HOLY FAMILY NURSING AND MIDWIFERY TRAINING COLLEGE,

BEREKUM

A CLIENT/FAMILY CENTERED MATERNITY CARE STUDY ON

MADAM OSEI VERONICA

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, labor 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, Osei Veronica a 27year-old woman, gravida 3 para 2 during the period of pregnancy, labor and puerperium.

The interaction with her started on the 16th August, 2023. When she came for routine antenatal visit at Yamfo Health Centre which is located at Yamfo in the Ahafo Region. She was in her 36^{+4}days gestation. After an interaction for about 15 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 Veronica identified problems during pregnancy, labor 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 27th 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 labor, 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

LITERATURE REVIEW

This literature review gives information about what authors of different books report on pregnancy, labour and puerperium.

PREGNANCY PREGNANCY

Pregnancy: The state of carrying a developing embryo or fetus within the female body. This condition can be indicated by positive results on an over-the-counter urine test, and confirmed through a blood test, ultrasound, detection of fetal heartbeat, or an X-ray. Pregnancy lasts for about nine months, measured from the date of the woman's last menstrual period (LMP). It is conventionally divided into three trimesters, each roughly three months long (Davis, 2021). The most important tasks of basic fetal cell differentiation occur during the first trimester, so any harm done to the fetus during this period is most likely to result in miscarriage or serious disability. There is little to no chance that a first-trimester fetus can survive outside the womb, even with the best hospital care. Its systems are simply too undeveloped. This stage truly ends with the phenomenon of quickening: the mother's first perception of fetal movement. It is in the first trimester that some women experience "morning sickness," a form of nausea on awaking that usually passes within an hour. The breasts also begin to prepare for nursing, and painful soreness from hardening milk glands may result (Davis, 2021).

As the pregnancy progresses, the mother may experience many physical and emotional changes, ranging from increased moodiness to darkening of the skin in various areas. During the second trimester, the fetus undergoes a remarkable series of developments. Its physical parts become fully distinct and at least somewhat operational. With the best medical care, a second-trimester fetus born prematurely has at least some chance of survival, although developmental delays and other handicaps may emerge later. As the fetus grows in size, the mother's pregnant state will begin to be obvious. In the third trimester, the fetus enters the final stage of

preparation for birth. It increases rapidly in weight, as does the mother (American College of Obstetricians and Gynecologist, 2018).

According to Davis (2021), conception to about the 12th week of pregnancy marks the first trimester. The second trimester is weeks 13 to 27 and the third trimester starts about 28 weeks and lasts until birth. Women gain weight all over their bodies while they are pregnant.

Fetal weight accounts for about 7 1/2 pounds by the end of pregnancy. The placenta, which nourishes the baby, weighs about 1 1/2 pounds. The uterus weighs 2 pounds. A woman gains about 4 pounds due to increased blood volume and an additional 4 pounds due to increased fluid in the body. A woman's breasts gain 2 pounds during pregnancy. Amniotic fluid that surrounds the baby weighs 2 pounds. A woman gains about 7 pounds due to excess storage of protein, fat, and other nutrients. The combined weight from all these sources is about 30 pounds (Davis, 2021).

The World Health Organization (WHO) envisions a world where “every pregnant woman and newborn receives quality care throughout the pregnancy, childbirth and the postnatal period” (Tunçalp, et al., 2019). Antenatal care (ANC) can be defined as the care provided by skilled health-care professionals to pregnant women and adolescent girls in order to ensure the best health conditions for both mother and baby during pregnancy (World Health Organization, 2016). According to the World Health Organization (2016), the components of ANC include: risk identification; prevention and management of pregnancy-related or concurrent diseases; and health education and health promotion.

ANC reduces maternal and perinatal morbidity and mortality both directly, through detection and treatment of pregnancy-related complications, and indirectly, through the identification of women and girls at increased risk of developing complications during labour and delivery, thus ensuring referral to an appropriate level of care (World Health Organization, 2016). In addition, as indirect causes of maternal morbidity and mortality, such as HIV and malaria infections, contribute to approximately 25% of maternal deaths and near-misses (9), ANC also provides an

important opportunity to prevent and manage concurrent diseases through integrated service delivery (World Health Organization, 2016). Through this form of preventive health care, women can learn from skilled health personnel about healthy behaviours during pregnancy, better understand warning signs during pregnancy and childbirth, and receive social, emotional and psychological support at this critical time in their lives. Through antenatal care, pregnant women can also access micronutrient supplementation, treatment for hypertension to prevent eclampsia, as well as immunization against tetanus (United Nations Children's Funnd (UNICEF), 2022).

LABOR

Labor consists of a series of rhythmic, involuntary or medically induced contractions of the uterus that result in effacement (thinning and shortening) and dilation of the uterine cervix (Artal-Mittelmark, 2022). The World Health Organization (WHO) defined normal birth as "spontaneous in onset, low-risk at the start of labor and remaining so throughout labor and delivery. The infant is born spontaneously in the vertex position between 37 and 42 completed weeks of pregnancy. After birth, mother and infant are in good condition" (WHO, 2020).

The stimulus for labor is unknown, but digitally manipulating or mechanically stretching the cervix during examination enhances uterine contractile activity, most likely by stimulating release of oxytocin by the posterior pituitary gland (Artal-Mittelmark, 2022). Normal labor usually begins within 2 weeks (before or after) the estimated delivery date. In a first pregnancy, labor usually lasts 12 to 18 hours on average; subsequent labors are often shorter, averaging 6 to 8 hours (Artal-Mittelmark, 2022).

As discussed by Artal-Mittelmark (2022) rupture of the chorioamniotic membranes or bloody show is diagnostic for onset of labor. Labor begins with irregular uterine contractions of varying intensity; they apparently soften (ripen) the cervix, which begins to efface and dilate. As labor progresses, contractions increase in duration, intensity, and frequency. As sepcified by Marshall and Raynor (2014), the onset of labour is a process, not an event; therefore it is very

difficult to identify exactly when the painless (sometimes painful) contractions of prelabour develop into the progressive rhythmic contractions of established labour.

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

1.**The 1st stage**—from onset of labor to full dilation of the cervix (about 10 cm). Begins with regular rhythmic uterine contractions to the full dilatation of the cervix and is managed by a partograph. The first stage lasts for about twelve to fourteen hours in primi gravida and six to twelve hours in multigravida (Artal-Mittelmark, 2022).

a.The **latent phase of labour** is prior to the active phase stage of labour and may last 6–8 hours in primigravidae when the cervix dilates from 0 cm to 4 cm dilated. The latent phase of labour is so subjective and poorly understood that a normal range is difficult to measure. According to Marshall and Raynor (2014), the cervical canal shortens from 3 cm long to <0.5 cm in length during this time. A woman may believe herself to be laboring, whereas sound midwifery judgement and understanding of the physiology of the first stage of labour may lead the midwife to the diagnosis of the latent phase of labour. Both the woman and midwife being aware of the latent phase of labour, and allowing this time to pass with no intervention, can prevent the medical diagnosis of poor progress or failure to progress later in labour. In a hospital setting, it is good practice not to commence the partograph until active labour has commenced. Assessing the active phase of labour has been highlighted as essential in reducing interventions in normal labour (Marshall & Raynor, 2014).

b. The **active phase** within the first stage of labour is the time when the cervix usually undergoes more rapid dilatation. This begins when the cervix is at least 4 cm dilated and, in the

presence of rhythmic contractions, progressively dilates to 10 cm or full dilatation. When in labour, contractions will often be accompanied or preceded by a bloodstained mucoid show: that is, the release of the operculum from the cervical canal as effacement and dilatation progresses. Occasionally, the membranes will rupture, at which stage the midwife may seek assurance that there are no significant changes in the fetal heart rate due to the rare complication of cord prolapse and that meconium is not present in the liquor, indicating fetal compromise (Marshall & Raynor, 2014).

c. The **transitional phase** of the first stage of labour is from when the cervix is around 8 cm dilated until it is fully dilated or until expulsive contractions associated with the second stage of labour are felt by the woman. There is often a brief lull in the intensity of uterine activity at this time. Many women may feel the urge to push during transition. In addition to physiological responses, women can experience a range of experiences and emotions. The woman may verbalize her distress, direct it at her birth partner(s), alternatively she may be quiet and contemplative (Marshall & Raynor, 2014).

2. **The second stage** of labour has traditionally been regarded as the phase between full dilatation of the cervical os, and the birth of the baby (Marshall & Raynor, 2014). On average, it lasts 2 hours in nulliparous (median 50 minutes) and 1 hour in multiparas (median 20 minutes). It may last another hour or more if conduction (epidural) analgesia or intense opioid sedation is used. For spontaneous delivery, women must supplement uterine contractions by expulsively bearing down. In the 2nd stage, women should be attended constantly, and fetal heart sounds should be checked continuously or after every contraction. Contractions may be monitored by palpation or electronically (Artal-Mittelmark, 2022). During the 2nd stage of labor, perineal massage with lubricants and warm compresses may soften and stretch the perineum and thus reduce the rate of 3rd- and 4th-degree perineal tears.

3. The **third stage** can be defined as the period from the birth of the baby to complete expulsion of the placenta and membranes. It involves the development of the relationship

between mother, baby and father, the separation, descent and expulsion of the placenta and membranes, the control of hemorrhage from the placenta site, and sometimes, the initiation of breast-feeding. Although traditionally labour is divided into three distinct component parts to aid comprehension, it should be viewed as one continuous process. With this in mind, it is important to understand that the physiology of the third stage depends, in part, on what has happened during pregnancy as well as during the first and second stage of labour, and on the woman's basic level of health and wellbeing. The midwife's knowledge and evidence-based skills play a crucial role in ensuring that the care received by the woman works with, not against, physiological processes. The placenta may shear off during the final expulsive contractions accompanying the birth of the baby or remain adherent for some time. The third stage usually lasts between 5 and 15 minutes, but any period up to 1 hour may be considered normal (Marshall & Raynor, 2014).

PUERPERIUM

The words “postpartum” and “postnatal” are sometimes used interchangeably. In this report we use the word “postpartum”, except in sections exclusively dealing with the infant. In those sections the word “postnatal” is used. The postpartum period (also called the puerperium) according to Western textbook definitions starts shortly after the birth of the placenta (American College of Obstetricians and Gynecologist, 2018).

Following the birth of a baby, placenta and membranes, the newly birthed mother enters a period of physical and emotional/psychological recuperation. Skin-to-skin contact is advocated immediately following birth and during the postnatal period as there is clear evidence of benefit to the mother and father. The puerperium starts immediately after birth of the placenta and membranes and continues for 6 weeks. In many cultures around the world 40 days for recuperation is a time-honored practice. A general expectation is that by 6 weeks after birth a woman’s body will have recovered sufficiently from the effects of pregnancy and the process of parturition. However, there has now been a recognition that the return to a non-pregnant state of health and wellbeing can take much longer (Marshall & Raynor, 2014).

According to Marshall and Raynor (2014), After the birth of a baby and expulsion of the placenta, the mother enters a period of physical and psychological preparation and this period, called the puerperium starts immediately after delivery of the placenta and membranes and continues for a period of 6 to 8 weeks. Puerperium is a period after childbirth where the uterus and other organs and structures which were affected by pregnancy returns to their non-gravid state. This period is also divided into three;

1. Immediate puerperium: this is the first 24 hours after delivery.
2. Early puerperium: is between the second and the seventh day after delivery.
3. Late puerperium: this is the period from the second week to the sixth week after childbirth.

During this time a number of physiological and psychological changes take place which are;

The reproductive organs return to the non-pregnant state.

1. Lactation is established
2. Bounding between infant and parents is also established

The mother recovers from the stresses of pregnancy and delivery, and assumes responsibility for the care and nurture of her infant. The main aim of management during puerperium is to;

1. Manage minor disorders in both mother and baby.
2. Counsel and teach on nutritional needs of the puerperal mother.
3. Counsel, teach and encourage the mother to breastfeed exclusively for six months and how to properly fix baby to breast.
4. Counsel and teach mother on importance of rest and sleep, ambulation and exercise as well as family planning.

The transition to parenthood involves major adjustments within a family and some mothers will welcome and actively seek help and support from a midwife during the postnatal period, but some women, for a range of reasons, may not. Women from different cultural backgrounds may have traditions that conflict with the current management of postpartum care consider that they already have sufficient skills and experience. Not being able to speak or understand English may also prevent a woman from seeking help. Although a visit to the home might have been planned, there will also be times when women are not at home when the midwife visits. It is important to keep in mind individual circumstances and whether these might have any bearing on a no-access visit. For example, parents with a disability such as hearing loss or poor mobility might not hear a doorbell. It is, therefore, important to make arrangements for contact to be made by alternative means (e.g. using a visual alarm or telephone to alert the woman of the visit beforehand). The midwife needs to recognize situations where the mother perceives she has different priorities from those routinely provided by the healthcare services (Marshall & Raynor, 2014).

WHY CLIENT WAS CHOSEN

Madam Veronica, G3 Para 2 with 36^{+4} weeks gestation was chosen as a client for the client/family centered maternity Care study on the 16th

August 2023 at Yamfo Health Center which happened to be her sixth 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 Veronica complained of lower abdominal pain and persistent waist pains. She was encouraged and reassured that her condition would be managed. Madam Veronica 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, labor 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 assured to be visited at home.

CHAPTER ONE

CLIENTS PARTICULARS

1.0 INTRODUCTION

This chapter gives a detailed information about the client's personal history, social history, family history, menstrual history, surgical history, past and present obstetrical histories and her habit of daily living.

1.1 PERSONAL AND SOCIAL HISTORY

Madam Veronica Osei is the name of the client chosen. She is G3 P2 and 27 years of age. Client comes from and lives at Yamfo in the Ahafo Region of Ghana. She stays with her husband and her 2 children. She is fair in complexion, weighed 58.7 kilogram and 168 centimeters tall at booking. She is a Christian by religion and worships at the Assemblies of God Church.

Madam Veronica had her formal education up to Senior High School. She has a husband by name Mr. James Osei, who is a driver and also a Christian. Madam Veronica is a trader. She speaks only Twi. Madam Veronica mentioned her mother as her next of kin and she is supported by her family.

1.2 FAMILY HISTORY

According to Madam Veronica. she said God blessed her parents with five children and she is the fourth born among the five. She said three are females and the remaining two are males. She said her father's name is Mr. Opoku and her mother's name is Madam Grace Opoku who are both farmers and natives of Yamfo. According to Madam Veronica, her family has no history of 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. There is no history of multiple pregnancies. She also added that all people who die in their family dies naturally.

1.3 MEDICAL HISTORY

According to Madam Veronica, 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 and she visits the antenatal clinic with the use of the National Health Insurance Scheme (NHIS).

1.4 SURGICAL HISTORY

According to Madam Veronica, she has never undergone any surgical operation and has never sustained any injury in the pelvic before. She has no history of any road traffic accident neither has she donated blood nor has she been transfused before. She said she wasn't given any episiotomy during her previous delivery.

1.5 MENSTRUAL HISTORY

Madam Veronica had her menarche at the age of 16. 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. Her last menstrual period was on 20th November, 2022 and her expected date of delivery was 27th August, 2023.

1.6 LIFESTYLES AND HOBBIES

Madam Veronica wakes up around 5:30am every day. When she wakes up, 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.

Madam Veronica takes her bath twice daily. She eats three times a day with her favorite food being fufu with palm nut soup. She does her washing on Saturdays but do wash on weekdays sometimes when the need arises. On Sundays, she goes to church with her children and with her husband. She is sociable and neither smokes nor takes in alcohol. She also scrubbed her bathroom and toilet every Saturday. Madam Veronica has a cordial relationship with her relatives as well as the people in her neighborhood.

1.7 PAST OBSTETRICAL HISTORY

Pregnancy

Madam Veronica gravida 3 para 2 went through her pregnancies successfully without any complication. She had her previous pregnancies in the year 2016 and 2019. She said during her previous pregnancy, she only experienced some minor disorders such as headache, waist pain, lower abdominal pain, constipation, leg cramps, frequency of micturition, nausea and vomiting of which she reported to the clinic and they were explained to her as a normal physiological changes 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 delivered her children at term. She has never suffered any pregnancy induced condition like gestational diabetes and pregnancy induce hypertension (pre-eclampsia). She also visited

antenatal clinic for at least seven (7) times during her previous pregnancies and received all doses of sulphadoxine pyrimethamine and three doses of tetanus diphtheria injection.

Labour

Madam Veronica delivered her children spontaneously per vagina at the hospital. She further stated that the duration for her delivery did not exceed 18 hours. Client's first child was delivered at Yamfo Health Center that was a female and weighed 2.8kg at birth .And her second child at Yamfo Health Centre and weighed 3.0kg at birth. She also said she has never had any perineal tear or been given episiotomy during her previous deliveries. She added that she had never experienced post-partum haemorrhage. Her placenta was delivered completely with no retained product of conception. She said her estimated blood loss for her previous delivery was small. Her children had no birth injuries, asphyxia or jaundice. They were active at birth and healthy.

Puerperium

She said she started breastfeeding them within the first hour after birth. She practiced exclusive breastfeeding for 6months and then added complementary feeds after the 6months for one and half years. She had a safe breastfeeding with no complication. She added that her children did not have any abnormalities like cleft lip, extra digits or webbed digits. Her children were fully immunized against the vaccine preventable diseases according to schedules. Her children never suffered any illness. She herself did not experience any illness such as puerperal psychosis, anaemia and malaria. She also did not experience problems like post-partum haemorrhage, puerperal pyrexia, puerperal sepsis, mastitis among others. 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 Veronica, G3 P2 began her antenatal clinic attendance on 20 February, 2023 at Yamfo Health Center at 11^{+3} weeks gestation and her history was taken by the midwife in charge. She gave her last menstrual period as 20/11/2022 and her expected date of delivery was calculated to be 27th August, 2023. 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	12.0 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 0
Stool test	No abnormality detected

Vital signs were checked and recorded as follows:

Temperature	36.2 degree Celsius
Pulse	80 bpm
Respiration	20 cpm
Blood Pressure	110/60 mmHg
Height	159cm
Weight	63.7kg

Head to toe examination was carried out and no abnormality was detected. On palpation, the uterus was palpable and she was 11^{+3} weeks of gestation, the symphysio-fundal height was 12cm, there was no descent and fetal movement was present. 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. She was educated on danger signs of pregnancy such as severe headaches, excessive vomiting, bleeding, oedema, and the need to prevent herself from getting malaria by sleeping under a treated insecticide mosquito net at night and the application of mosquito repellent whilst outside her room especially at nigh

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 Veronica Osei was on the 16 August 2023 when she was coming for her routine antenatal follow up at Yamfo Health Centre with 36^{+4} 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 sessions, Madam Veronica complained of lower abdominal pain and persistent waist pain. Madam Veronica 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 expressed for client to be used 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 .2 degrees Celsius
Pulse	80 bpm
Respiration rate	22 cpm

Blood Pressure	110/60 mmHg
Weight	70kg

The results of the various laboratory investigations done were as follows

Haemoglobin	14.0grams 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 on her 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 assisted to undress and asked to empty her bladder. 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

its 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.

Her breasts was exposed and inspected for the size and shape. The nipples for retraction, invertion 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. The upper extremities were in alignment with the body on inspection. There was no extra digits on the fingers on inspection. The lower extremities were also inspected for edema, varicose veins, calf tenderness but none was identified and they were of equal length and size. Client was turned and the back inspected but no abnormality detected.

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 35 centimeters.

Fundal palpation – facing the head of Madam Veronica, 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 Veronicas feet and she was asked to flex her kneel 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 fetal head.

Auscultation: On auscultation, the fetal stethoscope was warmed and placed at the area where the foetal 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 fetal 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. Permission was sought from her for home visits which she accepted and gave directions to her house as well as telephone number. She took her 3rd dose of Sulphadoxine Pyrimethamine under Direct Observation Therapy (DOT).

Her routine drugs were given as;

Tablet Folic Acid	5 milligrams daily for10days
Tablet paracetamol	1gram tid for 3 days
Tablet Ferrous Sulphate	200milligram daily for 10days.

2.2 FIRST ANTENATAL HOME VISIT

On 19th August 2023 at 3pm Madam Veronica as 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 neighbors. Client stays at Yamfo, at the back of the station near the Police Station. The distance to Madam Veronica house is about 10 minutes walk from the clinic.

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

Client's husband wasn't around but her children who happened to be two girls were with her.

Madam Veronica, her husband and children were happily living in a 5 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. Madam Veronica said, she stays in the house with her husband and children and other neighbors Madam Veronica 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 scrubbed 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. 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. Madam Veronica was then appreciated for the warm reception and permission was sought to leave and next visit scheduled to be on the 24/08/2023 and was then seen off by client.

PSYCHOSOCIAL

It was observed that Madam Veronica relates well with the other neighbors. Client has a friendly relationship with her relatives and other neighbors who stays around their area. Client said she doesn't have a lot of friends but she visits the few she has at the leisure time and they also visits her sometimes. She is jovial and does not have problems with her neighbors.

2.3 SECOND ANTENATAL HOME VISIT

Madam Veronica was visited the second time on the 24/08/2023 around 3:00pm. A seat and water were offered upon arrival after the exchange of pleasantries. The environment was tidy and well kept. She complained of constipation and heartburns after meals when her condition of health was inquired 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. She was encouraged to avoid taking spicy foods. She was asked to mention the true labour signs and she was able to recall all of them. She was also assured of the competency of the midwives and therefore need not to be anxious.

Enquiries were made about the support person who would take her to the hospital when labour sets in and she said her mother. She was also encouraged to make an arrangement with a taxi driver who would take her to the clinic when the need arises. The room was well

ventilated and her items had been neatly arranged, her room was very spacious upon entering. Permission was sought to leave and she was reminded of the next visit to the facility which will be on the 26/082023.

2.4 SUBSEQUENT VISIT TO THE CLINIC

On 26/08/2023, Madam Veronica 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	36.0 degrees Celsius
Pulse rate	82 bpm
Respiratory rate	20 cpm
Blood Pressure	110/60 mmHg
Weight	72 kilogram

After the recording of the vital signs, permission was sought to perform a head to toe examination which she agreed. She was ask 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. Symphysio-fundal height 37cm, lie longitudinal, and presentation, cephalic, descent $5/5^{th}$ foetal heart rate was 138 on auscultation. Her gestational age was 38weeks. 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 and was bid goodbye.

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

1. Waist pains 16th August 2023
2. Lower abdominal pains 16th August 2023
3. Constipation 26th August 2023
4. Heart burns 26th August 2023
5. Inadequate sleep 26th August 2023

SHORT TERM OBJECTIVES

1. Client will cope with waist pain throughout pregnancy.
2. Client will cope with lower abdominal pain throughout pregnancy.
3. Client will be pass stool once within 24 hours.

4. Client will be relieved of heart burns within 24 hours and should be able to cope throughout pregnancy

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

LONG TERM OBJECTIVE

Madam Veronica will go through pregnancy, labor and puerperium successfully without any complications to both mother and fetus.

NURSING CARE PLAN

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES/ OUTCOME CRITERIA	NURSING ORDER	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
16/08/23 9:00am	Waist pain Related to descent of fetalhead.	Client will cope with waist pains throughout pregnancy as Evidenced by client verbalizing that she can cope with waist pains.	1. Reassure client. 2. Educate client on the physiology ofwaist pains inpregnancy 3. Encourage client toassume proper bodymechanic when lifting. 4. Educate client to assume a comfortable position. 5. Served prescribedanalgesic.	1. Client was reassured that pain will soonend 2. It was explain to client that it was due todescent of the fetal head. 3. Client was told to bend from kneeinstead of waist. 4. Client was put to left lateral positionwhen she is in pain. 5. Client was served with tab paracetamol1g	29/08/24 9:00am	Goal fully met asclient verbalizedthat she was ableto cope with waist pain	A.B.J

CONTINUATION OF ANTENATAL CARE PLAN

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES/ OUTCOME CRITERIA	NURSING ORDER	NURSING INTERVENTION	DATE/TIME	EVALUATION	SIGN
16th August 2023 10:00am	Lower abdominal pain related to pressure on the lower abdominal muscle by the growing uterus	2. Client will cope with lower abdominal pain throughout pregnancy as evidenced by client verbalizing that she can cope with lower abdominal pain.	1. Reassure client. 2. Explain the physiology of lower abdominal pain to client. Teach client how to manage her pain. 4. Teach client deep breathingexercise. 5.Serve client with prescribed analgesic	1. Client was reassured that waist pain will soon stop. 2. Client was told that thepain is due to the relaxation of joints and ligaments. 3. Client was told to assumea comfortable position whenthere is pain 4. Client was supervised tobreath in and out. 5.Client was served withparacetamol 1g	30th August 2023 10:00am	Goal fullymet as client verbalized that she wasable to copewith the lower abdominal pain.	A.B.J

NURSING CARE ANTENATAL PLAN CONTINUED

DATE	NURSING DIAGNOSIS	NURSING OBJECTIVES/ OUTCOME CRITERIA	NURSING ORDERS	NURSING EVALUATION	DATE/ TIME	EVALUATION	SIGN
26/08/2023 8:00am	Impaired bowel movement [Constipation]related tothe activityof progesterone causing decreased peristalsis	Client will be pass stool once within 24 hours. as evidenced by Client verbalizing that shehas no difficulty in emptying her bowel due to relaxation ofthe smooth muscle of thebowel during pregnancy	1. Reassure client 2. Explain the physiology of constipation to client. 3. Educate client onfluid intake. 4. Educate client on diet. 5. Encourage client to ambulate	1. Client wasreassured that she will be able toempty her bowel within 24 hours. 2. Client was toldthat it is as a result of progesteronecausing relaxationof smooth muscle of bowel during pregnancy. 3. Client waseducated to take at least 8 glasses of water a day. 4. Client was told to add roughages and vegetables toher diet to prevent constipation. 5. Client was told to walk around.	27/08/2023 8:00am	Goal fully met as client verbalized that she emptied her bowel once daily.	A.B.J

ANTENATAL NURSING CARE PLAN CONTINUED

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
26/08/2023 9:00am	Heart burns related to effect ofprogesterone causing relaxation ofthe cardiacsphincter during pregnancy	Client will be relieved of heart burns within 24 hours and should be able to cope throughout pregnancy.as evidence by client verbalizing heart burns has relieved.	1. Reassureclient. 2. Educate clienton the physiology of heart burns. 3. Educate clienton diet. 4. Educate client to sit a while after eating. 5. Teach clienton proper sleeping position.	1. Client was reassured that her heart burnswill be relieved. 2. Client was told thatit is as a result of weak cardiac. sphincterduring pregnancy 3. Client was educated on the need to reduce the intake of oily and spicy foods. 4. Client was educated not go to bed immediately aftermeals to allow properdigestion of food. 5. Client was taught touse more pillows whensleeping to raise the head.	27/08/2023 9:00am	Goals fully achieved as client verbalizedshe is relieved.	A.B.J

ANTENATAL NURSING CARE PLAN CONTINUED

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES/ OUTCOME CRITERIA	NURSINGORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
26/08/2023 9:00am	Inadequate sleeprelated to frequency micturition on	Client will haveat least 2 hourssleep within theday and 4 hours at night within 24 hours as evidenced by client verbalizing that she was able to sleep.	1. Reassure client. 2. Educate client to take warm bathbefore going tobed 3. Educate clientto empty her bladder before going to bed. 4. Educate clientto reduce the intake of fluid. 5. Explain the physiology of frequent of micturition to client.	1. Client was reassured that everything willbecome normal after delivery 2. client was assisted to take warm bath 3. Client was educatedon the need to empty her bladder whenever she has the urge. 4. Client was educatedto reduce intake of fluid at night.	27/08/2023 9:00am	Goals fully met as client verbalized that, she was able to sleep 2 hour during the day and 6 hours during the night	A.B.J

CHAPTER THREE

LABOUR

3.0 INTRODUCTION

This chapter gives information about labour, admission and management of the various stages of labour, 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 27th August, 2023 at 8am, Madam veronica arrived at the Yamfo Health Center with a neighbor. They were warmly welcomed and seats offered to them. She complained of severe lower abdominal pains and waist pains. Madam Veronica said she had noticed some mucoid blood stain vaginal discharge (show) around 7:30am before coming. She was asked if she has taking any drug or eating, and she said she has taken her routine drugs this morning and has eaten rice with light soups she added that she has emptied her bowel this morning. She was taken to the delivery room, she was offered a bed. Procedures to be done were explained to her and consent was gained. Her vital signs were checked and recorded as follows;

Temperature	36.9 degree Celsius
Pulse rate	80bpm

Respiration rate	20cpm
Blood Pressure	110/60 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, 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.

On abdominal examination; the abdomen was ovoid in shape and medium in size. Striae gravida and linea nigra were seen on the abdomen. The symphysio-fundal height was 37 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 38 weeks. On pelvic palpation, the lie was longitudinal and the presentation was cephalic. Examination for decent indicated a descent of 3/5th.

On auscultation, the foetal heart rate was 120 beats per minute then contractions were timed for 10 full minute by placing the palm on the fundus and it was two in ten (10) minutes lasting for thirty (30) seconds. 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 glove was 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 at 8am 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 and findings recorded on partograph. She was informed of progress of labour and educated on cervical dilation which was done with the help of a dilatation board.

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 labor and delivery as well as the care of the baby. The unskilled helper who was the client's neighbor 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 it 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 Veronica 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 feotal 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 and was seen anxious. Client further added that she did not know the outcome of the labor. Client was reassured of normal labor with a healthy baby without any complications after delivery. 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 fatique, 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 12:00pm, 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 feotal heart rate was 150 beats per minute contractions timed were 4 in 10 lasting 42 seconds. These findings were confirmed by the midwife in charge.

Vital signs were checked and recorded as:

Temperature $36.8\ ^{0}C$

Pulse	80 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 and recorded on a partograph.

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 cathe79'ter and drainage bag, identification band, examination gloves mackintosh, cot sheet, drum containing gauze and cotton wool, cheatle forceps in its container.

At 1:00pm, 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 0/5th above the pelvic brim, fetal heart rate was 140 beats per minute with good volume. Contractions were 4:10 lasting 44 seconds. She passed 120mls of urine and sample was tested for protein and glucose, which was negative. Hands were washed with soap under running water and dried with a clean dry towel.

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

Temperature	36.4 degree Celsius
Pulse	80 bpm
Blood Pressure	110/70 mmHg
Respiration rate	20 cpm

All findings were plotted on the partograph.

3.3 MANAGEMENT OF THE SECOND STAGE OF LABOUR

Client was assisted to assume the lithotomy position. Rubber apron, boots, goggles, maskand 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 fetal 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. Time of delivery was 1:30pm. The baby was dried thoroughly and wet cloth removed to prevent heat loss and covered with a new sheet. Apgar score was assessed and cord was clamped and cut. A healthy baby girl was delivered and sex confirmed by the mother. The baby was put on mother's chest and covered to continue skin to skin contact. Madam Veronica was congratulated for her effort and co-operation.

3.4 IMMEDIATE CARE OF THE BABY

As soon as the head of the baby was born, its eyes were cleaned with sterile gauze starting from the inner canthus to the outer canthus as well as the face. The liquor was cleaned from the baby's body thoroughly. The baby was placed skin to skin and covered with a warm dry cloth. The first minute Apgar score was assessed to be 8/10. The umbilical cord was clamped 2 fingers breaths away from the baby's abdomen and 3 fingers breaths away from the first clamp the cord was covered with a sterile gauze and cut in between the two clamps to separate the baby from the mother. The fifth minute APGAR score was 9/10. An identification band bearing mother's name, sex of baby, time and date of delivery was placed on baby's hand. Skin to skin care was continued to provide warmth and bonding. Breastfeeding was then initiated to promote bonding between mother and baby and also help to release natural oxytocin which would help in the contraction of the uterus. During the skin to skin care, baby's temperature and breathing were observed.

3.0 ACTIVE MANAGEMENT OF THIRD STAGE OF LABOUR

The procedure was explained to Madam Veronica. Within a minute after the baby was born,10 units of oxytocin was given intramuscularly to aid in the contraction of the uterus after confirming that there was no second twin on palpation of the uterus. The cord was re - clamped closer to the vulva and the hanging end was placed in the receiver in between her thighs to receive the placenta and membranes. The bladder was checked and it was empty. Controlled cord traction was used in the delivery of the placenta in order to prevent retained placenta or membranes and inversion of the uterus. The left hand was placed on the fundus to feel for contractions. When the uterus was well contracted, the left hand was removed and placed above the symphysis pubis with the palm facing the abdomen of the mother to stabilize the uterus to prevent inversion of the uterus. Anytime contractions wore off, drawing out of the placenta was stopped and the process was repeated when contractions reoccurs.

While at the same time the right hand held the cord and with downward and outward traction applied to the cord, the placenta appeared at the vulva. Both hands were used to hold the placenta and twisted gentle to prevent the membranes from tearing. The placenta and its membranes were delivered at 1:40pm. The uterus was massaged to maintain contraction and expel clots. Sterile gauze was wrapped around the first and second fingers of the two hands to inspect the cervix. The cervix was examined clockwise and the vaginal walls were inspected, there were no tears found in the cervix, the vaginal wall, the vulva and the perineum. Blood loss per vaginum was approximately 140mls. She was cleaned up nicely and a clean perineal pad was applied. She was covered with a new sheet and made comfortable in bed. Madam Veronica was encouraged to empty her bladder whenever she had the urge in order for the uterus to contract well and she was also taught how to massage the uterus herself and report any changes quickly. Madam Veronica was congratulated for the effort made

3.1 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 center 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 Veronica was thanked once again for her effort and cooperation.

3.2 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 Veronica 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 degree Celsius
Pulse	80bpm
Respiration	22cpm
Blood Pressure	120/70mmHg

Baby

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 and permission was sought from mother to examine the baby of which she agreed. Hands were washed with soap under running water, cleaned and dried and examination gloves were worn. The baby was examined from head to toe to detect any deviations from normal. Baby was positioned on a warm safe flat surface within the view of the mother. Baby was unwrapped and general observation was done. Baby's skin was pink in colour on observation. The head was examined for shape, size, widened sutures, bulging and sunken fontanelles, lacerations, any edematous swelling or caput succedaneum but no abnormality was detected. The ears were examined for size, shape, and patency, alignment and discharges. There was no abnormality detected and the upper notch of the pinna was aligned with the contours of the eyes. The sclera was examined for jaundice and blood stains, conjunctiva for pallor, presence of clear lens and discharges but there was no abnormality. The nose was examined for shape, size, patency, deviated septum and discharges but there were none. The mouth was inspected for false teeth, tongue tie, color of tongue and gum, cleft lip and palate by using the little finger to feel for palate, sub mucus cleft but everything was normal. The neck was also palpated for enlarged lymph nodes, rigidity and congenital goiter but none was present. The chest and abdomen was observed and respiratory movement was regular, nipples were in alignment without discharges, and breast had no mass the abdomen was examined for shape and size, with no bleeding from the umbilical site and abnormalities such as omphalocele and gastroschisis were absent. Examination of the upper extremities was done and hands were inspected for symmetry, clubbing, extra or missing digits and webbing. Hands and arms were inspected for movement, paralysis, palms for the number of palmer creases, nail beds were checked for color, and reflexes (Moro, grasping

reflexes) 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 and there was no dislocation since a 'clunk' sound was not heard. The back of the baby was examined and no abnormalities such as spinal bifida, meningocele of the spine detected. The genitalia and anus were well developed. The urethral and anal orifices were patent as she passed urine and meconium respectively. The baby was weighed and the weight was 3.0kg, head circumference was 33cm, length 49cm and temperature was 36.2. The baby was classified as normal. . Gloves were removed and disposed aseptically before washing hands with soap under running water and dried with clean dry towel. Findings were documented and communicated to client. Baby's vital signs and weight were checked and recorded as follows;

Temperature	36.2 degrees Celsius
Apex heart beat	138 beats per minute
Respiration	42 cycles per minute
Weight	3.0 kilograms

The baby's skin was smeared with baby oil, warmly wrapped with a clean dry sheet and placed beside her mother.

Mother

Madam Veronica was informed that her vital signs were checked every 15 minutes for 2 hours and every 30 minutes for an hour and 1 hour for 3 hours. Having sought permission from client, her vital signs were checked and recorded as follows;

Temperature	36.7 degree Celsius
Pulse	80 bpm
Respiration	20 cpm
Blood Pressure	120/60 mmHg

The uterus was massaged to feel for contractions. Blood clots were expelled and blood loss was 140 milliliters. The Symphysio -fundal height was 16 centimeters. At the end of the 6 hours monitoring, all findings were recorded on the partograph. Lochia was red in color (rubra), small in quantity and had no foul smell. Madam Veronica was educated on the need to urinate frequently and change perineal pad when soaked, how to fix baby to the breast, the importance of exclusive breastfeeding for the first 6 months and to feed the baby on demand. She was also encouraged to wash hands thoroughly with soap and water before and after breastfeeding of the baby and after changing perineal pad. General condition of client was good and all labor notes were recorded behind the partograph sheet.

3.3 SUMMARY OF LABOUR AND DELIVERY

Date of delivery	27th August, 2023
Time of delivery	1:30pm
Time of delivery of placenta	1:40pm
Type of delivery	Spontaneous vagina delivery
Estimated blood los	140ml

Duration of labour

First stage of labour	5 hours
Second stage of labour	30 minute
Third stage of labour	10 minute
Total duration of labour	5 hours 40 minutes

Condition of baby

Sex	Female
Birth weight	3.0kg
Apgar score 1st minute	8/10
Apgar score 5th minute	9/10
Full length	49cm
Head circumference	33cm
Meconium	Passed
Urine	Passed
Abnormality	None detected
General condition	Good

Condition of mother

Temperature	36.2degree Celsius
Pulse	80 bpm
Respiration	20 cpm
Blood pressure	120/70
mmHgUterus	Contracted
SFH	16cm
Lochia	Rubra
Condition	Satisfactory

Condition of placenta

Maternal surface	Normal
Fetal surface	Normal (Bluish grey)
Lobes and membranes	complete
Blood vessels	2 Arteries, 1 Vein

3.4 LABOUR CARE PLAN

PROBLEMS IDENTIFIED DURING LABOUR

1. Lower abdominal pains 27/08/2023

2. Waist pains 27/08/2023

3. Nausea and vomiting 27/08/2023

4. Anxiety 27/08/2023

5. Fatigue 27/08/2023

SHORT TERM OBJECTIVES

1. Client lower abdominal pain will be resolved after delivery.

2. Client waist pain will be resolved after delivery.

3. Client will stop vomiting within 6 hours.

4. Client will be relieved of anxiety after delivery.

5. Client will cope with fatigue within 24 hour.

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	NURSING OBJECTIVES /OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
27/08/2023 8:00am	Lower abdominal pains related to uterine contractions.	Client will be relieved of lower abdominal painswithin 6 hours as evidenced by client verbalizing that she isrelieved.	1. Reassure client. 2. Engage client in diversional therapy. 3. Encourage ambulation. 4. Teach client topractice deep breathing exercise. 5.Explain the physiology of lowerabdominal pain to client	1. Client was reassured that pain will soon end. 2. Client was engaged in a conversation. 3. Client was assisted to walk around. 4. Client was taught to breathin and out during contractions. 5.It was explain to client that pain is due to uterine	27/08/2023 2:00pm	Goal fully met as client verbalizedthat she is relieved of the lower abdominal pains	A.B.J

LABOUR CARE PLAN CONTINUED

DATE& TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES / OUTCOME CRITERIA	NURSING ORDER	NURSING INTERVENTION	DATE & TIME	EVALUATIO N	SIGN
27/08/2023 10:00am	Waist pain related to descent ofthe fetalhead.	Client's pain will be relieved within 8 hours evidence by client verbalizing that she was able to cope withpain.	1. Reassure client. 2. Educate client on the physiology of the waist pains. 3. Massage client sacral region. 4. Encourage her to assumea comfortable position. 5.Engage client in diversional therapy	1. Client was reassured that pain will stop soon. 2. Client was educated that pain is due to descent ofthe fetal head. 3. Client sacral region was massaged by a midwife. 4. Client was put to left lateral position. 5. The midwife stayed with client to converse.	27/08/2023 4:00pm	Goal fully met as client verbalizing that she can pain is relieved	A.B.J

LABOUR CARE PLAN CONTINUED

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES /OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
27/08/2023 10:00am	Nausea and vomiting related to reduced digestion during labour.	Client will stop vomiting within 6 hours as evidence by client verbalizing she is not vomiting anymore.	1. Reassure client. 2. Hydrate client. 3. Ensure oral hygiene. 4. Remove nauseating objects. 5. Serve client food to maintain her nutritional needs.	Client was reassured to allay fear and anxiety. Client was given oral fluid to maintain fluid loss. Client was given water torinse her mouth after vomiting. Bed pan was remove fromclient bed side. Client was given malt	27/08/2023 4:00pm	Goal fully met as client verbalized that she is no longer vomiting.	A.B.J

LABOUR CARE PLAN CONTINUED

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES /OUTCOME CRITERIA	NURSINGORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
27/08/2023 10:00am	Anxiety related to unknown outcome of labour.	Client will be relieved of anxietywithin 7 hours as evidence by client verbalizing she isno more anxious.	1. Reassureclient. 2. Encourageclient to ask questions. 3. Encourageclient to do deep breathingexercise. 4.Introduceclient to other staff who will attend to her. 5. Educateclient on positive outcome of labour.	1. Client wasreassured of safe delivery. 2. Answers were given to client questions appropriately. 3. Client was assisted to do deep breathing exercise. 4. The skilled helper was introduce to client. 5. Client was told thatlabour will be normalwithout complication	27/08/2023 3:00pm	Goal fully met as clientverbalized that she is no more anxious	A.B.J

DATE	NURSING DIAGNOSIS	NURSING OBJECTIVE/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
27/08/2023 10:00am	Fatigue relatedto stress of labour	Client will cope with fatigue within 24 hours as evidence by client verbalizing thatshe is no more tired	. Reassureclient. 2. Massageclient's body. 3.Encourageclient on positive outcome of labour. **4.**Encourage deep breathing exercise. **5.** Serve clientwith food tomaintain hernutritional needs.	. Client was reassured of safe delivery. 2. Client's body was massaged. 3. Clients were told that delivery will besuccessful deliverywithout anycomplication. 4. Deep breathing exercise was performby client. 5. The client wasserve with tea	28/08/20 23 11:00am	Goal fully met as clientverbalize that she is no moretired.	A.B.J

CHAPTER FOUR

PUERPERIUM

4.0 INTRODUCTION

This chapter talks about the management of both mother and baby from delivery to six weeks' post-partum and care plans drawn for the management of problems identified during puerperium.

4.1 DAY OF DELIVERY

Madam Veronica had a spontaneous vagina delivery to a live female child at 1:30pm on the 27th 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. She was educated on the need for exclusive breastfeeding for six months and how to fix baby to the breast. Emphasis was also made on proper hand washing before 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	36.7 degree Celsius
Pulse	82bpm
Respiration	20cpm
Blood pressure	120/70mmHg

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

Baby's vital signs

Temperature	36.2 degree Celsius
Pulse	138bpm
Respiration	42cpm

The symphysio - fundal height was 18 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 patograph

4.2 FIRST BABY BATH AND CORD DRESSING

SUBSEQUENT CARE OF BABY

Requirements for baby bath and cord dressing

The requirements for baby bath on the top shelf includes the following; 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. Items on the bottom shelf includes; jug of hot water, disposable gloves, jug of cold water, a bowl of mixing water, pomade, surgical gloves and mackintosh. The procedure was explained to Madam Veronica. 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 applied 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.

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 soaked in methylated spirit. 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 Veronica 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 Veronica 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 [D A Y OF DISCHARGE]

On the 28th August, 2023 which was the first day post-delivery, Madam Veronica woke up around 6:30am, emptied her bowel, and cleaned her teeth after which she was given warm water to bath. She complained of **after pains**. 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;

Assessment	Morning
Temperature	36.6 degree celcius
Pulse	80 bpm
Respiration	20cpm
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 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, with the intention of closing the fontanelles. The baby passed meconium. Her vital signs and weight were checked and recorded as follows;

Temperature	36.6 degree Celsius
Pulse	134bpm
Respiration	42cpm
Weight	2.9kg

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 Veronica took porridge and bread as her breakfast. She was reminded on the need for proper personal hygiene, good nutrition, and exclusive breastfeeding for six months. 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 03/09/2023. Posture and method of breastfeeding was demonstrated to Madam Veronica after which she was asked to do same and she did it perfectly. She was also educated on breastfeeding the baby on demand (not less than 8 times a day), and adequate feeding at night. Madam Veronica was educated on the importance of birth registration and was asked to register the baby. The baby was immunized with polio O vaccine 2 drop per mouth and BCG 0.5ml was administered intra-dermal to right upper arm. Madam Veronica 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 Veronica and her family were visited in their home on the 28th August, 2023 at 3:00pm 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 exam 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. No abnormality was identified on head to toe examination. The uterus was well contracted and the symphysio fundal height measured 15cm. Perineal pad was inspected and a small amount of lochia rubra which was not offensive was seen and her breast were soft and colostrum was expressed. Her vital signs were checked and recorded as;

Temperature	36.2 degree celcius
Pulse	80bpm
Respiration	20cpm
Blood Pressure	110/65mmHg

Exclusive breastfeeding and feeding on demand especially at night was also encouraged. 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. Head to toe examination was conducted on the baby and no abnormality was identified. As the baby was being top and tailed with warm water, it passed urine and meconium. The cord was also dressed with cottonwool soaked with methylated spirit. It was clean and kept dry. Baby's vital signs and weight were checked and recorded as follows;

Temperature	36.6 degree celcius
Pulse	135bpm
Respiration	44cpm

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

She was reassured that the problem was normal and would be managed and also she was educated and taught how to adapt a proper position during breastfeeding. 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 29th of August, 2023. Having been received warmly, the family responded of good health. When enquires were made about her complains of the previous day she said backache has stop. Every procedure to be performed on both client and baby were explained and she agreed. Head to toe examination was done on the mother and everything was normal. Her perineal pad was inspected and an odorless red (rubra) lochia was seen on perineal examination including a clean vulva and perineum. Her fundal height was 14centimeters. Client's vital signs were checked and recorded as follows;

Assessment	Morning	Evening
Temperature	36.8 degree Celsius	37.0 degree celsiuls
Pulse	79bpm	80bpm
Respiration	20cpm	21cpm
Blood pressure	100/60mmHg	109/63mmHg

The baby was top and tailed and cord was dressed with sterile cotton wool swabs and methylated spirit in the presence of the mother after head to toe examination with no abnormalities seen, the baby was dressed, wrapped and given to mother to breastfeed. Baby's vital signs and weight were checked and recorded as follows;

Assessment	Morning	Evening
Temperature	36.3 degree celciuls	36.8 degree celciuls
Apex heart beat	137bpm	137bpm
Respiration	46cpm	44cpm
Weight	2.8kg	2.8kg

Client complained of breast engorgement. She was reassured and helped to position and fix baby well to the breast while breastfeeding. She was also encouraged to make sure one breast is fully emptied before given the other breast. She was also encouraged to apply warm compress for relieve from pain. Permission was sought to leave.

4.6 THIRD POSTNATAL HOME VISIT

The third [3] home visit was made to Madam Veronica's house on the 30th August, 2023 around 7:00am and 4:30pm Greetings were exchanged. Mother and baby were in a healthy condition. Enquiry was made about the breast engorgement of which she said the engorgement and pain has been reduced. Client was encouraged to breastfeed baby on demand and also to apply warm compress on the breast. 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 complains of which she said there was none. Her symphysio - fundal height was measured and recorded as 12 centimeters. Client's perineal pad was inspected and it was bright red [rubra] with scanty flow without any offensive odor. Vital signs of mother was checked and recorded as;

Assessment	Morning	Evening
Temperature	37.2 degree Celsius	36.7 degree Celsius
Pulse	83bpm	81bpm
Respiration	22cpm	20cpm
Blood pressure	100/65mmHg	100/70mmHg

The baby was top and tailed and general examination was carried out on her. No abnormality was identified on examination. Baby passed stools and urine during bath. The cord was dressed with sterile cotton wool swabs and methylated spirit. Baby was dressed up nicely. Baby's vital signs and weight was taken and recorded as follows;

Assessment	Morning	Evening
Temperature	36.8 degree Celsius	37.0 degree Celsius
Apex heart beat	138bpm	138bpm
Respiration	46cpm	45cpm
Weight	2.7kg	2.7kg

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

4.7 FOURTH POSTNATAL HOME VISIT

Madam Constance was visited on the 31st August, 2023. At 6:30 am and 5:00pm. Client and baby were all in good health. Head to toe examination was done on the mother and everything was normal. Breasts were soft and lactating well. Symphysio fundal height was measured to be 10cm. Lochia was pink in color (serosa), small and without odour. Client's vital signs was checked and recorded as follows;

Assessment	Morning	Evening
Temperature	36.4 degree Celsius	37.0 degree Celsius
Pulse	77bpm	80bpm
Respiration	20cpm	20cpm
Blood pressure	100/65mmHg	100/70mmHg

Baby was top and tailed and general examination was carried out but nothing abnormal was identified. Baby passed stools and urine during bathing. Cord was dressed with sterile cotton wool swabs and spirit. The cord was dry and had begun to detach. Baby's vital signs and weight was taken and recorded as follows

Assessment	Morning	Evening
Temperature	36.8 degree Celsius	36.6 degree Celsius
Apex heart beat	138bpm	136bpm
Respiration	46cpm	44cpm
Weight	2.7kg	2.7kg

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

4.8 FIFTH POSTNATAL HOME VISIT

On the 1st September, 2023 at 4:00pm Madam Veronica 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. Her breasts were soft and lactating well. Her symphysio - fundal height measured 8 centimeters. Lochia was pink (serosa), small flow and had no odor. Client's vital signs was checked and recorded as follows:

Temperature	37.0 degree Celsius
Pulse	81cpm
Respiration	20cpm
Blood pressure	100/65mmHg

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

Temperature	36.2 degree Celsius
Apex heart beat	130bpm
Respiration	41cpm
Weight	2.8kg

Permission was sought to leave.

4.9 SIXTH POSTNATAL HOME VISIT

Client was visited again the 2nd September, 2023 around 5:00pm Madam Veronica was met with her mother who was washing some clothing. Greetings were exchanged. The condition of mother and baby was very good. She had already taken her bath 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 6cm. Client vital signs were checked and recorded as;

Temperature	37.0 degree Celsius
Pulse	81bpm
Respiration	22cpm
Blood pressure	100/70mmHg

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	37.0 degree Celsius
Apex heart beat	129bpm
Respiration	42cpm
Weight	2.9kg

Madam Veronica was reminded of the first postnatal visit to the clinic and also reminded ofthe termination of care on the next day which would be the last day of visit. 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 3rd September, 2023 around 6:00am. Client and baby were in a good condition. On head to toe examination, no abnormalities were seen on the mother. Her vital signs was checked and recorded as;

Temperature	37.2 degree Celsius
Pulse	80bpm
Respiration	22cpm
Blood pressure	110/60mmHg

Lochia was pink (serosa) with no odor. The symphysio – fundal height was 4 centimeters. Her breast was lactating well. Baby was already bathed and head to toe examination was done and no abnormality was found on the baby. Vital signs and weight of baby was checked andrecorded as

Temperature	37.1 degree Celsius
Apex heart beat	141bpm
Respiration	44cpm
Weight	3.okg

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

5.1 FIRST POSTNATAL VISIT TO THE CLINIC

Madam Veronica visited the clinic with her baby accompanied by her mother on the 4th September, 2023 around 9:30am. 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 degree Celsius
Pulse	78bpm
Respiration	20cpm
Blood pressure	100/60mmHg

Privacy was provided and Madam Veronica was helped to lie on the examination couch for head to toe examination while her mother carried the baby for that period. Her hair wasneatly and nicely braided. The eyes and ears had no discharges, conjunctiva had no pallor andthe sclera had no jaundice. The nose had no discharge neither did the neck had any nodulenor 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 edema. On abdominal examination, there was no enlargement and tenderness of both spleen and liver. There wereno warts, varicose veins or edema on the vulva. Lochia drainage was mild, serosa and not offensive. The uterus was 3cm. Madam Veronica was congratulated for keeping herself clean and was helped to get off the couch to redress.

Findings were then communicated to Madam Veronica 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 degree Celsius
Apex heart beat	142 beat per minute
Respiration	40 cpm
Weight	3.okg

Findings were communicated to mother and recorded. Madam Veronica 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 Veronica 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 Veronica visited the clinic with the baby for her sixth week postnatal review on the 13th October, 2023 and was warmly welcomed by the midwife-in-charge. Mother and baby were in healthy condition and had no complains. Her hemoglobin level was 12.5 gram per deciliter and urine tests for protein and glucose were negative. Her vital signs and weight were checked and recorded as;

Temperature	36.2 degree Celsius
Pulse	77bpm
Respiration	21cpm
Blood pressure	106/65mmHg
Weight	70kg

Head to toe examination was carried out on client but no abnormality was detected.

Temperature	36.0 degree Celsius
Pulse	40cpm
Respiration	135bpm
Weight	5.5kg

Baby's vital signs and weight was also checked and recorded as;

Baby's general condition was good on head to toe examination and baby's posterior fontanelle had closed and the anterior fontanelle was palpated for pulsation and it was normal. All findings were communicated to client and documented. Baby was given the due immunizations which included the following; polio(OPV1)2drops, rotavirus 2drops, pneumococcal 0.5 milligram and pentavalent (diphtheria, pertussis, tetanus, Hemophilus influenza type B, hepatitis B). These were recorded in the child record booklet. They were then handed over to the child welfare clinic and family planning unit to ensure continuity of care. Client was encouraged to visit the facility in case of any health-related problem. All findings were communicated to Madam Constance and was thanked for her cooperation and support throughout the care.

5.3 PUERPERIUM CARE PLAN

PROBLEMS IDENTIFIED

Client complained of;

1. After pain 27/08/2023
2. Loss of appetite 27/08/2023
3. Backache 29/08/2023
4. Breast engorgement 30/08/2023
5. Inadequate sleep 30/08/2023

SHORT TERM OBJECTIVES

Client will be relieved of after after pain within 24 hours

Client will regain her normal eating pattern within 24 hours

Client will be relieved of backache within 24 hours

Client will be relieved of breast engorgement within 24 hours.

Client will have adequate sleep of at least 7 hours within 24 hours.

LONG TERM OBJECTIVE

Client and her baby will go through puerperium successfully without any complication

PUERPERIUM NURSNG CARE PLAN

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES /OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
27/08/2023 2:00pm	After pain related to involution of the uterus.	Client will be relieved of after pain within 24 hours as Evidenced by client verbalizing painhas being relieved	1. Reassure client that the pain istemporal. 2. Explain the physiology of afterpain to client. 3.Educate client of the importance of breastfeeding. 4. Teach client how to applywarm compress on the abdomen 5.Serve client with prescribe medication.	1. Client was reassured that pain will be reduced. 2. It was explain to client that pain is due to the involution of the uterus. 3. Client was educated to continue breastfeeding on demand. 4. Warm compress was applyto client's abdomen. 5.Client was served with tab Paracetamol 1 g	28/08/20 23 2:00pm	Goal fully met as client verbalized that her pain has been relieved.	A.B.J

PUERPERIUM CARE PLAN CONTINUED

DATE/ TIME	NURSING DIAGNOSIS	OBJECTIVE/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
27/08/2023 3:00pm	Loss of appetite related to stress of labour	Client will regain her normal eating pattern within 24 hours as evidence by client reporting she can now eat well.	1. Reassure client. 2. Encourage client to practiceoral hygiene. 3. Serve client with nutritiousdiet. 4. Plan meal with client. 5. Serve prescribe medication.	1. Client was reassured that it temporal and therefore she will be relieved in no time. 2. Client was told to brushher teeth twice daily to boost her appetite. 3. Client was serve with rice and vegetable stew. 4. Client was involved in planning of her meal. 5. Multivitamin supplementwas administered to client.	28/08/2023 3:00pm	Goal fullymet as client verbalize shehas regain her normal eating pattern.	A.B.J

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATIO N	SIGN
29/08/2 0/23 3:00pm	Backache relating to poor positioning during breast feeding.	Client will be relieved of backache within 24 hours as evidence by client verbalizing relieved of backache .	1.Reassure clientthat the pains will be relived. 2. Educate client onposition duringbreast feeding. 3. Teach client to support her breast. 4. Educate client oncomfort measures. 5. Teach client howto relieve pain.	1.Client was reassured that she will be relieve of backache. 2.Client was assisted inpositioning and how fix babyto breast. 3. Client was taught to wearwell - fitting brassier to support the breast. 4.Client was taught to massage her back gently when there is pain. 5.. Warm compress was apply to client's back.	30/08/2023 3:00pm	Goal fully met as client verbalized thatshe has been relieved of pain.	A.B.J

PUERPERIUM CARE PLAN CONTINUED

DATE& TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES / OUTCOME CRITERIA	NURSING ORDER	NURSING INTERVENTION	DATE & TIME	EVALUATION	SIGN
30/08/2023 4:00pm	Breast engorgement related toinadequate emptying of the breast.	Client will breast engorgement will be relieved within 24 hours as evidence by clientverbalizing thatbreast is not engorge	1. Reassure client 2. Teach client on positioning and fixing baby to breast 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 she will be relieved. 2. Client was assisted client in positioning and how to fix baby to breast. 3. Client was taught to put on well –fitting brassier to support the breast. 4. Client was assisted to apply compress to her breast. 5. Client was told that she should feed baby on demand to make breast empty.	31/08/2023 4:00pm	Goal fully met as client verbalizedthat her breast isnot engorged any more.	A.B.J

PUERPERIUM CARE PLAN

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVE/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
30/08/2023 4:00pm	Inadequate sleep related to baby breast feeding atnight.	Client will be able to sleep at least 4hours during the night and 2 hours during the day as evidence by clientverbalizing she is able to sleep.	1. Reassure client. 2. Educate on how to breastfeed. 3. Encourage family supportwith household duties. 4. Encourage client to limitthe number of visitors. 5. Encourage client to rest and sleep.	1. Client was reassured that she will be able to sleep forat least 3 hours. 2. Client was educated to breast feed baby to her satisfaction. 3. Client relatives were encourage to help client with her duties to enable her to have enough. 4. Client was told that she should reduce her number of visitors to have enough sleep. 5. 5. Client was encourage to have periodic rest whenbaby is asleep.	1st Septem ber 2023 4:00pm	Goal fully met as client verbalizedthat she can now have enough sleep.	A.B.J

SUMMARY AND CONCLUSION

This family and client centered maternity care study was conducted on Madam Veronica, a 27year old woman, who is gravida 3 para 2. She was met at Yamfo Health Centre in the Ahafo Region. The client was 36 weeks gestation when she was met on 16thAugust, 2023.Client hails from Yamfo in the Ahafo Region. Care was given during pregnancy, labor and puerperium. She went through these processes safely without any complications.

Madam Veronica delivered a live female child on 27th August, 2023 through spontaneous vaginal delivery without any complications and went through a normal and safe puerperium. Madam Veronica 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 Veronica and her family has given 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

COMPLETE DIAGNOSTIC INVESTIGATIONS

DATE	SPECIMEN	INVESTIGATION	NORMAL RANGE	FINDINGS	REMARKS
20/02/2023	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	O	Normal
				Positive	
			Positive/Negative		

		Urine	Negative	Negative	Normal
23/03/2023	Urine	Protein Sugar	Trace Negative	Negative Negative	Normal Normal
18/04/2023	Urine	Protein Sugar	Negative Negative	Negative Negative	Normal Normal

19/05/2023	Urine	Protein Sugar	Negative Negative	Negative Negative	Normal Normal
16/06/2023	Urine	Protein Sugar	Negative Negative	Negative Negative	Normal Normal
19/7/2023	Urine	Protein Sugar	Negative Negative	Negative Negative	Normal Normal
16th August	Urine	Protein	Negative	Negative	Normal
2023		Sugar	Negative	Negative	Normal
26/08/2023	Urine	Protein Sugar	Negative Negative	Negative Negative	Normal Normal

COMPLETE DIAGNOSTIC INVESTIGATIONS

APPENDIX 11

PHARMACOLOGY OF DRUGS FOR MOTHER

NAME OF DRUG	CLASSIFICATION	DOSAGE	ROUTE	ACTION AND USES	ACTUAL EFFECT	SIDE EFFECTS	SIDE EFFECT 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 Multi	Vitamin Preparation	200 Milligrams	Oral	Increase Appetite,	Increased	Gastrointestinal	None

Vitamin		twice daily		helps in the formation of red blood cells	appetite.	Disturbance	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 ANDUSES	ACTUAL EFFECT	SIDE EFFECTS	SIDE EFFECT EXPERIENCED
Injection oxytocin	Oxytocic drug	10 units	Intramuscular	Stimulation of uterine contractions	Good uterine contractions and control of bleeding	Vomiting, rise in bloodpressure anduterine spasm	None observed
Tablet Sulphadoxine Pyrimethamine	Anti-malaria and prophylaxis	3 doses start from 16weeksor after quickening and the remaining doses within4weeks 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	CLASSIFIC-ATION	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 Dipthteria,Pertussis, Tetanus,Haemophilus 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(FH)	Complains	Treatment	Name and sign
20/02/2023	110/60	63.7	Negativee/ Negativee	11^{+3}	_	_	_	-	Feels well	Tablet (multivite,folic acid,ferrous sulphate)	
23/03/2023	100/60	66	Trace/ Negativee	15+6	16	_	_	-	Feels well	Tablet (multivite,folic acid,ferrous sulphate)	
18/04/	100/5	67.4	Negative	19^{+3}	20	_	_	-	Feels well	Tablet (multivite,folic	

2023	0		Negative						acid,ferrous sulphate)	
19/05/2023	100/60	68	Negative/ Negative	22	Cephalic	5/5th	138	Headache	Treatment (multivite,f olic acid,ferroussulphate)	
16/06/2023	110/70	69	Negative/ Negative	26	Cephalic	5/5th	139	Feels well	Treatment(multivite, f olic acid,ferrous sulphate)	
19/07/2023	100/60	69	Negative/	32	Cephalic	5/5th	139	Waist pains	Tablet (multivite ,folicacid,ferrous sulphate)	

			Negative								
16th August 2023	100/60	64	Negative/ Negative	36+4	35	Cephalic	5/5th	140	Abdominal pains	Tablet Folic acid Tablet Ferrous sulphate Tablet multivite	
26/08/ 2023	110/60	72	Negative/ Negative	38	37	cephalic	5/5th	136	Abdominal pains	Tablet folic acid Tablet Ferrous sulphate	

WHO Modified Partograph

Registration No.: 139/23 Name(Last, First) Osei Veronica Age: 27years
Date: 27/8/23 Parity/Gravida 3B^NA LMP: 20/11/22 EDD 27/8/23 Gestation(wks) 38wks
ROM: 1:00am Labor Duration (Hrs) 5hrs Facility/Clinic Name Yamfo Health Centre

FETAL HEART RATE

LIQUOR MOULDING

CERVIX (CM)

Plot X

DESCENT Plot C

Alert

Action

SVD @ 1:30pm
Sex - female
As - 8/10, 9/10
BW - 3.0kg
HC - 49cm
HIC - 33cm
Bf - 1hour

HOURS 0 1 2 3 4 5 6 7 8

TIME 8am 9am 10am 11am 12pm 1pm 2pm 3pm 4pm

CONTRACTIONS PER 10 MINS

Oxytocin U / L
Drops / minute

DRUGS & IV FLUIDS

BLOOD PRESSURE & PULSE

TEMPERATURE

URINE Amount Protein Acetone

LABOR NOTES

Client [illegible] came to the facility accompanied by her mother and complain of pain at the lower abdomen and painful contractions. Client's delivered a female baby at 1:30pm with Apgar Score of 3/10, respectively. 10 Units of oxytocin was given. Urine Catheter was passed to empty the bladder. client was debrief and congratulated. Client was made comfortable in bed with her baby girl.

Please circle or write responses.

DELIVERY

DATE: 27/8/23 TIME: 1:30pm METHOD: Spontaneous / Vacuum Extraction / C/S / Other

PERINEUM: Intact / Episiotomy / Laceration

ANESTHESIA: None / Local / General

THIRD STAGE

Active Management: Yes / No Medication: Time 1:35pm Type/Dose 10units of oxytocin

PLACENTA: TIME: 1:40pm Complete / Incomplete

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

BABY

Weight: 3.0kg

Sex: Male / Female

Baby Position: Vertex / Breech / Other

APGAR

Time	Color	Breath	Heart	Tone	Reflex	TOTAL
1min	2	2	2	1	1	8/10
5min	2	2	2	1	2	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	2:30	120/70	80	18	10mls	120mls
	2:45	109/60	74	Contracted	Not active	
	3:00	100/60	80	Contracted	Not active	Emptied.
	3:15	110/60	84	Contracted	Not active	
	3:30	111/70	82	Contracted	Not active	Emptied
	3:45	110/60	69	Contracted	Not active	
	4:00	119/70	72	Contracted	Not active	Emptied
	4:15	110/60	68	Contracted	Not active	
Every 30 minutes For 1 hour	4:45	100/60	75	Contracted	Not active	150mls
	5:15	100/60	70	Contracted	Not active	

Birth Attendant AKWARAH BALDOO JOSEPHINE Date 27/8/2023

ASSISTED BY OKUSU PERPECTUAL

MATERNITY CHART

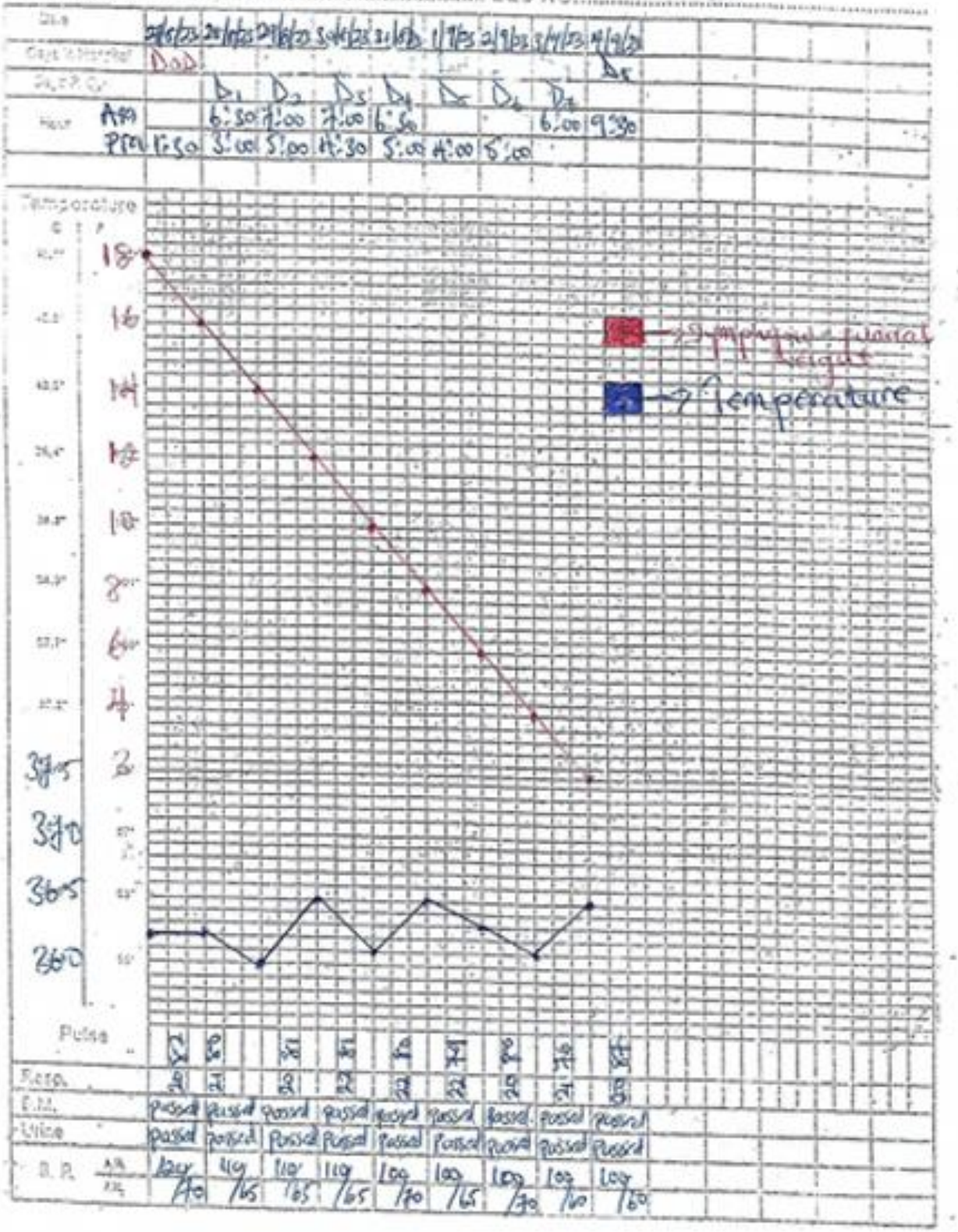
NAME: Madam Obi Veronica

AGE: 27 years

WARD: Labour - In

IP NO.: 189/23

BED NO.: 3



NEW BORN EXAMINATION FORM

Name: Baby of Victoria case — Date of Assessment: 27/05/2023 Time: 1:30pm

Date of Birth: 27/05/23 Time of Birth: 1:30pm Sex: ☑M ☐F Age at time of Assessment (days/hrs) 1 hour

Gestational Age ☐ ☐ Mode of Delivery: ☑Vaginal Assisted Vaginal C-Section

APGAR: 1min 9/10 ☐ 5min ☐ 9/10 Birth Weight: ☐ 3.0 kg ☐ Length: 49 cm Head Circumference: 33 cm

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

Name of Assessor (Midwife/Doctor): Nyaaboah Boadua Josephine

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

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

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

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

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

6. Cry
- ☑ Normal
- ☐ Shrill *
- ☐ Absent *

7. Suck
- ☑ Good
- ☐ Weak
- ☐ Absent

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

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

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

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

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

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

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

16. Clavicle
- ☑ Normal
- ☐ Swelling/Fracture

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

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

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

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

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

22. Limbs
- ☑ Normal
- ☐ Abnormal _____

23. Genitalia

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

Female Genitalia
- ☑ Normal
- ☐ Fistula(meconium/urine through abnormal opening in vagina)*
- ☐ Large 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) Term baby

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

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

NEW BORN EXAMINATION FORM

Name: Baby of Veronica Osei Date of Assessment: 28/05/23 Time: 7:00am
Date of Birth: 27/05/23 Time of Birth: 1:30pm Sex: ☐ M ☑ F Age at time of Assessment (days/hrs) 18 hours
Astational Age ☐ ☐ Mode of Delivery: ☑ Vaginal Assisted Vaginal C-Section
APGAR: 1min 9/10 ☐ 5min ☐ 9/10 Birth Weight: ☐ 3.0kg ☐ Length: 49 cm Head Circumference: 33 cm
Temperature at time of Assessment: 36.2 °C Urine passed: Yes No Meconium passed: Yes No
Name of Assessor (Midwife/Doctor): Nsoakoah Bradoo Josephine (Resident midwife)

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

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

3. Tone
☑ Normal
☐ Floppy *
☐ Increased *

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

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

6. Cry
☑ Normal
☐ Shrill *
☐ Absent *

7. Suck
☑ Good
☐ Weak
☐ Absent

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

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

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

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

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

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

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

16. Clavicle
☑ Normal
☐ Swelling/Fracture

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

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

19. Femoral pulse
☑ Present
☐ Not palpable*

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

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

22. Limbs
☑ Normal
☐ Abnormal _____

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

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

24. Anus
☑ Patent
☐ Imperforate*

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

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

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

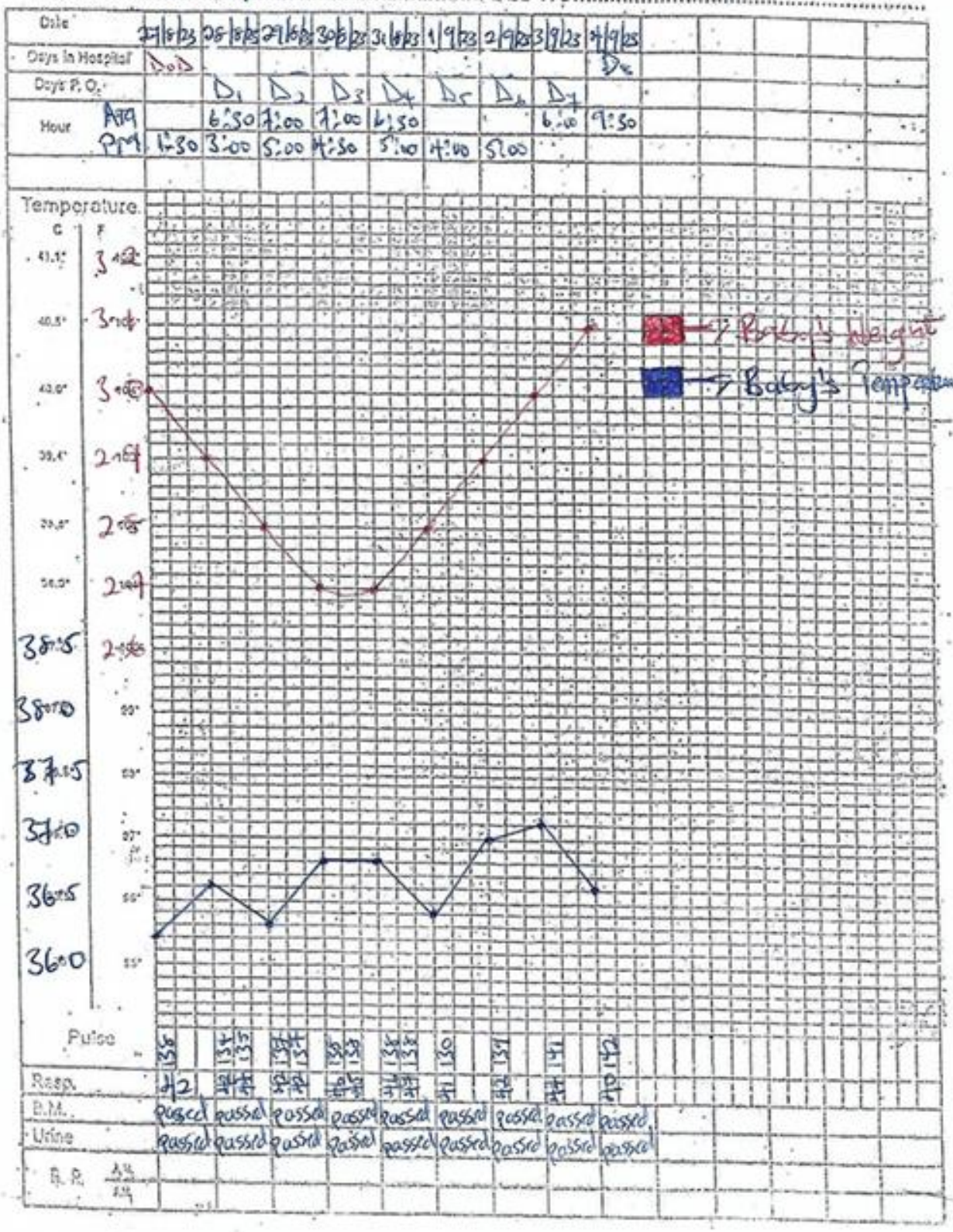
Classification: (Overall assessment) [ ] Normal [ ] Baby with a Problem [ ] Danger Sign/ <1500g/ severe Jaundice
Plan: [ ] Routine Care[ ]Problem. Continue supportive in-patient care [ ] Urgent Referral / Advanced Care[ ] Discharge

TEMPERATURE CHART

NAME: Baby of Osei Veronica

AGE: Neonate WARD: Lying - In

IP NO.: 139/23 BED NO.: 3



NEW BORN CHART

Name: Baby of Osei Veronica ..... No: 139/23 ..... Birth Weight: 3.0kg .....

Sex: Female ..... Mother's No: 139/23 ..... Length: 49cm .....

Nature of Delivery: Spontaneous Vaginal Delivery ..... Diagnosis: Term Baby .....

Date of Birth: 27/08/2023 ..... Time: 1:30pm ..... Date of Discharge: 28/08/2023 .....

Date	27/8/23		28/8/23		29/8/23		30/8/23		31/8/23		1/9/23		2/9/23		3/9/23		4/9/23					
No. of Days	D0		D1		D2		D3		D4		D5		D6		D7		D8					
Weight	3.0kg		2.9kg		2.8kg		2.7kg		2.7kg		2.8kg		2.9kg		3.0kg		3.1kg					
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	36.0°C	36.6°C	36.2°C	36.8°C	36.0°C	37.0°C	36.8°C	36.6°C		36.2°C		37.0°C	37.1°C		36.5°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 Limbs Genitalia → NAD																					

SIGNATORIES

THE STUDENT MIDWIFE

NAME: MISS AKWABOAH BAIDOO JOSEPHINE

SIGNATURE: .....

DATE: 7/6/2024

THE MIDWIFE IN- CHARGE AT THE YAMFO HEALTH CENTRE

NAME: MS. HAGAR SERWAA

SIGNATURE: ..... (Sn)

DATE: 7/6/2024

THE SUPERVIOR

NAME: MS. MARTHA KYEREMAA

SIGNATURE: .....

DATE: 7/6/2024

THE PRINCIPAL

NAME: MS. MONICA NKRUMAH

SIGNATURE: .....

PRINCIPAL
HOLY FAMILY NURSING AND
MIDWIFERY TRAINING COLLEGE
BEREKUM

DATE: 10/06/2024