HOLY FAMILY NURSING AND MIDWIFERY TRAINING COLLEGE BEREKUM

A CLIENT FAMILY CENTERED CASE STUDY

ON

MADAM ZULIAHA SAYUBA

WRITTEN BY

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A CLIENT FAMILY CENTERED MATERNITY CASE STUDY SUBMITTED TO THE NURSING AND MIDWIFERY COUNCIL OF GHANA IN PARTIAL FULFILMENT FOR THE AWARD OF LICENCE TO PRACTICE AS A PROFESSIONAL REGISTERED MIDWIFE

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PREFACE

The practice of midwifery has been in existence for so many years, though with-it traditional background, it has undergone many changes to meet the ever-changing needs of client and her family both locally and globally. Each client is a special person and therefore needs individualized care.

Client and Family Centered Maternity Care Study is a holistic obstetric nursing care rendered to a pregnant woman and her family so as to enhance quality health services and client satisfaction. This care is rendered right from pregnancy through labour to the end of puerperium. This is based on the understanding that the woman is a unique individual with physical, spiritual, psychological and socio-economic needs. It also helps to prepare the family mentally in reception of the new born.

This family centered maternity care study gives a student midwife the necessary opportunity to utilize or put into practice her acquired knowledge in the classroom to identify client's problem in order to manage her well during pregnancy, labour and then puerperium.

Lastly, it helps the student midwife to gain knowledge in the changes that has brought about new management ideas and practices of audit and quality assurance in the various hospitals, clinics and maternity homes. It is done by every final year student of registered midwifery program to satisfy the Nurses' and Midwives' Council of Ghana to help contribute to the award of diploma in licensing professional certificate in midwifery at the end of the three years course.

ACKNOWLEDGEMENT

My sincere gratitude goes to the Almighty God for the life, opportunities, knowledge, wisdom, understanding and strength He gave me throughout the training and more especially in the course of writing this care study.

My profound gratitude also goes to my supervisor Ms. Celestine Ahiawornu, Madam Zuliaha Sayuba my client and her family members, for offering me the permission to use her and also providing all the necessary information needed

Again, special thanks goes to the Midwife- in Charge, Mrs. Rachel Owusuaa of Rachel's Health Centre in Dormaa East (Bono Region) and other supporting staff members for the tremendous support and care given to me during my care study

My next appreciation goes to the principal of this college, Monica Nkrumah, and teaching and non – teaching staff for their unconditional support throughout my work.

Also special thanks to my family, Mr. and Mrs. Manu, my lovely siblings, Mr. Benjamin Manu, my mentor Ms. Barbara Kwarko and Mr. Anti Dickson (A.K.A Mr. Good) who endlessly helped me throughout my training physically, financially and spiritually.

Finally, my sincere thanks go to the authors of the various books used as references, I say God richly bless you all and everybody who contributed to this work for it to become successful.

INTRODUCTION

A client's family-centered maternity care study involves the client's history, care rendered to that particular client and her family right from the first day of visit to the antenatal clinic through labour up to six weeks of the postnatal period.

This information was obtained from the client during assessment at the clinic through interviews, observation and examination and also during home visits. The aim was to establish good rapport with client and her family and also help the pregnant woman get safe delivery to a healthy normal baby.

The study is on Madam Zuliaha Sayuba and family. She is twenty-five years of age; gravida 2 Para 1^{A}.

She was first met on the 20^{th} of May, 2022 at Rachel's Health Centre with 36wks+4days gestation and had come for her fifth antenatal care.

Introduction was done as a student midwife who wished to take care of her throughout the rest of her pregnancy through delivery and then puerperium. She was in good health when we met. The client and the entire family were included in the care. She was visited severally at home.

The interaction ended after client had delivered spontaneously to a live male baby without any complications. Both Mother and baby's condition were satisfactory at the end of the study. The client and baby were handed over to the midwife in – charge for continuity of care in a healthy state after five weeks of care.

There are four chapters outlined in this script and they are as follows:

Chapter one: This chapter talks about data gathering or an assessment of client and family. This assessment is done to detect if there was any deviation and whether any possible solution or treatment could be given. This chapter can also be called "the histories".

Chapter Two: Involves antenatal care which begins from the time of conception till 40 weeks when the woman was due for delivery and their management.

Chapter Three: Is about the care given to the client during labour and delivery.

Chapter Four: Talks about the puerperium which is the period of the expulsion of the placenta and its membranes up to the end of six weeks after delivery.

At the end of chapters two, three and four, care plans were drawn in order to identify client's problems and how well they could be managed to solve the problems as early as possible to prevent complications.

There is also summary and conclusion, bibliography and various appendices like antenatal records, labour records, postnatal records and pharmacology of drug

LITERATUE REVIEW

PREGNANCY

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

Weller (2014) defines pregnancy as being with child, the condition from conception to the expulsion of the fetus. During this period, a lot of physiological and psychological changes take place in the woman. This affects the entire system as a result of hormonal influence, some women suffer minor disorders like vomiting, heart burns, constipation, waist pains, nausea, ptyalism (excessive salivation), food craving and others which most of these changes go away after delivery. Also, if these are not treated early, they can lead to severe complications which could be life threatening, therefore, it is important for the pregnant woman to attend antenatal clinics as soon as she realizes she is pregnant, for supervision, observations, investigations, and examinations for early detection and treatment of any deviation from normal. During this period, the expectant mother needs special education, encouragement and care, in order to cope with these minor disorders. These educations are given at the antenatal clinics by the attending midwife. Antenatal care is a special care to promote a healthy mother and foetus. Focus antenatal is a special care given to a pregnant woman by the attending midwife and an obstetrician, during pregnancy to ensure that, maternal and foetal health are normal. The aim of focus antenatal is to detect early and treat any abnormalities, prevent complications, promote health and educate mothers on complication readiness.

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

According to Perry (2013), pregnancy is the period of physical and physiological preparation for child birth and parenthood. According to him, the expectant mother ideally should begin prenatal visit soon after the first missed menstrual period for early detection of complications and to ensure good health of the expectant mother and foetus. He also stated that normal pregnancy last for about fourty (40) weeks or two hundred and eighty (280) days and healthcare providers refer to early, middle and late pregnancy as trimesters. The first trimester last from week one (1) to thirteen (13) weeks and the second from fourteen (14) to twenty-six (26) weeks whereas the third trimester from twenty-seven (27) weeks to fourty (40) weeks. Any pregnancy that advances from thirty-eight (38) to forty (40) weeks is considered to be at term.

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

LABOUR

Perry (2013) stated that five factors affect the process of labour and birth. These are the Passenger which is the fetus and placenta, Passageway which is the birth canal, Powers which is the contractions, Position of the mother and Psychological responds. He further identifies the stages of labour as follows; the first stage of labour begins with the onset of regular uterine contractions, effacement, dilatation of the cervix and progress in descent of the presenting part. The first stage of labour has been divided into three phases namely; the latent phase where there is more progress in effacement of the cervix and a little increase in descent. Active phase and transitional phase where there are more rapid dilation of the cervix and increase rate of the descent of the presenting part. The second stage of labour; this stage begins with full cervical dilation (10 centimeters) and complete effacement and ends with the baby's birth. He continued that, the second stage takes an average of 20 minutes for multiparous women and 50 minutes for nulliparous women. The third stage of labour which lasts from the birth of the fetus until the placenta is delivered. He stated that the placenta normally separates with the third or fourth strong contractions after the infant has been born. The duration of the third stage may be as short as 3-5minute although up to 1 hour is considered within the normal limits. Lastly, the fourth stage of labour last for 6 hours after delivery of the placenta. It is the period of immediate recovery when homeostasis is re-established. It is an important period of observation for complication such as bleeding.

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

Foetus is born at term and alive

Presented by vertex

Process complete spontaneously by natural unaided effort of mother

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

Baby is born without complications.

Marie (2013) defines labour as a series of events that takes place in the genital organs in effort to expel the viable products of conception out of the womb through the vagina into the outer world. Labour is called normal if it fulfills the following criteria; Spontaneous in onset. With vertex presentation. Without undue prolongation. Natural termination with minimal aids. Without having any complication affecting the health of the mother and/ or the baby. The features of true labour signs are: Painful uterine contraction at regular intervals. ‘’Show’’. Progressive effacement and dilatation of the cervix. Formation of the’’ bag of waters’’. The events of labour are divided into four stages; first, second, third and fourth stage. First stage starts from the onset of true labour pain and ends with full dilatation of the cervix. Its average duration is 6 hours in multipara. Second stage starts from full dilatation of the cervix and ends with expulsion of the foetus from the birth canal. Third stage begins after the expulsion of foetus and ends with the expulsion of the placenta and membranes (afterbirth). Average duration is about 15 minutes in both multi and primigravidae. Fourth stage is the stage of observation after the expulsion of the afterbirth. Four factors are significant in the process of labour; that is the pelvis, passenger, powers and psyche. These are known as the four P’s.

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

Littleton (2012), normal labour is a sequence of events that occurs to expel the fetus, placenta and its membranes through the birth canal which starts with regular painful uterine contractions and dilation of the cervix. Also gives a full description of the four stages of labour. The first stage comprising of the latent phase where the cervix takes eight hours to dilate from 0-3 centimeter and the active phase, where the cervix dilates one centimeter every hour from 3- 10 centimeter. The second stage begins when the cervix becomes fully dilated to complete delivery of the baby. The third stage is the complete expulsion of the placenta, membranes and the control of hemorrhage. The fourth stage is the period of six hours observation of both mother and the baby after the third stage is completed. According to the above definitions, it means labour is the process in which the fetus, the placenta and its membranes are expelled through the birth canal after 28 weeks of pregnancy

PUERPERIUM

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

Fraser & Cooper (2012) states that, puerperium begins immediately after delivery of the placenta and membranes and continues for six (6) weeks. The expectation is that by 6th week after birth, all the systems affected by the pregnancy in the woman's body would have recovered and returned to their non-pregnant state except the breast because of lactation. Myles also striked the difference between exercise and healthy activity verses rest, relaxation and sleep. Exploring each person's level of activity will encourage advice in relation to appropriate exercise and by association, nutritional intake and rest or relaxation and sleep. Undertaking regular pelvic floor exercise is of benefit to the woman's long-term health.

According to Marie (2013) puerperium is the period following childbirth during which the body tissues, especially the pelvic organs revert back approximately to the pre-pregnant state both anatomically and physiologically. The period is divided into; Immediate –within 24 hours. Early- up to 7 days, Remote –up to 6 weeks. Immediately following delivery, the uterus becomes firmer and retracted with alternating hardening and softening. At the end of 6 weeks, its measurement is almost similar to that of the non-pregnant state and it weighs 60 grams. The vaginal discharge for the first fortnight during puerperium is the lochia. The lochia originates from the uterine body, cervix and vagina. Depending upon the variation of the colour of the discharge it is named as: Lochia rubra (red) 1 -4 days. Lochia serosa

(yellowish or pink or pale brownish) 5-9 days. Lochia alba (pale white) 10 -15 days. The average amount of discharge, for the first 5-6 days is estimated to be 250 ml.

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

A) Lactation is well established

B) The reproductive organs return to their non- pregnant state

C) Other physiological changes which occur during pregnancy are reversed.

D) The foundations of the relationship between the infant and it's parents are laid.

E) The mother recovers from physical and emotional stresses of pregnancy and delivery and assumes responsibilities for the care and nature of the infant.

According to Littleton, (2012) puerperium last from delivery of the placenta to approximately 6 weeks afterward. The immediate postpartum period consists of the first 24 hours after delivery. On palpation of the breast after delivery, breasts usually are enlarged, soft, warm and contain only a small amount of colostrum, the first milk. The nipples should be intact without redness, tenderness, cracks or blisters. Colostrum may be expressed. The breast may be engorged (enlargement and filling of the breast with milk), which may begin as a tingling sensation in her breast, 2 to 4 days after delivery. Also, with the uterus, immediately after delivery, it begins the process of involution or reduction in size. It generally takes 6 weeks for complete physiologic involution and for the reproductive system to be restored to its non-pregnant state. Sub involution or the failure of the uterus to return to a non-pregnant state, occurs when the process of involution is prolonged or stopped as a result of hemorrhage, infection or retained placental parts. Uterine involution involves the return of the uterus to a non-pregnant condition, diminishing in size and weight, and anatomic location back into the pelvis. The placental site usually is completely healed without scarring by 6 weeks postpartum. Immediately after delivery, the uterus weighs about 1000g. At the end of 6 weeks postpartum, the uterus weighs 50 to 100g. Littleton (2012) furthermore says that, with the fundus, immediately after delivery, the fundus usually can be located midline at the level of or one to two finger breadths below the umbilicus. The position of the fundus also should be noted because the broad and round ligaments were greatly stretched during pregnancy and become very lax after the loss of the enlarged uterus after delivery, the uterus is easily displaced (usually above the umbilicus) by an overfilled bladder. The displacement interferes with the uterus ability to contract after delivery resulting in uterine atony and hemorrhage. However, with lochia, is the usual uterine discharge of blood, mucus and tissue after childbirth. Lochia contains the sloughing of decidua's tissues, including erythrocytes,

epithelia cells and bacteria. Lochia is assessed according to color, amount and change with activity and time. Lochia rubra is the term given to the discharge on the first 3 days after delivery. Lochia rubra is small to moderate in amount and has a bright-red color. Lochia serosa, which occurs 4 to 10 days after delivery, is a watery, pink or brown tinged color, which is lighter in amount than is lochia rubra. Lochia serosa primarily contains serous fluid, leukocytes, erythrocytes and decidual tissues. Lochia Alba, a whitish yellow creamy discharge on days 10-17. Many women may have minimal discharge by day 14, however, it is not uncommon for lochia alba to last until 6 weeks postpartum. Lochia Alba consists of a mixture of leukocytes, decidual tissue and decreasing fluid content. Littleton (2005) again talked about the composition of breast milk which includes: Carbohydrate, protein, fat, sodium, potassium, calcium and iron. Breast milk is nutritionally superior to formula. Breast milk contains immunoglobulins, enzymes, and leukocytes to protect against infection. Breast milk is easily available at a perfect temperature and with no preparation. It also reduces the risk of bacterial contamination, and reduces the risk of allergies. Breastfeeding enhances mother-infant attachment and promotes the development of facial and jaw muscles. It is therefore important for mothers to practice exclusive breastfeeding. Furthermore, once the infant is born and taken to the assessment room, a complete head to toe physical assessment is done to determine the infant's health status. A general inspection is done first to identify abnormalities. The body is inspected for color and texture. The newborn's heart is auscultated for rate and rhythm. Sometimes suctioning is required to remove residual fluid from the infant's mouth. The axillary body temperature is taken. The newborn is weighed and the infant's head circumference is measured (frontal occipito circumference). The face is inspected for symmetry, birth marks, milia, and nevi over the forehead and eyelids. The mouth is inspected for natal teeth and abnormalities of the hard and soft palate, the tongue should be at midline. The genitalia is also inspected by palpating scrotum to check for descent of the testes if a male. Suckling reflex is sometimes demonstrated spontaneously during the examination.

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descent of the testes if a male. Suckling reflex is sometimes demonstrated spontaneously during the examination.

WHY CLIENT WAS CHOSEN

Madam Zuliaha Sayuba was chosen as client for my family centered case study on 20/05/22, which happened to be her 4th visit to the clinic. She was chosen that day because she fell within the required criteria used in maternity care study. She so much contributed in the discussion on exclusive breastfeeding of babies on that day during the education at the antenatal clinic. Her enthusiasm compelled me to glance through her antenatal book and it was discovered that she fell perfectly within the criteria for selecting client.

Introductions were made once again to her as a student midwife who wishes to use her for a study by taking care of her throughout the rest of her pregnancy days till delivery and up to one week postpartum.

She accepted the proposal and agreed to be used for the study. The midwife in charge was informed and she also accepted it.

She then gave me her phone number and directions to her house.

CHAPTER ONE

CLIENT PROFILE

1.0 INTRODUCTION

This chapter talks about client's particulars, 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 Zuliaha Sayuba 25-year-old pregnant woman stays at Kyeremasu in Dormaa East District in Bono region. She speaks Twi and English. She is dark in complexion with the average height of 156centimetres and a weight of 72 kilograms during her first antenatal visit to the clinic. According to Madam Zuliaha, she completed JHS and she is a Seamstress. She continued to say that she has been in a relationship for 4 years with Mr. Musa who is a driver and he is 30 years of age, the father of her child. She has no abnormalities both physically and psychologically. Madam Zuliaha is a Muslim, likewise her husband. She mentioned her next of kin as Abdul Rahim, her son.

1.2 FAMILY HISTORY

Madam Zuliaha is from a family of nine (8) which consists of her parents, her six (5) siblings and herself, they are four (4) females and three (2) males. According to her, both parents are Mosi where they currently live in Kyeremaasu. Madam Zuliaha said that she is the third born among her siblings. According to her, the family has no hereditary diseases like hypertension, heart diseases, sickle cell disease, diabetes, leprosy, epilepsy, liver diseases, mental illness, asthma and no congenital abnormalities, likewise the husband's family. Her family has a history of multiple pregnancies. She stated that her family members seek medical intervention at the health centre whenever they are not well and her relatives mostly die naturally.

1.3 MEDICAL HISTORY

Madam Zuliaha said she has never been admitted to the hospital for any serious illness like heart disease, hypertension, sickle-cell disease, diabetes, jaundice, respiratory disease or any psychiatric disorder such as epilepsy and mental illness. There is no history of prolonged cough for more than one month and also she has no known allergies and has never reacted badly to any drug, food or environmental hazard. She has no history of sexually transmitted

infections such as gonorrhea and syphilis. There is also no history of chronic lower abnormal pain. She reports to the out patients' department of the Rachel's Health Centre for the treatment for minor ailments. She has never donated blood or received blood in her life

1.4 SURGICAL HISTORY

Madam Zuliaha has never undergone any surgical operation as evidenced by the absence of scars on the body during hair to toe examination. She has never had any road traffic accident in her entire life and no injuries that have affected her pelvis.

1.5 MENSTRUAL HISTORY

Madam Zuliaha had her menarche at the age of 14. Her regular menstrual cycle is 28 days which flows moderately for six days. She uses sanitary pad during the flow and changes it two times daily. She gave her last normal menstrual period as 09/09/2021 and her expected date of delivery was calculated to be 16/06/2022.

1.6 CLIENT'S LIFESTYLE AND HOBBIES

Madam Zuliaha said she usually sleeps around 9:30pm and wakes up around 5:00am. She then has her prayers for about 10 minutes. After prayers, she brushes her teeth, sweeps her compound with the help of other relatives, cleans the bathroom, mops her room and prepares breakfast for the family. She then takes her bath and prepares for work. She said she empties her bowels when she feels the urge daily, and baths twice daily, morning and evening. She makes sure the child is ready and leaves the house with him on weekdays, for school and she go to work.

The client watches television as her hobby and twi telenovela is her favorite program. The family lives together and patronizes health care service from Rachel's health centre.

Client does the family laundry on Saturday mornings. She worships on Fridays with the Ahmadiyya Muslims. She said she neither smokes nor drinks alcohol.

She usually closes and goes to market around 3:30pm and then goes home at 4pm to prepare supper for the family on weekdays. She is a very calm person and a good communicator. Her favorite food is "banku" and okro stew and her hobbies are listening to music, watching movies and cooking.

1.7 PAST OBSTECTRICAL HISTORY

Pregnancy

Madam Zuliaha has had two pregnancies and live male child (G2 $P1^{A}$) and her pregnancies got to term before labour started. She had pregnancies with no history of spontaneous or induced abortion in her life. She had no anaemia, pregnancy induced hypertension and diabetes in her pregnancies and no danger signs of pregnancy such as antepartum hemorrhage. She experienced minor disorders such as nausea and vomiting, backache and headache in her previous pregnancy. The interval between the first and second pregnancies was two years. She also said she was given the first and second doses of tetanus-diphtheria (TD) and she was given three doses of sulphadoxine-pyrimethamine (SP) as prophylaxis against malaria during her previous pregnancy. She attended antenatal clinic till she delivered in her previous pregnancy.

Labour

At term she had a spontaneous vaginal delivery to her male child which was born in the year 2020 May, 5^{th} and he was born at the Rachel's Health Centre, and currently living with her. Client had spontaneous vaginal delivery at the Health Centre with little blood loss, no perineal tear or episiotomy, postpartum hemorrhage, retained placenta and her child cried at birth. She said it took about 5 minutes for the midwife to deliver her placenta after her delivery. According to her, her first child weighed 3.5kg at birth.

Puerperium

Her child was immunized against the childhood preventable diseases. She had no tears, episiotomy, excessive bleeding or postpartum hemorrhage or any other complications. She did not practice exclusive breastfeeding for the first six months for her child. She has never practiced any method of family planning before. She also said her family supported in the care of her child and she did not experience any puerperal psychosis and her baby is healthy.

1.8 PRESENT OBSTETRIC HISTORY

Madam Zuliaha reported at the antenatal clinic on 10/03/2022 with the last normal menstrual period of 09/09/2021. Upon this the expected date of delivery was calculated to be 16/06/2022. Serving as the baseline for the comparison with the subsequent antenatal records, the following laboratory investigations and vital signs were recorded on her booking visit as follows:

Temperature	36.8 degree Celsius
Pulse	80 beats per minute
Respiration	19 cycles per minutes
Blood Pressure	101/56 millimeters of mercury
Weight	72 kilograms
Height	156centimetres

The results of the various laboratory investigations done were as follows

Haemoglobin	11.2grams per deciliters
Sickling test	Negative
Blood group	B
Rhesus	positive
Malaria Parasite	No MPS
Hepatitis B	Negative
VDRL	Negative
G6PD	Normal
HIV status	280 (negative)
Urine (protein /sugar)	Negative

Physical examination conducted reveals that no abnormalities were detected on Madam Zuliaha after carefully conducting hair to toe examination. Her gestational age was 26 weeks + 4days with symphysio-fundal height of 26cm. She has no complains so she was served with the following routine drugs;

Tablet Folic acid 5g daily x 30 days

Tablet Ferrous Sulphate 200mg daily x 30 days

Tablet Multivitamin 200mg daily x 30 days

She was scheduled to come a month later for the next antenatal visit, but should report to the Health Centre immediately she detected any danger sign like vaginal bleeding, severe headache, dizziness, and excessive vomiting, also received education on nutrition, rest, sleep, exercise and danger signs of pregnancy as per her card. The Antenatal records on the card indicated she had visited the clinic for 4th time already before we met on the 20th of May 2022 and had her first visit on 10th of March 2022. Madam Zuliaha was a healthy pregnant woman on the first day of contact.

CHAPTER TWO

ANTENATAL CARE

2.0 INTRODUCTION

Chapter two is about the antenatal care given to Madam Zuliaha from time of conception till labour. This includes physical examination, histories taken and assessment, home visits during antenatal period and care plans drawn to solve any problem faced by the client.

2.1 FIRST CONTACT WITH CLIENT

Madam Zuliaha was a regular attendant to the antenatal clinic and it was through one of these visits that she was met on 20th of May 2022 at 9:35 at 36wks+4days gestation which was her 4th visit to the clinic. She was warmly welcome and offered a seat. Client was educated on exclusive breastfeeding and she contributed so much during the discussion. Her antenatal booklet was collected and glanced through to note the previous recordings. The midwife in charge was already informed about a request to find a client who met the criteria to be used and introduction was made to her as a student midwife from Nursing and Midwifery Training College – Berekum, who came to have clinical experience and then wished to use her for care study because she met the criteria to be used for the client and family centered maternity care study. Detailed information and procedures involved in the study were explained to her and she gladly agreed and promised to give all the information needed and her maximum cooperation. She was asked to empty her bladder after a specimen bottle was given to her and it was explained to her the need to obtain midstream urine to check for protein and glucose. The urine reagent strip was used to check the urine and after one minute, the strip was compared with the corresponding colour on the strip container and the test results were negative for protein and glucose. Her haemoglobin level was 11.0g/dl and HIV screening was negative. Client complain of loss of appetite and education was given to her that loss of is normal and she should talk her routine drugs regularly and eat bit by bit but in frequently and it will help to improve her appetite level. Her history, vital signs and weight were taken and the findings recorded in her antenatal book as follows;

Temperature	36.6degree Celsius
Pulse	80bpm
Respiration	20cpm

Blood Pressure	106/68mmhg
Weight	72kg

Head to toe examination

Madam comfort's consent was sought to perform general head to toe examination, after she had emptied her bladder to prevent discomfort during the procedure and to prevent inaccurate measurements and findings. She was reassured that all findings would be communicated to her afterwards. Her manner of walking was seen to be normal as she walked into the examination room. She was assisted to change into a gown, and was helped onto the examination couch by making her sit, she lied in a lateral position, then to a dorsal position and draped with clean sheet. Hand washing was performed with soap under running water and dried with clean hand towel. Palms were warmed by rubbing them together. A head-to-toe examination was conducted under the supervision of the midwife in-charge.

Head and Neck

On the head, her hair was neatly braided and the scalp was clean with no dandruff, lice and breakages found. The face looked cheerful without any edema. The conjunctiva was pink, the sclera was clear without any jaundice. The eyes were without discharge. The ears and nose were inspected with no discharges. The mouth, teeth and tongue were clean with no dental caries or offensive odor. She had no cracks, pallor or inflammation of the lips. The neck was inspected and palpated for swelling, enlarged lymph nodes and distended veins and none were detected**.**

Breast Examination

Her desire to breastfeed was positive as her child was breastfed and without any problem. Before the breast was palpated, the breasts were exposed to check for size, shape, signs of pregnancy, dimpling and nipple retraction and condition of the skin. Then one breast was covered and she was asked to put the hand of the part to be examined under her head. The breast was palpated systematically in a circular manner starting from the axillary region using the inner aspect of the fingers and client was taught self - breast examination. She was advised to examine her breast regularly for early detection and reporting of any abnormalities. Areola was squeezed gently to examine the kind of discharge whether bloody or pussy. The same was done for the other breast and no abnormality was noted.

Extremities

The Upper Extremity was inspected and she was asked if she feels any tingling and tightness of the fingers on making a fist. The hands and fingers were also inspected for edema, pallor of palms nails beds and capillary refill but no deviation from the normal was detected. The Lower Extremity was inspected and palpated for edema, tenderness in calf muscles, varicose veins and the size, equality and alignment of the legs but everything was in its rightful place.

Back

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

Abdominal examination

Before abdominal examination, palms were rubbed together to provide warmth to prevent inducing contractions.

Inspection: The abdomen was inspected and the shape was ovoid, size corresponded with the gestational age of 36wks+4days and striae gravidarum and linea nigra and fetal movement were seen but no scars were noticed.

Measurement of the symphysio-fundal height: Hands were warmed by rubbing them together to avoid initiating contractions. The upper border of the symphysis pubis and fundus were located. The zero mark of the tape measure was placed on the upper border of the fundus and extended along the contour of the abdomen along the midline to the symphysis pubis and it measured 35cm as compared to the gestational age of 36wks+4days.

Fundal palpation: Standing on her right side and facing Madam Zuliaha, both hands were laid on the side of the fundus with fingers held close together and curved round the upper border of the uterus to determine what occupied the upper pole, a soft mass was felt which indicated the buttocks of the foetus. The abdomen was also palpated to detect enlargement or tenderness of the liver and spleen but none was detected.

Lateral palpation: This was done to locate the fetal back in order to determine the position. It was done with palms on both sides of the abdomen, midway between the symphysis pubis and fundus; the abdomen was stabilized with one hand and examined with the other hand. The palpation was done through the entire midline to the lateral side of the abdomen, and from the symphysis pubis to the fundus in a rotational manner, the foetal back (the smooth part) was located at the left side of her abdomen, and the limbs (rough part) were at the right side. The position was therefore left occipito-anterior.

Pelvic palpation: It was done upon facing the woman's feet. The knees were flexed to relax the abdominal muscles. She was asked to breathe in and out slowly and the palms were placed just below the level of the umbilicus with the fingers directed towards the symphysis pubis and thumbs almost meeting, a hard round mass was felt indicating the head of the foetus. The presentation then was cephalic.

Descent: location of the anterior shoulder was made using two fingers of the non-dominant hand, the symphysis pubis was also located and with the ulna border just above the symphysis pubis and the anterior shoulder, five fingers occupied the space between the anterior shoulder and the symphysis pubis indicating descent of $5/5^{th}$.

Auscultation: The fetoscope was warmed by rubbing it in the palm then foetal heart was auscultated by placing foetal stethoscope (fetoscope) on the abdomen where the back was

located; the ear was placed against the fetoscope, making sure hands were not touching the fetoscope and the foetal heart beats were counted, comparing the rate with the maternal pulse and counting how many beats were heard for one full minute, it was 119 beats per minute (bpm) with regular rhythm and volumes. She answered positively when asked if she had been feeling the foetal movement.

VULVA EXAMINATION

Her permission was sought for vulva inspection and she agreed. The vulva was well shaved and clean. Hands were washed with soap and water and dried with clean towel, clean gloves were worn on both hands and the vulva and the perineum were examined for abnormal discharges, rashes, wart growth and ulcers, episiotomy scars and varicose veins. The Labia Majora and minora were examined for size and shape, redness, swelling, and tenderness but nothing abnormal was detected. The clitoris was also present.

Madam Zuliaha was thanked for her cooperation and the findings were communicated to her after assisting her to get up from the couch and dressing up.

All equipment's used were decontaminated appropriately according to infection prevention protocol. The gloves were removed and also discarded. Hands were washed thoroughly with soap under running water and dried with clean dry towel. Health education was given on birth preparedness and eating of nutritious diet (that is food that contain the three main groups of nutrients, body building food, energy given food and protective foods) to prevent anaemia. After all the examinations, it can be said that the lie was longitudinal, presentation was cephalic, position was left occipito-anterior and descent was $5/5^{th}$. She was congratulated for taking good care of herself and was urged to continue with it. She complains of loss of appetite and she was reassured that it can be managed. She was assisted to plan her meals, encourage to eat in bit but regularly and to wash the mouth before and after meals.

She was also informed of home visits which she agreed and her phone number was taken.

The routine drugs served were as follows;

Tablet Folic acid 5g daily x 7 days

Education on well-balanced diet as indicated in her antenatal booklet was shown to her and was informed about her next antenatal visit which was on the 27^{th} of May 2022. Permission was then asked from Madam Zuliaha for home visit and it was granted, she then gave directions to her house as well as her contact number. She was thanked and seen off.

2.2 FIRST ANTENATAL HOME VISIT

On 22/05/2022 at 4:30pm, Madam Zuliaha was visited in her house as arranged. The main purpose was to check on how she was feeling, her physical wellbeing as well as her surroundings. The house is about 10minute walk using the direction she gave on the day she came for antenatal care. On arrival, a seat was offered. Introduction was made between her husband and myself as a student midwife from Holy Family Nursing and Midwifery Training College Berekum who is doing a care study and she agreed to be chosen for the study. Her husband was also happy about it.

PHYSICAL

The house is built with cement blocks, plastered and painted with white outside and blue inside; it also has a very clean environment. The floors of the house are not cemented and its doors and windows have nettings which prevent mosquitoes from entering the rooms. The source of water is from the community's bore hole which is just five minutes' walk from the house. They use this water for domestic purposes and also as a drinking water. She uses her corridor as a kitchen and cooks with a coal pot. There is a toilet and a bathroom which is built with blocks and is semi-detached from the main building. Both toilet and bath were very neat on inspection. The house environment was very neat with no bushes around. Refuse was kept in a plastic container with a lid at the back of the house which is sent to the main refuse damp every morning. The rooms are very spacious and well ventilated. She sleeps under insecticide treated net. Her room is divided with a cross bar and curtains forming a bedroom and a hall. The bedroom had no bed and her mattress is on the floor, a center table and one television. They sleep with their child.

An opportunity was then taken to inspect her layette. She said she has gotten all the needed items for labour and were well packed so permission was sought to inspect the items, they were accurate as she had said. Client was educated on sibling rivalry and already excited about the unborn brother or sister. Her husband was encouraged to support her in any way he could to ease stress and pressure. Client was asked about her general condition and she complained of backache and constipation. Explanations was given to her that backache is one of the minor disorders that pregnant woman may experience. Backache in pregnancy typically happens the stretched abdominal muscles lose their ability to maintain posture so the lower back has to support the majority of the weight. Client was advised to avoid sitting without a back rest, standing for too long and wearing high heeled shoes and was also advised to maintain good posture, sleep on a firm mattress and if the backache persist

severely, she should report to the facility. With the constipation too, education was given that constipation normally happens in pregnancy when changing of hormones level cause the intestine to slow down the bowel movement and also pressure from the uterus. In late pregnancy, the growing uterus can put pressure on the bowel, making it harder to move stool through the intestine. Client was counseled on the intake of fruits, vegetables and more intakes of fluids and water. Client was also advise to take in food which contain more fiber and move her bowel immediately after she feels the urge. She was encourage to cultivate the habit of regular bowel movement and do mild exercise to relieve constipation.

Madam Zuliaha and her family were then appreciated for their warm reception and permission was sought to leave and next visit scheduled. She was reminded of her next visit to the health centre.

PSYCHOSOCIAL

Madam Zuliaha, her husband, her child and family have a good relationship with each other. She has a good personal relationship with her neighbor, she has no personal issues with relatives she lives with. She attends social gathering like outdooring and weddings, she sometime helps in settling disputes when issues arise in her neighborhood. She generous and kind and not find it difficult making new friends. She also added that she has respect for everyone who comes her way being it a child, age mate or elderly. She indeed loves everyone unconditionally. Client was congratulated and was asked to keep it up.

2.3 SECOND ANTENATAL HOME VISIT

The second home visit to Madam Zuliaha's house was made on the 25/05/2022 around 3:00pm. I went to check how my client was feeling. When I arrived there, she was busy doing her household choice and she was doing very well with no complain. I waited for her to finish so that we have some discussions. After she was done, she took her bath and dressed up. She was asked to mention the true labour signs and she was able to recall all of them and also rechecked her layette and they were complete and well packed. She was then advised to report immediately to the health facility if she experienced any labour signs. She was asked of the one who would accompany her to the health facility and she said her sister in-law. She was also advised to arrange with a taxi driver who would pick her to the facility when the need arise. The compound was checked and everything was well kept. I also told her to call

me in case of anything. Permission was sought to leave and she was reminded of the next visit to the facility.

2.4 SECOND ANTENATAL VISIT TO THE CLINIC

On the 27/05/2022, at 10:00am Madam Zuliaha reported at the facility as scheduled. She was warmly welcomed, offered a seat and congratulated for her regular attendance. Her antenatal book was collected and glanced through. All the routine procedures to be carried out were explained to her and her consent was sought. Her vital signs and weight were checked and recorded as follows:

Temperature	36.8 degrees Celsius
Pulse	84 beats per minute
Respiration	22 cycles per minute
Blood pressure	112/66 millimeters of mercury
Weight	77 kilograms

She was asked to empty her bladder and mid-stream urine was tested for the presence of protein and glucose which were both negative. She was then sent to the palpation room; she was assisted to position herself on the examination bed. After hand washing with antiseptic soap under running water and well dried with a clean dry towel, head to toe examination was done and no abnormality was detected. Abdominal inspection was done and there was no abnormality detected. On palpation, the gestation was 37weeks+ 4 days; Symphisio-fundal height 38cm, lie longitudinal, and presentation cephalic, descent 5/5th, foetal heart rate was 120bpm on auscultation. She was then congratulated, asked to lie on her left side, sit and the get up from the examination bed. A seat was offered to her and findings were communicated to her.

She complained of lower abdominal pains and frequent micturition which was interrupting her sleep which she much worried about it. she was educated that the lower abdominal pains were due to the descending foetal head into the pelvis. She was then encouraged to have enough bed rest and sleep and was asked to come to the facility in a week's time if she had not delivered . It was explained to her that as time goes on especially if the presenting part of the fetus exerts pressure on the bladder it reduces the capacity of the bladder leading to the frequency of micturition. She was encouraged on her personal hygiene so that there will be no conducive environment created for microorganisms to grow and multiply and also to keep a covered chamber pot in her room so she can frequently empty her bladder into it especially during the night.

Madam comfort was also encouraged to observe vulva hygiene and was reassured that the situation will resolve after delivery so she should try and cope with it. She was served with

tablet paracetamol 1g three times daily for five days. She was not served with any of her routine drugs because the previous once were not yet finished. She was then thanked and seen off.

2.7 NURSING CARE PLAN ON ANTENATAL

PROBLEM IDENTIFIED

Nursing care plan is a guideline to nursing action in order to promote individualized care and continues care of the client. It is written to aid in identification of client's problems, out of which nursing diagnosis is made with the specific objective set regarding the problem. Interventions and evaluations are made at the end to ensure that all the objectives are met. Again, it ensures continuity of care and paves way for good interpersonal relationship among staff, client and relatives.

PROBLEMS IDENTIFIED DURING ANTENATAL CARE

1. Loss of appetite 20/05/2022
2. Constipation 22/05/2022
3. Backache 22/05/2022
4. Lower abdominal pains 27/05/2022
5. Frequent micturation 27/05/2022

SHORT TERM OBJECTIVES

1. Madam Zuliaha will tolerate at least half plate of food served within 24 hours.
2. Client will regain her normal bowel action within 48 hours.
3. Client will cope with backache within 24 hours
4. Madam Zuliaha will cope with lower abdominal pains within 24 hours.
5. Madam Zuliaha will cope with frequent micturation within 48 hours.

LONG TERM OBJECTIVE

Client will be able to carry the pregnancy to term safely without complications to both mother and foetus.

NURSING CARE PLAN DURING ANTENATAL

DATE& TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTIONS	DATE & TIME	EVALUATION	SIGN
20/05/2022 9:30 am	Loss of appetite related to the advance stage of pregnancy.	Madam Zuliaha will eat at least half plate of meals served within 24hours as evidenced by; 1.client verbalizing that she can eat at least half plate of every meal served. 2.Client husband confirmed that client was able to	1. Reassure client that she will be able to eat at least half plate of meal served within 24 hours. 2. Encourage client to serve food of her choice. 3. Encourage client to eat in bits and at regular intervals. 4. Encourage client to take in fruits available such as orange. 5. Serve vitamin supplement.	1. Client was reassured that she would be able to tolerate at least half plate of meal served. 2. Client was encouraged to serve food of her choice. 3. Client was encouraged to eat in bits and at regular intervals. 4. Client was encouraged to take in fruits available to help boost her appetite. 5. Madam Zuliaha was served with folic acid and iron	21/05/2022 9:30 am	Goal fully met as Madam Zuliaha said she ate at least half plate of every food served.	**AMS**

		eat well.					

CONTINUATION OF ANTENATAL CARE PLAN

DATE& TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES/ OUTCOME	NURSING ORDER	NURSING INTERVENTION	DATE &	EVALUATION	SIGN

		CRITERIA			**TIME**		
22/05/2022 4:30pm	Constipation related to decreased gastrointestinal motility secondary to hormonal action	Client will regain her normal bowel action within 48hours as evidenced by 1. client verbalizing that she can empty her bowel. 2.Client husband testify that client emptied her bowel twice daily.	1. Reassure Client to allay anxiety that she will regain her bowel movement. 2. Educate client to take enough water. 3. Encourage client to take in diet rich in roughages 4. Educate client to perform minimal exercise such as walking. 5. Encourage client to empty her bowel when she feels the urge.	1. She was reassured that she would move her bowel daily. 2. Client was educated to take at least 8 glasses of water daily. 3. Client was encouraged to take in diet rich in roughages like orange. 4. Client was educated to walk around. 5. Client was encouraged to empty her bowel when she had the urge.	24\5\22 4:30pm	Goal fully met as client stated that she was able to move her bowel every day	AMS

DATE & TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES/ OUTCOME CRITERIA	NURSING ORDER	NURSING INTERVENTION	DATE & TIME	EVALUATION	SIGN
22/05/2022 4:30 pm	Backache related to exaggerated lumbar curvature in pregnancy.	Madam Zuliaha will cope with the pains within 24 hours as evidenced by 1. Client verbalizing that she is coping with the pain. 2.Midwife observing client perform some activities.	1. Reassure her that pain will reduce. 2. Encourage her to bend from the knees not the waist to release pressure from the waist. 3. Educate client on workload. 4. Encourage her to take adequate rest in between activities. 5. Administer prescribed analgesics.	1. She was reassured that pain would reduce. 2. She was encouraged to bend from the knees and not the waist to release pressure from the waist. 3. Client was educated on minimal work. 4. She was encouraged to take adequate rest in between activities. 5. Tab paracetamol 1g was administered.	23/05/2022 4:30 pm	Goal was met as Madam Zuliaha reported that she is coping with the pain.	AMS

CONTINUATION OF ANTENATAL CARE PLAN

DATE& TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES/OUTCOME CRITERIA	NURSING ORDER	NURSING INTERVENTION	DATE & TIME	EVALUATION	SIGN
27/05/2022 10:00 am	Lower abdominal pain related to fetus exerting pressure on the pole of the uterus.	Client will be able to cope with the lower abdominal pains within48 hours as evidenced by 1. Client verbalizing that she is coping with the lower abdominal pain. 2.Client husband comfirm that client is coping with the lower abdominal pain.	1. Reassure client that this physiological disorder will reduce soon after delivery. 2.Explain the physiology of lower abdominal pain to the client. 3.Encourage client to practice deep breathing exercise during and rest in between. 4.Educate client to on the side with knees and hip bent. 5.Advice client to wear low heel sandals.	1.Client was reassured that the lower abdominal pains will reduce after delivery. 2.She was told it is due to descent of the presenting part. 3.She was encouraged to practice deep breathing exercise during contraction and rest in between. 4.Client was encouraged to lie on the side with knees and hip bent. 5.Client wore low heels sandals.	29/05/22 10:00am	Goal met as Madam Zuliaha said that she is coped with the lower abdominal pain.	AMS

DATE& TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES/OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTIONS	DATE/ TIME	EVALUATION	SIGN
27/05/2022 10:00am	Altered sleep pattern related to frequent micturation	Client will have at least 2 hours of sleep during the day and 6 hours during the night within 48 hours as evidenced by 1.Client verbalizing her ability to have 2 hours sleep during the day and 6 hours at night. Client will have at least 2 hours of sleep during the day and 6 hours at night	1. Reassure client. 2. Encourage client to put pale beside her bed when sleeping. 3. Encourage client to empty bladder completely when voiding. 4. Encourage client to limit intake of fluids containing natural diuretics. 5. Encourage client to void frequently	1.. Madam Zuliaha was told it was due to pressure of the enlarging uterus on the urinary bladder. 2 Pale was placed beside client bed. 3. Client was encouraged to lean forward when voiding to help empty the bladder completely. 4. Client was encourage to stop fluids like coffee and tea at night. 5.Client was encourage to void immediately she had the urge to.	29/05/2022 10:00am	Goal fully met as Madam Zuliaha verbalized having adequate sleep	AMS

CHAPTER THREE

LABOUR

3.0 INTRODUCTION

This chapter consists of the management of the four stages of labour. It also includes the immediate care of the baby after delivery. Problem of client identified during this period were managed with the care plan which has been attached to this chapter.

3.1 ADMISSION AND MANAGEMENT OF FIRST STAGE OF LABOUR

Admission

On Wednesday 15th of June, 2022 during a night shift, Madam Zuliaha's husband called me on phone to give information about the wife not feeling well. At 6:20pm she came to the Health Centre accompanied by her sister in-law. They were warmly welcomed and she complained of waist pains, lower abdominal pains and she was anxious and did not know what would happen to her. She and sister in-law were reassured of the competency of the midwives and also encouraged her to ask any question that baffled her. She also complained of painful uterine contractions. Her sacral region was rubbed whenever there was pain. Her sister in-law was offered a seat in the waiting room and reassured while the client was attended to. Her antenatal card was collected and glanced through quickly to check her obstetric history and assessment was done to rule out the urge to push before client was taken through admission process and according to her, labour started around 4:00am and she was asked whether she has seen mucoid discharge mixed with blood (show) and she said yes and contractions were frequent. Enquires were made to know if she has taken any medication or herbs since the pains started and the responds was no. Client was reassured of competent care to be rendered after which she was made comfortable in bed and privacy maintained. Client layette was arranged by her bed side. The procedures to be carried out on her were explained to her and permission sought was granted. Hand washing was done with antiseptic soap under running water and dried with clean dry towel. She was helped onto the examination bed. Vital signs and results of other investigation were recorded as follows;

Temperature	36.7 degree Celsius
Pulse	76 beats per minute
Respiration	20 cycles per minute
Blood pressure	134/82 millimeters of mercury

Madam Zuliaha was taken to the labour admission room for monitoring. Items needed for delivery were sent to the labour room and the remaining sent to her bed side. She was asked to urinate before the head-to-toe examination starts to prevent interruption. Midstream urine was taken for glucose and albumin to be tested and it was negative. 120ml of urine was excreted which was amber in colour. An intravenous cannula was passed as per facility's protocol. Client was assisted to undress and was draped with a cover cloth. Privacy was provided and client was helped onto the examination couch sideways then to a lithotomy position. Hand washing was done with soap under running water, dried and warmed by rubbing both hands together.
Head to toe examination was done; there was no pallor, oedema nor jaundice. No abnormalities were detected.

Abdominal palpation.

Inspection was done with the shape of the abdomen noted to be ovoid and the size medium. The abdomen was inspected for scars, straie gravidarum, linea nigra, and in all ,linea nigra and straie gravidarum was found to be present with no scars.

Measurement of sympysio-fundal height was done by placing the zero end of the measuring tape on the fundus and then extended to the upper boarder of the symphysis pubis. The symphysio-fundal height was 37cm and gestational age was 40weeks +2days.

Fundal palpation was carried out while facing client, the fundal palpation was done with both palms cure inward at the fundus if the uterus. Through the process, it was detected that the buttocks of the foetus was occupying the fundus since soft mass was felt.

Lateral palpation was completely with one hand used to stabilized the right side of the maternal uterus, the other hand was moved gently on the left side of the maternal uterus and rough part was felt indicating limbs. This was repeated at the right side and a smooth part was felt, indicating the foetus back. This help to locate where to place the fetoscope to listen to the foetal heart sound.

Decent was assessed as the anterior shoulder of the foetus and the upper boarder of the symphysis pubis were located. Five fingers were admitted between the anterior shoulder and the symphysis pubis, indicating that descent was $4/5^{th}$.

Auscultation followed with a fetoscope placed at the smooth surface which is an indication of back to listen to the foetal heart sounds, whiles comparing with the maternal pulse. Foetal heartbeat was 140 beat per minute with good rhythm.

Contractions was 2 in 10 -minutes lasting for 20 seconds.

Vaginal Examination
Hands were washed with antiseptic soap under running water and dried with clean towel and surgical gloves were put on. Her vulva was inspected for inflammation, rashes, discoloration varicosity, ulceration but none was found. Whiles still in a lithotomy position, vulva swabbing was done with swabs soaked with savlon solution, vaginal examination was done to confirm if it was true

labour. On examination, vagina was warm and moist. The cervix was effaced; cervical dilation was 4centimeters with membranes intact and no moulding. The cervix was soft and the presenting part was well applied to the cervix, the sacrum was well curved, the ischial spines were blunt, the pubic arc was wide and the intertuberocial diameter admitted a fist.
Perineum was cleaned and client was made comfortable in bed. Education on deep breathing exercise was given as the pain increased. She was encouraged to empty her bladder frequently and take fluid whenever she feels thirsty. The findings were communicated to her and she was thanked for her co-operation. The information gathered was documented on to a partograph sheet.

Preparation for birth

In preparing for birth, skilled and unskilled helpers must be identified. The skilled helper identified was the midwife in-charge whiles Madam Zuliaha's sister in-law served as an unskilled helper. She was told she would help by running errands when needed and be called in case of any emergency. The emergency plan which includes transportation in case of any referral, the midwife in-charge was also informed that her assistance would be needed in the care of the laboring woman.

The area for delivery was prepared by closing the windows to provide warmth and all fans were switched off to receive the new born into a warm room. The mother's hands and chest were cleaned to prepare for skin-to-skin care. The light was tested to check if it was working and lamp was made available to be used in case of light out. The area for ventilation and equipment were checked. The ventilation bag, sucker and mask were tested and they were in good shape for use.
Delivery set, drugs and protective clothing (boots, goggle, face mask, cap and apron) were all made available for use. Head covering, scissors, cord clamp and sterile gloves were also made available.

MANAGEMENT OF FIRST STAGE OF LABOUR

Madam Zuliaha was closely monitored on partograph throughout the first stage of labour, maternal and fetal conditions were recorded and labour progressed well. Uterine contractions, maternal pulse and foetal heart rate were monitored every 30 minutes and dilatation, moulding, descent, temperature and blood pressure were monitored every 4 hours. Urine test for protein and acetone was done every 4 hours. The findings were recorded on pathograph.

At 10:30pm vaginal examination was repeated and the cervical os was 8cm dilated membranes raptured and it was clear with moulding+ and descent was 1/5. Volume of urine passed was 100mls without protein, glucose or acetone, maternal pulse 86bpm, foetal heart rate -142bpm, contraction 3 in 10s lasting for 44 seconds.

Vital signs were checked and recorded as follows:

Temperature	36.1^{o}C
Pulse	86bpm
Respiration	20cpm

Blood pressure 120/70 mmHg

Water was provided for her to drink frequently to prevent thirst and dehydration. A bottle of malt drink was also provided for her. She was also encouraged to empty her bladder whenever she had the urge, this would help in the descent of the foetal head. She was also encouraged to do the deep breathing exercise with contractions as taught during the antenatal period and asked not to push to prevent rigid and edematous cervix. The physiology of the labour pains was explained to her. Education on perineal hygiene; the need to put on a clean pad when the old one is soiled and also not reuse a pad that had fallen were reinforced. Her sister in-law was informed about the progress of labour and was taught to massage the sacral region.

The delivery trolley was set paying attention to sterility and it contained the following items;

Top shelf contained:

A HLD delivery packs containing;

2 sterile artery forceps

Cord scissors

4 Sterile drapes

Sterile towels

Sterile galipot containing sterile cotton wool swabs

A HLD episiotomy set containing; dissecting forceps, episiotomy scissors, sterile galipot containing sterile gauze and needle holder.

Receiver/kidney dish

Clean sucker

Bottom shelf contained:

Bed pan

Warm towel and blanket

Cheatle forceps in it container

Measuring jug for blood loss

Perineal pads

Syringes and needles

Antiseptic lotion

Examination gloves

Fetoscope

Drainage bag and catheter

Sutures

Pair of sterile gloves

Cord clamp

Identification band

Two cot sheets

Bulb syringe in a bowl of water

A drug tray containing 10 units of Oxytocin, Water for injection, Chloramphenicol eye drop, lidocaine, and vitamin K.

And resuscitation area was already prepared.

At 1:00am madam Zuliaha was asked about her waist pains and she said she was coping. She complained of fatigue and frequency of micturation , explanation was given to her that the fatigue was as a result of increase physical demands of labour and client was served with 500mls of water and fruit juice as well. She was encouraged to avoid shouting to reserve her little energy and instead do more deep breathing exercise. Client was educated on the physiology of frequent micturition as due to the descent of the foetal hand putting pressure on the bladder and that it will resolve after delivery. She was encourage to urinate into the pale provided. Enquires about the fatigue and frequency of micturition was made and she said she was copping. Client complained of bearing down, so vaginal examination was repeated and the cervical os was 10cm dilated with clear liquor, moulding++ and descent was $0/5^{th}$ and contraction 4 in 10 lasting 56 seconds, maternal pulse 91 bpm and foetal heart rate 150bpm. Volume of urine passed was 60mls without protein, glucose or acetone. Vital signs were checked and recorded as follows:

Temperature	$36.8^{o}C$
Pulse	91bpm
Respiration	20cpm
Blood pressure	134/76 mmHg

The client was encouraged to breathe through the mouth, the perineum was quickly examined, the vulva and anus were gaping, perineum was bulging and a trickle of blood was evident. Progress of labour was communicated to the midwife in-charge and the client was informed that the cervix was fully dilated. The midwife in-charge confirmed full dilation of the cervix.

3.2 MANAGEMENT OF SECOND STAGE OF LABOUR

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. Madam Zuliaha was positioned on the delivery bed in the second stage room. I assisted the client to lie on her left lateral side as prepared by putting on my mackintosh apron, mask and boots. Client was reassured and explained every procedure to be done to her. client abdomen was draped with warm cot sheet and reminded her that baby would be delivered onto her abdomen and that she will support the baby. Hands were washed and dried with a clean towel and a pair of sterile gloves was won under supervision of midwife in- change. Client was reposition in a lithotomy position, midwife in- charge was ask to confirmed full dilatation. Client anal region was covered with perineal pad to prevent faces contaminating the delivery field. She was encourage to bear down during uterine contraction and rest in between and assistant was ask to check maternal blood pressure and foetal heart rate after each contraction so as to detect my deviation. The left hand was used to hold pad in position and aided flexion by gently placing the right index and middle fingers on the occiput to press downward to enable the smallest diameter of the foetal head to distend the perineum so as to prevent any injury to the mother and baby. Descent of the foetal head continued till crowning of the head occurred. Client was asked to stop pushing and pant to prevent rapid expulsion of the foetal head which could lead to perinatal tear.

The sinciput, face and chin swept the perineum and were gently delivered by extension. Baby eyes were cleaned from the inner canthus the outer canthus with sterile swabs and also mouth and nostril was suction with bulb syringe to remove mucus from mouth and nose, face was cleaned with sterile gauze swabs. Then quickly felt for cord around baby's neck and there was none.

After restitution and external rotation of the head which indicated that the shoulder was in the anterior–posterior diameter of each pelvic outlet. Hand was placed on each side of baby's head over the ears and deliver the anterior downwards traction. After wards, the posterior shoulders sweep the perineum and were delivered. I did this gently by moving the baby's head towards the mother's abdomen. The rest of the baby was delivered by lateral flexion onto the mother's abdomen. The time was quickly noted at it was 1:10am. She delivered a live male baby who cried lustily immediately when he was out.

3.3 IMMEDIATE CARE OF THE BABY

The immediate care of the baby starts from the delivery of the baby's head to the delivery of the whole body. Baby's face was cleaned with sterile gauze as soon as the head was born. The eyes were then wiped from the inner cantus to the outer cantus with sterile gauze. The liquor was cleaned from the baby's body thoroughly. The baby was placed skin to skin and covered with a warm dry cloth and a cap put on. The first minute Apgar score was assessed to be 8/10. Within 3 minutes the cord was clamped tightly with a cord clamp 2 centimeters away from the baby's abdomen and 3cm away from the first clamp to prevent bleeding. The cord was cut in between the two clamps to separate the baby from the mother. Baby was shown to mother to identify sex. An identification tag was put on the baby's wrist which bears the mother's name, baby's sex, date and time of delivery. The fifth minute Apgar score was assessed to be 10/10. Skin to skin care was continued for one hour to provide warmth and bonding. During the skin-to-skin care, baby's temperature and breathing were observed. Breastfeeding was then initiated and client was congratulated

APGAR SCORE	FIRST MUNITE	FIFTH MUNITE
Appearance	2	2
Pulse/ heart rate	2	2
Grimace / reflex	1	2
Activity/ muscle tone	1	2
Respiration	2	2

3.4 MANAGEMENT OF THIRD STAGE OF LABOUR

The procedure was explained to Madam Zuliaha. Immediately the baby was delivered the uterus was palpated to exclude a second twin, 10 units of oxytocin was given to mother intramuscular on the left thigh to help the uterus to contract. The cord was reclamped 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 and as soon as there was contraction, the left hand was moved onto the lower abdomen in the suprapubic area with the palm facing the mothers to support the uterus. This was done to prevent inversion of the uterus. The clamped cord was held in the right hand.

When the uterus was contracted, a very steady and gentle pull was applied on the cord to give a downward traction, still maintaining counter pressure. The cord was re-clamped with an artery forceps closer to the vulva as it lengthened. The downward traction was maintained until the placenta was visible at the vulva. The two hands were used to receive the placenta and twisting the placenta into a rope-like manner to prevent tearing of the membranes, the placenta, including the membranes was expelled completely at 1:20am. The placenta was quickly examined and placed in a receiver. The uterus was massaged to maintain contraction and expel clots. This was repeated every 15 minutes for two hours.

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 200mls. She was cleaned up nicely and a clean perineal pad was applied. She was covered with a new sheet and made comfortable in bed. She was encouraged to rest at the labour ward. The client was taught to massage her uterus and she was encouraged to do same to aid in contraction and involution. Baby was put to breast; she was also encouraged to urinate whenever she had the urge so that the uterus could contract well to help in involution and to prevent postpartum haemorrhage.

3.5 EXAMINATION OF THE PLACENTA AND MEMBRANES

The placenta was placed in 0.5% chlorine solution before it was examined thoroughly. The placenta was held by the cord with the membranes hanging and the membranes were examined for completeness and it was intact. The placenta was then laid on a flat surface for further examination. The amnion was peeled from the chorion up to the umbilical cord and was fully viewed, the lobes fit together without any gap and edges also forming uniform circle at the maternal surface and this meant there was no missing lobe, there was no white patches on the maternal surface, there was also no blood vessels radiating into the membranes which meant no succenturiate lobe. The cord was situated at the Centre of the placenta with one vein and two arteries seen in the cord. No knots were found in the cord. Sulci were marked with complete lobes without any abnormalities. The fetal surface appeared greyish and shiny with blood vessels radiating through. Both placenta and membranes were complete and was therefore discarded according to the protocol of the clinic. 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 ready for sterilization. Hands were then washed with antiseptic soap under running water and dried with clean dry towel. Findings

were recorded on the partograph. Madam Zuliaha was thanked once again for her cooperation. It was also explained to her that they would be observed every 15 minutes for two hours and thirty minutes for one hour.

Condition of the placenta

Membranes - intact

Lobes - intact

Cord vessels - two arteries and one vein

Cord insertion - centrally situated

Maternal surface - Dark red

Foetal surface - greyish blue

Stage of placenta - complete

Blood loss – 200mls

3.6 MANAGEMENT OF FOURTH STAGE OF LABOUR

The fourth stage of labour is a period of close observation of mother and baby for the first six hours following the delivery of the placenta and its membranes as well as the control of haemorrhage to detect any deviation from normal. Close observation was made on mother and baby before transferring them to the lying-in ward and made comfortable.

Management of Mother

Having sought permission from Madam Zuliaha, after she has been assisted to the lying-in-ward, her immediate post-delivery vital signs were checked and recorded as follows:

Temperature	36.3 degrees Celsius
Pulse	88 beats per minute
Respiration	20 cycles per minute
Blood pressure	120/70 millimetres of mercury

Her vital signs were checked every 15 minutes for two hours, 30 minutes for one hour and one hourly for 3 hours. Uterus was massaged every 15 minutes for the first two hours and then every 2 hours subsequently. It remained firm and contracted. Symphysio-fundal height measured 16cm. Lochia was red (rubra) and flow was small without offensive odour. She was encouraged to empty her bladder frequently to ensure effective uterine contraction and also to change soiled pads frequently to prevent infections. She was also educated to wash her hands with soap and water after changing her pad and also before and after attending to the baby.

She was also encouraged to breastfeed the baby on demand. The baby slept after suckling for some time and was also helped to take her bath.

Management of Baby

Prevention of diseases of the new born

After an hour skin-to-skin, client was informed baby will be given some prophylaxis for the eye to prevent infection and vitamin k injection to also help establish the baby's clotting time. She was also made aware of cord dressing. Hand washing was performed and dried. Chloramphenicol eye drop was instilled on the inner canthus of the eye with the hand pressing on the cheek. The procedure was repeated for the other eye. The umbilical cord was dressed with cotton wool swabs and methylated spirit. Because Vitamin k1 was given after the examination to prevent hemorrhagic disease of a newborn. Mother was educated not to put any herbs on the cord.

Examination of the newborn

Permission was sought from mother to examine the baby and the procedure was explained to her and she gave her consent. Hands were washed and dried with a clean dry towel. 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 body was pink all over and very active. He was then covered with a clean sheet and exposed systematically as it was examined from head to toe.

The head was examined for the shape and size, widened sutures, bulging fontanelles, and any edematous swelling or caput succedaneum but no abnormalities were found. A tape measure was used to encircle its head starting from the occipital protuberance to the supraorbital ridges to measure the head circumference and it was 34centimetres.The ears were examined for size, shape, and patency, alignment and discharges. There was no abnormality detected and the pinna was aligned with the upper 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 examined by pressing the angle of the jaw which opened the mouth and the tongue, gum and palate were inspected and there was also no false tooth noticed. The palate was high arched, intact and the uvula centrally placed. There was no cleft palate or cleft lip, tight frenulum or tongue tie, colour of tongue and gum, but no abnormality was detected.

The neck was examined for nodules, rigidity and congenital goiter and none was found flexion and rotation was good.

On the chest**,** the 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 cord and abnormalities such as omphalocele and gastroschisis were absent.

The upper extremities were inspected for equality, number of palmer creases, clubbed fingers, extra or lost digits. Baby's ability to perform Moro and grasp reflexes was present when checked. The lower extremities were inspected for equality, club feet, extra or lost digits and there was none. Congenital hip dislocation was also checked by using the Barlow's test and it was absent.

With baby lying prone, its back was examined for abnormalities like spinal bifida, meningocele and oedema which were all absent.

The genitalia and anus were well developed with testis descended into the scrotum and urethral and anal orifices patent as it passed urine and meconium respectively.

The baby was weighed and the weight was 3.6kg, head circumference was 34cm and length 50cm.

In all, there was no abnormality detected. The baby was classified as normal and routine care of the baby initiated. Gloves were removed and disposed aseptically before washing hands with soap under running water and dried with clean dry towel. The baby's skin was smeared with baby oil, wrapped and mother was thanked for her cooperation. Gloves were removed and disposed aseptically before washing and drying hands.

All the findings were communicated to the parents and recorded afterwards. The baby was therefore classified as normal and routine care rendered. Baby's vital signs were checked and recorded as follows;

Temperature	36.7 degrees Celsius
Apex heart beat	142bpm
Respiration	42cpm

Baby condition was satisfactory and mother was then assisted to put baby to breast for natural release of oxytocin to aid in involution and bonding between her and the baby.

3.7 SUMMARY OF LABOUR AND DELIVERY

Date of delivery- 16th June, 2022.

Time of delivery- 1:10am.

Type of delivery- spontaneous vaginal delivery.

Time of placental delivery- 1:20am.

Drug given-Injection Oxytocin 10 units

Duration of labour

1st Stage	6 hours 30 minutes
2nd Stage	10 minutes
3rd Stage	10 minutes
Total duration	6: hours 50 minutes

Condition of the mother

Temperature	36.7oC
Pulse	88bpm
Respiration	20cpm
Blood pressure	120/70mmHg
Uterus	Contracted
Symphysio fundal height	15cm
Perineum	Intact.
Lochia	Rubra
Condition	Satisfactory

Condition of baby at birth

Temperature	36.6oc
Apex heart beat	142 bpm
Respiration	42cpm
Sex	Male
Head circumference	34cm
Length	50 cm
Weight	3.6kg
Condition	Satisfactory
Congenital Abnormalities	None detected

Within few minutes after birth, baby passed urine and meconium.

3.8 CARE PLAN DURING LABOUR

PROBLEMS IDENTIFIED DURING LABOUR

1. Anxiety was observed among client and support person.
2. Client complained of lower abdominal pain.
3. Client complained of waist pain.
4. Client complained of fatigue
5. Client complained of frequent micturition.

SHORT TERM OBJECTIVES

1. Client and support person will be relieved of anxiety within an hour.
2. Client will be able to cope with lower abdominal pain within 5 hours and throughout labour.
3. Client will be able to cope with waist pain within 6 hours.
4. Client will have enough energy within 4 hours.
5. Client will cope with frequency of micturition within 3 hours and through labour.

LONG TERM OBJECTIVES

Client will go through labour and delivery safely without any complication to the mother and the new born baby and the entire family.

NURSING CARE PLAN DURING LABOUR

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVE/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
15/06/2022 6:30pm	Anxiety /Fear related to unknown outcome of labour.	Client and support person will be relieved of anxiety within an hour as evidence by 1. Client being relaxed and showing a less signs of anxiety. 2.Midwife observing client looks less tense.	1. Reassure client that she is in competent hand. 2. Encourage client to express her concerns. 3. Address client concern appropriately. 4. Explain every procedure to be Carried on her in simple terms. 5. Engage client in conversation to take her mind off the pain.	1. Client was assured that she is in competent hand. 2. She was encouraged to express her concern. 3. Client was addressed with her concern appropriately. 4. Every procedure carried out was explained to her. 5. Client was engaged in conversation to keep her mind off the pain.	15/06/2022 7:30pm	Goal fully met as Client should relaxed and cheerful facial expression throughout labour.	AMS

CONTINUATION OF LABOUR CARE PLAN

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES/ OUTCOME CRITERIA	NURSING ORDER	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
15/06/2022 6:30pm	Lower abdominal pain related to uterine contraction.	Client will be able to cope with lower abdominal pain within 5 hours and throughout labour as evidence by 1. client verbalizing that she is coping with pain. 2. Midwife observing client adopt coping mechanisms.	1. Reassure client that she is in competent hand 2. Explain the physiology of lower abdominal pain to client. 3. Encourage client to practice deep breathing exercise during contraction and rest in between. 4. Encourage client to assume a comfortable position.	1. Client was reassured of safe and competent hands. 2. The physiology of lower abdominal pain was explained to her. 3. She was encouraged to practice deep breathing exercise during contraction and rest in between. 4. Client was encouraged to assume a comfortable	15/06/2022 11:30pm	Goal fully met as she said she was able cope with lower abdominal pain throughout labour.	AMS

			5. Stay with client and encourage her in conversation as a divisional therapy.	position. 5. Client was engaged as a divisional therapy.			

CONTINUATION OF LABOUR CARE PLAN

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES	NURSING ORDER	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
15/06/2022 6:30pm	Waist pain related to descent of fetus into the pelvis	Client will be able to cope with waist pain within 6 hours and throughout labour as evidence by 1. Client verbalized that she is coping with pains. 2. Midwife observing client is coping with the waist pains.	1. Reassured client that she is in competent hands. 2. Explain the physiology of waist pains to client. 3. Allow client to adapt to comfortable position like left lateral position. 4. Give client sacral massage to help her relieve the pain 5. Provide diversional therapy to client by engaging her in her a conversation.	1. Client was reassured that she is in competent hands. 2. The physiology of waist pain explained to client that it was due to relaxation of pelvic joints. 3. She adopted a comfortable lateral preferably 4. Client was given sacral massage to help relieve pains. 5. Conversational therapy was engaged as divisional therapy.	16/06/2022 12:30am	Goal fully met as client verbalized, she was able to cope with pain throughout labour.	AMS

LABOUR CARE PLAN CONTINUED

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES	NURSING ORDER	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
16/06/2022 1:00am	Fatigue related to increased physical demands of labour.	Client will have enough energy within 4 hours as evidenced by 1.client being able to bear down during second stage. 2. Midwife observing client was able to push during 2nd stage of labour.	1. Reassure client that fatigue will be relieved. 2. Provide quiet environment. 3. Serve client with nutrition light diet. 4. Encouraged client to rest in between contractions. 5. Encourage client to do slow deep breathing and breath out exercise and rest between contractions.	1. Client was reassured that fatigue will be relieved. 2. Quiet environment was provided for the client. 3. Client was served with nutritious light diet. 4. Client was encouraged to rest in between contractions. 5. Client was encouraged to do slow deep breath in and slow deep breath out exercise and rest contractions.	16/06/2022 5:00pm	Goal full met as evidenced by client showed good maternal effort in second stage of labour.	AMS

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
16/06/2022 1:00am	Frequency of micturition related to pressure from descending of the feotus on the bladder.	1.Clients will cope with the physiology of frequency of micturition within 3hours as evidence by 1. client verbalizing that she is coping with frequency of micturition. 2.Midwife observing client coping with the frequency of micturition.	1.Ressure clients that frequency of micturition will stop after delivery 2. Explain to client that it is as a result of pressure from descending foetus on the bladder. 3. Provide covered bed pan for client. 4.Encourage Client to void if she has the urge 5. Measure urine output.	1. Client was reassured that she will be well. 2. The physiology of frequent micturition was due to the pressure from descending foetus on the bladder. 3. Client was served with covered bed pan. 4. Client was encouraged to avoid if she feels the urge. 5. Client pass 200ml of urine.	16/06/2022 4:00am	Goal fully met as evidence by Client said she understands the cause of frequency of micturition	AMS

CHAPTER FOUR

PUERPERIUM

4.0 INTRODUCTION

This chapter gives detailed information about the subsequent care given to the mother, the baby and family from the day of delivery till two weeks postnatal.

4.1 DAY OF DELIVERY

Madam Zuliaha delivered on Thursday, 16th June, 2022 to alive baby boy. Client was transferred into the lying-in-ward after an hour close observation when conditions were satisfactory, she and her baby were made comfortable in bed. 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 also educated to change her perineal pad frequently to help prevent infections and was asked to wash hands with soap and water aseptically after removing her perineal pad, visiting the toilet and before touching her breast and the baby.

Her immediate post-delivery vital signs at 1:30am recorded as follows;

Mother's vital signs

Temperature	36.2 degrees Celsius
Pulse	88 beats per minute
Respiration	22 cycles per minute
Blood pressure	120/70 millimeters of mercury

Head to toe examination was performed on her and no abnormalities were detected. The lochia was red in colour, small in quantity with no offensive odour. Symphisio-fundal height was 16 cm. The uterus was massaged by rubbing the fundus with the palm to help in the involution of the uterus and arrest hemorrhage and she was taught how to massage the uterus by herself. Client was asked to report any changes or abnormality like bleeding immediately. She complained of after pains and she was reassured that the pain was as a result of

involution of the uterus. Client was given tablet paracetamol 1g start. She was served with malt and bread. He was dressed nicely, wrapped in a warm sheet to maintain his temperature and placed beside his mother to suckle. The mother was once again congratulated for a successful delivery.

4.2 SUBSEQUENT CARE OF THE BABY

Baby bathing and Cord dressing

After six hours of delivery, permission was sought from the mother to bath the baby of which she consented. Hand was wash with soap and water and dried with towel Head to toe examination was done and the cord was dressed with six sterile cotton wool swab soaked in spirit but no abnormality was detected. The baby passed meconium and urine which indicated that his urethra and anus were patent. The cord was inspected for bleeding and discharge but there was none. The vital signs checked and recorded as follows;

Baby's Vital Signs

Temperature - 36.7 degree Celsius

Apex beat - 144 beat per minute

Respiration - 42 count per minute

Weight - 3.6 kilogram

Requirements needed for baby bath

1. Soap
2. Sponge
3. Cream/ powder/oil
4. Sterile cotton in a galipot or wrapped
5. Basin
6. Towels: 1 big towel and 3 small ones

7. Cot sheets 2

8. Apron

9. Gloves

10. A clean baby dress, cap and socks (if available)

11. Mackintosh

12. 2 jugs containing hot and cold water each

13. Two receptacles for used water and dirty linen

14. A receiver for used swab

15. Methylated spirit

The procedure was explained to mother and a trolley was set. A plastic apron was worn and hands were washed with soap, water and dried with a clean towel. The water was mixed and the temperature was tested using the elbow. Sterile gloves were worn and baby was placed on a flat surface. He was undressed and wrapped in a big cot sheet. The eyes were cleaned with cotton wool swabs soaked in sterile water from inner cantus to outer cantus. Her face was cleaned with damp face towel and dried. The baby's neck was supported with one hand using two fingers of the hand to protect the ears and the head was washed with soapy sponge. With the body resting on the forearm and still supporting the neck the baby was place at the edge of the bowl to rinse the soap off the head and dried. She was exposed; arms and front of trunk to the feet were washed paying attention to skin folds. The baby's back was turned with one hand supporting the chest and back was washed down to the feet paying attention to the skin folds. He was immersed in a bath of warm water and rinsed thoroughly with the head above the water. The baby was place on a flat surface covered with clean sheet. The baby was dried by using a clean small towel paying attention to the skin folds. He was oil, powdered and dressed up with cord left exposed.

Hands were washed with soap under running water and dried with clean towel after baby was bathed, sterile gloves were worn, and the clamp of cord was observed for looseness. The cord was dressed with cotton wool swabs soaked in methylated spirit, baby was wrapped in a towel to keep him warm and the mother was asked to protect him whiles on the table. A cotton wool swab was used to hold the tip of the cord with one swab soaked in spirit. 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 swabbed with cotton wool swab soaked in methylated spirit, cord was then left exposed to facilitate dry gangrene. A diaper was put on the baby folded below the umbilicus, baby dressed and wrapped with clean cot sheet and given to his mother and offered feedback, the waste materials were discarded according to infection prevention protocol the gloved hands were immersed in 0.5% chlorine solution and removed inside out. Hand washing was done with soap and water and dried with a clean towel and findings recorded.

Mother was informed that the baby will be immunized against tuberculosis and poliomyelitis.

4.3 THE FIRST DAY POST DELIVERY/DISCHARGE

On the 16th of June 2022, on the same day after delivery, Madam Zuliaha and her baby were very healthy with cheerful looking face when she woke up around at 7:00am. All procedures to be carried out on both the mother and baby were explained. Perineal pad was inspected and blood flow was small and red in color (Rubra) without odour and enquire about the bladder habit was asked, of which she said was resuming normal. She brushed her teeth, visited the toilet, and after which she was given warm water to bath. She complained of not having enough sleep due to demand of feeding baby at night and after pains, she was reassured in getting enough sleep and the pains would be managed and was asked to cope with it. She was also given 1gram of paracetamol to help relieve her pain after she was served with porridge

and bread as her breakfast. She made comfortable in bed. Her vital signs and assessment were then checked and recorded as follows:

MOTHERS ASSESSMENT

VITALS SIGNS	MORINING
Temperature	36.5 degrees Celsius
Pulse	86 beat per minute
Respiration	22 cycle per minute
Blood pressure	100/60 mmHg
Uterus	Contracted
SFH	15cm
Lochia	Rubra
Breast	Lactating

Madam Zuliaha's symphysio- fundal height was 15 centimeters above the symphysis pubis; her lochia was red (rubra) in colour and amount was small and not offensive. 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 having received the first bath. On examination, there was no abnormality detected. The cord was inspected for bleeding but there was none. He passed meconium and urine after the examination. Client was advised not to put anything on the cord except what was given to her. His vital signs and assessment were checked and recorded as follows;

BABY'S ASSESSMENT

Temperature	36.6^{o}c
Apex heart beat	130bpm
Respiration	40cpm
Weight	3.6kg
Skin colour	Pink
Stool colour	Meconium
Cord Bleeding	None
Suckling	Good

He was re-dressed and wrapped in a warm sheet and was given to his mother for breastfeeding. All findings were communicated to the mother.

Posture and method of breastfeeding was demonstrated to her after which she was asked to do same and she did it perfectly. Afterwards, she was told that she would be discharged. She was educated on healthy and adequate nutritious diet to help in the production of more breast milk and improve her immune system as well, also educated on personal hygiene and good hand washing practices, postnatal exercises (kegel), adequate sleep, continuous immunization of the baby and the various family planning methods available. The essence of the exercise was explained to her that it would help the pelvic organs to return to their original positions and also help in the flow of lochia. She was also educated on feeding the baby on demand (not less than 8 times a day), adequate feeding at night and also to feed baby exclusively for six months, also encouraged not to apply anything on the cord aside the use of cotton and methylated spirit, danger signs in new born such as yellowish discoloration of the sclera and reddened around the umbilicus and bulging or sunken fontanelles were described to her. She

was asked to report immediately to the facility whenever she saw any of these signs or anything that may seem unusual.

Educated on the importance of birth registration and was asked to register the baby and also reminded to bring the baby for immunization at the time scheduled. Client was served with rice balls and groundnut soup from the family. After the meal, she was helped to pack her things and was informed that she would be visited at home for seven days starting from the evening of discharge which she agreed. She paid her bills by the National Health Insurance Scheme and was given the following drugs according to the facility's protocol

Capsule's iron III polymaltose complex 150mg daily for 30 days

Capsule's amoxicillin 500mg tds for 7 days

Tablet metronidazole 400mg tds for 7 days

Tablet paracetamol 500mg 2 tds for 5 days.

The dosage and time of medication was explained to her. She thanked all the staff and expressed her appreciation for the care. They decided to walk and she was accompanied to the house.

4.4 FIRST POSTNATAL HOME VISIT (2ND DAY POSTPARTUM)

On 17th June, 2022 client and family were visited both morning and evening around 6:30am and 5:10pm respectively. She was asked how she and her baby were faring after greetings were exchanged and she said they were doing well. The family was much pleased to see me. Explanation was given to Madam Zuliaha that she and the baby were going to be examined from head to toe to detect any abnormality for early treatment. After given her consent, she was asked to empty her bladder and made comfortable in her bed. Hands were washed aseptically and the examination proceeded. Her hair was neatly tied up with scarf. The conjunctiva and palm were examined and there was no pallor, the breasts were firm, soft and

lactating. The uterus was well contracted and the symphysio - fundal height measured 13cm. The perineum was clean when inspected; lochia was red with small flow and not offensive. Her vital signs were taken and recorded as follows

MOTHERS ASSESSMENT

VITALS	MORINING	EVENING
Temperature	36.9	36.7
Pulse	80bpm	78bpm
Respiration	18cpm	20cpm
Blood Pressure	110/60mmHg	113/68mmHg
Uterus	Contracted	Contracted
Lochia	Rubra	Rubra
SFH	14cm	14cm
Breast	Lactating	Lactating

Permission was sought to top and tail the baby and it was granted. As the baby was being top and tailed, it was also demonstrated to her. The baby had passed stools and urine when the diaper was removed. Baby was examined from head to toe after the top and tail no abnormality was found, he was neither jaundiced nor pale and was able to suckle well. The cord was also dressed with cotton wool soaked in methylated spirit; it was cleaned and kept dry. Baby's vital signs were taken and recorded as follows.

BABY's ASSESSMENT

	MORNING	EVENING
Temperature	36.6^{o}c	36.8^{o}c
Apex heart beat	134bpm	138bpm
Respiration	41cpm	40cpm
Weight	3.5kg	3.5kg
Skin colour	Pink	Pink
Stool colour	Meconium	Meconium
Cord bleeding	None	None
Suckling	Good	Good

Madam Zuliaha was encouraged to breastfeed the baby on demand. She was also encouraged to practice kangaroo mother care to help maintain baby's temperature and encouraged to have enough sleep. She was asked if there was any complain but she said no and a promise was made to visit them the next day.

4.5 SECOND POST NATAL HOME VISITS (3RD DAY POSTPARTUM)

On the 18th of June, 2022 the second visit was made to client's house both in the morning and in the evening around 6:45am and 5:00pm respectively, Madam Zuliaha, the baby and the other family members were all doing well. Permission was sought to perform the various examinations and was granted. Head to toe examination was done on the mother and everything was normal. Her breasts were firm and lactating well. Symphisio-fundal height was 12 centimeters. Inspection of her perineal pad was done and lochia was found to be

scanty, red in colour (rubra) and not offensive. Her vital signs were checked and recorded as follows;

MOTHER'S ASSESSMENT

VITALS	MORINING	EVENING
Temperature	36.7	36.9
Pulse	84bpm	78bpm
Respiration	22cpm	18cpm
Blood Pressure	110/60mmHg	113/68mmHg
Uterus	Contracted	Contracted
Lochia	Rubra	Rubra
SFH	13cm	13cm
Breast	Lactating	Lactating

The baby was top and tail and general examination was carried out and no abnormality was present. The cord was aseptically dressed with methylated spirit. The baby had passed stools and urine. Baby Yaw's vital signs and weight were taken and recorded as follows;

BABY'S ASSESSMENT	MORNING	EVENINING
Temperature	36.6^{o}c	36.6^{o}c
Respiration	41cpm	38cpm
Apex heart beat	134bpm	132bpm
Weight	3.4kg	3.4kg
Cord bleeding	None	None

Skin colour	Pink	Pink
Stool colour	Meconium	Meconium
Suckling	Good	Good

Client was assisted to position and fix baby well to the breast while breastfeeding. She complained of breast tenderness and inadequate sleep. I encouraged her to continue breastfeeding the baby on demand and ensure complete emptying of the breast to prevent breast engorgement and also wear a well-fitting brazier to support the breast. She was again educated to breast to breastfeed baby frequently and also make sure one breast is completely empty before given the other one to baby, also educated on the need to apply cold compresses on the breast. Client was educated to continue to express as often as necessary milk to make her comfortable until engorgement stops and findings were recorded .

Permission was sought to leave and come the next day. Client said she was very grateful and appreciated the care that was given to them.

4.6 THIRD POSTNATAL HOME VISIT (4^{TH} DAY POSTPARTUM)

On the 19^{th} of June 2022, the third home visit was made to Madam Zuliaha's house both in the morning and in the evening around 6:30am and 5:10pm respectively, greetings were exchanged. Mother and baby were doing well. Permission was sought to perform head to toe examination and it was granted. Her breasts were lactating well. Symphysio-fundal height was 11cm. On inspection of her perineal pad, lochia was pink with scanty flow without any offensive smell. Her vital signs were checked and recorded as follows;

VITALS	MORINING	EVENING
Temperature	36.7	36.4
Pulse	78bpm	78bpm
Respiration	19cpm	18cpm
Blood Pressure	118/60mmHg	113/68mmHg
Uterus	Contracted	Contracted
Lochia	Rubra	Rubra
SFH	12cm	12cm
Breast	Lactating	Lactating

The baby was top and tailed and general examination was carried out on him. No abnormality was present. Baby had already passed stools and urine. The cord was aseptically dressed. Baby's vital signs were taken and recorded as follows;

BABY'S ASSESSMENT

	MORNING	EVENING
Temperature	36.8^{o}c	36.6^{o}c
Respiration	38cpm	40cpm
Apex heart beat	134bpm	132bpm
Weight	3.3kg	3.3kg
Skin colour	Pink	Pink
Stool colour	Meconium	Meconium

Cord condition	Clean and dry	Clean and dry
Suckling	Good	Good

Client complained of backache which was due to improper posture during breastfeeding. Client was taught proper sitting position during breastfeeding and encourage her to sit upright position with the legs elevated on a stool during breastfeeding. The husband was encouraged to give her a massage.

Permission was sought to leave and Madam Zuliaha said she was very grateful and appreciated the care that was given to them very much.

4.7 FOURTH POSTNATAL HOME VISIT (5TH DAY POSTPATUM)

The fourth home visit was made to client's house at 7:00am on the 20th of June 2022. Madam Zuliaha complained of having constipation and excessive sweating. She was encouraged to take in more fluids and fruits. Again she was encouraged to ensure that there is good ventilation in her room by opening her windows and should have luke warm bath before going to bed. Lochia was pink (serosa), scanty and not offensive on inspection. Head to toe examination was done and everything was normal. Her vital signs and symphysio- fundal height were checked and recorded as follows;

VITALS	MORINING
Temperature	36.7
Pulse	70bpm
Respiration	22cpm
Blood Pressure	110/60mmHg
Uterus	Contracted

Lochia	Serosa
SFH	11cm
Breast	Lactating

Baby was top and tailed and general examination was carried out; no abnormality was found. The cord was clean and quite dry; it was neatly dressed with methylated spirit. The baby passed stools and urine during top and tail. Baby's vital signs and weight were taken and recorded as follows;

BABY'S ASSESSMENT

Temperature	37.0^{o}c
Respiration	38cpm
Apex heart beat	140bpm
Weight	3.3kg
Skin colour	Pink
Stool colour	Yellowish
Cord condition	Clean and dry
Suckling	Good

She was also educated on personal hygiene and good nutrition to prevent infections and to boost her immunity respectively. She was reminded that care would be terminated officially within the next few days but there would be occasional visits.

4.8 FIFTH POSTNATAL HOME VISIT (6TH DAY POSTPARTUM)

The fifth postnatal home visit was on 21th June, 2022 at 7:00am. Greetings were exchanged with client and her family after which a seat was offered in client's room. Mother and baby were both in a healthy condition according to mother and she added that she has been passing voluminous urine at frequent intervals. She was told it is normal during puerperium to compensate for the hemodilution that occurred in pregnancy as well as the excretion of the waste product of autolysis. Her breasts were now soft and lactating well. Lochia was pink {serosa} and not offensive. Symphysio – fundal height was 10cm. Head to toe examination when done no abnormality was detected. Client's vital signs was checked and recorded as follows:

MOTHER'S ASSESSMENT

VITALS	MORINING
Temperature	36.6
Pulse	70bpm
Respiration	22cpm
Blood Pressure	110/60mmHg
Uterus	Contracted
Lochia	Serosa
SFH	10cm
Breast	Lactating

Baby was bathed since the cord has fallen off and head to toe examination was done; no abnormalities were found, the cord had dried and fall off. The cord stump was dressed with sterile cotton wool swabs and methylated spirit. Vital signs and weight were taken and recorded as follows;

BABY'S ASSESSMENT

Temperature	36.8^{o}c
Respiration	38cpm
Apex heart beat	130bpm
Weight	3.4kg
Skin colour	Pink
Stool colour	Yellowish
Cord	Off
Suckling	Good

Permission was sought to leave and was granted. Client was bid farewell.

4.9 SIXTH POSTNATAL HOME VISIT (7TH DAY POSTPARTUM)

Madam Zuliaha was visited again on 22nd June, 2022 at 5:00pm. Everybody in the house was in good health. Client was seen happy and was smiling all round as she had an adequate support and love from her relatives and friends as well. Every procedure to be carried out was explained to her. The symphysio-fundal height was 8cm, perineal pad was examined and the colour was pink {serosa} without any offensive odour, also head to toe examination was done and no abnormality was detected. Madam Zuliaha's vital signs and assessment recorded as follows;

MOTHER'S ASSESSMENT

VITALS	MORINING
Temperature	36.5
Pulse	80bpm
Respiration	22cpm
Blood Pressure	110/60mmHg
Uterus	Contracted
Lochia	Serosa
SFH	9cm
Breast	Lactating

Baby was given a warm bath by the mother and cord stump dressed under supervision as the cord had detached the previous day . Head to toe examination was done and no abnormality was found. Baby's vital signs and weight were checked and recorded as follows;

BABYS ASSESSMENT

Temperature	36.8^{o}c
Respiration	38cpm
Apex heart beat	136bpm
Weight	3.5kg
Skin colour	Pink
Stool colour	Yellowish
Cord condition	Off and clean
Suckling	Good

Madam Zuliaha was very grateful after all the findings were explained to her. She was told about the last home visit being the next day. Permission was sought to leave and was granted.

4.10 SEVENTH POSTNATAL HOME VISIT (8TH DAY POSTPARTUM)

The final postpartum home visit was conducted on the 23rd June, 2022 at 6:30am. At the house, pleasantries were exchanged as procedures leading to the visit were duly explained to client. Head to toe examination was carried out on baby as well as the mother and no abnormal signs detected. Baby breastfed well, perineal pad inspection was also carried out as lochia flow was creamy white and scanty without any offensive smell. The vital signs as well as SFH of the mother and baby's weight checked and recorded as follows:

MOTHER'S ASSESSMENT

VITALS	MORINING
Temperature	36.9℃
Pulse	76bpm
Respiration	19cpm
Blood Pressure	115/65mmHg
Uterus	Contracted
Lochia	Serosa
SFH	8cm
Breast	Lactating

BABYS ASSESSMENT

Temperature	36.6^{o}c
Respiration	38cpm
Apex heart beat	134bpm
Weight	3.6kg
Cord	Off
Skin	Pink
Suckling	Good
Stool colour	Yellowish

Baby was seen to be active and in good health. Umbilical stump was clean and not healed. It was cleaned with cotton wool and methylated spirit after bath. Client was encouraged to maintain good nutritious diet at all times to enable the baby get the required nutrients. Client and family were informed of the end of the scheduled visits. She was encouraged to report to the hospital immediately she detected any unhealthy signs or health challenges and reminded of the first postnatal visit to the clinic as well as baby's circumcision. She was again reminded once more for the need to visit the Clinic at six weeks for postnatal care.

They were then discharged from home visits, client and family were thanked for their hospitable nature as well as cooperation in all aspects throughout the study and emphasis of that visit being the last was made again. Client and her family were also thankful and showed great sense of appreciation. Permission was sought and exited.

4.11 FIRST POSTNATAL VISIT TO THE CLINIC

Madam Zuliaha and her baby accompanied by her sister in-law made the first postnatal visit to the facility on the 23rd June, 2022 at 9:30am. They were welcomed to the facility and seats offered. The visit was required for further examination of both mother and baby to ensure they were in good health.

On observation, both mother and baby were looking healthy and she was having a cheerful face. Their vital signs were checked and recorded follows:

MOTHER'S ASSESSMENT

VITALS	MORINING
Temperature	36.8^{o}c
Pulse	94bpm
Respiration	22cpm
Blood Pressure	108/71mmHg
Uterus	Contracted
Lochia	Serosa
SFH	8cm
Breast	Lactating

BABY'S ASSESSMENT

Temperature	36.7^{O}C
Respiration	38cpm
Apex heart beat	138bpm
Weight	3.6kg

Skin	Pink
Cord	Off
Stool colour	Yellowish
Suckling	Good

A specimen bottle was given to Madam Zuliaha to collect midstream urine sample to check for protein and glucose and they all tested negative. She was also asked to go the laboratory for haemoglobin estimation and the result was 12.0g/dl.

She and her baby were sent to the examination room for examination. Procedure was explained to her and I sought permission from her and she agreed. Privacy was provided and she was helped unto the examination couch. Hands were washed with soap and water and dried. Madam Zuliaha was examined from head to toe and no abnormality was detected. The head, eyes, nose, ears and mouth were examined with no abnormalities detected. The arms and hands were examined for oedema and equality and also checked for capillary refill of fingernails beds. There was no engorgement, pain, cracks in the breast when examined and she was taught to do self-breast examination. There was no tenderness in the abdomen and the fundus was not palpable in abdomen. Vulva was without sore and lochia was light creamy. There was no oedema at sacral region and no deep vein thrombosis or oedema at the legs.

Findings were communicated to her and she was congratulated for keeping herself neat. Baby also was examined and no abnormality detected. Baby's skin was pink with no rashes. The head, neck, chest and abdomen were examined. The abdomen was soft and not distended. The umbilical stump was completely healed. During the examination, baby urinated indicating patency of the urethra but uncircumcised penis and anus was patent. The lower extremities were examined and no abnormality detected. The back was examined for spinal bifida and there was none.

Findings were communicated to her and she was congratulated for taking good care of herself and the baby. Madam Zuliaha was still educated on exclusive breastfeeding for 6 months and on the various family planning methods. She was further educated and encourage on the need to register the baby at the birth registry and attending of the child welfare clinic in order to monitor the growth of her baby and to detect any infection and the need to complete all the immunization. She was reminded of her second post-natal visit to the clinic and also encouraged to do pelvic floor muscle exercise and then handed over to the community health nurse in-charge for continuity of care.

She was thanked for her cooperation, support and time spent with me. Findings were documented .

4.11 SECOND POSTNATAL VISIT TO THE CLINIC

The midwife-in-charge, recorded that client visited the clinic on the 28th July, 2022 for her sixth week postnatal visit. They were warmly welcome and they were in healthy condition. General examination was conducted from head to toe as well as vital signs after permission was sought.

Her vital signs and weight were recorded as;

MOTHER'S ASSESSMENT

Temperature	36.3^{o}c
Pulse	78bpm
Respiration	22cpm
Blood pressure	110/68mmHg

Weight	68kg
Uterus	Not palpable
Breast	Lactating
Lochia	None

She was given a urine sample container to provide urine for urine analysis and sample of blood was also taken. The result from the laboratory investigations were as follows;

Haemoglobin level 12.9g/dl

Urine protein Negative

Glucose Negative.

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

BABY'S ASSESSMENT

Temperature	36.3^{o}c
Respiration	36cpm
Heart beat	124bpm
Weight	5.5kg
Skin	Pink
Stool	Yellowish brown
Cord	Off and healed
Suckling	Good

Physical examination was carried out on her and no abnormality was detected. Breasts were lactating well; involution had taken place but menstruation had not commenced. Baby's general condition was good on head-to-toe examination; baby's posterior fontanelle was closed. Client was handed over to the reproductive and child health unit for the six weeks baby's immunization against Polio, Diphtheria, Pertusis, Tetanus, Haemophilus influenza

type B and Hepatitis B.(Pentavalent). They were encouraged to visit the child welfare clinic and family planning unit to ensure continuity of care and she was educated to consult them in case of any problem. She was encouraged ask question but she asked none and made no complaints either. All findings were communicated to Madam Zuliaha, she was congratulated, thanked for her cooperation and understanding during our interaction and was bid farewell

4.12 PUERPERIUM CARE PLAN

PROBLEMS IDENTIFIED

Client care plan of:

1. after pain on 16/06/2022
2. inadequate sleep on 18/06/2022
3. breast tenderness on 18/06/2022

4. backache on 19/06/2022
5. constipation on 20/06/2022

SHORT TERM OBJECTIVES

1. Client breast tenderness will subside within 24 hours.
2. Madam Zuliaha will be relieved of after pains within 72 hours.
3. Client will be able to sleep within 48 hours.
4. Madam Zuliaha backache will reduce within 24 hours.
5. Client will be able to pass stool within 48 hours.

LONG TERM OBJECTIVES

Madam Zuliaha and her baby will go through a normal puerperium without any complication to both mother and baby.

PUERPERIUM CARE PLAN

DATE TIME	**NURSING DIAGNOSIS**	**NURSING OBJECTIVES/ OUTCOME CRITERIA**	**NURSING ORDERS**	**NURSING INTERVENTION**	**DATE/ TIME**	**EVALUATION**	**SIGN**
16/06/2022 7:00am	After pain related to involution of the uterus.	Client will have relieved of after pains within 72 hours as 1. client verbalized that she has been relieved of the pains. 2.Client's sister in-law testify that client stop complaining of after pain.	1. Reassure client that she will be relieved of after pains 2. Explain the physiology of after pains to the client 3. Encourage client to continue breastfeeding the baby 4. Educate client on sacral massage 5. Serve prescribed drugs	1. Client was reassured that she will be relieved of after pains 2. The physiology of after pains was explained to the client as a result of strong uterine contractions for the uterus to go back to its non-pregnant state 3. Client was encouraged to continue breastfeeding the baby 4. Client was given a sacral massage to apply warm compress. 5. Prescribed analgesics were served that tablet paracetamol 1g was given	19/06/2022 7:00am	Goals were fully met as client verbalized that pain was relieved	AMS

PUERPERIUM CARE PLAN CONTINUED

DATE **TIME**	**NURSING** **DIAGNOSIS**	**NURSING** **OBJECTIVES/ OUTCOME CRITERIA**	**NURSING ORDERS**	**NURSING** **INTERVENTIONS**	**DATE** **TIME**	**EVALUATION**	**SIGN**
18/6/2022 5:00pm	Sleeplessness related to presence of many visitors	Client will have enough sleep within 48 hours as evidenced by client 1. Client verbalizing that she was able to sleep soundly for at least 2 hours during the day and 5-6 hours during the night 2. Observed by client's husband that client was able to have enough sleep	1. Reassure client that she will be able to sleep well 2. Teach client the importance of rest and sleep 3. Encourage client to sleep when baby is sleeping 4. Ask family members to restrict visitors as much as possible 5. Educate family members on the importance of rest and sleep during the puerperium	1. Client was reassured that she will be able to sleep well 2. Client has been taught the importance of rest and sleep 3. Client has been encouraged to sleep when baby is sleeping 4. Family members have been asked to restrict visitor as much as possible 5. Family members have been educated on the importance of rest and sleep during the puerperium	20/06/2022 5:00pm	Goals were fully met as client verbalized she slept well soundly and client's husband visualized that she was able to sleep	AMS

CARE PLAN DURING PUERPERIUM

DATE/ TIME	**NURSING DIAGNOSIS**	**NURSING OBJECTIVES/ OUTCOME CRITERIA**	**NURSING ORDERS**	**NURSING INTERVENTION**	**DATE/ TIME**	**EVALUATION**	**SIGN**
18/06/2022 5:00pm	Breast tenderness related to incomplete emptying of the breast at a feed	Client breast tenderness subside within 24 hours evidenced by client verbalizing she is no more feeling the tenderness and midwife examining the breast for tenderness	1. Reassure client to allay fears and anxiety 2. Educate client to continue breastfeeding the baby on both breasts 3. Encourage client to wear a well-fitting brassier with broad stripes 4. Encourage mother to allow baby to empty one both breast completely 5. Teach client correct positioning and attachment	1. Client was reassured to allay fears and anxiety 2. Client has been educated to continue to breastfeed the baby on both breasts 3. Client has been encouraged to wear a well-fitting brassier with broad stripes 4. Client was encouraged to allow baby to empty one both breast completely 5. Client was taught correct positioning and attachment	19/06/2022 At 5:00pm	Goals were fully met as evidenced by the midwife examined the breast and there was no tenderness and the client verbalized that she is relieved of pains	AMS

PUERPERIUM CARE PLAN CONTINUED

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES/OUTCOM CRITERIA	NURSING ORDER	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
19/06/2022 6:30am	Backache related to poor position and attachment of the baby to the breast	Client backache will reduce within 24 hours as 1. client verbalizing that her backache subsided. 2. Midwife observing client carried out some daily activities without complaining of backache	1. Reassure client that backache will resolve 2. Teach the client the proper positioning and attachment of baby to the breast 3. Educate client to sit on a chair with the back straight parallel to the wall before breastfeeding 4. Educate client to adopt a comfortable position when breastfeeding 5. Serve prescribed drugs	1. Client was reassured that backache will resolve 2. Client was taught the proper positioning and attachment of baby to the breast 3. Client was educated to sit on a chair with the back straight parallel to the wall before breastfeeding 4. Client was educated to adopt a comfortable position when breastfeeding 5. Prescribed analgesics were served that tablet paracetamol 1g was given	20/06/2022 6:30am	Goals fully met Client verbalized the absence of backache	AMS

PUERPERIUM CARE PLAN CONTINUED

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES/OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
20/06/2022 7:00 am	Constipation related to a decrease in muscle tone in the intestine as a result of elevated progesterone.	Client will be able to pass stool frequently within 48 hours as evidenced by 1. client verbalizing that she is able to empty her bowel. 2.Reported by client's husband that client was able to pass stool twice a day.	1. Reassure client on her condition that it can be managed. 2. Explain the physiology behind her problem. 3. Educate client on adequate intake of fibre diets. 4. Educate client to perform postnatal exercise. 5. Educate client on good bowel habit formation.	1. Client was reassured on her condition that it can be managed. 2. The physiology of constipation was explained to a decrease in muscle tone in the intestine as a result of elevated progesterone. 3. Client was educated to include more fibre and roughages to her diet to prevent constipation. 4. Client was educated to do regular exercise walking around after eating to improve	22/06/2022 7:00am	Goals were achieved as client was able to empty her bowel twice within 48hours.	AMS

				bowel movement. 5. Client was educated to empty her bowel whenever the urge is felt by so doing she is forming a habit of bowel movement.			

SUMMARY AND CONCLUSION

Pregnancy, labour and puerperium are one of the important events in a woman's child bearing period, which must be managed carefully and skilfully to prevent maternal and infant morbidity and mortality.

The client and family centered maternity care study provides a detailed and up to date information on the study that was carried out on Madam Zuliaha Sayuba 25 years old gravida 2 para 1 alive (G2P1A). She was a regular antenatal attendant at Rachel's Health Centre.

Client attended her first antenatal visit on 10th of March 2022 and was a regular attendant.

My first encounter with her started at antenatal clinic on the 20th May, 2022 with gestational age of 36wks+4days.

Various examination and laboratory investigations were done and no abnormalities were detected. Client carried the pregnancy to term at 40 weeks plus 2 day and had a spontaneous vaginal delivery and delivered an alive male baby on 16th June, 2022 at 1:10am.

The baby weighed 3.6kg, Apgar score was 8/10, 10/10 with no complications to mother and baby and they were discharged on the 16th June, 2022.

Home visits were carried out from the 2nd day of delivery to the 7th day. Client and baby made their first week postnatal visit to the clinic on 23nd June, 2022. General Head to toe examination was done from head to toe on mother and baby and no abnormalities were detected on them.

Problems identified were managed through the use of nursing care plan management of client and by continue at home and during the clinic visit. Client went through puerperium normally, practised exclusive breastfeeding and baby was immunized against the childhood killer diseases.

Postnatal care was done and afterwards client was handed over to the community health nurse for continuity of care.

During my interaction of my client and family, I had the chance to educate them, advised and nurse her and baby to achieve what I had been taught in class room successfully.

It has enlightened and equipped me to render a comprehensive maternity care and to render a comprehensive maternity care to expectant mothers and their families that may come under my care during my midwifery practise.

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APPENDIX I

COMPLETE DIAGNOSTIC INVESTIGATION

DATE	SPECIMEN	INVESTIGATION	NORMAL VALUES	FINDINGS	REMARKS
10/03/2022	Blood	Hemoglobin	11.4-16g/dl	11.2g/dl	Normal
		Blood group	A, B, AB, O	B	Normal
		Rhesus factor	Positive/Negative	Positive	Normal
		Sickling	Negative	Negative	Normal
		HIV	Negative	Negative	Normal
		VDRL	Negative	Negative	Normal
		Hepatitis	Negative	Negative	Normal
		Malaria parasite	Negative	Negative	Normal
	Urine	Protein	Negative	Negative	Normal
		Glucose	Negative	Negative	Normal
20/05/2022	Blood	Hemoglobin	11.4-16g/dl	11.0g/dl	Normal
	Urine	Protein	Negative	Negative	Normal
		Glucose	Negative	Negative	Normal
27/05/2022	Urine	Protein	Negative	Negative	Normal
		Glucose	Negative	Negative	Normal
15/06/2022	Blood	Haemoglobin	11.4-16g/dl	10.8g/dl	Normal
	Urine	Protein	Negative	Negative	Normal
		Glucose	Negative	Negative	Normal

APPENDEX 11

COMPLETE DIAGNOSTIC INVESTIGATION CONTINUED

DATE	SPECIMEN	INVESTIGATION	NORMAL VALUES	FINDINGS	REMARKS
16/06/2022	Urine	Protein	Negative	Negative	Normal
		Glucose	Negative	Negative	Normal
22/06/2022	Urine	Protein	Negative	Negative	Normal
		Glucose	Negative	Negative	Normal
23/06/2022	Urine	Protein	Negative	Negative	Normal
		Glucose	Negative	Negative	Normal
	Blood	Heamoglobin	11.4-16g/dl	12.0g/dl	Normal

APPENDIX III

PHARMACOLOGY OF DRUGS USED DURING ANTENATAL

DRUGS	CLASSIFICATION	DOSAGE	ROUTE	ACTION & USES	SIDE EFFECTS	EFFECTS ON CLIENT
Folic Acid	Haematnics	1. Aids in the form action of red blood cell. 2. Supplement of iron requirement. 3. For iron deficiency anaemia.	200mg two times daily for seven days.	To build hemoglobin level	Gastrointestinal tract infection.	Client's hemoglobin
Ferrous	Haematenics	200mg daily for 30	Oral	It improves appetite.	Constipation, black stool and	Improved client's haemoglobin

Sulphate		days.			occasionally diarrhoea.	level.
Multivitamin	Vitamins	1 daily for 30 days.	Oral	It protects the body against diseases and helps in formation of red blood cells.	Diarrhea, gastro intestinal tract irritation.	Client's haemoglobin level improved.
Tetanol Dipthenia	Anti Tetanol Serum.	0.5mls repeated at four weeks interval.	Intramuscular	Stimulates body for the formation of antibodies against tetanus organisms.	Fever, pain and tenderness at the site of injection.	Client had slight pain at the site, mother and baby had no tetanus.
Tablet paracetamol.	Analgesics and antipyretic.	1gm 3 times daily for 5 days.	Oral	Relief of pain and reduce temperature of the body.	Inflammation of the liver when taking overdose.	Relieved clients pain.
Sulphadoxine pyrimethamine	Anti-malaria	3 tablet start, repeated 4 weeks interval.	Oral	It is a prophylaxis, treatment for malaria and it help prevent malaria.	Gastro intestinal upset and nausea.	Free from malaria throughout pregnancy.

PHARMACOLOGY OF DRUGS USED DURING LABOUR

DRUGS	CLASSIFICATION	DOSAGE	ROUTE	ACTION & USES	SIDE EFFECTS	EFFECTS ON CLIENT
Injection Oxytocin	Oxytocic Agent	10 international unit	Intramuscular on the left lateral thigh of the mother.	Stimulate uterine contraction to control bleeding in the 3rd stage of labour. For induction and augmentation of labour.	Fetal disturbances, uterine nature and over dose cause excessive uterine contraction.	Contracted the uterine muscles and arrested haemorrhage.
Vitamin K	Group K vitamin	1 mg	Intramuscular	Production of prothrombin to aid in clothing	No bleeding	None
Chlorampheni	Antibodies	2 drops	Instillation on	To prevent eye	Infections of eye	None

col eye drops			the eyes	infections	was prevented	

PHARMACOLOGY OF DRUGS USED DURING PUERPERIUM

NAME OF DRUG	CLASSIFICATION	DOSAGE	ROUTE	ACTION AND USES	ACTUAL EFFECTS	SIDE EFFECTS	SIDE EFFECT EXPERIENCED
Tablet paracetamol.	Analgesics and antipyretic.	1gm 3 times daily for 5 days.	Oral	Relief of pain and reduce temperature of the body.	Inflammation of the liver when taking overdose.	Relieved client pain.	None
Capsule amoxicillin	Third generation cephalosp-orin	500 milligram thrice daily	Oral	To prevent infection.	No infection observed.	Vomiting, nausea and diarrhoea.	None
Bacillus calmet Guerin.	Vaccine live attenuated.	0.05mls.	Intrader mal on the night	To produce immunity against	Formation of blister, paint at site and	Provided immunity against tuberculosis,	None

			shoulder.	tuberculosis.	pyrexia.	small swelling at injection site.	
Oral polio vaccine.	Vaccine.	2 drops.	Oral.	To prevent poliomyelitis.	Vomiting.	Protected against poliomyelitis.	Dizziness
Capsule Iron III polymaltose Complex	Iron preparation	150mg once daily for 30 days	Oral	1. Helps in formation of red blood cell. 2. Supplement iron requirement of the baby and used in the treatment of iron deficiency anaemia.	1. Gastro intestinal disturbances. 2. Diarrhea 3. Dark stool.	Client's haemoglobin increased. No side effect was observed.	None

Tablet metronidazole	Antibiotics	Prevention and treatment of infection	400milligrams three time daily for seven days	Oral	Diarrhea, nausea, vomiting.	None observed	None

Ultrasound Scan Results						
NUMBER	DATE	Placenta Location	Amniotic Fluid Volume	Gestational Age	Presentation	Any Abnormality (Specify)
First Scan (Before 20 Weeks)	10 / 3 /22	Posterior	Normal	26wks plus 4days	Cephalic	None
Second Scan (After 32 Weeks)	20 / 05 /22	Posterior	Normal	36wks plus 4days	Cephalic	None
Others	/ /	Posterior/ Anterior/ Low	Normal / Abnormal			

Antenatal Records												
Date	Weight (KG)	BP (mmHg)	Urine (-/+/++/+++) Protein/Sugar	Gest. Age in weeks	Fundal Height (cm)	Presentation	Descent	Fetal Heart Rate (/bpm)	Number of days IFA* Supplied	Complaints/ Remarkss**	Name & Signature	Date of Next Visit
10 /3 /22	72	101/56	Neg/Neg	26+4	26	Cephalic	-	140	30	No complains	KP	7 / 4 /22
7/4/22	65	97/58	Neg/Neg	30+4	30	Cephalic	-	Fm+	30	Vaginal discharge	KP	12 / 5 / 22
12/5/22	70	86/60	Trace/Neg	35+4	35	Cephalic	-	121	15	No complain	KP	19 / 5 / 22
20 / 5/ 22	70	106/68	Neg/Neg	36+4	35	Cephalic	-	119	CT	Loss of appetite	MAS	27 / 5 / 22

27 / 5 / 22	77	112/66	Neg/Neg	37 +4	38	Cephalic	-	120	15	Lower abdominal pains	MAS	03 / 6 / 22
03 / 6 / 22	80	119/72	Neg/Neg	38+4	37	Cephalic	-	125	CT	No complains	MAS	10/ 6 / 22
10 / 6 / 22	80	117/69	Neg/Neg	39+4	37	Cephalic	5/5	130		Anxiety	MAS	17 / 6 / 22

Tetanus – Diphtheria Immunization Schedule

Tetanus – Diphtheria Dose	Date Given	Batch Number
Tetanus – Diphtheria 1		
Tetanus – Diphtheria 2		
Tetanus – Diphtheria 3	10 / 3 / 2022	2331X004B
Tetanus – Diphtheria 4		
Tetanus – Diphtheria 5		
Tetanus – Diphtheria 5+ (Received up to five doses. Vaccine not required. Record date seen at facility)		

Malaria Prevention	
Long Lasting Insecticide Treated Net (LLIN)	Date Supplied 10……/……3……2022……..
G6PD Status	No Defect

Intermittent Preventive Treatment (IPTp) For Malaria	Date Given	Gestational Age in weeks
IPT 1	10 / 03 / 2022	26 weeks+4days
IPT 2	07 / 04 / 2022	30 weeks +4days
IPT 3	27 / 05 / 2022	37 weeks +4days
IPT 4		
IPT 5		

NEWBORN EXAMINATION FORM

Sayuba Zuliaha

Date of Assessment: 16/4/2022 Time: 2:10pm

16/22 Time of Birth: 1:10am Sex: ☑M ☐F Age at time of Assessment(days/hrs) ____

4ot2 Mode of Delivery: ☑Vaginal ☐Assisted Vaginal ☐C-Section

5/10 ☐ 5min 10/10 ☐ Birth Weight: ☐3.6 Kg ☐ Length 50 Cm Head Circumference 34 Cm

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

or (Midwife/Doctor): Alice Manu Sefete (Student midwife)

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im*

vement
ous symmetric
t
/Absent
t in > 1 limb
ment*

ter
bout blue
ter*

ting pus

7. Suck
- ☑Good
- ☐Weak
- ☐Absent*

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

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

10. Fontanelle
- ☑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

14. Neck
- ☑Normal
- ☐Swelling
- ☐Webbed
- ☐Other:

15. Clavicle
- ☑Normal
- ☐Swelling/Fracture

16. Chest
- ☑Normal (shape/movement)
- ☐Abnormal

17. Heart rate

Rate: 144
- ☐Normal (100-160)
- ☐<100*
- ☐>160*

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

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

20. Black (spine)
- ☑Normal
- ☐Abnormal Swelling*
- ☐Hairy patch over spine
- ☐Abnormal dimple
- ☐Abnormal curvature

21. Limbs
- ☑Normal
- ☐Abnormal

22. Genitalia Male Genitalia
- ☑Normal
- ☐Undescended tests
- ☐Abnormal meatus
- ☐Hernia
- ☐Other:

23. Female Genitalia
- ☐Normal
- ☐Pistula (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. Service provided
- ☑Vitamin K given
- ☑Eye care provided
- ☑Cord care provided
- ☑Breastfeeding initiated
- ☑Breastfeeding established
- ☑BCG ☑Polio Immunization
- ☐Antibiotics in mother
- ☐Antenatal corticosteroids

te severe disease that requires urgent referral

(if known) Normal Healthy Baby

[ ] Normal [ ] Baby with a Problem [ ] Danger Sign/s [ ]800g [ ] severe jaundice

(Circle) [ ] Routine [ ] Urgent Referral Advanced

NEWBORN EXAMINATION FORM

e: Baby Sayuba Zuliaha Date of Assessment: 16/06/22 Time: 8:10am
of Birth 16/6/22 Time of Birth 1:19pm Sex: ☑M ☐F Age at time of Assessment(days/hrs)
ational Age: 40+2 Mode of Delivery: ☑Vaginal ☐Assisted Vaginal ☐C-Section
AR: 1 min 8/10 ☐ 5min 10/10 ☐ Birth Weight: ☐ 3.66 Kg ☐ Length 50 Cm Head Circumference 34 Cm
perature at time of Assessment: 36.7°C Urine passed: (Yes) No Meconium passed: (Yes) No
e of Assessor (Midwife/Doctor): Alice Manu Sekete Student Midwife

1. Respiration
e 40
ate < 30 b/m*
ate > 60 b/m*
0-60 b/m
Retractions*
Grunting*
Stridor*

2. Activity Movement
Spontaneous symmetric movement
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*
Jaundice*

5. Cord
Normal
Red draining pus
Bleeding

6. Cry
Normal
Shrill*
Absent*

7. Suck
☑Good
☐Weak
☐Absent*

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

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

10. Fontanelle
☑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:

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

15. Clavicle
☑Normal
☐Swelling/Fracture

16. Chest
☑Normal (shape/movement)
☐Abnormal

17. Heart rate
Rate: 144
☑Normlal (100-160)
☐<100*
☐>160*

18. Fermoral pulse
☑Present
☐Not palpable*

19. Abdomen
☑Normal
☐Distended*
☐Scaphold*
☐Abdominal defect*
☐Masses:
☐Other:

20. Black (spine)
☑Normal
☐Abnormal Swelling*
☐Hairy patch over spine
☐Abnormal dimple
☐Abnormal curvature

21. Limbs
☑Normal
☐Abnormal

22. Genitalia Male Genitalia
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☐Hernia
☐Other:

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

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☑Eye care provided
☑Cord care provided
☑Breastfeeding initiated
☑Breastfeeding established
☑BCG ☑Polio Immunization
☐Antibiotics in mother
☐Antenatal corticosteroids

...y indicate severe disease that requires urgent referral
...gnosis (if known) Normal Healthy Baby
...Overall assessment: [ ] Normal [ ] ... [ ] Danger Sign/<1800g [ ] severe Jaundice
... [ ] Problem Continue supportive ... Urgent Referral Advanced

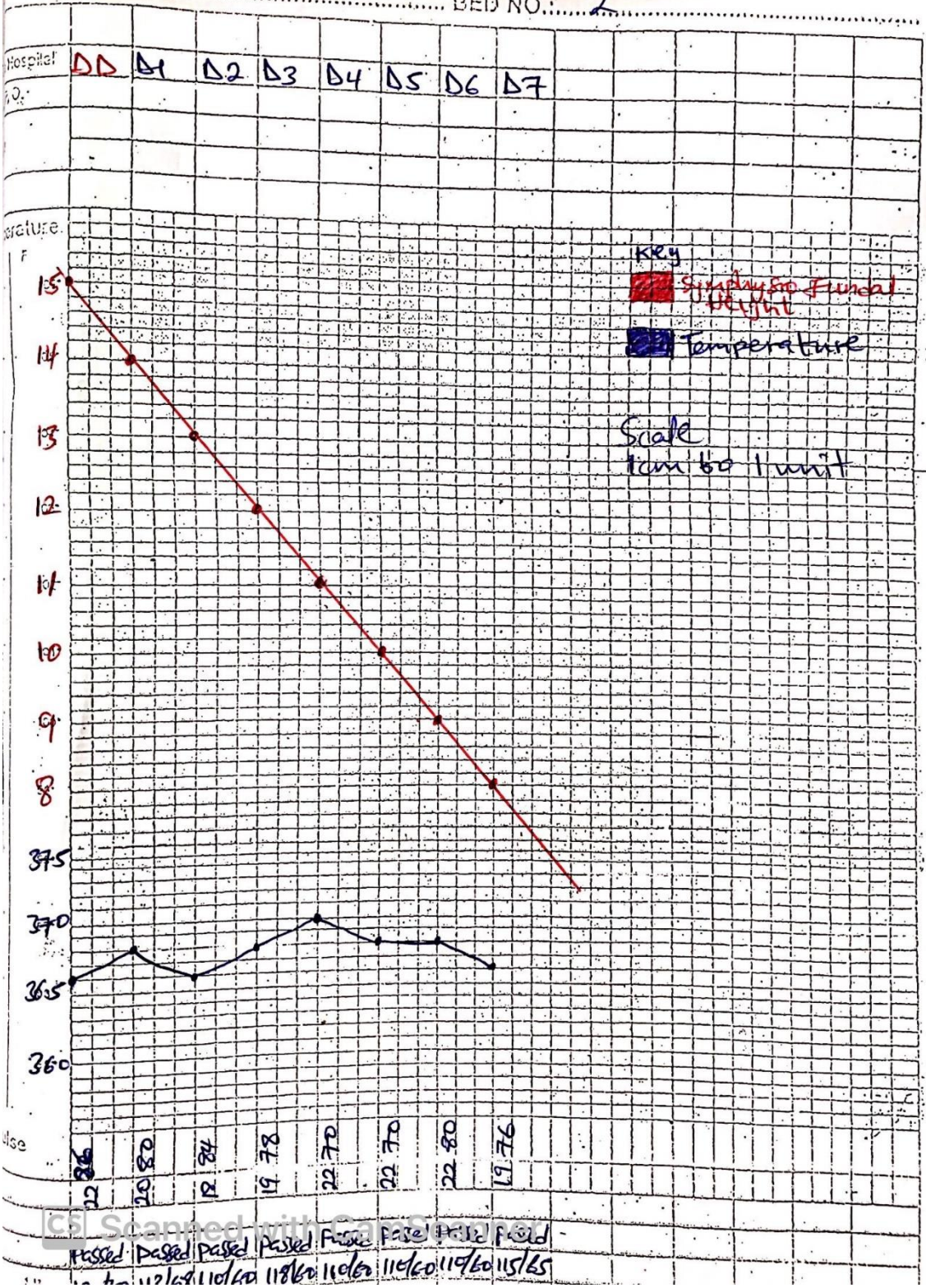
MATERNITY CHART

Sayuba Zuliana

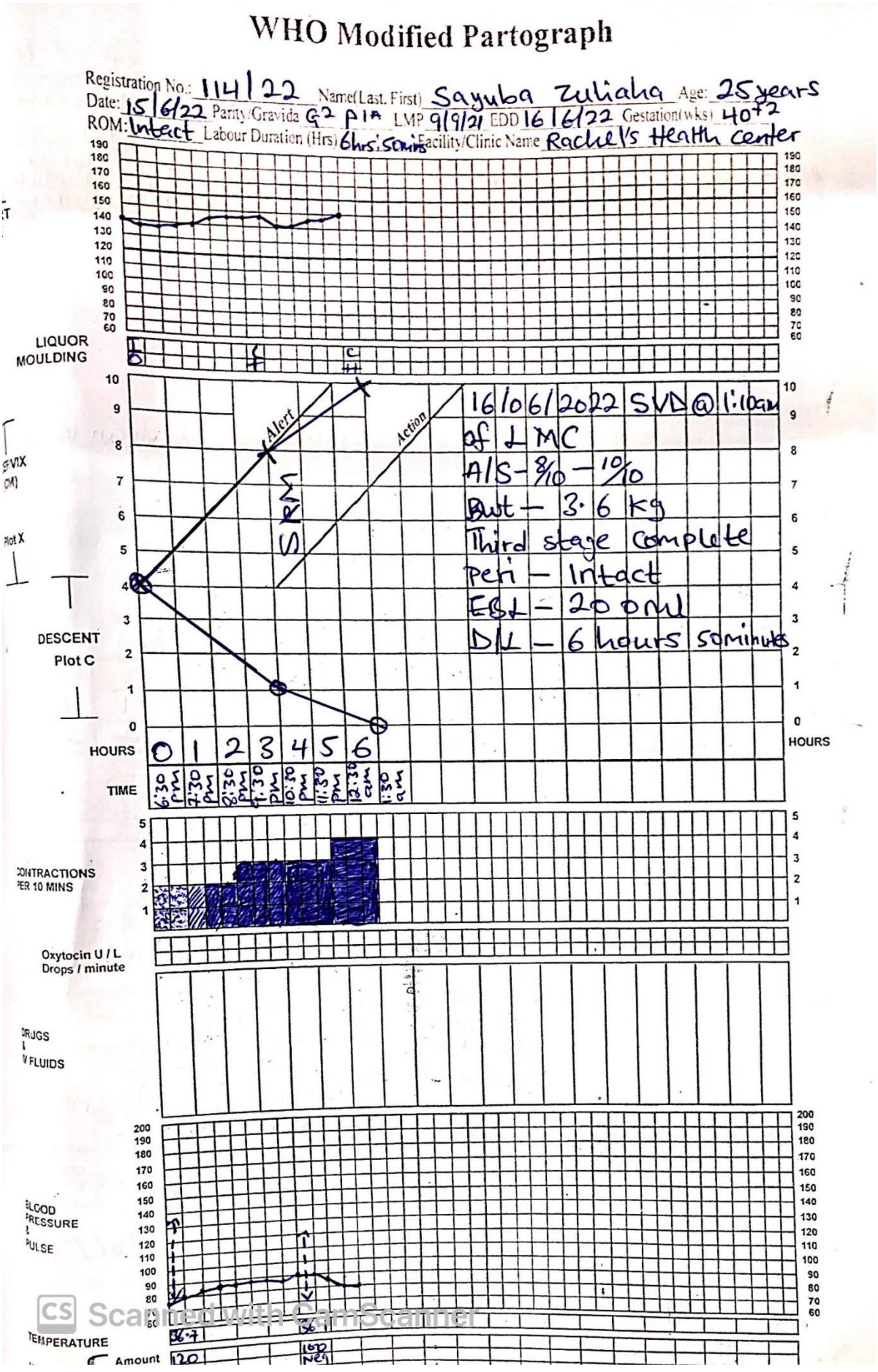
25 years

WARD: Lying - IN

BED NO.: 2



WHO Modified Partograph



LABOR NOTES

Client G2P1A reported to the facility with a complain of Labour Pains. OE Gestational Age – 40+2, SFH – 37cm, FHR – 140bp VE done cervical os – 4cm dilated, descent – 4/5, cervix – S and thin, Membranes – intact.

Client had SVD at 1:10am to 9 LMC on the 16/6/2022 wi AIS – 8/10 – 10/10, Bwt – 3.6kg, BL – 50cm, HC – 34cm. Head to toe examination on baby done – NAD. Third stage completed at 1:20am with Control Cord traction, EBL – 200ml, Pennuem – Int

Please circle or write responses.

DELIVERY

DATE: 16/6/22 TIME: 1:10am METHOD: (Spontaneous) / Vacuum Extraction / C/S / Other

PERINEUM: (Intact) / Episiotomy / Laceration

ANESTHESIA: (None) / Local / General

THIRD STAGE

Active Management: (Yes) / No Medication: Time 1:11am Type/Dose oxytocin 10 units

PLACENTA: TIME: 1:20am (Complete) / Incomplete

200ml (Small (Less than 250 cc))

BLOOD LOSS AMOUNT: Moderate (250-499 cc)

Large (more than 500 cc)

Significant for mother

BABY

Weight: 3.6kg

Sex: (Male) / Female

Baby Position: (Vertex) / Breech / Other

APGAR

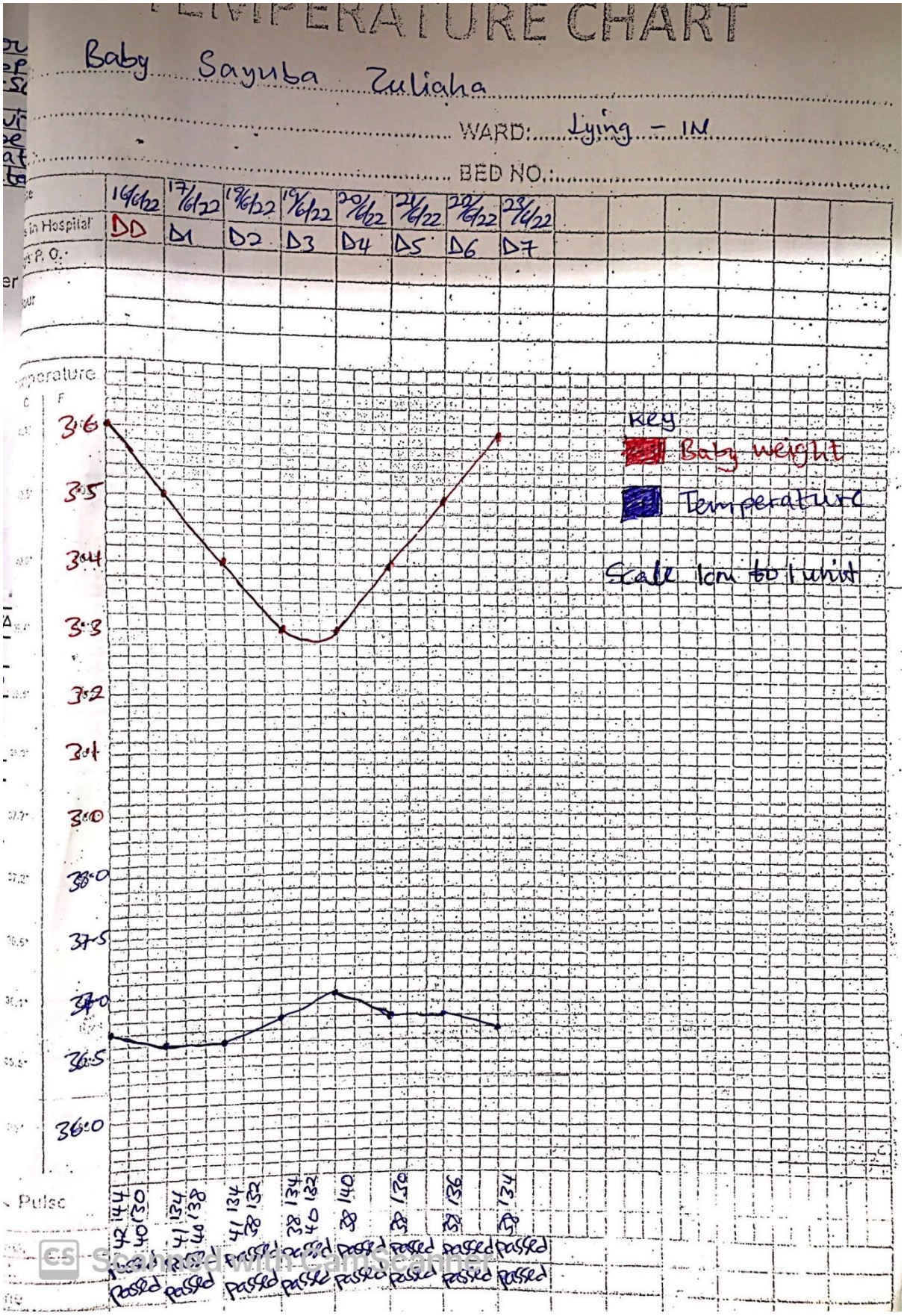
Time	Color	Breath	Heart	Tone	Reflex	TOTAL
1min	2	2	2	1	1	8
5min	2	2	2	2	2	10

COMPLICATIONS OF MOTHER / BABY: None / Other: NAD

FOURTH STAGE MONITORING

Frequency	Time	B/P.	Pulse	Fundus	Bleeding	Bladder
Every 15 minutes first 2 hours	1:30am	120/70	88	16cm	200ml	100ml
	1:45am	120/70	88			
	2:00am	118/72	86			
	2:15am	115/70	88	Contracted		
	2:30am	110/70	80		Scanty	
	2:45am	110/70	86		Scanty	
	3:00am	110/60	78		Scanty	
	3:15am	110/60	80		Scanty	
Every 30 minutes For 1 hour	3:45am	110/60	82		0	80ml
	4:15am	110/60	82		2	

Birth Attendant Alice Many Sekete Supervised by Doris Obeng Date 16/06/2022


TEMPERATURE CHART
Baby Sayuba Zuliaha
WARD: Lying - IN
BED NO.:
16/6/22 17/6/22 18/6/22 19/6/22 20/6/22 21/6/22 22/6/22 23/6/22
Days in Hospital D0 D1 D2 D3 D4 D5 D6 D7
Temperature
Pulse
Key
Baby weight
Temperature
Scale 1cm to 1unit
Scanned with CamScanner

NEW BORN CHART

Name: Baby Sayuba Zuliaha ..... No: ..... Birth Weight: 3.6 kg

Sex: Male ..... Mother's No: ..... Length: 50 cm

Nature of Delivery: Spontaneous Vaginal Delivery ..... Diagnostics: .....

Date of Birth: 16/06/2022 ..... Time: 1:10am ..... Date of Discharge: 16/06/2022

Date	16/6/22		17/6/22		18/6/22		19/6/22		20/6/22		21/6/22		22/6/22		23/6/22			
No. of Days	Δ Δ		Δ1		Δ2		Δ3		Δ4		Δ5		Δ6		Δ7			
Weight	3.6		3.5		3.4		3.3		3.3		3.4		3.5		3.6			
	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM
Temperature	36.7°C	36.6°C	36.6°C	36.8°C	36.6°C	36.6°C	36.8°C	36.6°C	37.0°C		36.8°C			36.8°C	36.6°C			
Stool	Passed	Passed	Passed	Passed	Passed	Passed	Passed	Passed	Passed		Passed			Passed	Passed			
Urine	Passed	Passed	Passed	Passed	Passed	Passed	Passed	Passed	Passed		Passed			Passed	Passed			

Remarks

Head
Neck
Limbs
Trunk
Genitalia

No abnormalities Detected.

SIGNATORIES

THE STUDENT MIDWIFE

NAME: MISS. ALICE MANU SEKETE

SIGNATURE: .....

DATE: 29/06/2022

THE MIDWIFE IN-CHARGE

NAME: MRS. RACHEL OWUSUAA

SIGNATURE: .....

DATE: 1st July, 2022

THE SUPERVISOR

NAME: MS. CELESTINE AHIAWORNU

SIGNATURE: ..... (For)

DATE: 04/07/2022

PRINCIPAL

NAME: MONICA NKRUMAH

SIGNATURE: ..... (for)

DATE: 5th September, 2022

ACADEMIC CO-ORDINATOR-NURSING
HOLY FAMILY NURSING & MIDWIFERY
TRAINING COLLEGE, BEPOSUM