior shoulder was done and two fingers were placed on it. The symphysis pubis was located with the right ulna border, just above the symphysis pubis and the anterior shoulder, five fingers admitted the space indicating descent of 5/5th.

Pelvic examination; this examination was done facing Madam Mavis feet. She was asked to flex her knee slightly and breathe in and out slowly. The palms were placed just below the level of the umbilicus with the fingers directed towards the symphysis pubis and thumb almost meeting, a hard mass was felt at the lower pole which indicates the foetal head.

Auscultation: On auscultation, the fetal stethoscope was warmed and placed at the area wherefoetal back was located to listen to the foetal heart rate. With one hand at the maternal radius to ensure that it is not the maternal pulse being listened to, the foetal heart rate was checked for one minute which was 138 beats per minute.

Vulva examination- Permission was sought to inspect the vulva of the woman and she agreed. The procedure was explained to the client and privacy was provided. Client was helped to assume the lithotomy position. Mons pubis was nicely shaved. There were no warts, ulcer of the vulva, discharges, varicose veins, oedema or rashes on examination. She was encouraged to continue practicing good vulva hygiene. Client was asked to assume lateral position and sit up before getting out of bed. Hand washing was done under running water and dried with a clean dry towel.

All findings were recorded in her antenatal record book and communicated to her as well. She was asked if she had any complain and she complained of waist pains and lower abdominal pains. It was explained to her that the waist pains and the lower abdominal pains were as a result of the foetal head descending into the pelvis during the latter end of pregnancy. She was educated not to stand for longer periods but should have moments of relaxation in between activities and should avoid lifting heavy loads. She was informed of her next date of visit to the clinic which was on the 21st August, 2023. Client was encouraged to visit the hospital if she feels unwell before the scheduled date. Her address was taken for home visits which she accepted and gave directions to her house as well as telephone number.

Her routine drugs were given as;

Tablet Folic Acid	5 milligrams daily for 10 days
Tablet paracetamol	1gram tid for 3 days
TabletFerrous Sulphate	200milligram daily for 10days.

She was escorted as she left the facility to her house.

2.2 FIRST ANTENATAL HOME VISIT

Physical environment

On 14th August, 2023 at 5:00pm, client was visited in her house as arranged. The main purpose was to check on how she was doing and to observe her surrounding, condition of the house, relationship with family and neighbours. Client stays at Nkrankwanata, at the back of the market near a printing press. The distance to client's house is about 15 minute's walks from the clinic.

On arrival, pleasantries were exchanged, seat and water were offered and a brief introduction was made since she was already aware of the visit.

Client's husband wasn't around but her child who happened to be a boy was with her.

Madam Barbara, her husband and child were happily living in a 7 bed- room compound house of which they were occupying one room. The compound was neat, no stagnant water or choked gutters and the refuse were kept in a dust bin, neatly covered and she empties it whenever it's full at the community refuse dump. There was a pipe in the house, she fetches it and store in a clean container with lid, and their source of light was electricity. According to client, she stays in the house with her husband and child and other neighbours. Client has a trap door in addition to her main door and her windows are made of louvers of which both the door gate and windows are covered with net to prevent mosquitoes from entering the room.

The bathroom and toilet were very neat which she said they scrubs every Saturday, the bathroom and toilet were built within the house.

Client does her cooking at her kitchen. The room is very spacious and well ventilated. Client's layette was inspected and everything was intact with the exception of antenatal card

and health insurance. The items were neatly arranged in a medium-sized travelling bag and they included items such as; cot sheets, baby's clothing including socks and cap, perineal pads, toilet rolls, rubber (mackintosh) for delivery, cloths, and many more. She was also educated on true labour signs such as appearance of "show" and painful rhythmic regular contractions. Client was asked to add her antenatal card and health insurance to the layette. Madam Barbara was then appreciated for the warm reception and permission was sought to leave and next visit scheduled to be on the 16/08/2023 and was then seen off by client.

PSYCHOSOCIAL

It was observed that client relates well with the other neighbors and also attends every funeral ceremony, weddings the community undergoes and also participates in the activities of the community. She is jovial and does not have problems with her neighbours

2.3 SECOND ANTENATAL HOME VISIT

Client was visited the second time on the 16/08/2023 around 4:00pm. A seat and water were offered upon arrival after the exchange of pleasantries. She complained of constipation and heartburns after meals and she was educated not to take much oily food especially in the evenings and should always eat in bits and early for digestion to take place before she goes to bed and also, she was encouraged to avoid taking spicy foods. The layette was again inspected and everything was intact.

Enquiries were made about the support person who would take her to the hospital when labour sets in and she said her sister. She was also encouraged to make an arrangement with a taxi driver who would take her to the clinic when the need arises. Permission was sought to leave and she was reminded of the next visit to the facility which will be on the 21/08/2023

2.4 SUBSEQUENT VISIT TO THE CLINIC

On 21/08/2023, Madam Barbara came for her next antenatal visit as scheduled. She was warmly welcomed and offered a seat to rest for a while. Client's vital signs and other records were checked and recorded in her antenatal record book as;

Temperature	36.8^0C
Pulse rate	84 bpm
Respiratory rate	20 cpm
Blood Pressure	113/73 mmHg
Weight	63 kilogram

After the recording of the vital signs, permission was sought to perform a head to toe examination which she agreed. She was asked to empty her bladder and urine was checked for protein and sugar but was negative/negative and after that, she was sent to examination room. She was assisted unto the couch for examination. Hands were washed under running water with soap dried with clean towel. Head to toe examination was done and no abnormality was detected. Symphisio-fundal height 37cm, lie longitudinal, and presentation, cephalic, descent $5/5^{th}$ foetal heart rate was 138 on auscultation. Her gestational age was $38+^2$weeks. She was then congratulated, asked to lie left side, sit and then get up from the examination bed. A seat was offered to her and findings were communicated to her.

She complained of inadequate sleep and she was educated to take a warm bath and warm drink before going to bed. Client was seen off.

2.5 ANTENATAL NURSING CARE PLAN

Nursing care plan is a guideline to nursing action in order to promote individualized care and continues care of the client. It involves identification of problems, making of nursing

diagnosis of the problems identified, setting of objectives regarding the client, taking actions to solve the problems identified and evaluating the objectives that were set.

PROBLEMS IDENTIFIED DURING ANTENATAL CARE

Client complained of

2. Lower abdominal pains on the 14th August, 2023.

3. Constipation on the 21st August, 2023.

4. Heart burns on the 21st August, 2023.

5. Inadequate sleep on the 21st August, 2023.

SHORT TERM OBJECTIVES

1. Client will understand and cope with reduced waist pains within 48 hours.

2. Client will cope with reduced lower abdominal pain within 48 hours.

3. Client will be able to empty her bowel once daily within 24 hours.

4. Client's heart burns will resolve within 48 hours.

5. Client will have at least 2hours sleep during the day and 6 hours at night within 48 hours.

LONG TERM OBJECTIVE

Madam Barbara will go through pregnancy, labour and puerperium successfully without any complications to both mother and foetus.

ANTENATAL NURSING CARE PLAN

DATE/ TIME	NURSING DIAGNOSIS	OBJECTIVE/OUT COME CRITERIA	NURSING ORDERS	NURSING INTERVENTIONS	DATE/ TIME	EVALUATION	SIGN
14/08/23 9:00am	Waist pain related to relaxation of the pelvic joints.	Client will understand and cope with reduced waist pains within 48hour as evidenced by; client verbalizing that waist pain has subsided and the midwife observes client perform activities of daily living.	1.Reassure client that the pain is temporal and hence will resolve. 2.Encourage client to assume proper body mechanic when lifting. 3.Ask client to rest in between activities. 4.Encourage client not to assume the same position for a long time. 5.Encourage client to take prescribed analgesics.	1.Client was reassured that the pain is temporal and hence will resolve. 2.Client was encouraged to bend from knee instead of waist. 3.Client was asked to rest in between activities. 4. Client was encouraged not to assume the same position for a long time. 5.Client was encouraged to take prescribed analgesis.	16/08/23 9:00am	Goal fully met as client verbalized that she was able to cope with waist pain and midwife observed client performing her daily living activities.	A.B. A

ANTENATAL NURSING CARE PLAN

DATE/ TIME	NURSING DIAGNOSIS	OBJECTIVE/OUT COME CRITERIA	NURSING ORDERS	NURSING INTERVENTIONS	DATE/ TIME	EVALUATION	SIGN
14/08/23 10:00am	Lower abdominal pain related to descent of the fetal head.	Client will cope with lower abdominal pain within 48 hours as evidenced by; client verbalizing that pain has reduced and midwife observing that client is comfortable doing her activities.	1.Reassure client to allay anxiety that pain will reduce. 2. Explain the physiology of lower abdominal pain to client. 3. Teach client how to manage her pain. 4. Teach client deep breathing exercise. 5. Serve client with prescribed analgesics.	1. Client was reassured to allay anxiety that pain will reduce. 2. Physiology of lower abdominal pain was explained to client 3. Client was taught how to manage her pain. 4. Client was taught deep breathing exercise. 5. Client was served with prescribed analgesics.	16/08/23 10:00am	Goal fully met as client verbalized that she was able to cope with the lower abdominal pain and midwife observed client performing her daily activities without complaining.	A.B. A

ANTENATAL NURSING CARE PLAN

DATE/ TIME	NURSING DIAGNOSIS	OBJECTIVE/OUT COME CRITERIA	NURSING ORDERS	NURSING INTERVENTIONS	DATE/ TIME	EVALUATION	SIGN
21/08/23 8:00am	Constipation related to the activity of progesterone causing decreased peristalsis and relaxation of the smooth muscle of the bowel during pregnancy	Client will pass stool once within 24 hours as evidenced by; Client verbalizing that she has no difficulty in emptying her bowel and client's husband verbalizing that the wife does not complain of difficulty in emptying her bowel.	1. Reassure client to alley anxiety and that she will be able to release her bowels. 2. Explain the physiology of constipation to client. 3. Educate client on fluid intake. 4. Educate client on diet. 5. Encourage client to ambulate.	1. Client was reassured to alley anxiety that she will be able release her bowels. 2. Physiology of constipation was explained to client. 3. Client was educated on fluid intake. 4. Client was educated on diet. 5. Client was encouraged to ambulate.	22/08/23 8:00am	Goal fully met as client verbalized that she has been able to empty her bowel once.	A.B. A

ANTENATAL NURSING CARE PLAN

DATE/ TIME	NURSING DIAGNOSIS	OBJECTIVE/OUT COME CRITERIA	NURSING ORDERS	NURSING INTERVENTIONS	DATE/ TIME	EVALUATION	SIGN
21/08/23 9:00am	Heart burns related to relaxation of the cardiac sphincter of the GIT due to effects of progesterone.	Client's heartburns will resolve within 48 hours as evidenced by; client verbalizing that she is relieved of the burning sensation in her chest and midwife visualizing that client no more complains of heart burns.	1. Reassure client that the condition can be managed. 2. Educate client on the cause of heart burns. 3. Encourage to relax for some time before lying down to sleep after eating. 4. Ask client to reduce the intake spicy foods. 5. Educate client to eat early.	1. Client was assured that the condition can be managed. 2. Client was educated on the cause of heart burns. 3. Client was encouraged to relax for some time before lying down to sleep after eating. 4. Client was asked to reduce the intake of spicy foods. 5. Client was educated to eat early.	23/08/2023 9:00am	Goals fully achieved as client verbalized, she is relieved of burning sensations in the chest and midwife observed a cheerful facial expression.	A.B. A

ANTENATAL NURSING CARE PLAN

DATE/ TIME	NURSING DIAGNOSIS	OBJECTIVE/OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTIONS	DATE/ TIME	EVALUATION	SIGN
21/08/23 9:00am	sleep pattern related to frequency of micturaton.	Client will have at least 2 hours of sleep within the day and 6 hours at night within 48hours as evidenced by; client verbalizing her ability to have 2 hours sleep during the day and 6 hours at night and midwife observes client appears refreshed or revived.	1. Reassure client that the condition can managed. 2. Encourage client to reduce the distance taken to void and get a bed pan or pal by her bed side 3. Encourage client to empty her bladder completely when voiding. 4. Encourage client to limit intake of fluid containing natural diuretics. 5.Encourage client to void frequently	1. Client was reassured that something can be done about her sleeping pattern. 2. Client was encouraged to reduce the distance taken to void by getting a pal by her bed side. 3. Client was encouraged to empty her bladder completely when voiding. 4. Client was encouraged to limit intake of fluid containing natural diuretics. 5. Client was encouraged to void frequently.	23/08/23 9:00am	Goals fully met as client verbalized that, she was able to sleep 2 hours during the day and 6 hours during the night.	**A.B.** **A**

CHAPTER THREE

LABOUR

3.0 INTRODUCTION

This chapter gives information about labour, admission and management of the various stages of labour. It emphasizes on the partograph, immediate care of the newborn, subsequent care of the newborn, examination of the newborn and care plans drawn for the management of the problems encountered during this period.

3.1 ADMISSSION AND MANAGEMENT OF FIRST STAGE OF LABOUR

Admission

On 30th August, 2023 at 3:30 am, client arrived at the Dormaa West District hospital Nkrankwanta with Madam Mary (her sister) per ambulatory. They were warmly welcomed and seats offered to them. She complained of severe lower abdominal pains and waist pains. Madam Barbara said she had noticed some mucoid blood stain vaginal discharge (show) before coming. She was taken to the delivery room, and her sister was given a chair to sit outside at the visitor's lunge. At the delivery room, client was oriented and wash room shown to her, she was offered bed. Procedures to be done were explained to her and consent was gained. Her vital signs were checked and recorded as follows;

Temperature	36.6^0C
Pulse rate	80bpm
Respiration rate	20cpm
Blood Pressure	110/70 mmHg

A specimen bottle was given to client for the midstream urine collection for urine examination and a bed pan was also served. The amount of urine produced was 140mls. A urine reagent strip was used to test for acetone and protein and the results were negative and the colour of urine was amber, clear and not offensive. She was assisted unto the couch, after changing into gown hands were washed under running water and dried with a clean dry towel. Client was examined from head to toe and no abnormalities were detected.

Inspection; The abdomen was ovoid in shape and medium in size. Striae gravida and linea nigra were seen on the abdomen. And the foetal movement were present but no scar was found.

Palpation; The symphysio-fundal height was 38 centimeters. The fetal buttocks were felt occupying the upper pole of the uterus. The fetal limbs were palpated at the right side whilst the fetal back was felt on the left side and with a gestational age of 39 weeks + 2days. On pelvic palpation, the lie was longitudinal and the presentation was cephalic. Examination for decent indicated a descent of 3/5th.

Auscultation; The foetal heart rate was 145 beats per minute then contractions were timed for 10 full minutes by placing the palm on the fundus and it was two in ten (10) minutes lasting for thirty (30) seconds each.

Vaginal Examination; A tray already set had two sterile gloves and two sterile gallipots with one containing sterile cotton while the other contained savlon, a receiver for the used swabs and a clean perineal pad. Client was assisted to assume a dorsal position with the knees flexed and a mackintosh and towel placed under client. Hands were washed with soap under running water and dried with a clean dry towel. A pair of sterile gloves were worn and client was draped afterwards. She was asked to flex her knees and expose vulva.

The Mons pubis was neatly shaved; there were no sores, rashes, varicose veins, and oedema of the vulva, vulva warts and no perineal scars from previous episiotomy or tears. Five sterile cotton wool swabs were used for swabbing. The dominant hand was used to pick the cotton wool and dipped into the savlon, swab was dropped from the right hand into the left hand and swabbed per stroke from upward starting with the labia majora and swabbed downwards and the used swab was disposed of. The labia minora was swabbed also from upward to downward and the used swab was disposed into a receiver. The labia minora was separated to pat the vestibule using the non-dominant hand. A swab was used to wipe the vestibule downward and the used swab was disposed into the receiver. Using the right hand, the middle and index fingers were inserted gently into the vagina pressing firmly downwards. The vagina was warm and moist, ischial spines were blunt, the sacrum was well curved, and the sacral promontory was not reached. The cervix was soft and thin and four (4) centimeters dilated with membranes intact and there was no moulding. The presenting part was cephalic and well applied to the cervix. Hands were removed and observed but nothing abnormal was seen. The Midwife in charge was asked to confirm the dilatation. A clean perineal pad was applied on the vulva and client was asked to lie on her left side to prevent supine hypotension syndrome. Client was tidied up neatly and placed in a comfortable position. Gloves were dipped in 0.5% chlorine solution and removed inside out. Hands were washed with soap under running water and dried with a dry clean towel. All findings and the progress of labour was explained client. The dilation board was used to explain the cervical dilation and the progress of labour to her. She was thanked for her cooperation. And all information gathered was recorded on a partograph sheet around 4:00am.

Preparation for birth

During the preparation for birth, 2 helpers were identified, that is skilled and unskilled helper. The skilled helper was the Midwife-In-Charge who would supervise labour and delivery as

well as the care of the baby. The unskilled helper who was the client's sister would assist in times of need. The emergency plan was reviewed by calling a taxi driver, he was informed that he would be called in case of any emergency and his number was kept. The contact numbers of the referral hospital were active when checked. Client was informed that after delivery, baby will be placed on her chest for skin to skin contact for one hour of which she responded positively. Mother's hands were washed with soap and water and her abdomen and chest were washed with savlon in preparation for skin-to-skin care prior to the second stage of labor. The area for delivery was also prepared. Madam Barbara was told that, the windows and doors would be closed and fan put off when delivery is eminent to provide warmth for the baby. There was adequate lighting and a portable light was available. Hands were washed thoroughly with soap under running water. A dry, flat resuscitation area was prepared and equipment's were tested in case the baby will need any ventilation. Equipment assembled to prepare for birth included the following; sterile gloves, cot sheets, scissors, cord clamps, suction device, ventilation bag and mask, stethoscope, timer (second hand), head covering. The delivery set and emergency drugs were all checked and they were available and ready for use when needed.

3.2 MANAGEMENT OF FIRST STAGE OF LABOUR

When the preparation for birth was done, contractions, pulse and foetal heart rate were monitored every 30 minutes whiles dilatation, descent, temperature and blood pressure were monitored every 4 hours and recorded on the partograph to detect any deviation from normal. Client was having nausea and vomiting. She was educated not to use her perineal pad when it falls. She was encouraged to breathe through her mouth when there was contraction and also to avoid pushing during contractions since the cervix was not fully dilated and to prevent edematous cervix. Bedpan was provided for her to empty her bladder frequently to enhance

effective contraction and descent of the fetal head since full bladder slows down the progress of labor.

She complained of fatigue, she was reassured everything will be alright. All findings and the progress of labor were explained to client. She was encouraged to change her perineal pad when soaked and walk around to facilitate descent and cervical dilatation. Client was made comfortable and encourage to ambulate.

At 8:00am, client was due for next vaginal examination, she was assisted to assume a lithotomy position for the examination. On vaginal examination, the vagina was warm and moist, membranes were still intact cervix was 8cm dilated with a well applied presenting part, moulding was (+), and descent was $1/5^{th}$. On auscultation foetal heart rate was 140 beats per minute with good volume. Contractions were 3:10, 4:10, 4:10 lasting 40 seconds and 45 seconds respectively. These findings were confirmed by the midwife in charge. Hands were washed with soap under running water and dried with a clean dry towel. All findings were plotted on the partograph.

Vital signs were checked and recorded as:

Temperature	36.5^0C
Pulse	76 beats per minute
Respiration	23 cycles per minute
Blood pressure	110/70mmHg

The following investigation were also done and recorded as follows:

Urine for albumin	Negative
Urine for acetone	Negative
Urine for glucose	Negative

Urine passed was 120mls. Client was cleaned up, a new pad was applied to the perineum. She was made comfortable in bed for further monitoring and observation. All findings were communicated to client.

Delivery trolley was set with items on the top shelf including; two artery forceps, one cord scissors, four sterile towels, two gallipots with cotton wool swab and gauze, one receiver, episiotomy scissors. Items on the bottom shelf also includes; a jug for measuring the amount of blood loss, receiver for placenta, container with syringes and needles, fethoscope, an oxytocin drug, antiseptic lotion [savlon], sterile gloves, extra perineal pad, small bowel of water and a sucker [penguin], cord clamp, urethral catheter and drainage bag, identification band, examination gloves mackintosh, cot sheet, drum containing gauze and cotton wool, cheatle forceps in its container.

At 10:00am, there was spontaneous rupture of membranes, vaginal examination was done to exclude cord prolapse and to confirm full dilatation of the cervix, liquor was clear. On vaginal examination, the vagina was warm and moist, the cervix was 10centimeters (cm) dilated and well applied to the presenting part, moulding was ++, descent was $0/5^{th}$ above the pelvic brim. Hands were washed with soap under running water and dried with a clean dry towel. Client was informed of full dilation of the cervix.

3.3 MANAGEMENT OF THE SECOND STAGE OF LABOUR

Client was assisted to assume the lithotomy position. Rubber apron, boots, goggles, mask and head scarf were worn. Hands were washed with soap under running water and dried with clean dry towel. Privacy was provided. 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. Delivery pack was opened and a pair of sterile gloves was worn. The vulva and inner thighs were swabbed with sterile cotton balls soaked in savlon solution.

Client's abdomen and thighs were draped with a sterile dry towel. Client was informed again that the baby would be delivered onto her abdomen. She was again encouraged to push with contractions, rest in between contractions and adhere to instructions at this stage. A clean perineal pad was applied to the perineum to prevent fecal matter from contaminating the baby's face. The index and middle fingers were placed on the fetal head as it advanced to aid flexion to allow the smallest diameter to distend the vulva. This was done to prevent perineal lacerations and intracranial injury to the baby. When foetal head crowned, client was asked to pant with contraction. The occiput escaped the pubic arc and with extension of the head, the sinciput, face and chin swept the perineum and the head was born. Two fingers were passed around the neck to feel for cord around neck but there was none. The baby's face was cleaned and eyes were wiped inside out with sterile gauze. Restitution took place, thus there was external rotation of the head and internal rotation of the shoulders. The head of the fetus was held in both palms on each side of the bi-parietal bones and a downward traction was applied to allow the anterior shoulder to be slipped under the pubic bone. The posterior shoulder was delivered by an upward traction towards the mother's abdomen. The rest of the baby's body was delivered by lateral flexion onto the mother's abdomen to provide warmth and to create bonding. The Midwife In charge who was supervising the delivery noted the time of delivery as 10:40am. A healthy baby girl was delivered and sex confirmed by mother. Madam Barbara was congratulated for her effort and co-operation.

3.4 IMMEDIATE CARE OF THE BABY AT BIRTH

As soon as the head was born, baby's face was wiped with sterile gauze. The eyes were swabbed from the inner canthus to the outer canthus with different sterile cotton wool swabs. The index and the middle finger of the dominant hand were slide around the neck of baby to feel for cord around the neck which was absent.

The baby was not suctioned because the airway was clear and baby cried immediately. The APGAR score at the end of the first minute of birth was quickly assessed as 8/10. The umbilical cord was clamped 3 fingers breaths away from the baby's abdomen and 2 fingers breaths away from the first clamp the cord was covered with sterile gauze and cut in between the two clamps to separate the baby from the mother. The fifth APGAR score was 9/10. 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 of baby, 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.

Time	**Color**	**Breath**	**Heart**	**Tone**	**Reflex**	**Total**
1 minute	2	2	2	1	1	8/10
5 minute	2	2	2	1	2	9/10

3.5 ACTIVE MANAGEMENT OF THIRD STAGE OF LABOUR

Client still in the lithotomy position, a gentle palpation was done on the uterus to exclude undiagnosed foetus but there was none. Ten (10) units of oxytocin was given intramuscularly on the thigh to aid in the contraction of the uterus, the cord was clamped near the perineum with the artery forceps with a receiver placed in between the mother's thighs to receive the placenta. The clamped cord was held with the dominant hand whiles the non-dominant hand was placed above the fundus to feel for contractions. When a uterine contraction was felt, the non-dominant left was placed on the lower abdomen in the supra pubic area just above the symphysis pubis and counter traction applied to support the uterus to prevent uterine inversion whiles controlled cord traction was used in delivering the placenta until it was visible at the introitus. The non-dominant hand was released and both hands were used in

receiving the placenta and gentle twisting movement was made to ease pressure on the membranes till fully. The placenta and its membranes were delivered at 10:45am. 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 haemorrhage 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. Client was cleaned and made comfortable by applying a clean perineal pad to the perineum to absorb lochia drainage. The mother and baby were covered with a piece of cloth to ensure an hour effective skin to skin contact.

Madam Barbara was encouraged to empty her bladder whenever she has 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 made comfortable in bed and congratulated for the effort made. All findings were recorded on the partograph.

3.6 EXAMINATION OF THE PLACENTA AND MEMBRANES

The placenta was placed in 0.5% chlorine solution before thorough examination. The placenta was placed on a flat surface. On inspection, a sterile gauze was used to wipe the tip of the cord and checked. There was one big vein and two arteries in the cord with no abnormality detected. The cord was situated at the centre of the placenta. No knots were found in the cord. On examination of the maternal surface, it was dark-red in colour. There was no missing lobe. The placenta was held by the cord, allowing the membranes to hang down. A hand was inserted into the hanging membranes to spread it out and to aid in inspection of the membranes. The amnion was peeled from the chorion and examined. They

were both intact. The fetal surface was smooth, shiny and bluish-grey in color and with no abnormality. Both placenta and membranes were complete and was therefore discarded. After this, the items used for delivery were decontaminated in 0.5% chlorine solution for 10 minutes. Items were then washed, rinsed, dried and packed for sterilization. Hands were then washed with antiseptic soap under running water and dried with clean dry towel. Amount of blood loss was 140 milliliters. Findings were discussed with client and the necessary documentations were made. Madam Barbara was thanked once again for her effort and cooperation.

3.7 MANAGEMENT OF FOURTH STAGE OF LABOUR

This is the period of the six [6] hours following the birth of the placenta and its membranes and control of hemorrhage. It is also described as the critical moment of puerperium during which most complications can occur and therefore involves close monitoring of mother and baby. Madam Barbara and her baby were assisted and taken into the lying-in ward where they were closely observed for six hours after a successful completion of the third stage of labor. During this stage, the mother and the baby were assessed in every 15 minutes for 2 hours, 30 minutes for an hour and hourly for three hours which was recorded behind the partograph to detect any deviation from normal. Client vital sign were checked and recorded as fellows;

Temperature	36.7^0C
Pulse	80bpm
Respiration	22cpm
Blood Pressure	120/70mmHg

Prevention of disease

This was done within the first 90 minutes after delivery since the baby can contract infection during birth and the eye infection can lead to blindness. Hand washing was performed and dried with a clean dry towel, chloramphenicol eye drop was instilled onto the lower eyelids of the baby. The umbilical cord was dressed with cotton wool swabs and methylated spirit to prevent cord infection. Vitamin K 1 milligram was administered intramuscularly to prevent hemorrhagic disease of the new born. Mother was educated not to put any herbs on the cord and how to dress the cord. Hands were then washed with soap under running water and dried with a clean dry towel.

EXAMINATION OF THE NEWBORN

Procedure was explained vividly to client, examination gloves were worn and baby was examined from head to toe to see if there is any deviation from normal. Baby was put on a flat surface, undressed and covered with cloth. Baby was partially exposed and , respiration and skin colour was noted and the baby was covered again to be examined from head to toe.

Head and neck: On examination of the head, the index and middle fingers was run through the suture line to check for any bulging fontanelles but no abnormality was detected. There was no laceration on the scalp and no caput succedaneum. The ears were examined for size, shape, patency, position, softness of the cartilage but no abnormality was detected. The eyes were in alignment with the ears and presence of an eyeball. There was no redness of the conjunctiva or jaundice on the sclera. The nose was examined for shape, size, patency to rule out deviated septum and discharges but everything was normal. The mouth was examined for the presence of false teeth, cleft palate and tongue tie but there was none. Rooting, suckling and swallowing reflexes were present. There was no rigidity, congenital goitre and swelling of the neck.

Chest and abdomen: On the chest, respiratory movement was normal, and on breast examination there was no engorgement of the breast, had no masses on palpation and the nipple was inspected for position, extra nipple and everything was normal. There was no exomphalous, distention of the abdomen, and on palpation there were no enlarged spleen or liver as well as bleeding of the cord. There were three blood vessels that run through the cord which indicated two arterial cord vessels and a cord vein, abnormalities such as omphalocele and gastroschisis were absent. The skin was examined for skin color, vernix caseosa, and lanugo, peeling of the skin, rashes and birth mark but no abnormality detected.

Limbs: The upper extremities were equal with no extra digits. There were palmer creases and, no webbed fingers. Grasping and Moro reflexes were present. Hands and arms were inspected for movement, paralysis, nail beds were checked for capillary refill and everything was normal. The lower extremities were examined for equality, extra or missing digits, clubbed feet but no abnormality was detected. Congenital hips dislocation was checked using the ortolani's test. There was no dislocation since a 'clunk' was not heard.

Back: Baby was turn to the left side and on inspection there were no rashes, discolouration and hairy patches, the back was also palpated with the thumb to rule out spinal bifida or a missing vertebra but there was none.

Genitalia: 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 (32), length of baby (47) 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.

3.8 SUMMARY OF LABOUR

Client had a spontaneous vaginal delivery to a live female baby on 30th August, 2023 at 10:40am with birth weight 3.0kg with APGAR score 8/10 and 9/10. Placenta and membranes were completely delivered at 10:45am by controlled cord traction. Estimated blood loss was140mls. Condition of mother and baby was satisfactory and they were made comfortable in bed.

CONDITION OF BABY AT BIRTH

The general examination of baby was done and no abnormalities detected.

Temperature	36.2^0C
Respiration	42 cycles per minute
Apex beat	130 beat per minute
Weight	3.0 kilogram
Length	47centimeters
Head circumference	32centimeters
Sex	Female

APGAR score for the first and fifth minute of birth was 8/10 and 9/10 respectively.

Meconium	Passed
Urine	Passed
General condition	Very Good
Abnormalities	None detected

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	36.7^0C
Pulse	80 beats per minute
Respiration	20 cycles per minute
Blood pressure	120/60 millilitres of mercury
Symphysio fundal height	17 centimetres
Blood loss	140 millilitres
Perineum	Intact
Lochia	Rubra
Odour of lochia	Non offensive
General condition	Very good

3.9 LABOUR CARE PLAN

PROBLEMS IDENTIFIED DURING LABOUR:

On the 30th August, 2023 client made the following complains;

1. Lower abdominal pains

2. Waist pains

3. Nausea and vomiting

4. Fatigue

On the 30th August, 2023 client was at

5. Risk for fluid volume deficit

SHORT TERM OBJECTIVES

1. Client will understand and cope with lower abdominal pain within 2 hours.

2. Client will cope with waist pain within 1 hours.

3. Client will stop vomiting within 2 hours.

4. Client will be relieved of with fatigue within 1 hour.

5. Client will maintain adequate fluid volume throughout the second stage of labour.

LONG TERM OBJECTIVE

Client 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/OUT COME CRITERIA	NURSING ORDERS	NURSING INTERVENTIONS	DATE/ TIME	EVALUATION	SIGN
30/08/23 4:00am	Lower abdominal pains related to uterine contractions.	Client will cope with lower abdominal pains throughout the first stage of labour within 2 hours of labour as evidenced by; client verbalizing she is understand the pain and midwife observing client is coopreating	1. Reassure client that the pain will stop after delivery. 2. Involve client in a diversional therapy. 3. Encourage her to adopt a comfortable position that supports labour and delivery. 4. Encourage client to do deep breathing exercise. 5. Perform sacral massage for client	1. Client was reassured that the pain will stop after delivery. 2. Client was involved in a diversional therapy. 3. Client was encouraged to adopt a comfortable position that support labour and delivery. 4. Client was encouraged to do deep breathing exercise. 5. Sacral massage was performed for client.	30/08/2023 6:00am	Goal fully met as client verbalized that she is coping with pain and midwife observed client is copeerating	A.B. A

LABOUR CARE PLAN CONTINUED

DATE& TIME	NURSING DIAGNOSIS	OBJECTIVES/ OUTCOME CRITERIA	NURSING ORDER	NURSING INTERVENTION	DATE& TIME	EVALUATION	SIGN
30/08/23 4:00am	Waist pain related to pressure on the sacral nerves, ligament, and descent of the foetal head.	Client will cope with reduced waist pain within 1 hour of labour as evidenced by; client verbalizing her ability to cope with waist pain and midwife observing a relaxed facial expression	1. Reassure client the condition is temporal. 2. Explain the physiology behind waist pain in labour to client. 3. Massage client sacral region. 4. Encourage her to assume a comfortable position. 5. Teach and encourage client to do deep breathing exercise.	1. Client was reassured that the condition is temporal. 2. Physiology behind waist pain was explained to client. 3. Client's sacral region was massaged. 4. Client was encouraged to assume a comfortable position. 5. Client was encouraged to do deep breathing exercise.	30/08/23 5:00am	Goal fully met as client reported that she has been able to cope with reduced waist pain. And midwife observing a relaxed facial expression.	A.B. A

LABOUR CARE PLAN CONTINUED

DATE/ TIME	NURSING DIAGNOSIS	OBJECTIVES/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
30/08/2023 8:00am	Nausea and vomiting related to reduced digestion during labour.	Client will stop vomiting within 2 hours as evidence by; client verbalizing she is not vomiting anymore and midwife visualizing the stop of vomiting.	1. Reassure client that the nausea and vomiting will stop after delivery. 2. Hydrate client with infusion 3. Ensure oral hygiene. 4 .Remove nauseating objects. 5. Serve client with light meals to maintain her nutritional needs.	1. Client was reassured that the nausea and vomiting will stop after delivery. 2. Client was hydrated with infusion. 3. Oral hygiene was ensured. 4. Nauseated objects were removed from client bed side 5. Client was served with nutritional food.	30/08/2023 10:00am	Goal fully met as client verbalized that she is no longer vomiting. And midwife visualizing the stop of vomiting.	A.B. A

LABOUR CARE PLAN CONTINUED

DATE/ TIME	NURSING DIAGNOSIS	OBJECTIVES/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
30/08/23 8:00am	Fatigue related to stressors of labour pains and contractions	Client will be relieved of fatigue within 1 hour as evidenced by; client will regain strength to push during the second stage of labour and midwife observing client is able reamin strong and psuh during labour.	1.Reassure client that is she will have energy to push 2. Explain to client why she feels tired. 3. Give client iv infusion and malt to take and ensure nutrition 4. Encourage client to rest in between contractions. 5. Advice client to reduce shouting to prevent maternal exhaustion.	1. Client was reassured that she will have energy to push. 2. Client was taught why she feels tired. 3. Client was given iv and malt to take and nutrition was ensured. 4. Client was encouraged to rest in between contractions. 5. Client was advised to reduce shouting to prevent maternal exhaustion.	30/08/2023 9:00am	Goal was fully met as evidenced by midwife visualizing that client is able to push at the second stage.	A.B. A

LABOUR CARE PLAN

DATE/ TIME	NURSING DIAGNOSIS	OBJECTIVES/OUT COME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
30/08/23 8:00am	Risk for fluid volume deficit related to profuse sweating.	Client will maintain adequate fluid volume throughout the second stage of labour within 12 hours as evidenced by; client showing no signs of dehydration and midwife observing client is not dehydrated.	1. Reassure client that her fluid volume will be maintained. 2. Serve sips of nourishing drinks at regular interval. 3. Wipe client's face and body with cool damp towel. 4. Monitor client's intake and output. 5. Observe client for signs of dehydration such as dry and cracked lips.	1. Client was reassured that her fluid volume will be maintained. 2. Client was served with nourished drinks at regular interval. 3. Client's face and body were wiped with a cool damp towel. 4. Client's intake and output was monitored on a chart. 5. Signs of dehydration such as dry and cracked lips were observed.	30/08/23 8:00pm	Goal fully met as client showed no signs of dehydration. And midwife observing client did not show signs of dehydration.	A.B. A

CHAPTER FOUR

PUERPERIUM

4.0 INTRODUCTION

This chapter talks about the management of both mother and baby and the family at delivery of placenta to six weeks. Attached with care plans drawn for the management of problems identified during puerperium.

4.1 DAY OF DELIVERY

Madam Barbara had a spontaneous vagina delivery to a live female child at 10:40am on the 30th August, 2023. Client and the baby were cleaned neatly and transferred to the lying-in ward where her baby was wrapped nicely to prevent heat loss and put beside her after the third stage of labour. She was encouraged to empty her bladder frequently in order to prevent the occurrence of any postpartum haemorrhage early ambulation was emphasized to promote effective circulation and drainage of lochia. She was encouraged to change perineal pad when soaked to prevent ascending infection. Emphasis was also made on proper hand washing before and after breastfeeding or handling of the baby, after visiting the toilet, changing her perineal pad and changing of baby's soiled napkins or diapers. The following were her vital signs:

Temperature	36.3^0C
Pulse	80 bpm
Respiration	20 cpm
Blood Pressure	120/60 mmHg

The vital signs were monitored for every 15minutes for 2hours, 30minutes for 1hour and 1hour for 3hours.

Baby's vital signs

Temperature	36.2^0C
Pulse	130bpm
Respiration	42cpm

The symphysio-fundal height was 17 centimeters. Lochia was red, odorless and moderate. Throughout the six hours spent, client's vital signs were checked 15 minutes for 2 hours, 30 minutes for 1 hour and hourly for 3 hours to help assess the health of the client and all were recorded on the partograph

4.2 FIRST BABY BATH AND CORD DRESSING

SUBSEQUENT CARE OF BABY

Requirements for baby bath and cord dressing

Top shelf

Methylated spirit

Sterile cotton wool swabs and gauze in a gallipot

Baby's sponge

Baby's diapers

Baby's dress

Baby's soap in a soap dish

Baby's towel and cot sheet to wrap the baby.

Bottom Shelf

Jug of hot water

Disposable gloves

Jug of cold water

Bowl of mixing water

Pomade

Surgical gloves and mackintosh.

After six hours of birth, procedure was explained and consent was sought from Madam Barbara on the need for the baby to be bathed and she responded positively. Plastic apron was then worn, hands were washed with soap under running water and then dried with a clean dry towel. Cold and hot water were mixed and the elbow was used test for its temperature. Gloves were worn and the baby was placed on a protected warm flat surface, undressed and covered with the towel leaving the face. The eyes were cleaned with a sterile cotton, dipped in sterile water from the inner contours outwards and disposed off into a receiver. The face was cleaned with a wet face towel. The nape of the neck was supported with the left palm and the ears were plugged with the thumb and index finger to prevent water from entering the ears. The baby's head was washed in a circular motion with a soapy sponge after which it was rinsed out and dried with a towel. Baby was bathed, paying particular attention to the skin folds. The whole body was gently immersed in the water with the head supported above the water level. Baby's body was dried with towel paying attention to the skin folds. Vaseline was smeared all over the baby's body to provide warmth. The baby was then dressed up with cord left exposed. Gloves were removed, hands washed and dried with a clean towel.

CORD DRESSING

Sterile gloves were worn, and the clamp of cord was observed for looseness. Cord was inspected for bleeding but there was no bleeding. The cord was dressed with cotton wool swabs soaked in methylated spirit. A cotton wool swab was used to hold the cord clamp. The skin around the cord was swab 5cm away from the base of the cord. The stem of the cord was swab from base upwards using a swab for each stroke finally the tip of the cord was swab with cotton wool swab. Baby was wrapped neatly and the cord was left exposed to dry. Gloved hands were immersed in 0.5% chlorine solution and removed inside out. Hands were washed with soap under running water and dried with a clean towel.

Education to mother on baby

Madam Barbara was educated not to put anything on the cord but she should only dress cord with methylated spirit. The baby was wrapped nicely to maintain the temperature. The baby's head was covered to prevent heat loss and the baby was given to the mother to breastfeed. Madam Barbara was educated on the needs of exclusive breastfeeding for the first six months and she was encouraged to practice it. She was educated and encouraged to allow the baby to completely empty one breast before giving the other breast to the baby. She was also educated to report early to the health facility when she observes any danger signs such as irregular breathing rate, fever, poor feeding and jaundice. Client was told not to apply any hot water to the baby's fontanelles since they will close by themselves when the time is due. Client was educated on breastfeeding problems such as cracked or sore nipples, breast engorgement and mastitis. Mother was also educated and encouraged to eat a well-balanced diet and also to take her medications given.

4.3 FIRST DAY POST DELIVERY [DAY OF DISCHARGE]

31st August, 2023 happens to be the first day after delivery. Madam Barbara and baby were in good health. She woke up around 6:30am and brushed her teeth. She complained of after pain. She was told that the pain was as a result of involution of the uterus. She made herself comfortable in a white dress and all procedures to be carried out on her and the baby was explained to her to seek for consent which she agreed. Her vital signs were checked and recorded as;

Temperature	36.5^0C
Pulse	82bpm
Respiration	21cpm
Blood pressure	110/65mmHg

The symphysiofundal height was 16centimeters. The uterus was well contracted on palpation. Head to toe examination was done and nothing abnormal was detected. Lochia was red (rubra) in colour and amount was small and not offensive. She was reminded on changing of the perineal pad frequently to prevent ascending infection to the uterus. She was also reminded on how to perform self-breast examination and breast were somehow lactating exclusive breastfeeding was also encouraged. Permission was sought from the mother to re-examine the baby and the procedure was explained to her. Hand washing was done and the baby was examined. On examination, there was no abnormality detected. The baby was top and tailed and the cord dressed with sterile cotton wool swab soaked in methylated spirit. Opportunity was taken to teach the mother and the family about cord dressing of the baby. She was reminded not to put anything on the cord except what was given to her and also encouraged not to apply hot compress on the head, as that can damage and affect the brain.

The baby passed meconium. Her vital signs and weight were checked and recorded as follows;

Temperature	36.5 degrees celcius
Apex beat	135 bpm
Respiration	43 cpm
Weight	2.9 kg

Baby was re-dressed and wrapped in a warm sheet and was given to her mother for breast feeding. All findings were communicated to the mother. Madam Barbara took porridge and bread as her breakfast. She was reminded on the need for proper personal hygiene and good nutrition. Client was informed of possible discharge. She was encouraged to start and complete the immunization schedules at the child welfare clinic and its importance was stressed. She was also told to come for the first post-natal visit on 06/09/2023. Posture and method of breastfeeding was demonstrated to client after which she was asked to do same and she did it perfectly. She was educated on the importance of birth registration and was asked to register the baby. The baby was immunized with polio O vaccine 2 drops per mouth and BCG 0.5ml was administered intra-dermal to right upper arm. Client was educated not to apply anything on the injected site, she was told that the baby may have slight fever and swelling at the injection site which would subside. Client was informed that she would be visited at home for seven days and was helped to pack her belongings. Client was given the following drugs;

Tablet Folic Acid	5mg one tablet daily for 7days
Tablet Multivitamin	200mg daily for 7 days
Sulphate	200mg one daily for 7 days
Tablet Paracetamol	1g three times daily for 3 days

Client's bills were settled with her National Health Insurance Card. A taxi was hired so client was seen off.

4.4 FIRST POSTNATAL HOME VISIT

Madam Barbara and her family were visited at their home on the 31st August, 2023 at 4:00pm. Greetings were exchanged on arrival and was asked how she and her baby were faring and she said they were doing well. Permission was sought to perform head to toe examination on both mother and baby which she agreed. After given her consent, she was asked to empty her bladder and made comfortable in her bed. Head to toe examination was done paying attention to the breast, the uterus, the perinium and vaginal discharge. The breasts were somehow lactating. The uterus was well contracted and the symphysio fundal height measured 16cm. Perineal pad was inspected and a small amount of lochia rubra which was not offensive. Her vital signs were checked and recorded as;

Temperature	36.4^0C
Pulse	86 bpm
Respiration	22 cpm
Blood pressure	110/70 mmHg
Lochia	Rubra
Odour of lochia	Not offensive
Fundal height	16cm
Condition of uterus	Contracted
Breast	Lactating

Head to toe examination was conducted on the baby paying much attention on proper suckling, the cord and if baby is able to pass urine and stool but no abnormality was identified. Permission was sought to top and tail the baby and it was granted. Hands were washed with soap under running water and dried with a clean towel. As the baby was being top and tailed with warm water, the baby passed urine and stool. The cord was also dressed

with cotton wool soaked with methylated spirit. It was clean and kept dry. Baby's vital signs and weight were checked and recorded as follows;

Temperature	36.3^0C
Pulse	135 bpm
Respiration	44 cpm
Weight	2.9kg
Skin colour	Pink
Cord condition	Clean and fresh
Suckling	Yes
Stool colour	Meconium

Baby was wrapped nicely with a sheet and was given to the mother to breastfeed. All findings were communicated to Madam Barbara. Client complained of loss of appetite.

She was reassured that the problem was normal and would be managed. Another visit was scheduled for the next day.

4.5 SECOND POSTNATAL HOME VISIT

The second visit was made to client's house at 7:00am and 5:00pm on the 1st September, 2023. Having been received warmly, the family responded of good health. Every procedure to be performed on both client and baby were explained and she agreed. Head to toe examination was done on the mother paying attention to the breast, the uterus, the perineum, vagina discharge and everything was normal. Breasts were lactating well. Her perineal pad was inspected and an odorless lochia (rubra) was seen on perineal examination including a clean vulva and perineum. Her fundal height was 15 centimeters. Client's vital signs were checked and recorded as follows;

Assessment	Morning	Evening
Temperature	36.4^0C	36.7^0C
Pulse	79 beat per minute	80bpm
Respiration	20 cycle per minute	21cpm
Blood pressure	100/60 mmHg	110/70mmHg
Lochia	Rubra	Rubra
Fundal height	15cm	15cm
Uterus condition	Contracted	contracted
Breast	Lactating	Lactating

Head to toe examination was done on the baby checking for suckling, the cord if bleeding, and if urine and stool passed but no abnormalities were detected. The cord was clean. The baby was top and tailed and cord was dressed with methylated spirit and left open to dry in the presence of the mother. The baby was dressed, wrapped and given to mother to breastfeed and baby was suckling well. According to client, baby passed meconium about three times and urinated about six times in a day. Baby's vital signs and weight were checked and recorded as follows;

Assessment	Morning	Evening
Temperature	36.4^0C	36.6^0C
Apex heart beat	137 bpm	138bpm
Respiration	46cpm	45cpm
Weight	2.8kg	2.8kg
Skin colour	Pink	Pink
Cord condition	Clean but fresh	Clean but fresh
Cord bleeding	No	No
Stool colour	Meconium	Meconium
Urine	Passed	Passed

Madam Barbara, complained of burning sensation on micturation. Client was reassured that the condition is temporal and it is going to be managed. Permission was sought to leave.

4.6 THIRD POSTNATAL HOME VISIT

The third home visit was made to client's house on the 2nd September, 2023 around 7:00am and 4:30pm. Greetings were exchanged. Mother and baby were in a healthy condition. All procedures to be carried out were explained to client and she agreed. Head to toe examination was done on the mother but no abnormality was found. She was enquired about her previous day complains of which she said she feels beter. The breasts were filled with abundant milk. Her symphysiofundal height was measured and recorded as 14 centimeters. Client's perineal pad was inspected and it was bright red [rubra] with scanty flow without any offensive odor. Vital signs of mother were checked and recorded as;

Assessment	Morning	Evening
Temperature	36.5^0C	36.4^0C
Pulse	88 bpm	85bpm
Respiration	22 cpm	21cpm
Blood pressure	120/70 mmHg	110/80mmHg
Lochia	Rubra	Rubra
Fundal height	14cm	14cm
Uterus condition	Contracted	Contracted
Breast	Lactating	Lactating

Head to toe examination was done on the baby and no abnormalities were detected. The cord had begun to detach. The baby was top and tailed and cord was dressed with methylated spirit and left open to dry. Baby passed stools and urine during bath. Baby was dressed up nicely. Baby's vital signs and weight was taken and recorded as follows;

Assessment	Morning	Evening
Temperature	36.6^0C	36.8^0C
Apex heart beat	138bpm	138 bpm
Respiration	44cpm	45 cpm
Weight	2.8 kg	2.7kg
Skin colour	Pink	Pink
Cord condition	Clean and dry	Clean and dry
Suckling	Yes	Yes
Stool	Paased	Passed

All findings were communicated to Madam Barbara and permission was sought to leave

4.7 FOURTH POSTNATAL HOME VISIT

Madam Barbara was visited on the 3rd September, 2023. At 7:30 am and 5:00pm . Client and baby were all in good health. On head to toe examination, client breast was seen to be engorged and she confirmed it is painful. Client was reassured that it is going to be managed. Symphysio fundal height was measured to be 13cm. Lochia was pink in color (serosa), small and without odour. Client's vital signs was checked and recorded as follows;

Assessment	Morning	Evening
Temperature	36.7^0C	36.8^0C
Pulse	77 bpm	80 bpm
Respiration	20 cpm	20 bpm
Blood pressure	100/ 65 mmHg	100/70mmHg
Lochia	Serosa	Serosa
Fundal height	13cm	13cm
Breast	Lactating	Lactating but slightly engorged
Condition of the uterus	Contracted	Contracted

General examination was carried on baby but nothing abnormal was identified. Baby was top and tailed and cord was dressed with methylated spirit and left open to dry. Baby passed

stools and urine during bathing. The cord was shrinking. Baby's vital signs and weight was taken and recorded as follows;

Assessment	Morning	Evening
Temperature	36.5^0C	36.6^0C
Apex heart beat	138 bpm	136bpm
Respiration	46cpm	44cpm
Weight	2.9kg	2.9kg
Skin colour	Pink	Pink
Cord	Shrinking	Shrinking
Suckling	Yes	Yes
Stool and urine	Passed	Passed

All findings were communicated to client and documented. Permission was sought to leave.

4.8 FIFTH POSTNATAL HOME VISIT

On the 4th September, 2023 at 7:00am client was visited. Mother and baby were in a healthy condition. Client had already taken her bath so permission was sought for head to toe examination to be performed and no abnormality was detected. An enquiry was made on the previous complain and she said it's okay. Her breasts were soft and lactating well. Her symphysiofundal height measured 12 centimeters. Lochia was pink (serosa), small flow and had no odor. In the course of conversation, it was seen that, client lacks knowledge on family planning. Client's vital signs was checked and recorded as follows:

Temperature	36.6^0C
Pulse	81 cpm
Respiration	22 cpm
Blood pressure	110/65 mmHg
Lochia	Serosa

Breast	Lactating
Fundal height	12cm
Condition of the uterus	Contracted

Head to toe examination was done on baby and no abnormalities were found. Baby was top and tailed and she passed stool and urine. The cord was dressed with sterile cotton wool swabs and methylated spirit but it was almost off. Vital signs and weight of baby were checked and recorded as;

Temperature	36.3^0C
Apex beat	133 bpm
Respiration	41 cpm
Weight	3.0 kg
Skin colour	Pink
Cord	Dried and almost off
Suckling	Yes
Stool and urine	Passed

Permission was sought to leave.

4.9 SIXTH POSTNATAL HOME VISIT

Client was visited again the 5th September, 2023 around 7:30am Madam Barbara was met with her mother who was washing some clothing. Greetings were exchanged. The condition of mother and baby was very good and baby's water already prepared. Head to toe examination was done after explaining the procedure to client and nothing abnormal was detected. Lochia was pink in color (serosa), small and without odour. Her symphysio fundal height was 11cm. Client vital signs were checked andecorded as;

Temperature	36.5^0C
Pulse	83 bpm
Respiration	22 cpm
Blood pressure	100/70 mmHg
Fundal height	11cm
Lochia	Serosa
Breast	Lactating
Condition of the uterus	Contracted

Head to toe examination was done on baby and nothing abnormal was detected. Baby's cord came off when it was being top and tailed. Baby's vital signs and weight was checked and recorded as follows;

Temperature	36.5^0C
Apex beat	132 bpm
Respiration	44 cpm
Weight	3.1 kg
Skin colour	Pink
Cord	Off
Suckling	Yes
Stool and urine	Passed

Madam Barbara was reminded of the first postnatal visit to the clinic. An opportunity was taken to express my profound gratitude to the client and the family that, today will be my last but one visit but the family were sad and they were assured that official home visit will be made to their home and again the client and baby will be handed to the midwife in charge and the family was relieved. She was congratulated for her efforts and cooperation. All the findings were communicated to client and permission was sought to leave.

5.0 SEVENTH POSTNATAL HOME VISIT

The seventh day postnatal home visit was made to client house on the 6th September, 2023 around 7:30am. Client and baby were in a good condition. On head to toe examination, no abnormalities were seen on the mother. Lochia was pink (serosa) with no odor. Her symphysio fundal height was 10cm. Her breast was lactating well. Her vital signs were checked and recorded as;

Temperature	36.5^0C
Pulse	80 bpm
Respiration	22 cpm
Blood pressure	110/60 mmHg
Lochia	Serosa
Fundal height	10cm
Condition of the uterus	Contracted
Breast	Lactating

Baby bath was done by the mother under my supervision since its my last visit to the house and head to toe examination was done and no abnormality was found on the baby. Vital signs and weight of baby was checked and recorded as;

Temperature	36.2^0C
Apex heat beat	140 bpm
Respiration	44 cpm
Weight	3.2 kg
Skin colour	Pink
Cord	Healing
Suckling	Yes
Stool and urine	Passed

Client was thanked for her co-operation throughout the postnatal home visits. Madam Barbara was reminded to visit the clinic for her first one-week postnatal clinic.

5.1 FIRST POSTNATAL VISIT T O THE CLINIC

Client visited the clinic with her baby accompanied by her mother on the 7th September, 2023 around 10:00am. They were warmly welcomed and offered seats. Client was asked about how she and her baby were doing as well as her family and she said they were all doing well. Every procedure to be done was explained to her and permission was granted to begin the procedure. A specimen container was given to her for mid-stream urine collection for routine examination and urine protein and glucose both were negative when tested. Haemoglobin level was 11.5 grams per deciliter after blood sample was taken and tested. Client vital signs were checked and recorded as;

Temperature	37.0^0C
Pulse	85 bpm
Respiration	21 cpm
Blood pressure	110/70 mmHg
Haemoglobin level	11.5g/dl

Privacy was provided and client was helped to lie on the examination couch for head to toe examination while her mother carried the baby for that period. Her hair was neatly and nicely braided. The eyes and ears had no discharges, conjunctiva had no pallor and the sclera had no jaundice. The nose had no discharge neither did the neck had any nodule nor enlarged lymph node. The breast as well had no lump, engorgement, mastitis or nipple crack but was lactating well. The upper and lower extremities had no oedema. On abdominal examination, there was no enlargement and tenderness of both spleen and liver. There were no warts, varicose veins or edema on the vulva. Lochia drainage was mild, serosa and not offensive. The uterus was not palpable. Madam Barbara was congratulated for keeping herself clean and

was helped to get off the couch to redress. Findings were then communicated to Madam Barbara and recorded. Hands were then washed and dried with a clean dry towel. Permission was sought to perform head to toe examination on the baby which was granted. Baby's hair looked neat and nicely combed, with no abnormalities of the fontanelles and sutures present on palpation. The conjunctiva and sclera were inspected for pallor and jaundice respectively but none was present. The ears and nose were inspected as well as the lips and mouth, but no abnormality was found. There were no palpable lymph nodes on the neck. The chest was inspected and there was no in drawing. The abdomen was firm with a well healed umbilical stump and the skin had no rashes. The upper and lower extremities had no abnormality as well as the baby's back. The genitalia were also examined with no abnormality detected. The baby's vital signs and weight were checked and recorded as follows;

Temperature	36.5^0C
Apex heart beat	142 beat per minute
Respiration	40 cycle per minute
Weight	3.2 kilograms
Skin colour	Pinkish to brown
Suckling	Yes
Stool and urine	Passed

Findings were communicated to mother and recorded. Madam Barbara was educated on the importance of family planning to help her and the husband to space their birth and was also reminded to continue breastfeeding the baby exclusively. Client was also reminded on the need to attend child welfare clinic to complete the child's immunization schedules and also attend six weeks postnatal review. She was again reminded about the registration of her baby with the birth and death registry. Client was handed over to the Midwife in-Charge for the continuity of care. Madam Barbara was thanked for her cooperation and effort throughout the care.

5.2 SECOND POSTNATAL VISIT TO THE CLINIC

According to the Midwife in-Charge, Madam Barbara visited the clinic with the baby for her sixth week postnatal review on the 20th October, 2023 and was warmly welcomed. Mother and baby were healthy. Likewise, all examinations and investigations were within normal ranges. They were then handed over to the child welfare clinic and family planning unit to ensure continuity of care. According to Midwife in-charge, client was encouraged to visit the facility in case of any health-related problem and all findings were communicated to Madam Barbara and was thanked for her cooperation and support throughout the care.

5.3 PUERPERIUM CARE PLAN

PROBLEMS IDENTIFIED

Client complained of;

1. After pain on the 31st August, 2023
2. Loss of appetite on the 31st August, 2023
3. Burning sensation on micturation on the 1st September, 2023
4. Breast engorgement on the 3rd September, 2023

On the 4th September, client was noted to have

5. Knowledge deficit on family planning

SHORT TERM OBJECTIVES

1.Client will be relieved of after pain within 48 hours

2.Client will regain her normal eating pattern within 24 hours.

3.Client's burning sensation will resolve within 48 hours

4. Client will be relieved of breast engorgement within 48 hours.

5. Client will gain adequate knowledge on family planning within 3 hours.

LONG TERM OBJECTIVE

Client and her baby will go through puerperium successfully without any complications.

PUERPERIUM CARE PLAN

DATE/ TIME	NURSING DIAGNOSIS	OBJECTIVES/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
31/08/2023 7:00am	After pain related to contractions of the uterus due to release of oxytocin during breastfeeding	Client will be relieved of after pain within 48 hours as evidenced by; client verbalizing that pain has been relieved and midwife visualize client is relieved of after pains as client do not complain anymore.	1. Reassure client that the pain is temporal. 2. Explain the physiology of after pain to client. 3. Educate and assist client to do postnatal exercise. 4. Encourage client to apply pressure to the lower abdomen. 5. Serve prescribed analgesics.	1. Client was reassured that the pain is temporal. 2. Client was told about the physiology of pain. 3. Client was educated and assisted to do postnatal exercise. 4. Client was encouraged to apply pressure to the lower abdomen. 5. Prescribed analgesics were served.	02/09/2023 7:00am	Goal fully met as client verbalized that her pain has been relieved and midwife observing cheerful facial expression.	A.B. A

PUERPERIUM CARE PLAN

DATE/ TIME	NURSING DIAGNOSIS	OBJECTIVES/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
31/08/2023 4:00pm	Loss of appetite related to stress of labour.	Client will regain her normal eating pattern within 24 hours as evidenced by; client reporting she can eat well.	1. Reassure client that she will regain her normal eating pattern. 2. Encourage client to practice oral hygiene. 3. Serve client with nutritious diet. 4. Plan meal with client. 5. Serve prescribed medication.	1. Client was reassured that she will regain her normal eating pattern. 2. Client was encouraged to practice oral hygiene. 3. Client was served with nutritious diet. 4. Meals were planned with client. 5. Prescribed medications were served.	01/09/2023 4:00pm	Goal fully met as client verbalized she has regained her normal eating pattern.	A.B. A

PUERPERIUM CARE PLAN CONTINUED

DATE/ TIME	NURSING DIAGNOSIS	OBJECTIVE/OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTIONS	DATE/ TIME	EVALUATION	SIGN
01/09/23 3:00pm	Burning sensation on micturation related to lacerations of the vulva.	Client's burning sensation on micturation will resolve within 48 hours as evidenced by client verbalizing that the pain has subsided and midwife observing a relaxed facial expression.	1. Reassure client that the condition can be resolved. 2. Explain to client the physiology of pain. 3. Encourage client to empty her bladder. 4. Encourage client to have warm sits bath. 5. Encourage client to eat more fruits especially orange to help in healing and replacement of worn out tissues.	1. Client was reassured that the condition can be resolved. 2. Physiology of pain was explained to client. 3. Client was encouraged to empty her bladder. 4. Client was encouraged to have warm sit bath. 5. Client was encouraged to eat more fruits to help in and replacement of worn out tissues.	03/09/23 3:00pm	Goal fully met as client said she was coping with pain and midwife observing a cheerful expression.	A.B. A

PUERPERIUM CARE PLAN CONTINUED

DATE & TIME	NURSING DIAGNOSIS	OBJECTIVES/OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTIONS	DATE& TIME	EVALUATION	SIGN
03/09/23 4:00pm	Breast engorgement related to inadequate emptying of the breast.	Client's breast engorgement will be relieved within 48 hours as evidence by client verbalizing that the breast is not engorged anymore and Midwife observing that the engorgement has been relieved and he size the breast reduced and feels less tender to touch.	1. Reassure client that the engorged breast will be relieved. 2. Teach client on position when breastfeeding. 3. Teach client how to support the breast. 4. Teach client how to relieve pain. 5. Educate client on breast feeding.	1. Client was reassured that the engorged breast will be relieved. 2.Client was taught on position when breastfeeding 3. Client was taught how to support the breast. 4. Client was taught how to relieve pain. 5. Client was educated on breastfeeding.	05/09/2023 4:00pm	Goal fully met as client verbalized she is relived of the heaviness of the breast and feels no pain.	A.B. A

PUERPERIUM CARE PLAN

DATE/ TIME	NURSING DIAGNOSIS	OBJECTIVE /OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTIONS	DATE/ TIME	EVALUATION	SIGN
04/09/23 at 4:00pm	Knowledge deficit on family planning related to inadequate information.	Client will gain adequate knowledge on family planning within 3 hours as evidenced by client verbalizing at least 3 merits and demerits of family planning.	1. Explain family planning to client. 2. Educate client on the methods of family planning. 3. Educate client on the merits and demerits of the family planning. 4. Use visual aids in the education. 5. Encourage frequent breastfeeding especially at night.	1. Family planning was explained to client. 2. Client was educated on the methods of family planning. 3. Client was educated on merits and demerits of family planning. 4. Visual aids were used during education. 5. Client was encouraged on frequent breastfeeding especially at night on demand	04/09/2023 at 7:00pm	Goal fully met as evidenced by client answered correctly all questions asked about family planning.Which includes the demerits, demerits and the methods	A.B. A

SUMMARY AND CONCLUSION

This family and client centered maternity care study was conducted on Madam Barbara, a 28year old woman, who is gravida 2 para 1. She was met at Dormaa West District hospital Nkrankwanta in the Bono Region. The client was $37+^{2}$ weeks gestation when she was met on 14th August, 2023. Client hails from Nkrankwanta in the Bono Region. Care was given during pregnancy, labour and puerperium. She went through these processes safely without any complications.

Madam Barbara delivered a live female child on 30th August, 2023 through spontaneous vaginal delivery without any complications and went through a normal and safe puerperium. Madam Barbara and her family were cooperative, supportive and adhered to any form of education given to them. Through home visits, a close monitoring was made throughout pregnancy and puerperium. The baby was immunized on the day of delivery. Mother and her baby were in a healthy condition. Mother and baby were handed over to the Midwife- In-Charge for continuity of care.

The care rendered to Madam Barbara and her family has given me the opportunity to recognize the various needs of individual women during pregnancy, labour and puerperium. Hope the experienced of this care study will enable render quality nursing and maternity care to all expectant mothers and their families throughout the career as a midwife.

The care study is an important and managerial tool which gives opportunity to student midwives to put into practice the theoretical knowledge and the ability to deal with obstetric problems as midwifery professionals. Various observations and examination including laboratory investigations were carried out to aid in the progress of normal pregnancy, labour and puerperium.

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APPENDIX I

COMPLETE DIAGNOSTIC INVESTIGATIONS

DATE	SPECIMEN	INVESTIGATION	NORMAL RANGE	FINDINGS	REMARKS
02/03/2023	Blood	Hemoglobin level	11.06/dl	12.0g/dl	Normal
		Sickling status	Negative	Negative	Normal
		HIV/PMTCTVDRL	Negative	Negative	Normal
		G6PD	Negative	Negative	Normal
		HBsAg	Negative	Negative	Normal
		Blood Group	Negative	Normal	Normal
		Rhesus factor	A, B, AB, O	A	Normal
			Positive/Negative	Positive	Normal
		Urine	Negative	Negative	Normal
30/03/2023	Urine	Protein	Trace	Negative	Normal
		Sugar	Negative	Negative	Normal
27/04/2023	Urine	Protein	Negative	Negative	Normal
		Sugar	Negative	Negative	Normal
25/05/2023	Urine	Protein	Negative	Negative	Normal
		Sugar	Negative	Negative	Normal
08/06/2023	Urine	Protein	Negative	Negative	Normal
		Sugar	Negative	Negative	Normal
06/07/2023	Urine	Protein	Negative	Negative	Normal
		Sugar	Negative	Negative	Normal
03/08/2023	Urine	Protein	Negative	Negative	Normal
		Sugar	Negative	Negative	Normal
10/08/2022	Urine	Protein	Negative	Negative	Normal
		Sugar	Negative	Negative	Normal

APPENDIX II

PHARMACOLOGY OF DRUGS FOR MOTHER

NAME OF DRUG	CLASSIFICATION	DOSAGE	ROUTE	ACTION AND USES	ACTUAL EFFECTS	SIDE EFFECTS	SIDE EFFECTS EXPERIENCED
Tetanus diphtheria	Anti-tetanus vaccine	0.5milligram	Subcutaneous	Protect against tetanus	Client was protected against tetanus infection	Slight fever and chills	None observed
Tablet Multivitamin	Vitamin Preparation	200 milligrams twice daily	Oral	Increase Appetite, helps in the formation of red blood cells	Increased appetite.	Gastrointestinal disturbance	None observed
Tablet Ferrous Sulphate	Haematinics	200 milligrams daily	Oral	Helps in red blood cell formation.	Increase in hemoglobin level.	Gastrointestinal disturbance and blood stool	None observed
Tablet Folic Acid	Vitamin Preparation	5 milligrams Once daily	Oral	Proper formation and function of red blood cell	Hemoglobin level increased	Nausea and vomiting	None observed
Tablet Paracetamol	Analgesics	1 gram 3 times daily for 3 days	Oral	Helps to relieve pain	Pain was relieved	Prolong use causes damage to the liver.	None observed

PHARMACOLOGY OF DRUGS FOR MOTHER CONT'D

NAME OF DRUG	CLASSIFICATION	DOSAGE	ROUTE	ACTION AND USES	ACTUAL EFFECT	SIDE EFFECTS	SIDE EFFECTS EXPERIENCED
Injection oxytocin	Oxytocic drug	10 units	Intramuscular	Stimulation of uterine contractions	Good uterine contractions and control of bleeding	Vomiting, rise in blood pressure and uterine spasm	None observed
Tablet Sulphadoxine Pyrimethamine	Anti-malaria and prophylaxis	3 doses stat from 16weeks or after quickening and the remaining doses within 4weeks interval until she delivers.	Oral	Prevention of malaria	Malaria was prevented	Nausea, vomiting, itching, dizziness and headache	None observed

PHARMACOLOGY OF DRUGS FOR BABY

NAME OF DRUG	CLASSIFICATION	DOSAGE	ROUTE	ACTION AND USES	ACTUAL EFFECT	SIDE EFFECT	SIDE EFFECT EXPERIENCED
Vitamin K	Coagulant	1milligram	Intramuscular	Production of prothrombin	No bleeding	None	None observed
Chloramphenicol eye drop	Prophylaxis antibiotic	2 drops	Instillation	To prevent eye infections	Infection of the eye prevented	Nephroxicity	None observed
Oral Polio Vaccine	Antigen	2 drops	Oral	Production of antibodies against poliomyelitis	Diarrhea may occur	There may be diarrhea	None observed
Bacillus Calmette Guerin injection	Antigen	0.05mg	Intradermal	Immunity against Tuberculosis	Prevention of Tuberculosis	Mild fever, swelling at injected site and blister formation	Blister noticed
Pneumococcal 1	Antigen	0.5 ml	Intramuscular (right thigh)	Immunity against pneumonia	Baby is under observation	Fever and redness at the site of injection	None observed
Pentavalent 1	Antigen	0.5 ml	Intramuscular (left thigh)	Immunity against Diphtheria, Pertussis, Tetanus, Hemophilus influenza B and Hepatitis B	Baby is under observation	Low grade Fever	None observed
Rotavirus 1	Antigen	1.5ml (2 drops)	Oral	Immunity against rotavirus(diarrhea)	Baby is under observation	Vomiting	None observed

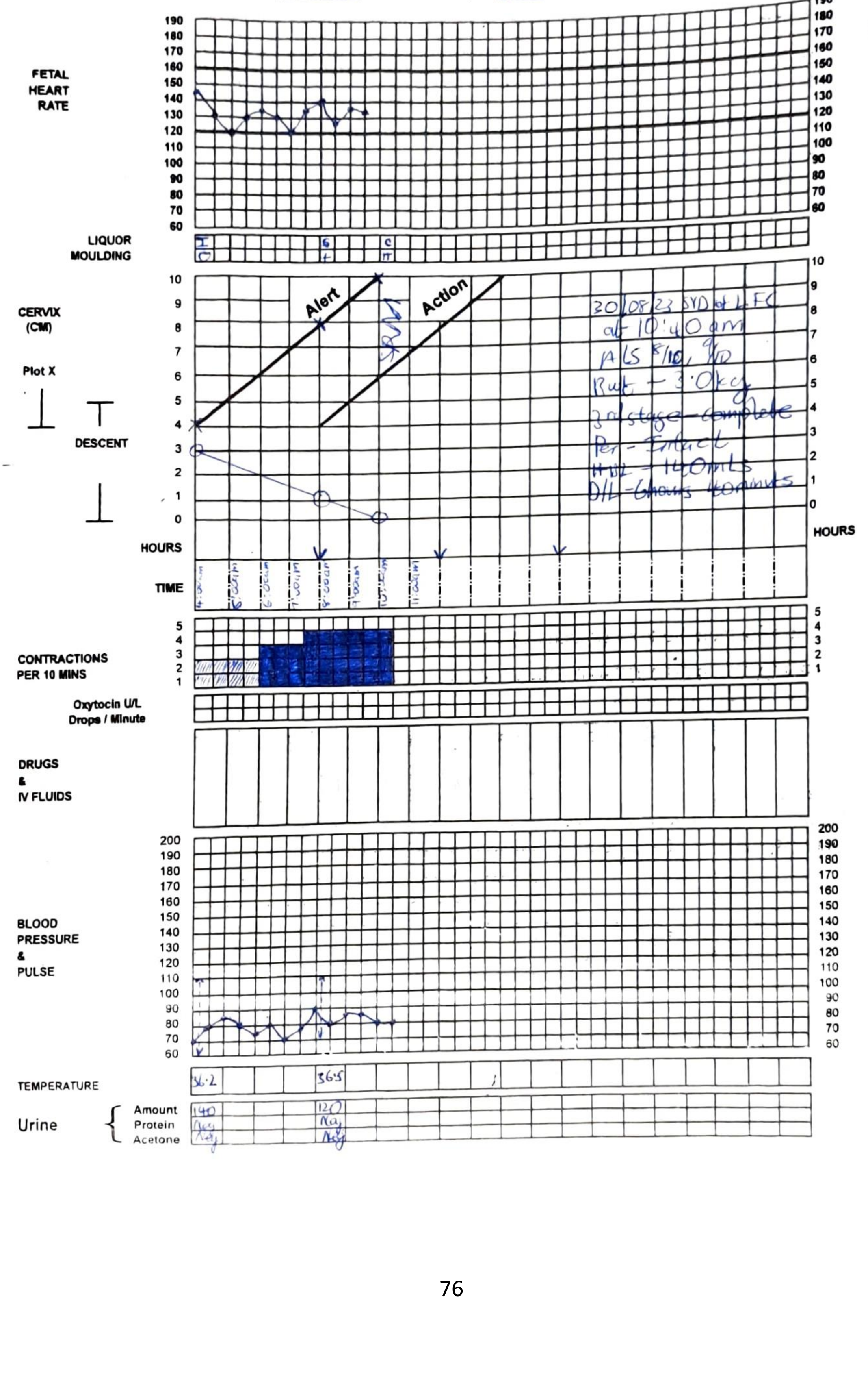
APPENDIX III

ANTENATAL CHART RECORD

Date	BP (mmHg)	Weight (kg)	Urine Protein/ Sugar	Gestation (weeks)	Fundal Height (cm)	Presentation	Descent	Fetal Heart Rate (FHR)	Complains	Treatment	Name and sign
30/03/23	110/70	56	Negative/ Negative	14	12	_	_	-	Feels well	Tablet (multivite, folic acid, ferrous sulphate)	A.B.A
27/04/23	100/60	59	Trace/ Negative	18	16	_	_	-	Feels well	Tablet (multivite, folic acid, ferrous sulphate)	A.B.A
25/05/23	110/60	59	Negative/ Negative	22	20	_	_	-	Feels well	Tablet (multivite, folic acid, ferrous sulphate)	A.B.A
08/06/23	100/60	60	Negative/ Negative	27	26	Cephalic	5/5th	138	Headache	Treatment (multivite, folic acid, ferrous sulphate)	A.B.A
06/07/23	110/70	60	Negative/ Negative	30	28	Cephalic	5/5th	139	Feels well	Treatment (multivite, folic acid, ferrous sulphate)	A.B.A
03/08/23	100/60	61	Negative/ Negative	33+1	31	Cephalic	5/5th	139	Waist pains	Tablet (multivite, folic acid, ferrous sulphate)	A.B.A
10/08/23	100/60	62	Negative/ Negative	37+1	35	Cephalic	5/5th	138	Abdominal pains	Tablet Folic acid Tablet Ferrous sulphate Tablet multivite	A.B.A
17/08/23	110/60	62	Negative/ Negative	39+1	37	Cephalic	5/5th	138	Abdominal pains	Tablet folic acid Tablet Ferrous sulphate	A.B.A

WHO Modified Partograph

Registration No. AMD4358 Name (Last, First) Ayeliwaa Achampong Barbara Age 28yrs
Date 30/08/23 Parity/Gravida 1 / 2 LMP scan EDD 01/09/23 Gestation (wks) 39+2
ROM (Time, Date) 10:00 / 30/08/23 Labour Durable (Hrs) 6hrs 40mins Facility/Clinic Name Damongo West District Hospital Nkwanta



LABOUR NOTES

Client delivered an active female child with APGARS 8/10, 9/10, Bwt 3.0kg, FL 47cm, HC 32cm. Inj oxytocin 10units given. Third stage completed by controlled cord traction, bladder emptied and uterus massaged to expel any clots. BLS 140mls. Post delivery vital signs was checked and recorded as Bp 120/60mmHg, PR 80bpm, Temp 36.2°C and respiration 22bpm. Baby's temperature was checked and recorded as 36.3°C. Cord and eye care done for baby. No abnormalities detected on both mother and baby. Both mother and baby cleared for close monitoring of fourth stage.

Please circle or write responses.

DELIVERY

DATE: 30/08/23 TIME: 10:40am METHOD: (Spontaneous) / Vaccuum Extraction / C/S / Other

PERINEUM: (Intact) / Episiotomy / Laceration

ANESTHESIA: (None) / Local / General

THIRD STAGE

Active Management: (Yes) / No Medication: Time 10:40am Type / Dose Inj. oxytocin 10units

PLACENTA: Time: 10:45am (Complete) / Incomplete

BLOOD LOSS AMOUNT: 140mls (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
1 min	2	2	2	1	1	8/10
5 min	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	11:00am	120/80	80bpm	17cm	140mls	120mls
	11:15am	110/79	95bpm	well contracted	No active bleeding	Voided
	11:30am	120/60	90bpm	well contracted	No active bleeding	Voided
	11:45am	110/80	92bpm	well contracted	No active bleeding	Voided
	12:00pm	120/70	88bpm	well contracted	No active bleeding	Voided
	12:15pm	100/70	90bpm	well contracted	No active bleeding	Voided
	12:30pm	120/80	87bpm	well contracted	No active bleeding	Voided
Every 30 minutes for 1 hours	1:00pm	120/70	84bpm	well contracted	No active bleeding	Voided
	1:30pm	110/70	90bpm	well contracted	No active bleeding	Voided

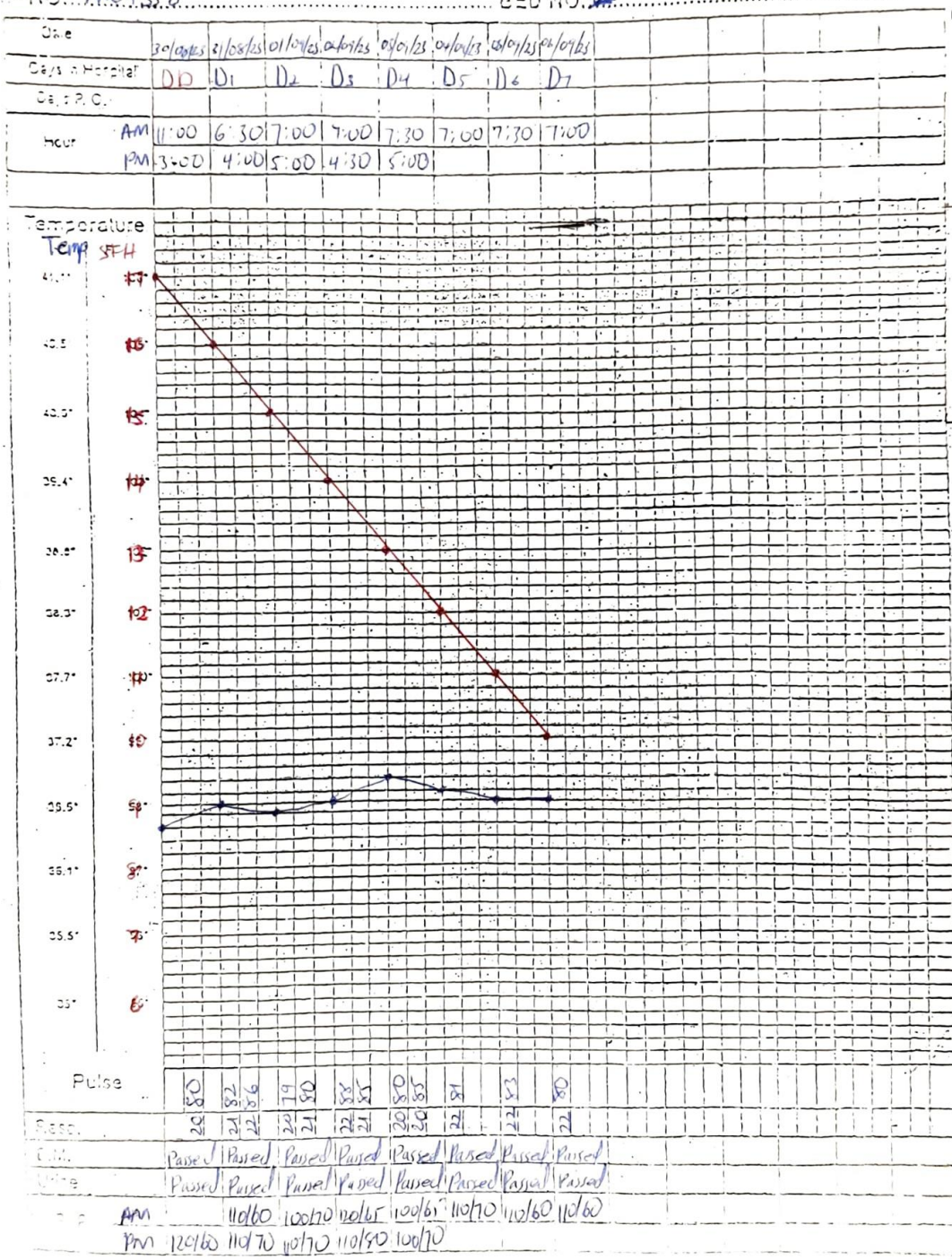
Birth Attendant Adjei Bernice Anastasia and Akua Yeboah (staff midwife) Date 30/08/23

MATERNITY CHART

NAME: Agyeiwaa Achempong Barbara

AGE: 2 8 years WARD: Labour

P.NO.: AM04338 BED NO.: 2



NEW BORN EXAMINATION FORM

Name: Baby Agyiriba Akompong Barbara | Date of Assessment: 20/08/23 | Time: 12:10pm
Date of Birth: 20/08/23 | Time of Birth: 10:40am | Sex: ☐ M ☑ F | Age at time of Assessment (days/hrs) 90minutes
Gestational Age ☐ | ☐ Mode of Delivery: ☑ Vaginal | Assisted Vaginal | C-Section
APGAR: 1min 9 | 5min 10 | Birth Weight: ☐ 3.0 kg ☐ | Length 47 cm | Head Circumference: 32 cm
Temperature at time of Assessment: 36.2 °C | Urine passed: Yes ✓ No | Meconium passed: Yes ✓ No
Name of Assessor (Midwife/Doctor): Alice Bernice Anastasia (student midwife)

1. Respiration
Rate 42
- ☐ Rate < 30 b/m *
- ☑ Rate < 60 b/m *
- ☐ 30-60 b/m
- ☐ Retractions *
- ☐ Grunting *
- ☐ Stridor *

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

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

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

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

6. Cry
- ☑ Normal
- ☐ 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: 130
- ☑ Normal (100-160)
- ☐ <100 *
- ☐ >160*

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

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

21. Back (spine)
- ☑ Normal
- ☐ Abnormal Swelling *
- ☐ Hairy 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 clitoris *
- ☐ 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 Agyeiwaa Achempong Barbara Date of Assessment: 31/08/23. Time: 6:30a
Date of Birth: 30/08/23 Time of Birth: 10:40am Sex: ☐ M ☑ F Age at time of Assessment (days/hrs) 1 Shrs
Astational Age ☐ ☐ Mode of Delivery: ☑ Vaginal Assisted Vaginal C-Section
APGAR: 1min 8 5min 8 Birth Weight: ☐ 2.9 kg ☐ Length 47 cm Head Circumference: 32 cm
Temperature at time of Assessment: 36.2 °C Urine passed: Yes ✓ No Meconium passed: Yes ✓ N
Name of Assessor (Midwife/Doctor): Abel Reinata Anastasia (student midwife)

1. Respiration
Rate 42
- ☐ Rate < 30 b/m *
- ☐ Rate < 60 b/m *
- ☑ 30-60 b/m
- ☐ Retractions *
- ☐ Grunting *
- ☐ Stridor *

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- ☐ 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: 130
- ☑ 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 Immunizatic
- ☑ 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 Agyeiwaa Athempong Barbara ..... No: A04 ..... Birth Weight: 3.0kg

Sex: Female ..... Mother's No: AA3435.8 ..... Length: 47cm

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

Date of Birth: 30/08/23 ..... Time: 10:40am ..... Date of Discharge: 31/08/23

Date	30/08/23		31/08/23		01/09/23		02/09/23		03/09/23		04/09/23		05/09/23		06/09/23							
No. of Days	DD		D_1		D_2		D_3		D_4		D_5		D_6		D_7							
Weight	3.0kg		2.9kg		2.8kg		2.8kg		2.9kg		3.0kg		3.1kg		3.2kg							
Temperature	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM
	36.2°C	36.2°C	36.5°C	36.3°C	36.4°C	36.6°C	36.6°C	36.8°C	36.5°C	36.6°C	36.3°C		36.5°C		36.2°C							
Stools	Passed	Passed	Passed	Passed	Passed	Passed	Passed	Passed	Passed	Passed	Passed		Passed		Passed							
Urine	Passed	Passed	Passed	Passed	Passed	Passed	Passed	Passed	Passed	Passed	Passed		Passed		Passed							
Remarks	Head Neck Trunk Genitals Lower limbs → NAD																					

TEMPERATURE CHART

NAME: Baby Agyeiwaa Achampong Barbara

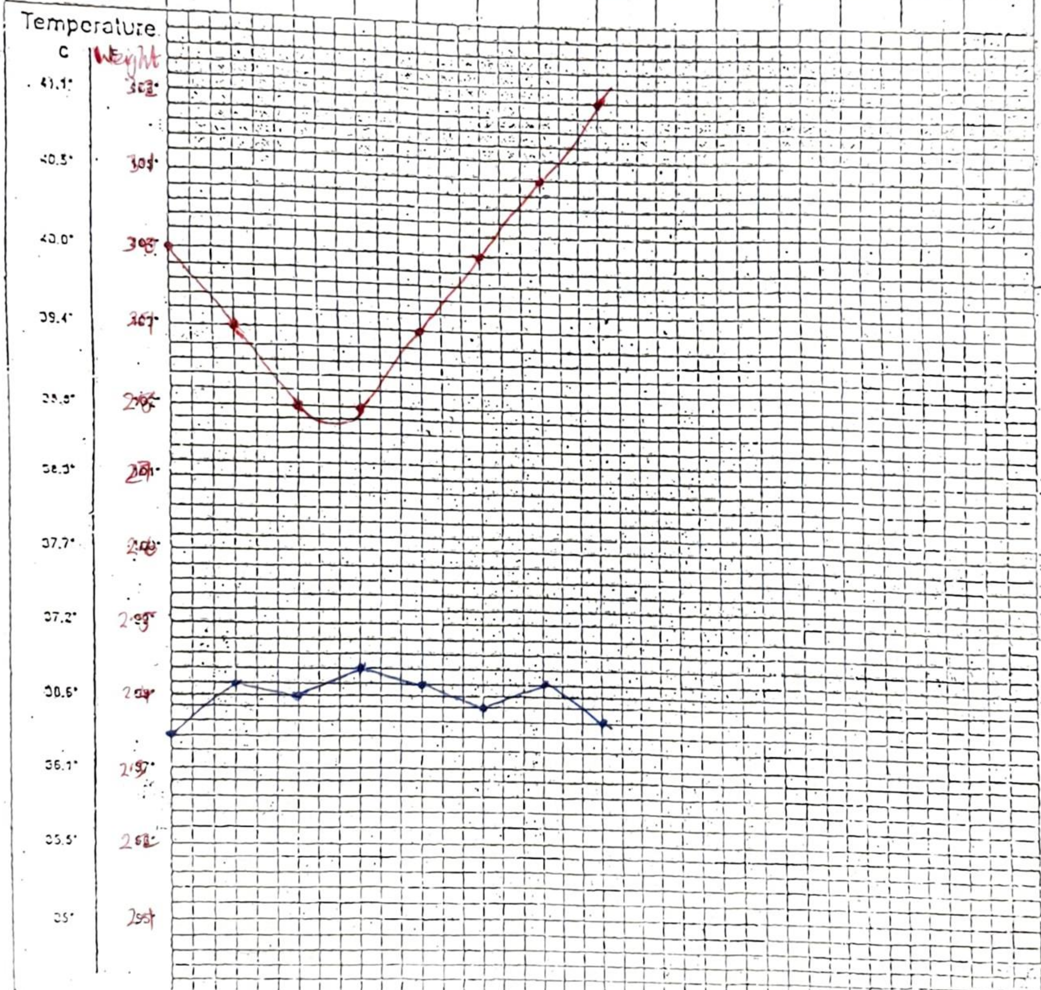
AGE: Newborn

WARD: Lying-In

IP NO.: 4484338

BED NO.: Cot 2

Date	30/03/23	31/03/23	01/04/23	02/04/23	03/04/23	04/04/23	05/04/23	06/04/23						
Days in Hospital	DD	D1	D2	D3	D4	D5	D6	D7						
Days P. O.														
Hour AM	11:00	6:50	7:00	7:00	7:30	7:00	7:30	7:30						
Hour PM	3:00	4:00	5:00	4:30	5:00									



	30/03/23	31/03/23	01/04/23	02/04/23	03/04/23	04/04/23	05/04/23	06/04/23
Pulse	130	135, 137	137, 137	138, 138	138, 136	133	132	140
Resp.	42	41, 44	43, 45	44, 45	46, 44	44	43	44
B.M.	Passed	Passed	Passed	Passed	Passed	Passed	Passed	Passed
Urine	Passed	Passed	Passed	Passed	Passed	Passed	Passed	Passed
B.P. AM / PM								

SIGNATORIES

THE STUDENT MIDWIFE

NAME: ADJEI BERMAA ANASTASIA

SIGNATURE: .....

DATE: 07-06-2024

THE MIDWIFE IN CHARGE (DORMAA WEST DISTRICT HOSPITAL, NKRANKWANTA)

NAME: MS. YEBOAH CONSTANCE

SIGNATURE: ..... (R.M)

DATE: 07-06-2024

THE SUPERVISOR

NAME: MS DORCAS OSEI

SIGNATURE: ..... (for)

DATE: 07-06-2024

THE PRINCIPAL

NAME: MONICA NKRUMAH

SIGNATURE: .....

PRINCIPAL
HOLY FAMILY NURSING AND MIDWIFERY TRAINING COLLEGE
BEREKUM

DATE: 10-06-2024