HOLY FAMILY NURSING AND MIDWIFERY TRAINING COLLEGE, BEREKUM

A CLIENT/ FAMILY CENTERED MATERNITY CARE STUDYON

MADAM AKUA SERWAA

BY

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PREFACE

The family centred Maternity care is an academic work which gives the student midwife the chance to nurse a client during pregnancy, labour and puerperium using the knowledge and skills acquired during the programme of studies. For this study, the student midwife chooses a pregnant woman, manage her during pregnancy, labour, puerperium by practicing Respective Maternity Care (RMC) which is a universal human right that every pregnant must enjoy whenever they go for services. It encompasses the principles of ethics and respect for the women's feelings, dignity, choices and preferences. It involves counselling and encouraging of mothers on exclusive breastfeeding for at least first six month of baby's life.

Client and family centred Maternity care is a standardized approach of rendering care to an expectant mother and her family through pregnancy, labour and puerperium.

This care is based on a clear understanding that every client is a unique person with specific problems or needs that need to be addressed. This basically include physical, emotional and psychological aspect of nursing to the anticipating mother and her family. The study helps the student midwife to put into practice the knowledge and skills she has acquired during her training.

A client centred maternity care helps to create good interpersonal relationship between clients and the student midwife and also strengthens the trust that exists between them.

The care study is a partial fulfilment of the requirement by the Nursing and Midwifery Council of Ghana in awarding a Midwifery certificate to graduate at the end of the two years studies to enable one to practice as a Registered midwife wherever she finds herself.

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I wish to express my sincere appreciation to the staff of St Mary's Hospital Drobo most especially the maternity staff for their support, knowledge, encouragement and skills imparted on me. God bless them for the good work they are doing in Drobo and its surrounding communities.

My profound gratitude also goes to my client Madam Akua Serwaa and her family for their cooperation and support and also allowing me to use them for my case study.

Lastly, I wish to express my sincere appreciation to my husband Mr. Sani Mohammed for his love, prayers, support. I say God bless you.

Finally, my thanks go to the authors whose books were consulted for references.

INTRODUCTION

On 15th November, 2022, Madam Akua Serwaa a pregnant woman, gravid 2 para 1 alive, was met and nursed during the district practical at St Mary's Hospital Drobo. Madam Akua Serwaa was cared for during pregnancy, labour and puerperium.

Throughout the study the name Madam Serwaa will be used in place of client's full name. The first interaction with her was at clinic, when she visited the facility for her antenatal care. She was neatly dressed in her straight gown and her hair was neatly braided with care-row. Introduction was done as a final year student from the Holy Family Nursing and Midwifery Training college, Berekum and rapport was established, through interaction with, it was realized she is Gravida 2 Para 1A.Her antenatal card was checked and she is within the criteria for the study thus her gestational age was 36weeks. She had gone through normal spontaneous vaginal delivery during her previous delivery; she had no complications during or after her previous delivery.

Permission to take her as a client for the study was obtained after an extensive explanation that she would be given focused antenatal care. She was also assured of confidentiality. The client was co-operative throughout the interactions with her. Contact was taken and promise made to call and visit her and her family at home. She received care during pregnancy, labour and she safely delivered a bouncing baby and was managed during puerperium without any complication. She was then handed over to the midwife in-charge who in turn handed her over to the community health nurse for continuity of care.

The study is divided into four chapters as follows:

Chapter One (1) talks about client's social history, medical, surgical, past obstetrical history, present obstetrical history, family history, menstrual history and habits of daily living.

Chapter Two (2) consists of care rendered in the antenatal period. The chapter ends with a care plan which outlines care given based on the nursing process.

Chapter Three (3) is narrative of the care given during first, second and third stages of labour and it ends with a care plan.

Chapter four (4) explains the care provided during puerperium. It consists of daily visit to the client and family. The chapter also explain clients visit to the facility for postnatal care and ends with a care plan. This script also contains summary, conclusion appendices and signatories and bibliography for future reference.

LITERATURE REVIEW

PREGNANCY

According to Marshall and Raynor (2014), pregnancy when a woman and their partners are especially open to reflecting on their lifestyle and health care options. For health professionals it provides an opportunity to help a woman learn how to use healthcare services effectively and to acquire information and skills that will enable them to have the best possible experience of birth and early parenting .it also states that during pregnancy the body systems undergo anatomical and physiological changes which are designed to support foetal growth and development.

It considers pregnancy to last approximately 40weeks and talks about antenatal care as the care that is given to pregnant women from the time of conception is confirmed until the beginning of labour. The midwife will provide a client-centred approach to the care for the woman and her family by sharing information with woman to help her to make informed choices about her care.

Some of the aims of antenatal care as stated by Fraser & Copper. (2009) include;

1. Being an advocate for the woman and her family during pregnancy, supporting her right to choose care that is appropriate for her own needs and those of her family.

2. Recognizing complication of pregnancy and appropriate referring the woman within the multidisciplinary team

3.Facilitating the woman to make an informed choice, methods of infant feeding and giving appropriate and sensitive education to support her decision

According to the Ghana Health Service (2008), antenatal care is defined as a health care and education/counselling giving during pregnancy.

Antenatal services are an important part of preventive health and promote health care aims of which include the following;

1.To promote and maintain the physical, mental and social health of the mother and baby and providing education to pregnant mothers on planning, immunization, danger signs of pregnancy, STIs, HIV/AIDS and birth preparedness plan and complication readiness.

2. To detect and treat high-risk conditions arising during pregnancy, whether medical, surgical obstetrical.

3. To deliver safe and a healthy postpartum period.

4.To ensure the delivery of a full-term healthy baby with minimal stress or injury to mother and baby.

According to Baker and Kenny (2017), signs and symptoms of pregnancy are in three categories;

1.Presumptive signs; these signs are those felt by the woman. examples are amenorrhea, fatigue, nausea and vomiting, changes in the breast, etc.

2. Probable signs; are signs observed by the examiner. Examples of includes chadwick's signs and pregnancy test indicating the presence of Human Chorionic Gonadotrophin.

3. Positive signs; these signs are only attributed to the presence of foetus. Examples are hearing of foetal heart rate, visualization of the foetus through a scan, and palpating foetal parts and movement.

From the above, it can be concluded that pregnancy is not a disease but a physiological change that the midwife can manage through antenatal care.

LABOUR

Labour is the process by which the foetus, placenta and its membranes are expelled through the birth canal. Normal labour is defined as a low risk throughout, spontaneous in onset with the foetus presenting by the vertex, culminating in the mother and infant in good condition following birth (Marshall & Raynor, 2014)

According to Fraser and Copper (2009),labour requires efficient uterine activity and is aided by moulding of the foetal. It also says that the mechanism of labour involves effacement and dilatation of the cervix, followed by the expulsion of the foetus by contraction. The lower part of the uterus is anchored by the pelvis by the transverse cervical ligament as well as the utero-sacralligaments, allowing the shortening of uterine muscles to drive the foetus downwards. Labour is said to be normal if it falls into the following criteria

1.Spontaneous in onset and at term.

2. Foetal present with vertex

3. Labour is without undue prolongation

4. Natural termination with minimal aids

5. Without having any complication affecting the health of the mother or baby.

From the Marshall and Raynor (2014), normal labour begins when there are regular, painful contractions lasting at least 20seconds (timed by a trained by a midwife),occurring at a frequency of at least two contractions in every 10minutes and with a cervical dilatation of at least 3cm.It further on explained that there are four stages of labour described as follows;

First Stage; This starts from the onset of labour till the cervix fully dilated and it is accompanied with painful rhythmic regular uterine contractions. It last for 6 to 10hours in

multigravida and12 to 14 hours in primigravida. Partograph is used to manage the first stage of labour(during the active).

Second stage; This stage starts from full dilatation of the cervix (10cm) to the expulsion of the baby through the birth canal. It usually lasts up to 30minutes in multiparous women and 60minutes in primigravida respectively.

Third stage; This stage starts after delivery of the baby and ends with delivery of the placenta and its membranes from the birth canal as well as control of bleeding after the expulsion.

Fourth stage; It is first six hours following the birth of the placenta. It deals with vigilant observation of both mother and baby immediately after the third stage of labour till the first six hours after delivery.

Fraser and Cooper(2009), says that, normal delivery is between 37 and 42weeks gestation and also stated that, the transition from pregnancy to labour is a sequence of event that often begins gradually.

It outlines four stages of labour as;

First stage; The stage starts when the cervix dilates from 0cm,in the presence of strong rhythmic uterine contractions and it completes when the cervix is fully dilated (10cm).

Second stage; It begins when the cervix is fully dilated and expulsion of the foetus. In the physiological labour, the woman usually feels the urge to expel the foetus and completes when the baby is born.

Third stage; this is the period from the birth of the baby to complete expulsion of the placenta and membranes and control of haemorrhage from the placenta site.

Fourth stage; during this stage, uterine contraction and blood loss are checked on several occasions during first hour

PUERPERIUM

Puerperium is a period which begins from the end of the 3rd stage, where the placenta and the membranes are expelled completely and bleeding is controlled to 40days.It is during this stage that the reproductive organs return to their non-pregnant stage, physiological changes that occurred during pregnancy is reserved and lactation established.

Ricci, (2016),described puerperium as the period following child birth during which maternal uterus and other organs and structures are returning to their non-pregnant state. It is the period of 6 to 8 weeks

The Ghana Health Services (2008), again states that puerperium is the period from the end of delivery to 6weeks after delivery and goes further to state that, the purpose of postnatal is to maintain the physical and psychological wellbeing of both mother and child.

The aim of puerperium according to Ministry of Health includes;

1. To encourage exclusive breastfeeding as well as the establishment of a bonding between mother and child.

2. To promote and also maintain the health of both mother and child

3. To supervise the mother to successfully adopt the roles of motherhood.

4. To facilitate involution of the uterus, prevention of infection as well as other complications that may arise during this period

Ricci, (2016), further that, stated puerperium is a time of major physiological change and a time of major emotional and personal upheaval.

It also says that, early postnatal checks are done on general emotional and physical well-being, infant feeding etc. Late postnatal checks are maternal haemoglobin and assessment of the baby and mother, looking particularly for tiredness and depression.

Perry, (2006), enumerates that there are 3 types of lochia namely;

- Lochia rubra; it is seen in the first 3days and consist of blood serum, trophoblastic debris and may contain some small clots. it is bright red in colour.
- Lochia serosa; it is seen during the next 4-9days and consist of blood serum ,leucocytes and tissue debris. It is pinkish in colour.
- Lochia Alba; it is seen after 10days and consists of leucocytes decidua epithelial cells and cervical mucus .it is white and continues for 10-14days.

Fraser & Cooper (2009) strike the importance between exercises and healthy activity verses rest, relaxation and sleep. Undertaking regular pelvic floor exercises is of benefit to the mother's long term health.

WHY CLIENT WAS CHOSEN

As required by the Nursing and Midwifery Council of Ghana for every student midwife to undertake the client/family centered maternity care study to help contribute to the award of professional certificate in Registered midwifery, the client should fall under the normal criteria, that is; she should have delivered at least one and at most three with no complications during pregnancy, labour and puerperium. Client should have regular Antenatal attendance record and also be a woman whose labour presumably will be uneventful.

Madam Akua Serwaa G2P1 reported to the antenatal clinic on the 15th of November, 2022 at 08:30am at St Marys Hospital Drobo Jaman- South District, Bono Region. It was her 7th antenatal visit, I approach her and greeted, I established rapport and we had a brief interaction and I realized there was the need to educate her on nutrition because she complained of heartburns, constipation. She was then educated on the need to eat bit by bit and wait for some time before going to bed. She was encouraged to have enough rest and sleep and to eat food rich in high fibre like cereals, vegetables and fruits. At a glance through the client Antenatal card, records indicated she could be used for case study also gestational age of 36weeks, I explain to her and permission was sought to use her for case study and she gladly accepted and promise to co-operate to make it successful. She was introduced to the midwife in -charge and her concern was given. Client gave out her house address and contact number to help make a visit to her home easi

CHAPTER ONE

CLIENT PARTICULARS

1.0 INTRODUCTION

This chapter gives an overview about the client and the family. It comprises personal and social, family, medical, surgical, menstrual, client lifestyle, past and presents obstetrical and psychosocial and environmental histories.

1.1 SOCIAL HISTORY

Madam Akua Serwaa is a thirty-two (32) year old Gravida 2 Para 1, she comes from Dormaa but lives in Drobo -Jaman south District, Bono Region with her husband a male child named Amoah Emmanuel, house numbered XCO732. client lives in a single room with her boy, since their house is uncompleted, her husband is a military officer who lives in aboard. client is dark in complexion, 155 centimetres in height and weighs 68 kilograms on the first day of her antenatal visit as documented in her antenatal book.

Client ended her education at senior high school of which she could not continue again due to financial constraints and currently a seamstress. Madam Serwaa is married to Amoah Maxwell for six years now, and he is a military officer by occupation. She speaks Twi. Her next of kin is her beloved husband. She and her family are all devoted Christians who worship at Methodist church.

1.2 FAMILY HISTORY

Madam Serwaa is born to Ms. Adubea rose and Mr. kofi kyere. Both parents come from Dormaa in the Bono Region. But currently resides in Drobo in the Bono Region of Ghana. Both parents are farmers at Drobo. She is the only child to her parents.

After an extensive conversation with the client, it was noticed that her family does not have any history of an inherited condition such as hypertension, heart disease, sickle cell disease, diabetes, no birth defects and mental health disorder in either side of her parent's family or her husband's family.

And also, no known congenital abnormalities like cleft lip and palate, missing digits or extra digits, has not been noticed yet. She said there is a history of multiple pregnancies in her family and that of her husband's. Client said in their family, death is of natural means.

1.3 MEDICAL HISTORY

According to Madam Serwaa, she has no known medical condition like hypertension, asthma, sickle cell disease, diabetes, epilepsy, heart diseases, respiration TB, mental illness, medication history, HIV infection and allergies (drugs /food). Client has never been hospitalized. She said occasionally suffers from minor ailment like headache, general body pains and takes in self-medication like paracetamol from the community pharmacy of which she was educated on the effects of over the counter drugs.

1.4 SURGICAL HISTORY

Madam Serwaa has never undergone any kind of surgical operation. According to client, she had never been involved in any road traffic accident which could affect her pelvis. Client has never been transfused neither has she donated blood. On examination there was no scar indicating previous laparotomy such as caesarean section or appendectomy.

1.5 MENSTRUAL HISTORY

According to Madam Serwaa, she had her menarche at the age of fourteen (14) years and has a regular menstrual cycle of twenty-eight days (28). Client`s menstrual flow is moderate and lasts for four days with no dysmenorrhea. Madam Serwaa had never experienced any menstrual

disorder or missed her regular menstrual period until she got pregnant. Client said her last menstrual period was 8/03/2022 and her expected date of delivery was calculated as 15th of December, 2022 but scan gave her 17th December, 2022 as evidenced by her antenatal care.

1.6 CLIENT'S LIFESTYLE/HOBBIES

Madam Serwaa usually wakes up around 5:30am. When client wakes up in the morning, she prays with her family for about twenty minutes, after which client sweeps the compound and empties the dustbin. She also said that, she brushes her teeth with toothbrush and tooth paste preferably pepsodent. Client usually prepares porridge together with fry groundnut for her family as their breakfast after which she baths her children and dresses them up for school. Fortunately, she gets her source of water from a pipe borne in front of her husband uncompleted building near the house. At 8:00am Client performs household chores like cooking, washing of clothes, utensils. Madam Serwaa normally prepares lunch before her child when he returns from school, she said the entire family normally pray and washes their hand before eating, she prepares their super around 3:30pm. They pray and take their super at 5:00pm. Every evening after meals she washes her cooking utensils and assists her children to bath and ensure the children does their homework. Client then takes her bath, and watch television.

According to her, she attends evening church service on Wednesdays and main service on Sunday. Client's favourite food is fufu and light soup with dried fish. she also said she eats at least three times a day., She often empties her bowel at least once a day especially in the morning and empties her bladder about five times a day.

She does general cleaning in and around her house on Saturdays and normally rests by having some time with the family. As part of her favourite hobbies, client likes listening to gospel music and watching of videos. Madam Serwaa is sociable and is in good talking terms with

everybody especially people around her house. Client dislikes gossips, liars and alcoholics and client neither drink alcohol non smoke cigarettes.

1.7 PAST OBSTETRICAL HISTORY

pregnancy

Madam Serwaa G2P1^{A} has one child a male name Amoah Emmanuel who is six (6) years old as recorded in her antenatal book and also confirmed by the client. She has never had any abortion or any pregnancy induced diseases like diabetes, pregnancy induced hypertension or eclampsia. According to client, her previous pregnancy reached term (39 weeks of gestation) before labour was due. During pregnancy, client experienced some minor disorders such as backache, waist pains, and frequency of micturition, which subsided after delivery. She had no danger signs of pregnancy such as severe abdominal pains, severe anaemia, bleeding, severe headache, Severe vomiting and she said she really eats well during her previous pregnancies. Client said she attended antenatal clinic during her previous pregnancy till labour was due and received all the doses of sulphadoxine pyrimethamine (SP) and Tetanus Toxoid Respectively.

labour

According to Madam Serwaa, her first baby was delivered at Drobo health centre spontaneously when labour was due with no complications such as retained placenta and postpartum haemorrhage. Client said her labour started at night in the house before she was sent to the health centre and her labour did not exceed 18hours. She is expecting this current pregnancy to be the same. Client also experienced waist pains and lower abdominal pains during labour. She also said that her baby cried immediately after delivery and placenta and its membranes were delivered immediately after delivery with small amount of blood loss. Also, she said that her baby had an average weight of 2.8kg

puerperium

According to Madam Serwaa, her baby was breastfed for two (2) years and exclusively for six (6) months. Her previous baby was immunized against the childhood preventable diseases at Drobo St Mary's hospital. Client went through puerperium successfully without any complications such as breast engorgement and emotional disturbances like maternal blues, depression and puerperal psychosis.

Client's baby also went through puerperium successfully without any complications. Client received adequate support from her mother and family. she uses condom to space out her child. Client was then educated that breastfeeding as she breastfeeds exclusively for six months is another form of family planning method.

1.8 PRESENT OBSTETRICAL HISTORY

Having glanced through, client first visited antenatal clinic on 15th November, 2022 where she was with a gestational age of 36weeks

Madam Serwaa last menstrual period was 8th March, 2022 and her expected date of delivery was calculated as 15th December,2022. However ultra- scan gave her 17th December, 2022. which she was informed to help her prepare towards her confinement.

Client said that, with this pregnancy too, she had appetite for any food and has no problem.

On Client first antenatal visit, Client's weight and height were 68Kilogram and 155 Centimetres respectively. Vital signs and physical examination were done and findings were recorded as follows;

Temperature…… 36.8 Degrees Celsius

Pulse……. 70 Beats per Minute

Respiration…….. 20 Cycles per Minute

Blood pressure……134/81 Millimetre of Mercury

The results for laboratory investigation conducted were as follows:

1. Haemoglobin level……...11.3 gram per decilitre
2. Urine Protein ……Negative
3. Glucose …… Negative
4. Urine albumin…… Negative
5. Stool test……. No abnormality detected
6. Antibody Screening for HIV……. Non- reactive
7. Sickling Test……. Negative
8. Blood group……...AB
9. Rhesus factor……. Positive
10. Syphilis……. Negative

Head to toe examination was carried out and no abnormality was detected. During client first antenatal visit, the following drugs were given;

Tablet Folic Acid 5mg once daily for 30 days

Tablet Ferrous Sulphate 200mg once daily for 30 days

Tablet Multivitamin 200mg once daily for 30

She was educated on the importance of these drugs encouraged to take them routinely for effective outcome.

Her condition was good and then scheduled for the next visit on 22nd November, 2022.

Madam Serwaa attended all scheduled visits and received all the necessary care before 15th November, 2022. when she was met and chosen for the study. She received education on topics

like nutrition, minor disorders of pregnancy, birth preparedness, personal hygiene, and exercises.

CHAPTER TWO

ANTENATAL CARE

2.0 INTRODUCTION

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

2.1 FIRST CONTACT WITH CLIENT

On 15th November,2022, madam Serwaa came for antenatal care at St Marys Hospital Drobo. She was 36weeks pregnant and it was her seventh time of attending antenatal clinic. Greetings were exchanged and she was offered a seat. Glancing through her antenatal card and personal interview with her indicated that the client fell within the criteria used in selection for the study thus her parity was within one to three, she delivered her child spontaneously and it was without complications. She was then chosen to render holistic care to her throughout the later part of pregnancy, labour, and delivery. During palpation, it was noticed that Madam Serwaa was 36weeks pregnant and she was informed about the interest of using her as a client for the care study. The introduction was done and her consent was sought for the study to which she agreed and promise to co-operate to ensure successful completion of the study. The midwife in-charge was informed and her approval was given for her to be use. The in-charge again assured her of safety as she alone has gotten a full nurse to take care of her both at home and at the facility through delivery until they attain a week after delivery so she should co-operate and ask any question she has in mind concerning pregnancy, labour and puerperium. Privacy was provided and client was asked to empty her bladder into a container which a sample was used to test for protein and glucose. Her vital signs and weight were checked and recorded as;

Blood pressure	-	137/76mmHg
Temperature	-	36.5 ^{o}C
Pulse	-	74bpm
Symphysio-fundal	-	36cm
Weight	-	70kg
Urine for protein and sugar	-	Negative

Madam Serwaa was examined under the supervision of the midwife in-charge, after permission was sought from her and she agreed.

Procedure from head to toe examination was explained. Washing of hands was done with soap and water and dried with a clean towel. having emptied her bladder, privacy was ensured and she was assisted onto the examination couch.

PHYSICAL EXAMINATION

The examination began with the client's hair for cleanliness, lice, dandruff, ringworm, alopecia, skin infection and no abnormality was detected. The client was congratulated for keeping her hair clean and encouraged to keep it up. The face was inspected for oedema, rashes, and chloasma and no abnormality was detected Her eyes were inspected for the pallor of the conjunctiva, yellowish, or jaundice of the sclera but no abnormality was detected. Upon inspection of the ears for discharges and alignment, nothing abnormal was detected. The mouth was inspected for dryness, cracks, and infection of the lips. The gum and tongue for pallor, sore, and lesions and the teeth for decay but no abnormality were detected. She was encouraged to brush her teeth at least twice a day and rinse her mouth after each meal. The neck was palpated for the enlarged thyroid gland, distended neck vein, and enlarged lymph node and nothing abnormal was detected.

On breast examination, her breasts were exposed to be observed for rashes, shape, inversion of the nipple, and sore of the nipple, but none were found. Again the breasts were equal in size and shape and condition of the skin was normal. The nipples were centrally situated with no crack or sores present, areola was dark, the nipples were pointed. On palpation no lump was felt and there were no discharges from the nipples when squeezed. The right breast was covered and she was asked to put her left hand under her head. The left breast was then palpated systematically in a circular manner using the inner aspect of the fingers for masses, enlarged auxiliary lymph glands, and nothing abnormal was detected and she was also taught self-breast examination. Nipples were squeezed gently for fluid (colostrums) and cleaned with a cotton wool swab and were examined for odour and blood but no abnormality was detected. The same was done for the other breast and no abnormality was also detected. Breastfeeding history was asked and her desire to breastfeed was positive.

The hands and fingers were inspected for oedema pallor of palms no abnormality was detected. The lower extremities were of the same size and were of equal symmetry. It was also palpated for oedema, tenderness in the calf muscles, varicose veins but no abnormality was detected. There was no deformity of the spine, oedema of the sacral region.

ABDOMINAL EXAMINATION

On abdominal inspection, she was helped to uncover her abdomen while covering her breasts as well as her lower extremity with a drape. She was asked to lie in the dorsal position with her legs flexed; the abdomen was ovoid in shape. No scars were indicating the previous operation, no rashes were seen but linea nigra, straiegravidarum and foetal movement were all present. She was asked to extend her legs on the bed and again bent it while observing her facial expression for pain.

Her abdomen was also observed for pendulous abdomen.

With Measurement of symphysio-fundal height, palms were rubbed together to generate warmth to prevent premature contractions. The fundus and upper border of the symphysis pubis were located. The fundus was palpated to get what is occupying the upper pole of the fundus. The zero end of the measuring tape was placed on the fundus of the uterus along the contour of the abdomen to the midline of the upper boarder of the symphysis pubis and the symphysio-fundal height measured 38cm and her gestational age was 36weeks 4days.

On fundal palpation; Upon facing the head end of the woman, the fundus was palpated, a soft mass was felt indicating the foetal buttocks is occupying the upper pole of the uterus.

On lateral palpation; while standing by the side of the client still facing the client head, using the flat pad on one hand while the other hand was positioned on the other side of the abdomen, the back and the limbs were felt on both left and right side of the abdomen respectively, while the foetal back was located to help make it easy when auscultating. The lie was longitudinal.

On pelvic palpation, position was changed this time facing the foot end of my client, she was asked to flexed her knees, Palms were placed on either side of the uterus with the palms just below the level of the umbilicus and finger directed inwards towards the symphysis pubis with thumbs almost meeting and a hard mass was felt indicating the head which showed that presentation of the foetus was cephalic.

In assessing descent of the foetal head, the anterior shoulder was located below the umbilicus approximately 2.5cm from the linea nigra, where the limbs are located. Two fingers were kept over the anterior shoulder, the symphysis pubis was also located and the right ulnar border was placed between the symphysis pubis and the anterior shoulder, five fingers covered the foetal head indicating a descent of $5/5^{th}$ above the pelvic brim. The position was left occipito anteria

On auscultation, the pinnard was warmed by rubbing it in my palm to create heat to prevent contraction when placed on the abdomen, where the back of the foetus was located and when

checking the foetal heart rate simultaneously, client was asked to extend her legs. Maternal pulse was felt on her wrist to ensure that the foetal heart rate was correctly felt. It was 148 beats per minute (bpm). It was regular, clear and rhythmic.

She was asked to turn to her left side and inspection was done at her back while uncovered and there was no deformity of the spine, or oedema of the sacral region, as well as no rashes or scars found.

Vulva examination

Client's permission was sought to examine her genital area for any abnormality and to treat if any to prevent complications.

Hands were washed with soap and water and dried with a clean towel, surgical gloves were worn on both hands before the examination was started.

On inspection, the vulva was neatly shaved; labia majora was of the same size and shape. there were no varicocele, vaginal warts, oedema, rashes, and ulcers seen. The clitoris was intact, no scarring of episiotomy or laceration from previous deliveries was noted.

All these procedures were carried out in a hurriedly to prevent supine hypotension syndrome.

Client was educated on vulva hygiene. She was educated to clean the vulva in the anterior-posterior direction anytime she passes urine and faeces because cleaning from back to front can introduce bacteria from the anal region to the vagina. She was encouraged to wash her panties and underwear regularly and dry them in the sun as well as avoiding the insertion of drugs and herbs as a form of douching

Hand washing was done after the procedure and dried. She was then assisted to get up from the couch. She was thanked for her cooperation and findings were communicated to her. Madam Serwaa was asked whether she had any complaint which she said no. She was counselled on

true signs of labour and that the labour could start anytime. She was encouraged to support her back with a pillow when sitting and was also educated to rest for at least 6hours during the night. Counselling was given on birth preparedness and complication readiness and support person, eating of a nutritious diet that would help increase her haemoglobin level. She was again encouraged to report any abnormality detected to the facility very early and was reminded of the next visit to the maternity home and documentation was done in her maternal health record book.

The intention of visiting her house was made known to her. She was not served with any medications since she had some of the drugs at home.

She was encouraged to take the drugs as prescribed and reminded again of the next visit to the health facility. She was thanked for her cooperation and was bid goodbye at the clinic gate.

2.2 FIRST ANTENATAL HOME VISIT

Madam Serwaa and her family were visited on the 17th November,2022 at 11:09am. She lives at krupiase near the light house school Drobo. The aim of the visit was to enquire more about her and her family and identify the sanitation at home, psychosocial environment and her physical environment and to ensure continuity of care.

She was called in the morning before setting off from the house and direction was given. Accompanied by the midwife in-charge. client's house was located. Welcome message was given by her.

After greetings were exchanged, they were told the aim of the visit which was to observe her environment, source of water, light, ventilation, number of people who share the room interpersonal relationship with her family members and neighbours, inspection of layette for delivery and give education where necessary. Enquiries was made about her health and

wellbeing and according to her, they were all doing well. She lives with her child, her parents, 2 siblings and her cousin in the house.

PHYSICAL ENVIRONMENT

The house is built with bricks and plastered, roofed with zinc. The house consists of four rooms painted light green but faded. She said she live in one room, with her child, her parents live in one, her 2 siblings, and the other room for her cousin. There is a wooden structure roofed with grasses which serves as a kitchen. Their bathroom and toilet were at the back of their kitchen, build with blocks and covered with roofing sheet. Their compound was clean with rocks all around, no stagnant water, no weeds were found and they were encouraged to keep it up. She said their source of water is from a commercial borehole behind their house from two different areas. She was encouraged to stake in well-nourished diet while taking her prescribed drugs. She was encouraged to take energy giving foods such as plantain, cassava, yam, corn etc. protective foods like fruits (orange, banana etc.) and green leafy vegetables (kontomire, ayoyo, turkey berries etc.) and body building foods such as beans, fish, meat etc., were also recommended for her to help her increase her haemoglobin level as well as boosting her immune system. Again, she was encouraged to drink a lot of water which also helps in boosting immunity. She was then educated on the signs of the onset of labour and was encouraged to report to the facility when there is the need to. The client complained of: heartburns, constipation. She was then educated on the need to eat bit by bit and wait for some time before going to bed. She was encouraged to have enough rest and sleep and to reduce fluid intake at night.

PSYCHOSOCIAL

Through our discussion, I noticed that madam Serwaa was living harmoniously with her husband and co-tenants. They are very friendly and do most of their things together, example

eating and sometimes taking a stroll. She said her co-tenants also takes very good care of her. The husband is the decision maker in the house, since he is the breadwinner of the family. I encouraged her husband and co-tenants to help in the care of client since she was approaching delivery. They were glad and pledged their full support. I further asked if she had friends around or joined any association in the community and she answered that, she has a peaceful and friendly relationship with the family members and the neighbours. Permission was sought with the promise of visiting again for which was decided on 25th November,2022 but the time was not confirmed but promise to get in touch with her. She was reminded of her next visit to the facility

2.3 SECOND ANTENATAL HOME VISIT

Madam Serwaa was visited the second time on 25th November, 2022 at 4:00pm. The aim was to check if there has been improvement in her complains and the health of her family. Client and her family were greeted and a warm welcome was given. Seat was offered and Madam Serwaa was alerted of my arrival. At a glance her surrounding was neat and clean. She was asked about her previous complaints and she said she had been able to have enough rest and sleep as well as a normal bowel movement.

Counselling on the true signs of labour which begins with painful, regular strong rhythmic uterine contraction, the presence of show and bearing down sensation was given to her. She was asked to call me or report to the facility as soon as possible when she sees those signs. Client was educated on types of positions which could be used or accepted during second stage of labour and she was made known that she would be positioned according to her preference that her baby would be delivered on to her abdomen and she agreed. Once inside her room, Madam Serwaa was requested to bring her layettes for inspection. She brought the items and everything was intact upon inspection and so she was congratulated. Her National Health

Insurance card was checked and it was valid when checked. When asked if she has any problem, she complained of insomnia and frequency of micturition

to which she was reassured condition can be managed and educated on the need to keep a pale by her side at night and also take in small amount of water at night. Client was reminded of her next visit to the clinic. The family was thanked and permission was sought to leave.

2.4 SUBSEQUENT VISIT TO THE FACILITY

On 22th November.2022, Madam Serwaa reported to the facility at 8:32am for her antenatal. She was welcome and offer a seat. She was asked about her general condition and she complained of lower abdominal pain. Every procedure to be carried on her explained to her. Her vital signs were checked and recorded as,

Temperature	36.2^{o}C
Pulse	91bpm
Respiration	22cpm
Blood pressure	130/80mmHg
Urine for sugar and protein	Negative
Weight	72kg

She was asked to go to the laboratory to check haemoglobin level which is 10.9g/ld. She was asked to empty her bladder. Hand washing was done with soap and water and dried with a clean towel after which physical examination was done and no abnormality was detected from head to toe, she was helped onto the couch. Abdominal examination was done and was ovoid in shape, medium in size and foetal movement were seen. On abdominal palpation, symphysio-fundal height was 37cm and gestational age was 37weeks. The lie was longitudinal with

cephalic presentation. The descent of the fatal head was 5/5th above the brim during auscultation, the foetal heartbeat was 142bpm. all findings were communicated to her. She complained of lower abdominal pains, she was reassured and educated on the causes of the lower abdominal pains. She was not given any drug since she still has some. She was encouraged to take her drugs regularly and come back in a week but was told to report to the facility if labour commences or any problem occur.

SUBSEQUENT ANTENATAL VISITS TO THE CLINIC

Madam Serwaa visited the clinic on Monday 29th November, 2022 at 8:20am as scheduled. She was welcomed and seat was offered to her to rest for a while. Enquiries were made on her health and she said all was well. History taken and routine care carried out and vital signs checked and recorded as follows:

Temperature……. 36.5 degree Celsius

Pulse……73 beat per minute

Respiration…… 18 cycles per minute

Blood pressure…….121/81 millimeters of mercury

Weight…….74 kilograms

Hemoglobin level ……11.4grams per deciliter

Urine for glucose and protein……Negative

She was asked to empty her bladder and every procedure to be carried out was explained to her and privacy was provided. Hands were washed with soap under running water and dried with a clean dry towel. On physical examination, there was no deviation from normal. On inspection, the abdomen was medium in size and ovoid in shape. On palpation, the lie was

longitudinal, presentation Cephalic, symphysio-fundal height measured 37cm and the gestation was 38 weeks. On auscultation, fetal heart rate was 142bpm with good volume and rhythm. All findings were

NURSING CARE PLAN ON PREGNANCY

PROBLEMS IDENTIFIED

Actual Problems

On 17th November, 2022, Madam Serwaa complained of;

1. Constipation
2. Heartburns

On 25th November,2022, Madam Serwaa complained of;

3. Insomnia
4. Frequency of micturition

On 22nd November,2022

5. Lower abdominal pain

Potential Problems

Knowledge deficit on the importance of Antenatal care

Short Term Objectives

1. Client will have a normal bowel movement of once daily within 24hours.
2. Client will have her heartburns subsiding within 24hours.
3. Client will have a normal sleep of at least 1hour during the day and 3hours interrupted in the night within 48hours
4. Client will be able to cope with frequency of micturition within 3 hours
5. Client will have attained adequate knowledge on the importance of ANC within 2hours

Long Term Objectives

Client would go through pregnancy without any complication to both mother and baby

NURSING CARE PLAN ON MADAM SERWAA DURING ANTENATAL

DATE/ TIME	NURSING DIAGNOSIS	OBJECTIVE / OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
17/11/2022 at 11:09am	Constipation related to inadequate intake of fruits and fibres during pregnancy.	Client will be able to move her bowel at least once daily within 24hours as evidence by client verbalizing that she is able to move her bowel daily without straining and relative confirming that Client will be able to move her bowels daily without straining.	1. Reassure client that she will be able to empty her bowel within 48hours. 2. Explain the physiology of the constipation during pregnancy to client. 3. Educate client on the type of food to eat 4. Encourage client to take in at least 6 glasses of water a day. 5. Client was encouraged to make conscious effort to attend to natures call	1. Client was reassured that she will be able to empty her bowels within 48 hours 2. The physiology of constipation during pregnancy was explained to client. 3. Client was educated to eat soft diet, fruits and roughages. 4. Client took in more fluids at least 6 glasses of water a day. 5. Client was attending to natures call whenever she has the urge	18/11/22 at 11:09am	Goal fully met as client verbalized that she moved her bowels freely without straining in a day and a relative confirmed this.	MM

NURSING CARE PLAN ON MADAM SERWAA DURING ANTENATAL CONTINUED

DATE/ TIME	NURSING DIAGNOSIS	OBJECTIVE /OUTCO ME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
17/11/22 at 12:30pm	Heartburns related to the action of progesterone relaxing the oesophageal sphincter.	Client heartburns will be reduced within 24hours as evidenced by the client verbalizing that there is a reduction in heartburns. Client relatives confirmed that client condition has been reduces	1. Assure client that the discomfort will be manage with the necessary nursing interventions. 2. Explain the physiology of heartburns to client. 3.Encourage client to take her supper early. 4.Encourage client to lie in bed with pillows supporting her back. 5.Encourage client to reduce the intake of spicy foods.	1.Client was assured that the discomfort will be managed with the necessary nursing interventions. 2.The physiology of heartburns was explained to client that it was as a result of the effect of progesterone relaxing the oesophageal sphincter. 3.Client was encouraged to take her supper early before 6:00pm. 4.Client elevated the end of the bed with pillows supporting her back. 5.Client was encouraged client to reduce the intake of spicy foods.	18/11/22 at 12:30pm	Goal fully met as client verbalizing that heartburns had subsided. Client relatives confirmed that client condition has been reduces	MM

NURSING CARE PLAN ON MADAM SERWAA DURING ANTENATAL CONTINUED

DATE/ TIME	NURSING DIAGNOSIS	OBJECTIVE/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
25/11/22 at 4:00pm	Frequency of micturition related to descent of foetal head into the pelvic cavity	Client will cope with frequency micturition within 3 hours as evidenced by; client verbalizing that she is copping And the midwife observing that client has adapted some copping techniques	1. Reassure Client to relieve her of fear and anxiety 2. Explain to client the physiology of frequent micturition in late pregnancy. 3. Educate client to lean forward when voiding 4.Encourage client to reduce intake of natural diuretics 5. Encourage client to keep bed pan by her bed at night.	1.Client was reassured that the condition will subside after delivery 2. Client was made to understand that, the gravid uterus presses on the bladder. 3. Client leaned forward whenever she is voiding. 4. Client reduced intake of tea, caffeine, dandelion etc. 5. Client adopted urinating into a bed pan during the night to prevent her from walking which will alter her sleep.	25/011/22 at 7:00pm	Goal fully met as client verbalized she can cope with frequent micturition. And the midwife observing that client has adapted some copping techniques	MM

NURSING CARE PLAN ON MADAM SERWAA DURING ANTENATAL CONTINUED

DATE/ TIME	NURSING DIAGNOSIS	OBJECTIVE / OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
25/11/22 at 4:00pm	Insomnia related to frequency of micturition.	Client will be able to have a normal sleep pattern for 2hours during the day as evidenced by client verbalizing that she is able to sleep for at least 2 hours during the day and 3hours continuously during the night. Confirmed by relative's client was able to sleep during the day and night	Assure her that she will restore her normal sleep pattern. Encourage client to reduce her fluid intake before going to bed. Encourage client to take a warm bath before going to bed. Encourage client to empty her bladder before going to bed. Encourage client to sleep in conducive environment	She was assured that her normal sleep pattern will be restored through education. Client was encouraged to reduce her fluid intake before going to bed. 3. Client was encouraged to take a warm bath before going to bed to help induce sleep. 4. Client was encouraged to empty her bladder before going to bed. 5. Client was encouraged to sleep in a conducive environment.	26/11/22 at 900am	Goal fully met as evidenced by client verbalizing that she is able to sleep for about 2 hours during the day and 3hours continuously at night. Confirmed by relatives client was able to sleep during the day and night	MM

NURSING CARE PLAN ON MADAM SERWAA DURING ANTENATAL CONTINUED

DATE/ TIME	NURSING DIAGNOSIS	OBJECTIVE / OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
22/11/2022 at 9:am	Lower abdominal pain related to the growing foetus pressing on the pelvic ligaments.	Lower abdominal pain will be subsided within 24hrs as evidence by client verbalizing that the pain has subsided	1. Assure client that the pain is temporal and nursing orders will be done to help reduce the pain. 2. Explain the physiology of the pain to client. 3. Encourage client to have enough rest. 4. Encourage client to move bowel when there is the urge to do so. 5. Encourage client to do mild exercise.	1. Client was encouraged to take in fluid always to help increase bowel movement. 2. Client was educated to take in food rich in fiber such as fruits and vegetables. 3.Client was to have enough 4. Client was encouraged to move the bowel whenever there is the urge to do so. 5. Client was encouraged to do mild exercise like walking around the house every morning and evening.	23/11/22 at 8:00am	Goal fully met as evidenced by client verbalizing her ability to move bowel once a day	**MM**

CHAPTER THREE

LABOUR

3.0 INTRODUCTION

The management of labour, the immediate care of the new-born, examination of the new-born and the care plan drawn for the management of the problems encountered during labour and delivery are found in this chapter.

3.1 ADMISSION AND INITIAL ASSESSMENT OF THE WOMAN

On 8th December,2022, at 2:45pm Madam Serwaa reported to the facility with the history of lower abdominal pains and waist pain. She was welcomed and offered a seat. Client's antenatal card was collected for inspection and she was admitted. She said the pains increased in the when she was done with her chores in the morning. She said she took launch, but did not take any medication, or local concoction before reporting to the clinic. Findings were recorded in the labour notes and all her items for delivery and everything was intact. She was taken to the first stage room (observation room) where she emptied her bladder and 150mls of urine was passed.

Mid-stream urine sample was taken and tested for protein and sugar and result was negative. The urine was clear with no odour. Heamoglobin level was 10.6g/dl, her vital signs were checked and recorded as follow.

VITAL SIGNS

Temperature ……36.9ºC

Pulse rate……90bpm

Respiratory rate ……..23cpm

Blood pressure …… 122/80mmHg

Procedure for examination was explained to client. She was helped onto the couch and privacy was provided. She was assisted to undress and asked to lie in a lithotomy position. Hand washing was done and a thorough examination from head to toe did not reveal any abnormality.

On abdominal inspection, hands were warmed and abdominal palpation was done. Her abdomen looked globular in shape, Broad in size and foetal movements were observed. No scar formation on her abdomen but linea nigra and straiegravidarum. On palpation, gestation was 39weeks+2days with the fundal height of 37cm and the presentation was cephalic with longitudinal lie and the descent of 4/5th above the pelvic brim, foetal heart rate 140bpm. Uterine contractions were 3 in 10minutes lasting 30 to 35 seconds.

On abdominal palpation, fundal palpation, the upper pole of the uterus was occupied by the buttocks by feeling a soft mass and head occupied the lower pole by feeling a hard mass. The

On lateral palpation, the back of the foetus occupied the left side of the mother's abdomen and the limbs were found on the right side. On pelvic palpation, the presentation was cephalic and the position was left occipito anterior with descent being 4/5th above the symphysis pubis.

VAGINA EXAMINATION

Client was assisted to assume a supine position with the knees flexed and thighs parted. An already prepared tray including; examination gloves, surgical gloves galipot with cotton wool swab, a disinfectant, a sanitary pad and a receiver was set and brought to her bedside. Hands were washed with soap under running water and dried thoroughly with clean dry towel. The sterile cotton wool swabs were soaked in savlon solution. She was draped, washed and dried my hands and put on a sterile surgical glove and performed vulva swabbing.

On inspection, the vulva was neatly shaved, there were no sores, rashes or varicose veins, or oedema. Cotton wool swabs were picked with the right hand and dip into a galipot with savlon. A swab was then dropped from the right hand into the left hand and labia majora, labia minora and the vestibule were wiped from anterior to posterior per one stroke each. The labia minora was separated and the right middle finger was inserted into the vagina and was gently press downwards and index finger was inserted.

On examination, at 3:00pm the vagina was warm, moist and roomy. The cervix was soft, thin and well effaced with dilatation of 4cm and membranes intact. Presentation was cephalic. Promontory of the sacrum was not reached. Ischia spines were blunt and pubic arch was wide. Examination fingers were removed and fist was made and fitted into the intertuberous diameter and it was accommodated. Madam Serwaa was cleaned up, clean perineal pad applied and made comfortable in bed. Both hands were immersed in 0.5% chlorine solution before disposing off used gloves. Hands were washed with soap and water and dry with clean towel. She was informed on the findings and recorded on a partograph and was ask to walk around to aid decent of the foetal head.

PREPARATION FOR BIRTH

The skilled helper identified was the midwife in-charge who will help in caring for the baby and supervise the delivery as well. The emergency plan was reviewed by calling the ambulance service in case of any emergency. The telephone numbers of the referral centre were ready on the wall of the ward in case of referral.

The environment was already clean. Client was assisted to wash her hands and abdomen cleaned for skin- to- skin contact with baby after delivery.

Chargeable lights were there in case there is lights out to assess the baby and care of the mother. The delivery set and emergency drugs such as oxytocin, were also made readily available.

She was informed that the curtains of the windows will be drawn down, doors shut and radiant heat bulb turned on to provide a warm environment for the baby during the second stage. A dry, flat and safe area was prepared to receive the baby for ventilation if needed. All equipment such as Suction device, Ventilation bag-mask, Clean cloth, Timer, Identification band, Sterile gloves, cap for baby, Scissors, Cord clamp, Stethoscope were made ready for use and tested for their function.

3.2 MANAGEMENT OF FIRST STAGE OF LABOUR

Madam Serwaa was observed and monitored in the observation room after admitting her. She was educated on the need to pass urine and also walk around to help in the descent of the foetal head. She was also told to lie on her left lateral side to aid blood supply to the foetus. She was reminded to do deep breathing exercise during strong contractions to prevent exhaustion. She was also reassured and informed of the progress of labour using dilatation board. She was assured of a safe delivery. She was encouraged to drink enough fluid. Subsequent foetal heart rates, uterine

contractions and maternal pulse were checked every 30minutes while vaginal examination, descent of foetal head, blood pressure, moulding and amniotic fluid were checked every four (4) hours and temperature two hourly.

Vagina examination repeated at 7:00pm with cervical dilatation of 8cm and bulging membranes, head descent was $1/5^{th}$, uterine contractions were 4 in 10minutes lasting 43seconds. On auscultation, foetal heart rate was present with 145bpm with regular rhythm and good volume. A new pad was applied to the perineum. Urine passed was 100mls, protein Negative. Temp.36.4, B/P 123/75mmHg, pulse 88bpm resp.24cpm. Findings were communicated to her and recorded on the partograph. She was reminded of deep breathing exercise. Her vital signs were checked and recorded as follows:

Temperature ……36.4^{o}C

Pulse rate……...100bpm

Blood pressure …….123/75mmHg

Respiration…….24cpm

Client was sent to the delivery room after which delivery trolley was set and all preparation towards the second stage was done. She complained of increased waist pain for which she was reassured that it was due to the advancement in contractions. She was given a sacral massage and encouraged her to try and cope and relax. Contractions increased with pain. She also complained of fatigue due to labour pains. She was encouraged to rest when contraction ceases.

There was spontaneous rapture of membrane at 8:00pm, the liquor was clear, Vagina examination was done to rule out cord prolapse and there was nothing of that sort. Cervical os was 10cm dilated, moulding (++), descent of foetal head was $0/5^{th}$ below the pelvic brim, contractions were 4 in

10minutes lasting 48seconds and foetal heart rate was 132bpm.Findings were communicated to her and recorded

Blood pressure……...110/70mmHg

Pulse……..84bpm

Temperature……. 36.3^{oc}

Respiration…….24cpm

She was positioned on the delivery bed and the already prepared trolley was brought to the bed side with the necessary items such as

The top shelf:

- A sterile pack containing

  Cord scissors
  2 artery forceps

- 2 gallipots (containing cotton wool swabs and gauze)
- Receiver

Bottom shelf

- Cord clamp
- 2 cot sheets
- Episiotomy set containing ;(Needle holder, Suture needles, episiotomy scissors non-toothed dissecting forceps, sponge holding forceps, stitch scissors)

- 10 units of oxytocin draw into a syringe
- Pair of sterile gloves
- Measuring jug
- Sucker in a bowl of water
- Bed pan
- Examination gloves
- Perineal pad
- fetoscope
- Antiseptic lotion(savlon)

3.3 MANAGEMENT OF SECOND STAGE OF LABOUR

She was reassured and the procedure was explained to her. She was help in supine position with the knees flexed on the delivery bed as that was the position she opted for. Personal protective clothing was worn, hands washed and dried and sterile gloves were worn. Her thighs, pubis and perineum were cleaned with antiseptic solution (savlon). A clean pad was applied to the anal region to prevent faecal matter from contaminating the delivery field and also her perineum was protected to prevents tear. She was encouraged to bear down with each contraction, rest in between contractions and turn to left lateral when contraction wear off to prevent supine hypotension. Sterile cot sheet was place on the abdomen to receive the baby. The anus started gaping and the foetal head was advancing. Flexion of the foetal head was maintained to enable the smallest diameter distend the perineum using my left fingers while the right was supporting the pad on the perineum. She was informed that baby will be delivered on to her abdomen. The

foetal head crowned and client was asked to pant and also not raise her buttocks to prevent forceful delivery which can lead to perineal tears or intracranial injury or bleeding. After the widest diameter had come out (crowned), the head was extended and delivered. Cord around the neck was assessed and it was not there. The baby's face and eyes were cleaned from inside out with sterile gauze one for each, Restitution took place to confirm internal rotation of the shoulders and the anterior shoulder was delivered by downward traction, followed by upward traction to deliver the posterior shoulder.

The rest of the body was delivered by lateral flexion onto the mother's abdomen at 8:30pm, the baby immediately cried within the first minutes and lastly after birth. She was congratulated for her co-operation throughout the first stage and delivery of the baby.

IMMEDIATE CARE OF THE BABY

Immediately the head was delivered, the eyes were cleaned from inside out including the face with sterile gauze. The cord was clamped 2cm away from the base, 3cm from the first clamp and cut in between. The baby was shown to the mother to confirm the sex of her baby which she said he was a male. The Apgar score was 8/10 for the first minute and 10/10 for the fifth minute respectively. Baby was well dried worn with cap and kept on mother's abdomen and covered to promote skin-skin for thirty minutes to prevent hypothermia and to promote bonding. An identification band was placed on the baby's wrist with the name of mother, sex and date of birth by the midwife in-charge. Baby was put skin to skin on the mother's abdomen. Respiratory pattern was normal when checked as baby's head was also turned to the side to prevent suffocation. Baby was put on breast to start initiation of breastfeeding.

3.4 MANAGEMENT OF THIRD STAGE OF LABOUR

The third stage of labour is the period of delivery of the baby to the time placenta and membranes are expelled and haemorrhage controlled. Madam Serwaa remained in the dorsal position. The cut end of the cord was in a receiver in between her thighs to receive the placenta and blood clots. The abdomen was palpated to detect undiagnosed twin and there was none. IM oxytocin 10units was administered within a minute into 8:30pm on the thigh, and when contractions were felt; my left hand was placed on the symphysis pubis to brace the uterus while the right hand was used to hold the forceps and pulled gently down wards with steady traction following the curve of carus which

is control cord traction and counter traction. The forceps were use to re-clamp closer to the perineum. When the placenta was visible at the vulva, it was received in both palms and twisted until the delicate membranes were all out twisted to prevent the membranes from tearing and at 8:36pm, placenta was completely delivered.

A quick examination was done for completeness of lobes and membranes, presence of cord vessel abnormality, retro placental clots to exclude any retained product of conception before it was placed into the receiver for thorough examination later. The uterus was massaged to maintain contraction and to express blood clots. Client was thought how to massage the uterus and was asked to feel for the hardness of the uterus when well contracted. The genital tract was cleaned and gauze wrapped around the index and middle fingers to examine for bleeding, tears of the vagina wall, lacerations of the cervix and perineum which were all intact. Baby was put on the mother's abdomen skin-to-skin. She was congratulated.

Client was encouraged to empty the bladder frequently. The skilled helper, the midwife in-charge helped to fix baby to breast to initiate breastfeeding. At 8:50pm, the perineal pad was inspected for bleeding, the abdomen was palpated to see if the uterus is contracted and it was so. Client emptied the bladder and it was 130mls. Client was asked if she is feeling dizzy and she said no. Client was encouraged to report any bleeding immediately. Madam Serwaa was sent to the lying in ward with the assistance of my midwife in-charge after one-hour observation at the delivery room. Gloves were removed and also the plastic apron. Hands were washed with soap under running water and then dry thoroughly with clean towel. All findings were recorded on the partograph.

EXAMINATION OF THE PLACENTA AND MEMBRANES

The placenta was examined and cord was centrally inserted. Membranes intact when a hand was inserted through the hole where baby emerged. there was only one hole. Then sterile gauze was used to wipe the tip of the cord and checked. There was one big vein and two arteries in the cord, when hand was stroked round the cord too there was neither a true or false knot and the cord vessels were not radiating beyond the placental edge. The placenta was placed on a flat surface. The amnion was peeled from the chorion to visualize the chorion and it was intact. The foetal surface was intact with no abnormality such as infart deposition. On the maternal surface, the lobes fitted together and the edges forming a uniform circle which meant there was no missing lobe. The placenta was discarded into a receptacle provided. Blood loss was measured 150mls. Madam Serwaa was dried of liquor and blood. A new pad was applied to the vulva after cleaning her up and she was left comfortable in bed. She was then encouraged to put baby to breastfeed.

Placenta was then decontaminated with 0.5% chlorine solution, placed into a bucket and discarded into the pit later by the orderly.

All instruments used were soaked in 0.5% chlorine solution for10munites, washed, dried and made ready for high level disinfection for next use with the use utility gloves. The delivery bed, trolley and delivery room were cleaned with 0.5% chlorine solution Gloved hands were immersed in chlorine solution removed and discarded. Hands were washed, dried. Finally, the delivery summary was documented in the delivery book as well as in client's folder.

3.5 MANAGEMENT OF FOURTH STAGE OF LABOUR

The fourth stage of labour starts at the end of third stage up to six hours after delivery, both mother and baby were closely monitored for any change in condition and abnormality. Madam Serwaa

and her baby were monitored for the first 1hour at the labour room and the other five hours in the lying-in room. Their vital signs were checked every 15munites for the first 2hour, 30minutes for the next 1hours and then hourly for 3hours as follows

The mother's first vital signs were as follows:

Temperature ----------36.2ºC

Pulse ---------- 80bpm

Respiration ---------- 18cpm

Blood pressure ----------120/80mmHg

On palpation the uterus was firm and well contracted, fundal height was 17cm, lochia was dark red with small flow. She was advised to pass urine frequently and also change her pad to prevent infection and it would also help the uterus to contract well to prevent bleeding. The baby's apex heart beat was 142bpm, respiration 44cpm and skin were observed and it pink all over her body. There was no abnormality, the cord also checked and there was no bleeding. Madam Serwaa was thought how to position and attach the baby to breast for successful breastfeeding. She complained of lower abdominal pain and it was explained to her that it is due to involution of the uterus so she was reassured and given 1g of paracetamol tablet to relief the pain.

PREVENTION OF DISEASES

After an hour of continuous skin- to- skin with mother, procedure was explained to client and her consent was sought for the baby to receive eye and cord care.

Hand washing was performed and two drops of tetracycline eye ointment were instilled into the inner lower ophthalmic neonatorum eyelid outwards on each eye of baby to prevent any serious

eye infection such as, a condition that is notifiable which may lead to blindness. The cord was dressed with chlorhexidine to prevent infection such as tetanus neonatorum and to keep the cord dry at all times. Infection prevention techniques were also ensured to prevent crosss infection. Mother was to observe and continue at home. Injection vitamin K 1mg was given to baby intramuscularly to prevent haemorrhage.

EXAMINATION OF THE BABY

The procedure for head to toe examination was explained and carried out in the presence of the mother. This care helps to identify abnormality if any, so that immediate intervention can be carried out to prevent complication. Under good light and on a flat surface, the baby was undressed and covered with a warm towel, gloves were worn and the examination started. There was no caput succedaneum or cephalhaematoma, sutures and fontanels were normal and well pulsating on examination of the head. The conjunctiva were pink and there were no discharges from the eyes and nose and ears were normally situated. His mouth and tongue was clean with no sore or thrush; it had intact palate, no false teeth and no tongue tie. There was no enlarged thyroid gland on neck and breast tissue was palpated with normal nipples. The extremities were examined for equality with no webbed fingers, extra or missing digits There was capillary refill at the finger beds when pressed, there were palmer creases. The abdomen was soft and round, cord was situated at the centre of the abdomen without bleeding. The lower limbs were examined for equality and dislocation of the hips but none was noted. The back was examined for spinal bifida, missing vertebra and meningomyelocele but there was none. The urethral and anal orifices were patent since baby had passed urine and meconium. The skin of the baby was pink with no vernix caseosa or rashes, Moro, suckling and grasping reflexes were all present when assessed. Measurements were taken and recorded as:

Weight …….3.0kg

Head circumference …….36cm

Full length ……....51cm

MANAGEMENT OF THE MOTHER

Mother was then assisted to put baby to breast for natural release of oxytocin to aid in involution of the uterus and bonding between her and the baby. I explained to Madam Augustina that, her vital signs would be checked frequently for every 15 minutes for 2 hours, 30 minutes for 1 hour and hourly for 3 hours summing up to 6 hours.

Post- delivery vital signs checked and recorded as follows:

Temperature	36.2^{oc}
Pulse	80 bpm
Respiration	20 bpm
Blood Pressure	120/80 mmHg

She was encouraged to urinate frequently and change perineal pad when soaked. Lochia was red (rubra) in colour with small flow. She was educated on how to massage the uterus to aid in contraction and also to wash her hands with soap under running water after changing her pad and before attending the baby. Mother was advised to show pad for colour, amount, odour, and consistency before discarding it. Client and support person were educated on the need for ensuring proper positioning and attachment when breastfeeding. Mother and baby were in good condition.

SUMMARY OF LABOUR NOTES

Madam Serwaa had a spontaneous vaginal delivery to a live male neonate on 8th December,2022, at 8:30pm with birth weight 3.0kg with Apgar score8/10, 10/10. Placenta and membranes were completely expelled at 8:36pm by controlled cord traction and counter traction. Estimated blood loss was 150mls on examination of client after delivery, the uterus was well contracted and moderate bleeding per vaginum the Symphysio fundal height was measured and recorded 17cm. Mother and baby were in good condition were made comfortable in bed.

CONDITION OF MOTHER AFTER DELIVERY

Condition of mother	Satisfactory
Perineum	Intact
Fundal Height	17cm
Blood Pressure	120/80mmHg
Pulse Rate	80bpm
Temperature	36.2^{o}c

BABY

The baby was monitored for cord bleeding and there was none. Respiration, skin colour suckling reflex and activity were also monitored closely. Injection Vitamin K 1mg was given intramuscularly. The baby passed urine and meconium

CONDITION OF BABY AFTER DELIVERY

Temperature	36.4 ºc
Apex beat	142bpm
Respiration	44cpm
Skin colour	pink
Activity	normal
Condition of baby	Satisfactory

The baby's breathing pattern, colour and temperature was also checked every 15 minute by feeling the baby's feet and forehead and all were normal.

1ST MINUTE APGAR SCORE - 8/10

Appearance /colour		2
Pulse/heart rate	-	2
Grimace/reflex	-	1
Activity/muscle tone	-	1
Respiration	-	2

5TH MINUTE APGAR SCORE- 10/10

Appearance - 2

Pulse/heart rate - 2

Grimace/reflex - 2

Activity/muscle tone - 2

Respiration - 2

Total APGAR 8/10 - 10/10

Abnormalities - None

Condition of baby - Good

Baby was classified as normal.

Client was encouraged to feed baby on demand both day and night

3.6 LABOUR CARE PLAN

NURSING CARE PLAN ON LABOUR

Problems identified

On the 08/12/2022, Madam Serwaa complained of the following:

1. Waist pain.
2. Anxiety.
3. Lower abdominal pain.

Potential Problem

4. Risk of perinea tear.
5. Risk for infection (mother).

Short term Objectives

1. Client would be able to cope with waist pain within 1 hour and throughout labour.
2. Clients' anxiety would be allayed within 30minutes for labour to progress well.
3. Client would be able to cope with lower abdominal pain within one hour and throughout labour.
4. Client will not sustain any perinea tear within 20 minutes during the second stage of labour.
5. Client will be free from infections throughout labour.

Long term objectives

1. Client will go through labour and delivery safely without any complication to mother or baby.

NURSING CARE PLAN ON LABOUR

DATE/ TIME	NURSING DIAGNOSIS	OBJECTIVES / OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALAU-TION	SIGN
08/12/2022 at 2:45pm	Waist pain related to descent of foetal head secondary to the mechanism of labour.	Client will be able to cope with waist pains within 1 hour and throughout labour as evidenced by client verbalizing that she is able to cope and midwife noting that client is relaxed and no more complaint	1.Explain the physiology of waist pain to client. 2. Assure client that the pain will be subsided after delivery. 3. Encourage client to adopt a comfortable positioning during. 4. Give sacral massage. 5.Teach and encourage client to do deep breathing exercise. 6. Engage client in diversional therapy.	1. The physiology of waist pain was explained to client that it was as a result of overstretching of the pelvic ligament and backward movement of the coccyx due to descent of foetal head. 2. Client was assured the pain will subside after labour 3.Client adopted the left lateral position which to her was comfortable. 4. Client was given sacral massage to help relieve pain. 5. Client was doing deep breathing exercise to help her relieved of pain 6. Television was switched on for client to serve as a diversional therapy.	08/12/2022 at 3:45pm	Goal fully met. Client was able to cope with pain till the end of delivery.	MM

NURSING CARE PLAN ON LABOUR CONTINUED

DATE/ TIME	NURSING DIAGNOSIS	OBJECTIVES / OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALAU-TION	SIGN
08/12/2022 at 3:50pm	Anxiety related to the unknown outcome of labour.	Client will be free from fear and worry within 30minutes and throughout labour as evidenced by the student midwife observing that client is having a relaxed and cheerful facial expression. Client facial expression is cheerful confirmed by the midwife	1. Assure client that skilful delivery will be conducted. 2. Explain all procedure to be carried out client 3.Assure client that she will be free from complications. 4.Provide emotional support. 5.encourage client to ask questions boarding her.	1. Client was assured that she is in safe and competent hands. 2. Client received explanation to every procedure before they were carried out 3. Client was assured that measures will be put in place to prevent complications 4.Client was continuously reassured and commended for every effort of hers 5.Client's questions about labour and delivery were addressed.	08/12/2022 at 4:20pm	Goal met. Client was relaxed throughout labour and was with a cheerful face. Client facial expression is cheerful confirmed by the midwife	MM

NURSING CARE PLAN ON LABOUR CONTINUED

DATE/ TIME	NURSING DIAGNOSIS	OBJECTIVES / OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALAUTION	SIGN
08/12/2022 at 5:00pm	Lower abdominal pain related to painful uterine contraction.	She will be able to cope with the pain within one hour and throughout labour as evidence as client cooperating during labour. Confirmed by midwife as client cooperated during labour	1. Explain the physiology of abdominal pain to client. 2. Reassure client that this pain is temporal 3.Teach and encourage client to do deep breathing exercise. 4. Encourage client to void anytime she has the urge to do so. 5. Engage client in diversional therapy.	1. The physiology of pain was explained to client that it was as a result of uterine contractions due to the mechanism of labour. 2.Client was assured she would be relieved of pain after labour and delivery 3. Client was taken through deep breathing exercise to help relieve pain. 4.Client was voiding anytime she has the urge to do so to help hasten the descent of foetal head. 5.Client was engaged in conversation.	08/12/2022 at 6:00pm	Goal fully met. Client was able to cope with lower abdominal pain and cooperating during labour. Confirmed by midwife as client cooperated during labour	MM

NURSING CARE PLAN ON LABOUR CONTINUED

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVE/OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
08/12/22 at 8:00 pm	Risk for perinea tear related to client lifting her buttocks in second stage of labour.	Client will have intact perineum within 20mins during the 2nd stage of labour as evidenced by. The midwife observing an intact perineum after second stage of labour. Confirmed by the student midwife that client's perineum is intact	1. Reassured client to allay anxiety. 2. Confirm full dilatation of cervix before instructing client to push. 3. Educate client to put her buttocks on the delivery bed when bearing down. 4. Explain to client the dangers of lifting the buttocks. 5. Use all the skilful mechanisms in the management of second stage to deliver baby.	1. Client's anxiety was allayed. 2. Full dilatation of the cervix was confirmed, before client was asked to bear down. 3. Client positioned her buttocks after the education. 4. The dangers of lifting buttocks during second stage may cause serious tears 5. Flexion was aided, client was asked to pant when the head crowned and perineum supported.	08/12/22 at 8:30pm	Goal fully met as midwife observed an intact perineum. Confirmed by the student midwife that client's perineum is intact	MM

NURSING CARE PLAN ON LABOUR CONTINUED

DATE/ TIME	NURSING DIAGNOSIS	OBJECTIVES / OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALAUTION	SIGN
08/12/22 at 10:10pm	Risk for infection related to unhygienic handling of perineal pad and underwear	Client will be free from any infection throughout labour as evidenced by the student midwife observing that the client has no signs of infections. Confirmed by the midwife that client not showing any signs of infection	1. Explain to client on the need to maintain bed rest. 2. Encourage client to change perineal pads whenever soiled. 3. Encourage client to wash hands before applying anything to the vulva. 4. Encourage client to remove and apply perinea pads anterior posteriorly. 5. Discourage client from touching the perineum.	1. The need to maintain bed rest was explained to client to help prevent infections. 2. Client was encouraged to change perineal pad whenever soiled. 3. Client washed hands with soap and water before and after changing her perineal pad. 4. Client remove her perineal pad and clean her perineum anterior posteriorly. 5. Client reduced touching her perineum to prevent ascending infections.	08/12/22 at 9:00pm	Goal fully met. Client showed no signs of infection throughout puerperium. Confirmed by the midwife that client not showing any signs of infection	MM

CHAPTER FOUR

PUERPERIUM

4.0 INTRODUCTION

This chapter gives brief information about the subsequent care given to the mother and her baby after the third stage of labour. It also includes support and guidance in breastfeeding and care of the baby.

4.1 DAY OF DELIVERY

Madam Serwaa and baby's general condition were assessed, after they were transferred into the lying-in ward. Vital signs were checked and recorded as follows:

MOTHER

Temperature ……36.2°C

Pulse rate ……80bpm

Blood pressure ……...120/80mmHg

Respiration……..20cpm

BABY:

Temperature ……...36.4°C

Apex beat ……...142bpm

Respiration …….44cpm

Weight ……3.0kg

The lochia was red in colour, with moderate flow and uterus well contracted, fundal height was 17cm. she was encouraged to urinate frequently and change her pad when it is soiled to prevent infection and to catalyse involution. Also, she was encouraged to drink enough fluids, fruits and eat well-nourished diet to help build worn out tissues and boast her immunity.

She was taught the correct position of fixing baby to breast, so that the baby would be able to feed well. She later complained of lower abdominal pain (After pains) due to involution of the uterus. She was reassured and explained the physiology behind the pain. She was encouraged to continue breastfeeding which will help contract the uterus and to apply warm compress to the abdomen to reduce the pain.

The baby's colour was pink and cord was not bleeding. She looked healthy and suckled well. Her other siblings visited her to welcome the new-born. They expressed their joy for the safe delivery of the long awaiting new born baby. They were told she and the baby would be observed and explanation was made for her to know the need of staying at the Health centre for at least 6 hours and if no abnormalities detected they would be discharged home. Both mother and baby were left to rest and if possible sleep.

Below are the drugs routine given to Madam Serwaa after delivery;

- Capsules amoxicillin 500mg tid for 7 days.
- Tablets metronidazole 400mg tid for 7 days.
- Caps iron III Polymaltose1 dly for 30 days

  Tab paracetamol 500mg tis 3 days.

SUBSEQUENT CARE OF THE BABY

Head to toe examination, bathing and cord dressing was to be conducted on the baby so the following items were collected and gathered in the room where baby bathing is done.

BABY BATHING

Requirements

- Soap
- Sponge
- Cream/ powder
- Sterile cotton in a gallipot or wrapped
- Chlorhexidine
- Basin
- Towels: 1 big towel and 3 small ones
- Cot sheets 2
- Apron
- Gloves
- A clean baby dress, cap and socks
- Mackintosh
- Two jugs containing hot and cold water each
- Two receptacles for used water and dirty linen

- A receiver for used swab

PROCEDURE FOR BABY BATH

At 7:15am baby bath and cord dressing procedure was explained to client and she consented. Madam Serwaa was asked to bring out the toiletries and the clothing for the baby to be bathed. A flat surface where the baby will be bathed was prepared. Protective clothes were used to cover the flat surface on which the baby will be bathed. Baby was brought and laid on the flat protected surface. A plastic apron was worn after which hands were washed with soap under running water and dried them with clean towel. The water was mixed and the temperature of the water was tested with my elbow and it was moderately warm. Surgical gloves were worn, baby was undressed and exposed each parts; one at a time baby was bathed. The eyes were cleaned with cotton wool swab soaked in boiled cool water from inner cantus out and face wiped with a clean faced towel and dried.

The baby was supported with one hand by holding the nape of the neck, and ears plugged with two fingers in order to prevent water from entering into the ears, washed the head thoroughly,

rinsed and cleaned. The trunk washed down to feet paying attention to skin folds. Baby was turned by letting the chest rest on my hands to wash the back, the anal area and down to the feet. He was then immersed into the water with head above the water to totally rinse him. He was then removed and placed on a flat surface covered with a dry towel and used a small towel to dry him, paying attention to the folds. Baby was oiled and dressed exposing only the cord to be dressed.

DRESSING OF THE CORD

A sterile glove was worn and cord dressed with chlorhexidine, holding the cord clamp, the gel was applied from the base of the cord to the tip and some on the cord clump. Baby was then wrapped in a new cloth to keep baby warm and given to the mother to breast feed. Findings were communicated to the mother and documented. The area was tidied and items used were decontaminated, washed and kept for sterilization. Client was thanked for her co-operation.

4.2 DAY OF DISCHARGE

Client was discharged on the 9th December,2022. At 9:30am after the midwife in charge came for reassessed base on the facility protocol.

On discharge, client was educated on the importance of early ambulation and postnatal exercise. She was encouraged to maintain good personal and environmental hygiene, regular bathing, urinating frequently when she feels the urge and changing of the perineal pad when soiled to prevent infections. She was encouraged to breastfeed on demand and to empty one breast at a time. Again she should not apply anything on the cord.

Madam Serwaa was encouraged to protect baby and herself from mosquito bites by sleeping under treated mosquito bed nets at night to prevent malaria and to take her drugs as ordered. Client's mother came for her after discharge. She was reminded of the home visits discussed during the antenatal period.

4.3 FIRST POSTNATAL HOME VISIT

On the 10thDecember,2022 at 9:30am and 5:21pm, client, baby and the entire family received a follow-up visit home for continuity of care. They were happy to be visited as pleasantries were exchanged. Procedures on to be carried out on both mother and baby were explained, privacy was

provided, a thorough examination was done and no abnormality was detected on the baby. Baby was top and tailed considering the skin folds and following aseptic techniques. The skin was pink in colour and normal respiration present. The cord was dressed with chlorhexidine and left exposed to dry. Baby was pomade and dress up and handed to his grandmother.

Mother was also examined from head to toe and no abnormality was seen. Client was not pale, breasts were lactating, uterus was well contracted, perineum was clean and pad was observed for any bleeding, there was no active bleeding. Lochia was red (rubra), Both mother and baby were healthy.

Baby's vital signs and weight checked and recorded as follows

	Morning	**Evening**
Temperature.....	36.6	36.8
Apex beat……	141bpm	139bpm
Respiration ……..…	43cpm	44cpm
Weight …	2.9kg	

MOTHER	**Morning**	**Evening**
Temperature ……..…	36.7	36.2°C
Pulse rate ……..…….	86bpm	82bpm
Respiration……	24cpm.	22cpm

	Morning	Evening
Fundal height ……..16cm.		
Blood pressure……..…110/65mmHg		110/70mmHg
Lochia……..……Bright red (Rubra)		
Breast……...Firm and lactating		
Condition of Uterus…….well contracted		

Client thanked and Permission was sought to leave and client was promised to be visited the next day

4.4 SECOND DAY POST NATAL HOME VISITS

On the 11th December, 2022, at 6:58am and 4pm, Madam Serwaa and family were visited home as promised, to assess the general condition of the baby and his family. Client was at home with mother. General health condition of mother and baby was good

Explanation was given to her that she and her baby were going to be examined from head to toe to determine any abnormality for prompt treatment. Client was examined from head to toe and nothing abnormal was detected. Breast was lactating and baby was suckling well, a thorough examination was done and no abnormality was detected. Lochia was bright red and the flow was small with no offensive odour. Baby passed meconium during top and tailed. He was dressed and wrapped nicely for breastfeeding. Client complains of inadequate sleep and constipation. She was encouraged to sleep during the day and also to limit her engagement of visitors, and to eat enough fruits and vegetables, and take much fluids as well.

In the evening client was visited. Head to toe examination on both mother and baby revealed no abnormalities. Baby was top tailed bath paying attention to skin folds. Cord was dressed with chlorhexidine, after which baby was wrapped nicely before breastfeeding. Mother was asked if have any other complaints and she said no. Observations in both mother and baby for morning and evening recorded as follows:

Mother	**Morning**	**Evening**
Temperature	36.9^0C	36.2^0C
Pulse rate	80 bpm	78bpm
Respiration	22 cpm	20cpm
Blood pressure	122/82mmHg	120/80mmHg
Symphysio fundal height	15cm	
Weight	67kg	

Baby	**Morning**	**Evening**
Temperature	36.8^0C	36.6^oC
Apex beat	142 bpm	140bpm
Respiration	44cpm	44cpm
Weight	2.8kg	

Client thanked and permission was sought to leave and client promised to be visited the next day.

4.5 THIRD POSTNATAL HOME VISIT

On the 12th December, 2022, the third home visit was made to Madam Serwaa's house at 6:43am and 4:30pm, greetings were exchanged. Mother and baby were doing well. Her vital signs were checked and recorded. Permission was then sought to perform head to toe examination and nothing abnormal was detected, symphysio fundal height measured 16centimeters, lochia was pink, scanty flow without any offensive smell.

General examination was carried out on baby too and no abnormality was present. Baby's vital signs were checked and recorded; weight was 2.8 kilogram. Baby was topped and tailed in the presence of mother paying attention to skin folds. The cord was neatly dressed with no abnormality detected and given to mother to breastfeed. Client was informed that from the next day to the seventh day, would be visited once a day.

Mother's vital signs recorded as follows.

	Morning	**Evening**
Temperature	36.2ºC	36.6ºC
Pulse	74bpm	80bpm
Respiration	20 cpm	24cpm
Blood pressure	122/82 mmHg	122/80mmHg
Fundal height	14cm	

Baby's vital signs recorded as follows

	Morning	**Evening**
Temperature	36.8^{o}c	37.1^{o}C
Apex heart beat	140 bpm	138bpm
Respiration	38cpm	42cpm
Weight	2.8kg	

4.6 FOURTH POSTNATAL HOME VISIT

The daily visit started on 13th December, 2022 at 7:07am to continue with the care. The client was looking cheerful. After exchanging greetings, a seat was offered and procedure was explained to client and she agreed, so she was encouraged to empty her bladder whilst hands were washed and dried.

Head to toe examination was done on the baby and no abnormalities were found on head, face, neck, breast, abdomen and both upper and lower extremities. The cord stump was dry with no bleeding and his diaper was meconium stained. Baby was top and tailed with warm water and the cord aseptically dressed with chlorhexidine. She was encouraged to keep the cord dry always and also not to cover the cord with the baby's diaper.

No abnormality was detected. She was taught on the need to maintain good personal hygiene.

Vital signs were checked and recorded as follows.

Temperature…….36.4ºC

Apex beat…….. 138 bpm

Respiration ……..38 cpm

Weight……2.9kg

Client complained of heaviness of breast and that, it is painful when she removes her brassier. On head to toe examination, Madam Serwaa's breasts felt hard warm and tender but she was reassured and encourage to breastfeed the baby more frequently and to empty one breast at a time before offering him the other breast. She was thought on how to express the milk manually to relief the heaviness. Uterus too was well contracted. Vital signs were checked and other observation was recorded as follows.

MOTHER

Temperature……36.5ºC

Pulse rate……78bpm

Respiration……20 cpm

Blood pressure ……122/80mmHg

Symphio fundal height…….13cm

Breast……...Lactating

4.7 FIFTH DAY POST NATAL HOME VISIT

On the Fifth day 14th December,2022 at 7:00am. They were visited at home and enquiry from the mother about the feeding pattern of the baby was made and she revealed that, baby suckles well, passed stool and urine frequently. Baby's weight was 3.0kg. He was top and tailed. Cord was dressed with chlorhexidine and mother was educated to continue with the dressing.

Baby's vital signs were taken recorded as follows and

Temperature…….36.5°C

Apex beat……..142bpm

Respiration……38cpm

Weight……3.0kg

Examination was conducted on mother. The uterus on this day measured 15cm and well contracted and fundus palpated above the symphysis pubis. Lochia was pink in colour (serosa), scanty no odour. She said, she can now eat well and move her bowel as well when asked.

Mother actually was looking healthy.

Baby's cord was dry with no pus. No abnormalities were detected after examination. They were congratulated and promised to visit the following day. Client was asked to send the baby for BCG immunization at the RCH unit as she was told by the community health nurse that it is this day they will get some from the Health Directorate.

Mothers vital signs taken and recorded as follows

Temperature…….36.6^{o}c

Pulse rate …….78bpm

Respiration ……...18cpm

Blood pressure …….120/80mmHg

Fundal height.....12cm

4.8 SIXTH DAY POSTNATAL HOME VISIT

Madam Serwaa and her family were visited again on the 15th December,2022 at 6:54am pleasantries were exchanged and a seat and water offered. Baby was doing well as well as the mother. The cord has fallen off and without odour, mother was reminded to still continue dressing cord till wound is completely healed. Baby was thoroughly bathed paying attention to skin folds. Client was asked whether baby has reaction from the vaccine he took but client said no. She was educated not to apply anything on it.

Client complained of backache when breastfeeding which she was educated on the proper positioning and attachment when breastfeeding to prevent the backache. All examination findings were communicated to her. And symphysio fundal height measured 13cm. Madam Serwaa was reminded of baby's circumcision on the seventh day of delivery.

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

Temperature	36.3°C
Apex beat	140bpm
Respiration	43cpm
Weight	3.1kg

mother's vital signs were checked and recorded as follows

Temperature…….36.1^{o}C

Pulse rate …….78bpm

Respiration …….. 22cpm

Blood pressure …….122/80mmHg

Weight ……..70kg

Fundal height.....11cm

4.9 SEVENTH DAY POSTNATAL HOME VISITS

This was the last home visit, 16th December,2022. Client was visited at 5.00pm and she was met breastfeeding her baby. She was congratulated for attaching the baby to the breast correctly. Seat was offered it was enquired about how they were doing and she said they were doing very well. Head to toe examination was done on both the mother and the baby and no abnormality was detected. Cord stamp was examined and it was cleaned and dried. Mother was told to continue dressing until it heals completely. Baby was able to suckle well and had passed urine and stool according to her. Madam Serwaa was reminded again to send baby for circumcision.

Baby's vital signs were checked and recorded as follows

Temperature…….36.5°C

Apex beat……..138bpm

Respiration…….40cpm

Weight……3.2kg

Mother was encouraged to continue with the exclusive breast feeding, exercise and the intake of nutritious diet for strong immunity and promotion of lactation and also to continue visiting the clinic as scheduled even when this section of care ends and she should also report to the facility whenever the baby, herself or any other member of the family is not well. She should not always wait till the scheduled time to visit the facility.

Madam Serwaa was asked if she had any question or complaints and she said she had none. She expressed her gratitude for the care rendered and also added that she has really lent a lot from this interaction and she has also felt quite better than her previous pregnancy and labour experiences. Client and her family were thanked for their time and cooperation. She and her family were again informed that, this day is going to be the last day of visiting them at home but once still in town, they will once a while be visited but not every day as it used to be. They were thanked and permission was sought to leave and it was granted.

Mothers vital signs were checked and recorded as follows

Temperature…….36.0^{o}C

Pulse rate ……74bpm

Respiration……...24cpm

Blood pressure……..122/82mmHg

Fundal height…….....10cm

4.10 FIRST DAY POSTNATAL VISIT TO THE CLINIC

On the 16th December,2022. 8:00am. Madam Serwaa and her baby reported at the clinic for the first day postnatal visit to the clinic. Topics for health talk was immunization against preventable childhood diseases and family planning. On routine examination she said her baby breastfeeds well, slept well and moves his bowel 3-4 times in a day. These were the observations that she made about her baby.

The baby was undressed, wrapped in a cot sheet and examined on a safe flat surface in the presence of the mother after procedure had been explained to her. On examination, the fontanels were normal and sutures were not wide. There was no discharge from the eyes, ears and nose. The skin colour was pink without skin infection. The breast tissue was soft on palpation with normal nipples. The abdomen was not distended but soft and stump of umbilicus completely healed. The upper and lower extremities were equal. The genitalia were well developed and well situated and also mature to be circumcised.

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

Temperature ……..36.3^{o}c

Apex beat ……... 138bpm

Respiration …….39cpm

Weight …… 3.2kg

After examination of the baby, mother was examined after explaining the procedure to her and her vitals were taken and recorded before the procedure

Mothers vital signs were checked and recorded as follows:

Temperature…….36.3^{o}c

Pulse rate …….84bpm

Respiration …….. 22cpm

Blood pressure …….124/75mmHg

Fundal height……8cm

Weight……..70.5kg

Madam Serwaa was asked to empty her bladder. She was made comfortable and privacy ensured. Client was helped onto the couch for head to toe examination. The hair was neat, conjunctiva was pink and the nose, mouth and ears were clean. The breast was soft and lactating well with no abnormality. The abdomen was not tender and fundus still palpable abdominally. The lochia was pale and scanty. Uterus measured 11cm.The extremities were normal and palm pink. She was assisted to dress up and that of the baby. She was reminded to avoid overdressing the baby and to maintain personal hygiene that will promote healthy living. She was further advised to rest and have enough sleep. She was also adhered to the talk on immunization scheduled and then handed over to the midwife in charge for continuity of further care. Sincere thanks and gratitude to her and the family for their support and cooperation during the period of my encounter with them that led me achieving my aim was expressed.

The midwife in charge whole heartedly accepted them and promised to give them the best of care. She also promised to give an update when they come for their 6weeks postnatal visit which will

be 20th January,2023. She was thanked for all the support and the guidance given. Finally, preparation for circumcision was made.

Circumcision of the baby

After examination of the baby, Madam Serwaa was informed that baby is due to be circumcised. She was asked whether she wanted to observed and she responded no. The baby was prepared and circumcised by the Physician Assistance. Gel was applied to the circumcised area wrapped with sterile gauze after which baby was clothed and given to mother to breastfeed. Mother was educated on the need to wash hands with soap under running water before handling the baby to prevent infection. Keep the wound dry to prevent infection and to report any signs of bleeding, swelling or discharge. Client was reminded of her second postnatal visit to the facility. Baby was registered with the Births and Deaths Registry and client was handed over to the public health nurses for continuity of care. Madam Serwaa and her family were thanked for their co-operation and they were told that with their help the goal is fully met.

4.11SECOND POSTNATAL VISIT TO THE CLINIC

According to the midwife in-charge on 20th January,2022, Madam Serwaa visited the facility for 6weeks postnatal care at 9:10am. Head to toe examination was done on Madam Augustina and no abnormalities were detected. Her vital signs, including the weight were all within the normal

Madam Serwaa urine was checked for protein and sugar and it was negative for both, and the haemoglobin was 12.8g/dl. Her fundus was not palpable and no lochia observed.

The baby was examined from head to toe and no abnormality was found. Baby's weight was 5.0kg, vital signs and other observations were checked also recorded normal values.

Client was congratulated for taking good care of herself and the baby. And she also expressed her gratitude for all the support offered to them. She was also taken to the family planning unit and the child welfare clinic for immunization and continuity of care.

The following immunizations were given to the baby;

Vaccine	-	Dosage	-	Route of Administration
Polio 1	-	2 drops	-	Oral
Rotavirus	-	1millilitre	-	Oral
DPT-HepB-Hib1	-	0.5 millilitre	-	intramuscularly on the left thigh
Pneumococcal	-	0.5millilitres	-	intramuscularly on the right thigh

4.12 CARE PLAN DURING PUERPERIUM

PROBLEMS IDENTIFIED

1. After pain
2. Insomnia
3. Constipation
4. Backache
5. Heaviness of Breast

SHORT TERM OBJECTIVES

Client will experience a reduction in the intensity of the after pains within 3hours

Client will have enough sleep for at least 30minutes continuously during the day and 3hour at night within 24 hours

Client will be relieved of constipation within 48 hours.

Client will have no heaviness of breast within 48 hours

Client's backache will be reduced within 72hours.

LONG TERM OBJECTIVES

Mother and child will go through a normal puerperium without complication

NURSING CARE PLAN ON PUERPERIUM

DATE& TIME	NURSING DIAGNOSIS	NURSING OBJECTIVE	NURSING ORDERS	NURSING INTERVENTIONS	DATE &TIME	EVALU ATION	SIGN
09/12/22 at 11:20pm	After pains related to contractions of the uterus after the third stage.	Client will experience a reduction in the intensity of the after pains within 3hours as evidenced by client verbalizing, a reduced intensity of pain. And midwife visualizing that client is relaxed during breastfeeding.	1.Reassure client and explain the cause of pain 2. Encourage client to continue to breastfeed 3 Educate client on early ambulation and frequent emptying of the bladder. 4.Teach client how to massage the uterus to help it contract 5. Serve 1g of paracetamol when necessary	1. Client was reassured and understood the cause of the pain 2. Client breastfed baby on demand 3. Client walked around for at least 30minuts and emptied the bladder 4.Client massaged the uterus after the education 5. Client was served 1g of paracetamol.	09/12/2022 at 2:30pm	Goal fully met as client verbalized that pain had subsided. And midwife observing it through facial expression	MM

NURSING CARE PLAN DURING PUERPERIUMCONTINUED

DATE &TIME	NURSING DIAGNOSIS	NURSING OBJECTIVE /OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTIONS	DATE & TIME	EVALUATION	SIGN
14/12/22 at 5pm	Insomnia related to excessive cry of baby.	Client will be able to sleep at least 30minutes continues during the day and 3hours continues at night. Within 24hours And midwife visualizing it through client's appearance. Client verbalised that she was able to sleep at least 3hours at night	1. Reassure client to allay anxiety. 2. Encourage client to breastfeed baby well before sleeping. 3.Educate client to change soiled napkins or diapers to make baby comfortable 4. Educate client to minimize over dressing the baby at night. 5. Advice client to reduce time spent with visitors	1. Client was reassured to allay anxiety. 2. Client was breastfed baby well before sleeping. 3. Client changed soiled napkins or diapers to make baby comfortable. 4. Client dressed baby with light cloths at night. 5.Client limited time spent with her visitors. And attained sleep	15/12/22 at 5pm	Goal fully met as evidenced by client sleeping for at least 30mins continuously during the day and 3 hours continuously at night. Client verbalised that she was able to sleep at least 3hours at night	MM

NURSING CARE PLAN DURING PUERPERIUM CONTINUED

DATE & TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES/OUT COME CRITERIA	NURSING ORDERS	NURSING INTERVEN –TIONS	DATE & TIME	EVALUA-TION	SIGN
12/12/22 at 5:00 pm	Constipation related to inadequate of intake fluids and roughages/or foods rich in high fibre	Client will be relieved of constipation within 48 hours as evidenced by client passing stool once a day. And relative observing client having normal bowel movement.	1.Encourage client to take diet rich in fibre 2. Encourage daily intake of fruits and vegetables. 3. Educate client to drink enough water a day. 4. Educate client exercise a little	1.Client took diet rich in fibre 2. Client took fruits e.g. vegetable soup, mango and pear 3. Client drunk 3000mls of water in a day 4. Client was able to do postnatal exercise	14/12/22 at 5: 00pm	Goal met as client passed stool once a day. Relative observing client having normal bowel movement	MM

NURSING CARE PLAN DURING PUERPERIUM CONTINUED

DATE & TIME	NURSING DIAGNOSIS	NURSING OBJECTICVES/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTIONS	DATE & TIME	EVALUATION	SIGN
15/12/22 at 9:0am	Heaviness of breast related to incomplete emptying of the breast during feeding.	Client will have no heaviness of breast within 48 hours evidenced by reduction in client's breast size. And the midwife observing a reduction in breast size	1. Reassure client and explain the cause of breast heaviness to her. 2. Educate her to feed baby on demand, ensuring that she empties one breast at a time. 3. Teach client proper positioning and attachment of baby to breastfeed. 4.Educate client to express the breast when is too full and baby cannot empty all 5.Educate client to apply warm or cold compress on breast to relieve pain	1. Client understood and the cause of breast heaviness after explaining to her. 2. Client fed baby on demand, ensuring that she empties one breast at a time. 3. Client positioned baby correctly to breast milk. 4. Client expressed 30mls when the breast is too full 5.Client applied warm compress to breast	17/012/22 at 9:00am	Goal met as evidenced by reduction in client's breast size. And the midwife observing a reduction in breast size	MM

NURSING CARE PLAN DURING PUERPERIUM CONTINUED

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVE/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVEN-TION	DATE/ TIME	EVALUATION	SIGN
15/12/22 at 7:10am	Backache related to poor body posture during breast feeding	Client backache will be reducing within 72 hours as evidenced by; client verbalizing that the pain has subside And Midwife observing that client has a relaxed facial expression.	1.Reassure client that she will be relieved of pains 2. Teach client how to properly position herself when breast feeding. 3. Educate client to support her back with pillow during breastfeeding. 4. Advise client to lie down sometimes during breastfeeding 5. Serve prescribed analgesics.	1. Client was reassured 2. Client sat upright during breastfeeding. 3. Client supported her back with pillow during breastfeeding. 4.Client lied down when breastfeeding 5. Paracetamol was served as prescribed.	18/12/22 at 7:10am	Goal fully met as client said her pain has reduce and midwife observed that client had a relaxed facial expression.	MM

SUMMARY AND CONCLUSION

This family centered maternity care was written on Madam Augustina Akua Serwaa a 32years old pregnant woman, gravida 2 para 1 alive, who was nursed during the district practical experience at St Mary's Hospital Drobo. Madam Serwaa was cared for during pregnancy, labour and puerperium.

The first interaction with her was on 15th November, 2022 at St Mary's Hospital Drobo, when she visited the facility for her antenatal care as she usually does. Her gestational age as of that time, was 36weeks. Various observations and general physical examination and laboratory investigations were carried out with no abnormality detected. During pregnancy, she had some minor disorders which were successfully managed. She went through labour successfully and delivered an alive male infant, on the 8th December,2022, at 8:30pm. who weighed 3.0kg at birth. Her puerperium was managed successfully. Mother and baby were handed over to the midwife in charged at the reproductive and child health unit of St Mary's Hospital Drobo for further care and immunizations.

My care for Madam Akua Serwaa and her family gave me the opportunity to know the various individual needs of pregnant women during pregnancy, labour and puerperium. With this knowledge gained during this care study, I hope it will enable me give quality and adequate maternity and nursing care to all expectant women and their family throughout my carrier as a midwife and it has help me in asking questions concerning pregnant women and their family. It helped me to understand and practice what has been thought in classroom and have time for client and family.

Finally, this care should be given to all mothers since it helps in proper management of pregnant women and their babies till puerperium.

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APPENDIX I

ANTENATAL RECORDS

Date	**WT**	**BP. (mmHg)**	**Protein** / **Glucose**	**Gestational Age in Weeks**	**Fundal height** (cm)	**Presentation**	**Descent**	**F.H .R in (bpm)**	**Routine Drug IFA***	**Complain, Remarks**	**Name & Sign**	**Date of Next visit**
14/06/22	68kg	138/77	Neg Neg	14	12cm	-	-	-	1x30 days	Headache RDT-pos Itive	AG	12/07/22
12/07/22	69kg	131/74	Neg Neg	18	16cm	-	-	-	1x30 days	No complains.	AG	9/08/22
9/08/22	68.5 kg	120/78	Neg Neg	22	20cm	-	-	130	30	Feels well	AG	06/9/2022
06/09/22	70kg	137/76	Neg Neg	26	24cm	Ceph	-	148	30	Well	ABA	04/10/22
04/10/22	70.5 KG	125/68	Neg Neg	30	28	ceph	-	138	30	No complains	AD	01/11/22
01/11/22	70kg	118/77	Neg Neg	34	30	ceph	-	141	30	Well	KB	15/11/22
15/11/22	72kg	125/78	Neg Neg	36	34	ceph	5/5th	148	CT	No complains	MM	22/11/22
29/11/22	72kg	118/78	Neg Neg	38	36	ceph	5/5th	147	CT	No complains	MM	6/12/22
06/12/22	73kg	120/70	Neg Neg	39	37	ceph	5/5th	143	Routine drugs x7	No complains	MM	13/12/22

TETANUS-DIPHTHERIA IMMUNIZATION SCHEDULE

Tetanus-Diphtheria Dose	Date Given	Batch Number
Tetanus-Diphtheria 3	14/06/2022	222600620B

MALARIA PREVENTION

Long lasting Insecticide Treated Net (LLIN)	Date supplied :14/06/2022
G6PD status	No Defect

INTERMITTENT PREVENTION TREATMENT (IPTp) FOR MALARIA	DATE GIVEN	GESTATIONAL AGE IN WEEKS
IPT 1	12/07/2022	18weeks
IPT2	09/08/22	22weeks
IPT3	6/09/22	26weeks
IPT4	4/10/1/22	30weeks
IPT5	1/11/22	34weeks

NB: Sulphurdoxine – Pyrimethamine (SP) should be given to pregnant women between 16 weeks (after quickening and 36 weeks)

Directly observed therapy (DOT)

APPENDIX II

LABORATORY INVESTIGATION

TEST	DATE	RESULTS
BLOOD GROUP	14/6/2022	AB
Rh typing	14/6/2022	Positive
HBsAg	14/6/2022	Negative
Sickling	14/6/2022	Negative
G6PD	14/6/2022	No defect
VDRL/Syphilis	14/6/2022	Negative
HIV Antibody	14/6/2022	280
Repeat HIV Antibody (before 34weeks)	15/11/2022	Negative
BF for Malaria	14/06/2022	positive
Hb *(first visit)	14/6/2022	11.3g/dl
Repeat Hb* (at 28 weeks)	4/10/22	10.9g/dl
Repeat Hb*	29/11/22	11.4g/dl

APPENDIX III

PHARMACOLOGY OF DRUGS

DRUG NAME	CLASSIFICATION	ACTION/USES	ROUTINE	DOSAGE	SIDE EFFECT
Injection syntocinon	Oxytocin	Stimulates uterine contraction, control bleeding	Intramuscular intravenous	5 – 10 units	Uterine rupture if used in excess, nausea, vomiting
Bacillus Calmette, Guerin	Vaccine	Stimulates baby's body to produce antibodies against tuberculosis.	Intradermal	0.05mls	Small papules which persists for some weeks.
Polio	Vaccine	Stimulates the body to produce antibodies against poliomyelitis	Orally	2 drops	Gastrointestinal disturbance
Caps (iron III) polymaltose complex	Haematinics	Help in the production of red blood cells For improvement of appetite. Helps in the metabolism of carbohydrate, fat, and protein	Orally	1daily for 30 days	Gastrointestinal upset, black \stool, nausea.
Tab. Folic Acid	Vitamin preparation Haematinics	Prevents anaemia in pregnancy. Helps with the growth of the fetus.	Oral	5mg daily for thirty days	Abdominal discomfort, Anorexia, nausea, constipation.
Tab. Mebendazole	Anti-helminthics	It is used in the treatment of worm infection	Oral	500mg stat	Abdominal pain, diarrhoea hypersensitivity reaction.
Tab Paracetamol	Analgesic and anti-pyretic.	It reduces pain It also reduces body temperature.	Oral	1000mg 3 times daily for 3 days	Prolonged intake may damage the liver.

DRUG NAME	CLASSIFICATION	ACTION/USES	ROUTINE	DOSAGE	SIDE EFFECT
Sulphadoxine pyrimethamine(SP)	Anti-malarial	Intermittent preventive treatment in pregnancy	Oral	3 doses as single dose after 16wks.	Anorexia, seizures, vomiting, nausea, diarrhoea
Tab Metronidazole	Antibiotic	400mg 3 times daily for 7 days	Oral	Treats and prevents infection	Nausea and vomiting. Anorexia, Abdominal pains.
Capsule Amoxicillin	Antibiotic	500mg 3 times daily for 5 days.	Oral	Acts against grain wide range of grain positive and negative microorganisms.	Nausea and vomiting, Anorexia, Abdominal pains.
Injection Tetanus-Diphtheria	Vaccine	Stimulates the formation of antibodies against tetanus organism. Give the woman the ability to transfer immunity to the fetus.	Intramuscular Or Subcutaneous	0.5 mls	Pain and tenderness. Inflammation of the injection site, Slight rise in body Temperature.
Injection vitamin K	Anti-haemorrhagic vitamin	Help in blood clotting. Helps prevent haemorrhagic disease in the new born.	Intramuscular.	0.5-1mg	Flashes in the face.

WHO Modified Partograph

Registration No 732/17 Name (Last, First) Serwaa Akua Age 32 years
Date 8/12/22 Parity/Gravida 1 / 2 LMP 8/03/22 EDD 15/12/23 Gestation (wks) 39 weeks + 2 days
ROM (Time, Date) / Labour Durable (Hrs) 5hrs Facility/Clinic Name St mary's Hospital

FETAL HEART RATE

LIQUOR MOULDING

DESCENT

Alert

Action

Date of delivery 8/12/22
Time of delivery @ 8.30pm
Time of placenta delivery
Estimated blood lost 150mls
Birth weight 3.6kg
Sex - male
Apgar score 8/10, 10/10
First stage 5hrs
Second stage 30mins
Third stage 5mins

HOURS 1 2 3 4 5 6 7 8

TIME 3pm 4pm 5pm 6pm 7pm 8pm

CONTRACTIONS IN 10 MINS

Oxytocin U/L
Drops / Minute

DRUGS

FLUIDS

BLOOD PRESSURE

TEMPERATURE

Amount	5cm	NIL
Protein	NIL	NIL
Acetone	NIL	

LABOR NOTES

Client G2P1 at 39 weeks +2 days reported to this unit with the complains of labour pains. She progress successfully and had 3 contractions in 10 minutes. Vaginal delivery of a live male infant with Apgar score 8/10/10 Active management of 3rd stage of labour completed by 8 control traction cord and breast feeding initiated. Mother and baby made comfortable on bed.

Please circle or write responses.

DELIVERY

DATE: 8/12/22 TIME: 8:30pm METHOD: (Spontaneous) / Vacuum Extraction / C/S / Other

PERINEUM: Intact / Episiotomy / Laceration

ANESTHESIA: None / Local / General

THIRD STAGE

Active Management: Yes / No Medication: Time _____ Type/Dose oxytocin 10 unit

PLACENTA: TIME: (Complete) / Incomplete

BLOOD LOSS AMOUNT: Small (Less than 250 cc) 150mls / Moderate (250-499 cc) / Large (more than 500 cc) / Significant for mother

BABY

Weight: 3.0kg

Sex: (Male) / Female

Baby Position: (Vertex) / Breech / Other

APGAR

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

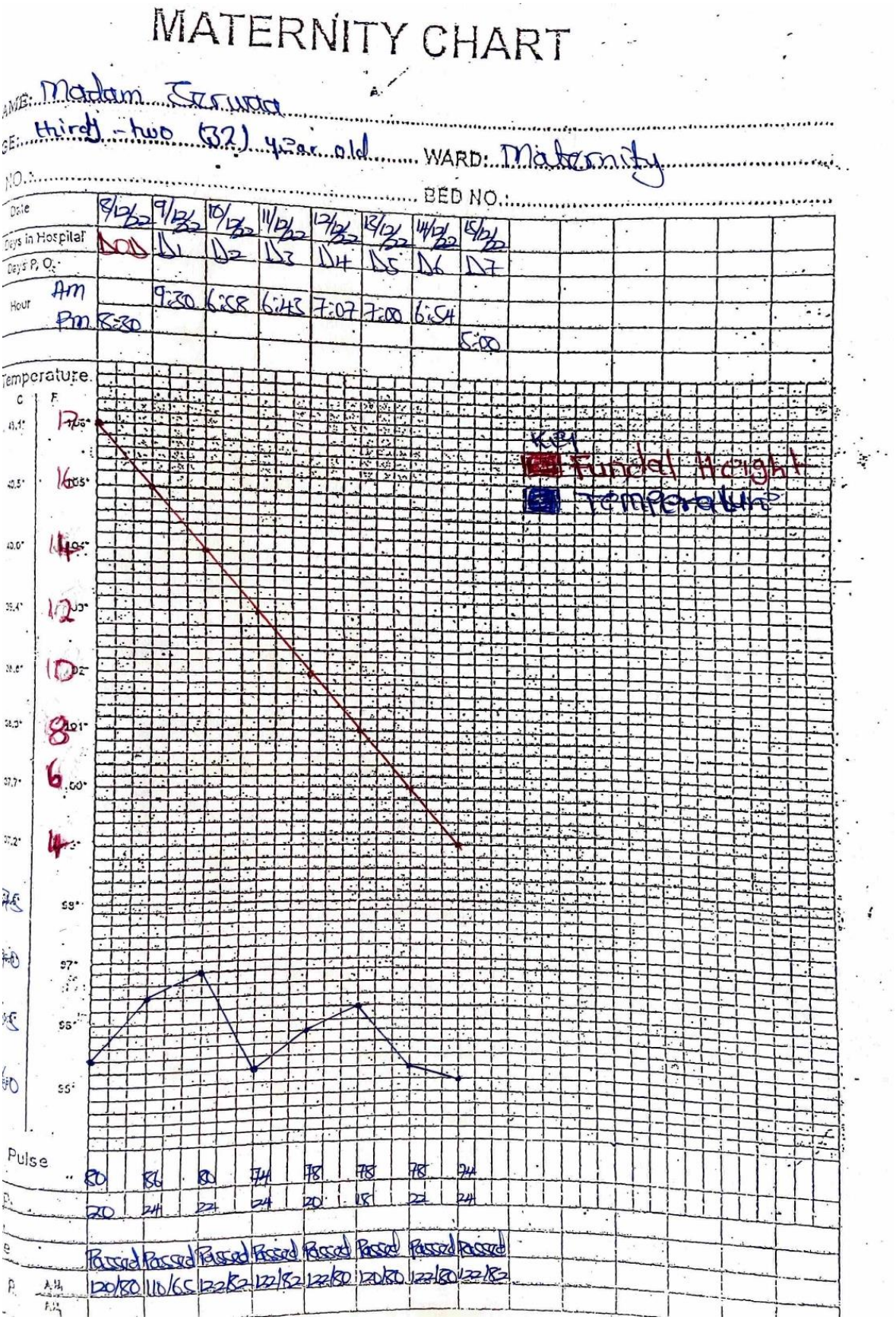
COMPLICATIONS OF MOTHER / BABY: None / Other: _____

FOURTH STAGE MONITORING

Frequency	Time	B/P.	Pulse	Fundus	Bleeding	Bladder
Every 15 minutes first 2 hours	8:55pm	120/80	80	18cm	Normal lochia	150mls
	9:10pm	120/80	80	well contracted	〃	
	9:25pm	123/78	82	〃	〃	Nill
	9:35pm	125/78	84	〃	〃	—
	9:50pm	123/68	88	〃	〃	—
	10:5pm	120/78	84	〃	〃	100mls
	10:20pm	120/70	82	〃	〃	
	10:35pm	120/68	80	〃	〃	—
Every 30 minutes For 1 hour	11:5pm	118/68	82	〃	〃	100mls
	11:35pm	116/70	80	〃	〃	—

Birth Attendant Musah Marshall Assisted by Naomi Kyere Date 8/12/2022

MATERNITY CHART



NEW BORN EXAMINATION FORM

Name: Baby Sonwaa
Date of Assessment: 8/12/22 Time: 9:30pm
Date of Birth: 8/12/22 Time of Birth: 8:30 pm Sex: ☑ M ☐ F Age at time of Assessment (days/hrs) 1 hour
Gestational Age ☐ ☐ Mode of Delivery: ☑ Vaginal Assisted Vaginal C-Section
APGAR: 1min 9/10 5min 10/10 Birth Weight: ☒ 10 kg ☐ Length: 51 cm Head Circumference: ____ cm
Temperature at time of Assessment: ____ °C Urine passed: (Yes) No Meconium passed: (Yes) No
Name of Assessor (Midwife/Doctor): ____

1. Respiration
Rate 44 cpm
☐ Rate < 30 b/m *
☐ Rate < 60 b/m *
☑ 30-60 b/m
☐ Retractions *
☐ Grunting *
☐ Stridor *

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

3. Tone
☑ Normal
☐ Floppy *
☐ Increased *

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

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

6. Cry
☑ Normal
☐ Shrill *
☐ Absent *

7. Suck
☑ Good
☐ Weak
☐ Absent

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

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

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

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

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

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

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

16. Clavicle
☑ Normal
☐ Swelling/Fracture

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

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

19. Femoral pulse
☑ Present
☐ Not palpable*

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

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

22. Limbs
☑ Normal
☐ Abnormal ____

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

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

24. Anus
☑ Patent
☐ Imperforate*

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

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

May indicate severe disease that requires urgent referral
Diagnoses (if known) ____
Classification: (Overall assessment) ☑ Normal [ ] Baby with a Problem [ ] Danger Sign/ <1500g/ severe Jaundice
Plan: ☑ Routine Care[ ]Problem. Continue supportive in-patient care [ ] Urgent Referral / Advanced Care[ ] Discharge

NEW BORN EXAMINATION FORM

Name: Baby Ezuwa Date of Assessment: 8/12/22 Time: 9:30
Date of Birth: 8/12/22 Time of Birth: 8:30pm Sex: ☑ M ☐ F Age at time of Assessment (days/hrs) 1hou
Astational Age ☐ ☐ Mode of Delivery: ☐ Vaginal Assisted Vaginal C-Section
APGAR: 1min 8/10 5min 10/10 Birth Weight: ☐ 3.0 kg ☐ Length: 51 cm Head Circumference: 36 cm
Temperature at time of Assessment: _____ °C Urine passed: (Yes) No Meconium passed: (Yes) N
Name of Assessor (Midwife/Doctor): _____

1. Respiration
Rate 44 cpm
☐ Rate < 30 b/m *
☐ Rate < 60 b/m *
☑ 30-60 b/m
☐ Retractions *
☐ Grunting *
☐ Stridor *

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

3. Tone
☑ Normal
☐ Floppy *
☐ Increased *

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

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

6. Cry
☑ Normal
☐ Shrill *
☐ Absent *

7. Suck
☑ Good
☐ Weak
☐ Absent

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

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

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

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

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

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

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

16. Clavicle
☑ Normal
☐ Swelling/Fracture

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

18. Heart rate
Rate: 142bpm
☑ Normal (100-160)
☐ <100 *
☐ >160*

19. Femoral pulse
☑ Present
☐ Not palpable*

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

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

22. Limbs
☑ Normal
☐ Abnormal _____

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

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

24. Anus
☑ Patent
☐ Imperforate*

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

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

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

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

Name: Baby Seruwa ..... No: ..... Birth Weight: 3.0kg .....

Sex: Male ..... Mother's No: ..... Length: 51cm .....

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

Date of Birth: 8/12/2022 ..... Time: 8:30pm ..... Date of Discharge: 9/12/22 .....

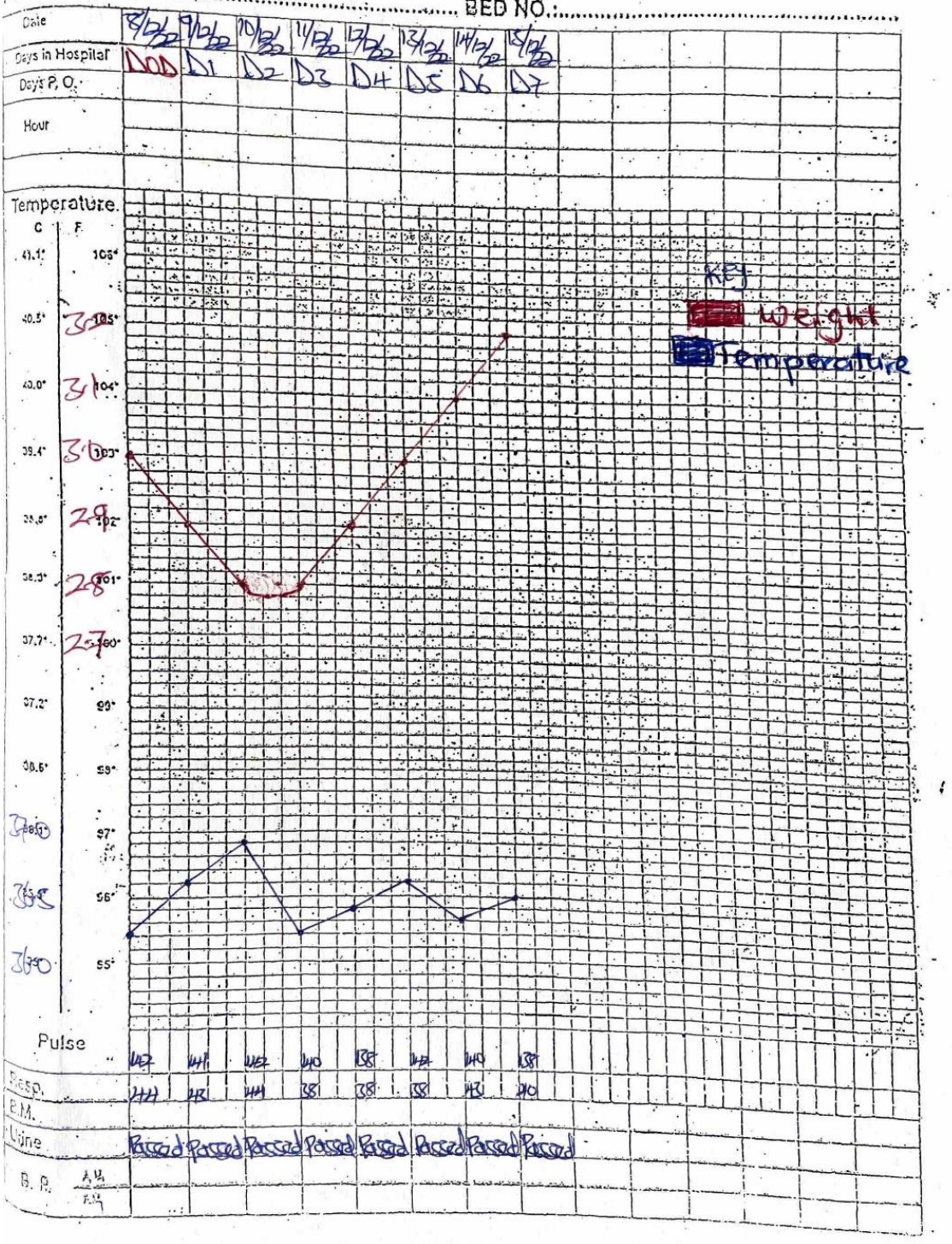
Date	8/12/22		9/12/22		10/12/22		11/12/22		12/12/22		13/12/22		14/12/22		15/12/22							
No. of Days	DOD		D1		D2		D3		D4		D5		D6		D7							
Weight	3.0		2.9		2.8		2.8		2.9		3.0		3.1		3.2							
	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM
Temperature		36.2	36.6	36.8	36.9	36.6	36.2	37.1	36.4		36.5		36.3		36.5							
Stools		Passed	Passed	Passed	Passed	Passed	Passed	Passed	Passed		Passed		Passed		Passed							
Urine		Passed	Passed	Passed	Passed	Passed	Passed	Passed	Passed		Passed		Passed		Passed							
Remarks	Head Neck limbs Truck Genital > NO abnormalities																					

TEMPERATURE CHART

NAME: Baby Sawda

AGE: New Born WARD: Maternity

P NO.: BED NO.:



SIGNATORIES

THE STUDENT MIDWIFE

NAME: MS MUSAH MARSHAH

SIGNATURE .....

DATE: .....08/06/2023.....

THE MIDWIFE IN-CHARGE

NAME: KYEREWAA NAOMI

SIGNATURE .....(for)

DATE: .....14/07/2023.....

THE SUPERVISOR

NAME: MS. ERNESTINA MENSAH

SIGNATURE: .....

DATE: .....09-06-2023.....

PRINCIPAL

NAME: MONICA NKRUMAH

SIGNATURE: .....

DATE: .....14/07/2023.....