HOLY FAMILY NURSING AND MIDWIFERY TRAINING COLLEGE BEREKUM

A CLIENT/FAMILY CENTERED MATERNITY CARE STUDY ON

MADAM TWUMWAA PATRICIA

BY

OWUSU YEBOAH ALFREDA

41222220129

A CLIENT/FAMILY CENTERED MATERNITY CARE STUDY SUBMITTED TO THE NURSING AND MIDWIFERY COUNCIL OF GHANA IN PARTIAL FULFILMENT TOWARDS THE AWARD OF LICENSE TO PRACTICE AS A PROFESSIONAL REGISTERED MIDWIFE

(DIPLOMA)

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PREFACE

Family centred maternity care study is a comprehensive, evidenced based learning solution built to help you enhance your ability to understand, diagnose and treat common clinical problems in maternity care of an expectant mother, her family and the entire community during pregnancy, labour and puerperium.

The care is individualized, based on identification and understanding of a client and family as unique people with specific needs and problems. These needs and problems could be psychological, physiological, emotional and spiritual which should be identified and solved. A comprehensive care is rendered based on the problems identified throughout pregnancy, labour and puerperium and solved using the nursing care plan. This helps to avoid complications which might arise during pregnancy, labour and puerperium.

The study gives the student the opportunity to choose and nurse a client and her family throughout pregnancy, labour and puerperium and also prepare the family to receive the newborn using the knowledge acquired in the study of midwifery.

It is also a requirement of the Nurses and Midwives council of Ghana, for the award of a professional registered midwifery certificate to students at the end of their three years study in school.

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A warm appreciation goes to the entire staff of Constance Maternity Clinic and Home, the midwife in Charge (Kunyo Patricia) and the midwives especially at the antenatal, maternity and labour units for their guidance, support and encouragement during my clinical experience.

Special thanks to Mrs. Twumwaa Patricia and her family for giving me the opportunity to nurse her. I appreciate her cooperation, understanding and efforts made to provide me with all the needed information for my write up.

I express my profound gratitude also to my parents Mr. Owusu Yeboah Charles and Mrs Asantewaa Patricia for their love, prayers, support and encouragement throughout my education.

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INTRODUCTION

Family centred maternity care study is a way of providing care for women and their families that integrates pregnancy, labour and puerperium and infant care into the continuum of the family life cycle as a normal, healthy life event.

Family centred maternity care is based on supporting the integrity of the family and individualizing the care given to promote individual and family health. Thus, it is possible for every setting and for every client and family, regardless of physical settings or characteristics.

This study was carried out on Madam Twumwaa a 34year-old gravida 2 Para 1 expectant mother during pregnancy, labour and puerperium. I met her on 14th of August, 2023 at Constance Maternity Home and Clinic when she was 37 weeks pregnant and was visiting the antenatal clinic for the 6th time. She was selected for the study after careful examination and explanation of the purpose of the study. A comprehensive care was rendered to the client throughout pregnancy, labour and the first seven days of puerperium through regular home visits and education. She was handed over to the public health nurse on the seventh day post-natal for continuity of care.

This write up is structured in four chapters; chapter one which consist of client particulars and histories that is the personal, social, family, medical, surgical, past and present obstetric history.

Chapter two is about the antenatal care rendered to client at the clinic and home till the onset of labour.

Chapter three is the care given throughout labour, how labour was managed and the immediate care given to both mother and baby.

Chapter four entails the care and management given to the client and baby within seven days postpartum.

A nursing care plan is drawn at the end of chapters 2, 3 and 4 to solve problems identified during pregnancy, labour and puerperium.

Finally, summary, conclusion and appendices on the study are attached.

LITERATURE REVIEW

PREGNANCY

Henderson (2009) stated that, pregnancy may be suspected by the woman base on her knowledge of her menstrual cycle, sexual activity and the signs of pregnancy. Women may confirm their pregnancy using home pregnancy test. Pregnancy may be sought from the midwife or doctor.
Detail history and relevant clinical examination based on the signs and symptoms of pregnancy. The signs and symptoms of pregnancy are; amenorrhea, breast changes, nausea and vomiting, and frequency of micturition, enlargement of the uterus, leg cramps, backache, skin changes and quickening. This signs will become obvious to the woman in sequential stages. The signs and symptoms of pregnancy may be considered as presumptive, probable and positive.

According to William (2014) is a condition from conception to the delivery of the foetus; the normal duration is 280 days (40 weeks or 9 months and 7 days) counted from the first day of a woman's last normal menstrual period to delivery or 265 days from conception to delivery. During this period, the woman undergoes numerous physical and psychological changes varying between body systems mostly due to estrogen and progesterone effects. These hormones help the woman nurture the foetus and prepare her body for labour and lactation.

Mayor (2009) Pregnancy is more than the growth of the uterus and the contained foetus. It is a state in which changes occur in all parts of the maternal body. Some of these changes are usually due to the influence of hormones; estrogen and progesterone. The production, circulation and metabolism of pregnancy hormones produce some minor ailments in pregnancy such as constipation, morning sickness, excessive salivation, heartburns, which if not appropriately managed, can be life threatening to both mother and foetus.

According to Tiran (2008) antenatal care is the care provided by midwives and obstetricians during pregnancy to ensure that fetal and maternal health are satisfactory, to enable early detection and treatment of any deviations from normal. Psycho-emotional preparation of the parents for labour and parenthood and health education are also included. Focus Antenatal Care (FANC) as a new approach to antenatal service, is an individualized client centred comprehensive care that focuses on disease detection rather than risk categorization. The goals of focus antenatal care are;

1. Early detection and treatment of problems and complications
2. Prevention of disease and complications
3. Birth preparedness and complication readiness
4. Health promotion

The advantages/benefits of FANC are:

1) Reduce maternal and perinatal mortality and morbidity.
2) It is the best approach for resource limited countries where both health providers and infrastructure are few.
3) Helps to detect both existing and potential diseases early, resulting in early intervention and better outcomes of pregnancy.
4) It solves the problem of pregnancy being unpredictable and a late phenomenon.

Myles (2009) states that as soon as pregnancy is confirmed, many physiological changes take place in the body and return to its pre-pregnant state during puerperium due to the effect of hormones namely estrogen and progesterone. These hormones are responsible for the major changes that take place during pregnancy. Even though these hormones have their own effects by causing the minor disorders that occur during pregnancy, they are one way or the other an

advantage for the mother and the growing foetus since the foetus depends solely on the mother for survival in utero. A variety of care that are rendered to the expectant mothers and their entire families which includes history taking, physical examination (head to toe examination and abdominal examination i.e. inspection, palpation and auscultation), laboratory investigation (urine, blood and stool), administration of routine drugs (folic acid, fersolate and multivitamin), Sulphadoxine Pyrimethamine as malaria prophylaxis and tetanus toxoid, education on minor disorders, danger signs of pregnancy, diet, travelling, rest and sleep, exercise, personal and environment hygiene, birth preparedness and complication readiness.

LABOUR

Tiran, (2008) defined labour as the process of giving birth also known as parturition. Normal labour occurs spontaneously between 37 and 41 weeks gestation with vertex presentation of a single foetus and is completed within 24 hours without any fetal trauma. Physiology depends on the interaction between the uterus, maternal pelvis and the foetus. Labour is divided into three stages; during the first stage, cervical effacement and dilatation occur; contractions are fundally dominant; contraction and retraction is facilitated by uterine polarity in the upper uterine segment and contraction and dilatation in the lower uterine segment. The second stage begins with full dilatation of the cervix until complete delivery of the baby. The third stage involves separation and expulsion of the placenta and membranes and the control of haemorrhage.

According to Fraser and Cooper (15thedition), labour is the process by which the foetus, placenta and membranes are expelled through the birth canal within 38 weeks of gestation.

The duration of labour varies from one woman to another but normal labour should not exceed 14 hours in the multiparous woman and 24 hours in a primiparous woman. There are two signs of

labour; pre labour signs and true labour signs. True labour is realized if only there is painful regular rhythmic uterine contractions with cervical dilatation and the appearance of show. Labour is characterized by four distinct stages. First stage; this begins with the onset of painful regular rhythmic uterine contractions with cervical dilatation and ends at full cervical dilatation of 10cm. First stage is also divided into latent, transitional and active phase. Latent phase is the beginning of uterine contraction to 4cm of cervical dilatation; transitional phase is from 4cm to 7cm and the active phase is from 7cm to 10cm. In a primiparous woman, the cervix dilates 1cm per hour in the active phase and 1.2cm per hour in a multiparous woman. Second stage begins from full cervical dilation to the expulsion of the foetus. This is also referred to as the pushing stage. The only true sign of second stage of labour is the absence of cervical rim. It is also divided into two phases; perineal and pelvic phase. Pelvic phase is when the cervix is fully dilated but the presenting part is high. Client should not push at this stage. Perineal phase begins when the presenting part reaches the pelvic floor and is associated with the strong urge to push or bear down. Second stage of labor should last 30 minutes to 1 hour in a primiparous woman and 5-30 minutes in a multiparous woman. Third stage begins immediately after the expulsion of the foetus. This is where placenta and membranes are delivered and ends when bleeding is controlled and the uterus is firm on its own. In active management of the third stage of labour thus; control cord traction. It should last between 5-30minutes. Client is relieved, elated and may experience some tremors. Fourth stage is when the mother and baby are monitored for the first six hours after delivery in the lying-in ward to detect, treat and to prevent complications.

Myles (2014) assert that, labour may be described as the process by which the foetus, placenta and membranes are expelled through the birth canal. Labour has four stages. Stage one comprises of latent phase and may last 6 to 8 hours in primigravidae. This begins at the onset to 3cm dilated

and in the presence of rhythmic contractions, progressively dilates to 10cm or full dilatation. Second stage of labour is the expulsion of the foetus. It begins when the cervix is fully dilated and the woman has the urge to expel the baby. There is stretching of the clitoris, gaping of the anus and bulging of the perineum. Labour completes when baby is born. In multigravida women, it last 15-30 minutes. Third stage begins after the expulsion of foetus and ends with the expulsion of the placenta and membranes (afterbirth). The fourth stage is a period of careful observation of the mother made to assess excessive bleeding and the firmness of the contracting uterus immediately after the third stage of labour and it last six hours after delivery of the placenta.

Safe Motherhood (2008), state that normal labour is defined as when there are regular, painful rhythmic contractions lasting at least 20 seconds (time by a trained midwife) occurring at a frequency of at least two contractions in every 10 minutes and with cervical dilatation of at least 3 centimeters. However in recent times active labour starts from 4 centimeters. The first stage is from the onset of labour to full dilatation of the cervix. This normally lasts up to 15 hours in multips and 18 or 24 hours in primigravidas. Second stage begins from the full dilatation of the cervix and when the woman feels the urge to expel the baby. It is complete when the baby is out. Third stage begins after the birth of baby until the expulsion of the placenta and its membranes it also involves the control of bleeding. Fourth stage is the stage of observation after birth.

In summary, labour is a process where there are painful rhythmic uterine contractions, with cervical effacement and dilatation resulting in the complete expulsion of the products of conception. Madam Patricia had a normal and successful labour resulting in the delivery of an alive female infant with no complications to both mother and baby**.** Her labour lasted 6hours, 8minutes.

PUERPERIUM

According to Tiran (2008) puerperium is defined as 6-8weeks period following childbirth during which the uterus and other reproductive organs and structures are returning to their non-pregnant state. During this period there is bloody discharge from the uterus through the vagina called lochia. It has a heavy, non-offensive fishy odour. It undergoes gradual sequential changes where there is change in colour, amount and consistency thus; lochia Rubra to Serosa and finally to Alba. It is alkaline in nature so organisms can flourish more rapidly. It is therefore important that client is educated on the need to practice personal hygiene.

Henderson (2009), the postnatal period or puerperium is traditionally defined as the time from immediately after the end of labour until the reproductive organs have returned as nearly as possible to their pre-gravid condition, a period estimated to be around 6-8 weeks.

The following are some of the aims of postnatal care, the successful achievement of which will result from the contribution to care made by the midwife and other members of the multidisciplinary healthcare team. To help the woman adapt and successfully fulfil the role and responsibilities of motherhood.

1. To promote and monitor the woman and the infant's physical well-being.
2. To promote and monitor the woman's psychological well-being.
3. To assist the woman with the successful establishment of her infant feeding.
4. To foster the development of maternal-infant chosen method of attachment.
5. To foster good family relationships.
6. To educate the woman and her family in the needs and development of the infant.
7. To enhance the woman's confidence in her ability to fulfil her role as a mother to promote health education.

During the puerperium the following physiological changes take place in all women as the body returns to its pre-pregnant state:

1. Involution of the uterus and other soft parts of the genital tract.
2. Commencement of lactation.
3. Physiological changes in other systems of the body.

It is important that the midwife is familiar with these to ensure that appropriate care and advice are given.

According to Jacob (2012) puerperium is a period following childbirth during which the body tissues, especially the pelvic organs, revert approximately to the non-pregnant state anatomically and physiologically. It last approximately for six weeks. Postpartum is arbitrary divided into; Immediate postpartum which is between the first 24 hours after delivery, Early postpartum which is between the 2nd to the 7th day postpartum and Late postpartum from the seventh day postpartum to six weeks.

Myles (2008) states that, following the birth of the baby and expulsion of the placenta, the mother enters a period of physical and psychological recuperation. Puerperium starts immediately after the delivery of the placenta and membranes and continues for six weeks. The overall expectation is that by six weeks after the birth of the baby, all the body systems will have recovered from the effects of pregnancy and return to their non-pregnant state. Myles also stated that puerperium starts immediately after the delivery of the placenta and membranes and continues for six weeks after which all the system in the woman's body will recover from the effects of pregnancy and return to their non- pregnant state. Myles also strikes the difference between exercise and healthy activity verses rest, relaxation and sleep. Exploring each person's level of activity will encourage advice in relation to appropriate exercise and by association, nutritional intake and rest or relaxation and sleep. Undertaking regular pelvic floor exercise is of benefit to the woman's long term health.

According, Copper (2009) defined puerperium as a period from childbirth to 6-8weeks postpartum when the woman is adjusting physiologically, socially and psychologically to motherhood. In puerperium, the uterus and other reproductive structures are gradually returning to their non-pregnant state. Minor disorders such as after pain, sub involution, tiredness/fatigue, and breast engorgement among others are likely to be experienced. The client should therefore be educated on the causes and management of these disorders.

WHY I CHOSE MY CLIENT?

Madam Twumwaa was among the pregnant women who attended Antenatal Clinic (ANC) on Monday 14th August, 2023 at Constance Maternity Home and Clinic, Madam Twumwaa was seen eating without washing her hands. She was taught on the importance of ensuring clean hands before and after eating. After which she was very grateful. Upon further conversation with her, she revealed that she did not practice exclusive breastfeeding to her first baby so the opportunity was given to help her to know the benefits of practicing the six months exclusive breastfeeding to her children and the need to take the Tetanus Diphtheria Injection to prevent Tetanus from entering the body through wounds and cut.

Familiarity was built between myself and her after glancing through her antenatal book, she felt within the criteria for the selection. After a comprehensive introduction to her. The In charge informed she about the idea of using her for the family centred maternity care study of which she gladly agreed. Phone contacts were exchanged and she was thanked for accepting the request.

CHAPTER ONE

CLIENTS PARTICULARS

1.0 INTRODUCTION

Chapter one gives a clear and vivid history about the client used for this study, her family and her community as a whole. It also gives an insight into the general assessment that was performed on the client, her family and the community as well. This Chapter also comprises of the past and present obstetric history, medical, surgical, menstrual, and family histories.

PERSONAL AND SOCIAL HISTORY

Madam Twumwaa was born on the 31st December, 1989 and she is a 34 years old expectant mother who comes from Nkrankwanta in the Bono Region but lives opposite Gasu House, a suburb of Dormaa. She lives with her husband. She speaks English and Bono. She is dark in complexion and is 164cm tall. According to Madam Twumwaa she had both her primary and junior high school education at Nkrankwanta. She is a teacher. Madam Twumwaa is married to Mr. Kofi Seth Amoah for about five years now. Mr. Amoah is 35 years of age and dark in complexion. He is a taxi driver.

Madam Twumwaa is a faithful and a devoted Christian and attends Methodist church. Mr. Amoah is a supportive husband and her next of kin.

1.2 FAMILY HISTORY

Opanin Badu and Madam Twumwaa are the parents of Madam Twumwaa. They are all alive and live at Penkwase in the Bono Region. Both parent of Madam Twumwaa are farmers. Madam Twumwaa is the first born of her parent. According to her, there are no known hereditary conditions such as diabetes mellitus, sickle cell disease, mental disorder, epilepsy and asthma in her family. She further stated that there is a history of multiple pregnancy in her family. Her older siblings who are the third born of her parents are twins. There is no congenital abnormalities like cleft palate, extra digits, spinal bifida etc. Death in her family occurs natural.

1.3MEDICALHISTORY

According to Madam Twumwaa she has never been admitted in a hospital before. Madam Twumwaa further stated that she sometimes experienced minor illness which is treated on OutPatient Department basis, and added that, she does not have any medical condition like asthma, hypertension, diabetes mellitus and tuberculosis. She has no known allergy to any drug or food and has never been transfused with blood before neither has she donated blood before. She is also not on any medication for any chronic illness.

1.4 SURGICAL HISTORY

Madam Twumwaa said that she has never had an accident that has affected her pelvis, spine or her reproductive organs neither has she undergone any surgical operation before. There is no episiotomy done on her previous delivery.

1.5 MENSTRUAL HISTORY

Madam Twumwaa has a regular menstrual cycle of 28days. Client had her menarche when she was 16 years old. She has six days duration of menses which flows moderately and has no dysmenorrhea. Madam Twumwaa said she changes her pad at least twice daily which indicates she has a normal flow. She had her last menstrual period on the 24th November 2022 and her expected date for delivery was calculated to be on the 31st August 2023.

1.6 CLIENT LIFESTYLE AND HOBBIES

Madam Twumwaa goes to bed around 8:00pm and wakes up around 6:00 am. She washes her face and brushes her teeth with tooth brush and tooth paste. The next thing she does is to sweep her room, corridor and her entire compound then mop her room and prepares breakfast for her husband and herself. Though Madam Twumwaa already have a daughter but she is currently staying with her grandmother at Penkwase because of her work and even her current pregnancy she would not have much time to spend with her. But according to the client she visits them frequently. She takes her bath immediately she is done with the preparation of their breakfast then she takes in her food. She lives closer to her work premises with her co-workers so she sometimes comes to prepare supper around 3:00pm and then goes. She eats three times and empty her bowel at least once a day. She neither smokes cigarettes nor take any alcohol or caffeine drink. On Saturdays, Madam Twumwaa cleans her room, goes to the market to buy food stuffs and shops for the items that she would need in the up keep of the house for the next week. Her dirty clothes as well as that of her husband is washed up during the weekend and dried in the sun. Madam Twumwaa's favourite food is banku and groundnut soup with beef. She enjoys reading her

bible and listening to music during her leisure time. On Sundays, Madam Twumwaa goes to church with her husband and closes around 12:00pm. She then comes home and prepares lunch for her husband and herself around 2pm and makes sure that her husband is served and see to it that he eat.

1.7 HOME ENVIRONMENT

Madam Twumwaa lives in an uncompleted self- contained house with three bedrooms and she occupies a room. Each tenant has his or her own corridor that has a door that is locked. Madam Patricia's room has two windows lined with mosquito proof net and on the trap door as well while the other window is made with tainted glasses. The house was built with cement blocks and is well roofed with Aluminium sheet. Madam Twumwaa keeps her things at the uncompleted building and they are neatly arranged. Madam Twumwaa has a clean plastic container with a cover in which she stores her water. The house has three uncompleted bathrooms and toilet facilities but there is a single temporal KVIP which is shared by the whole tenant. The source of water is a pipe borne which is situated at the back of Madam Twumwaa's room. Client disposes her refuse at the backyard of their house which is burnt every evening. Madam Twumwaa's room is well ventilated and has a good lightening system. The source of light is electricity. She sleeps on a latex foam mattress under a treated insecticide net.

1.8 PAST OBSTETRIC HISTORY

Pregnancy; Madam Twumwaa is gravida 2 Para 1, alive, went through her pregnancy without any ill-health and had a term pregnancy. The interval between the first and the current pregnancy is two years. There were no complications like ante- partum hemorrhage or abortion. She received

all the doses of Sulphadoxine pyrimethamine (SP) and her first and second doses of Tetanus Toxoid immunizations. She was a regular attendant to antenatal care till she delivered.

Labour; She had spontaneous vaginal delivery to an alive female infant at Constance Maternity Home and Clinic Penkwase. Her baby cried lustly as soon as she was delivered with birth weight of 2.9kg kilograms and the labour lasted for 6 hours. The third stage was actively and properly managed without any complications. The perineum was intact. In the fourth stage, the condition of the mother and the baby were good. The estimated blood loss was 150mls, but she said she had no postpartum hemorrhage.

Puerperium; Madam Twumwaa's puerperal period, according to her was also normal. She had no puerperal psychosis. She visited the postnatal clinic frequently. She and her baby were healthy throughout. She breastfed exclusively for six months. According to Madam Twumwaa her daughter received all the immunization against childhood preventable diseases and still continued to visit the child welfare clinic. She also said she received support from her husband, her siblings and mother during the previous delivery. Her daughter was healthy. Madam Twumwaa did not use any artificial family planning method but she only practiced the Lactational Amenorrhea Method (LAM).

1.9 PRESENT OBSTETRIC HISTORY

Having glanced through her antennal records book, client attended her first antenatal clinic visit on the 20/04/2022 at Constance Maternity Home and Clinic when she was 13weeks of gestation.On Madam Twumwaa's first antenatal clinic visit, her history was taken and recorded which included personal, family, medical, surgical and obstetrical histories. Laboratory

investigations were also taken and physical assessment was done and recorded. Results of investigations which were carried out were as follows;

Hemoglobin Level	-	12.0g / dl
Sickling Test	-	Negative
Blood group	-	O
Rhesus factor	-	Positive
G6PD	-	No Defect
Syphillis (VDRL)	-	Negative
HIV status	-	Negative
Urine R/E	-	No abnormalities
Hepatitis B status	-	Negative

The following observations were made and recorded; temperature $36.7^{O}_{C,Pulse}$ 82bpm, respiration 22cpm, Blood Pressure 120/70mmHg. Madam Twumwaa had her 3rd dose of tetanus Diphtheria on the 25th of July, 2023. She had her first dose of Sulphadoxine pyrimethamine on 22nd of August, at 24 weeks, second dose on 31st October 2023 at 36 weeks. Records on Madam Twumwaa's antenatal card indicated that she was examined from head to toe and no abnormalities were detected. Madam Twumwaa had no complains during her first visit. Therefore she was served with the following routine drugs;

Folic acid 5mg (1 daily) for 30 days

Tablet Ferrous Sulphate 200mg (1daily) for 30 days.

Madam Twumwaa honoured all scheduled visit correctly and carried out all the investigations requested. And all findings has been within normal ranges until she was met on the 14th August, 2023 when she was 37 weeks pregnant. Madam Twumwaa made five visits to the antenatal clinic before she was met for the first time.

CHAPTER TWO

ANTENATAL CARE

2.0 INTRODUCTION

This chapter gives an accurate information of the care rendered to Madam Twumwaa during her pregnancy specifically from the 37+1 weeks. It highlights more on the first contact with client, various home visits and subsequent visits to the clinic and also the nursing care plan drawn to solve her problems during pregnancy.

2.1 FIRST CONTACT WITH THE CLIENT

Madam Twumwaa was met on the 14th August, 2023 at Constance Maternity Home and Clinic Penkwase during the antenatal day when she was 37 weeks pregnant. It was her sixth visit to the facility. Introduction was made as Owusu Yeboah Alfreda, a student midwife from Holy Family Nursing and Midwifery Training College, Berekum sent to Constance Maternity Home and Clinic on clinicals to have a practical experience in midwifery. Her antenatal book was collected and found out that she fall within the criteria and she has been attending antenatal clinic regularly and have no abnormal condition which can be a threat to her pregnancy. A brief information was given to her about the care study and why she was chosen and she gave an assurance of full support and co-operation and she was happy as well. She was then taken through the general examination when it got to her turn after procedures were explained. She was encouraged to ask questions. Her vital

signs weight and urine were checked and recorded as follows; Temperature 36.5^{O}C, Pulse 80bpm, Respiratory rate 21cpm, Blood pressure 120/80mmHg and Weight 63kg

After the procedures, education was offered to her on the following; warning signs in pregnancy like vaginal bleeding, hyperemesis gravidarium, increase body temperature, increase or decrease or no movement of the foetus, convulsive fits, then also on budgeting and layette, signs of forthcoming labour, taking of medication as prescribed and avoidance of self- medication, avoiding caffeineted drinks, sleeping under an insecticide net to prevent malaria and good nutrition.

Permission was obtained to perform physical examination from head to toe after an explained procedure. She was asked to empty her bladder, privacy was ensured and she was helped to undress, assisted to lie on the examination couch and covered with a clean cloth. Hands were washed with soap and water and dried with a clean dry towel. Madam Twumwaa was examined from head to toe, under the supervision of the midwife in charge and no abnormality was detected. Madam Twumwaa's hair was examined and it was neatly braided with no dandruff or lice. The sclera and conjunctiva were normal with no yellowish discoloration. There were no discharge from the nose and ears. The mouth, tongue and teeth were clean. On neck palpation, no lymph nodes were felt. The breasts had no lumps, dimples or discharge during palpation. Madam Twumwaa was taught how to do self -breast examination and she was educated to examine her breast five days after her menstruation where the breast would have been free from any changes for early detection of any abnormalities. The hands and fingers were inspected and the nails were cut and neat. The lower extremities were examined and no abnormalities was detected. .The back was also inspected for oedema at the sacral region and the condition of the skin. There was no oedema at the areas inspected and the condition of the skin was good.

Abdominal Examination

Before abdominal examination, hands were rubbed together to provide warmth to prevent induced contractions.

Inspection: the abdomen was inspected for scars, rashes and striae gravidarum and none of these were detected. The size and shape was globular and medium respectively with some foetal movements.

Measuring of Symphysio-fundal height: The zero end of the measuring tape was placed on the fundus and the tape extended to the symphysis pubis of the uterus and the symphysio-fundal height measured 36centimetres and gestational age of 37weeks.

On fundal palpation: Upon facing the head of the woman on her right hand side, the fundus was palpated with both palms and the foetal buttocks were felt.

On lateral palpation: With one hand stabilizing the right side of the maternal uterus, the other hand was moved gently on the left side where rough parts were felt indicating the foetal limbs as palpated. This was repeated at the right side and a smooth round part was observe indicating the foetal back and this also helps to locate the position of the foetus to help listen to the foetal heart sounds by using the fethoscope.

On pelvic palpation: Upon facing the woman's lower limbs and placing the palms of both hands on either side of the lower abdomen below the umbilicus pointing downwards and in wards, the head was palpated. The lie therefore was longitudinal, presentation was cephalic and the position was right occipito-anterior.

Descent: The anterior shoulder was located and five fingers were admitted between the shoulder and the symphysis pubis indicating $5/5^{th}$ above the pelvic brim.

On Auscultation; A fetoscope was placed at the back of the foetus to listen to the foetal heart sounds whiles comparing it with the maternal pulse; foetal heart beat was 136 beat per minute**.** **On vulva examination;** Permission was sought to examine the vulva and it was granted. Hands were washed under running water with soap and dried with a clean towel and gloves were put on. The mons pubis was already well shaved; there were no scars, oedema, varicose veins and genital warts. Also, there was evidence of good vulva hygiene so she was applauded for that and was asked to continue with it. She was educated to wear cotton panties and avoid douching to prevent infections. Madam Twumwaa was asked to lie laterally and sit up before getting out of the couch. She was congratulated for allowing the procedure to be done on her. Hands were washed and dried and all findings were communicated to her and recorded in her antenatal book.

She complained of lower abdominal pains which she thought would affect the baby during delivery and puerperium. She was reassured and educated that it was due to the pregnancy since the fetus is engaging into the pelvis thereby exerting pressure on other organs and nerves in the sacral region. She also complained of waist pain, and it was explained to her that it was due to the relaxation of the joints of the pelvic bone by pregnancy hormones and she was educated to bend from the knees and also rest in between activities. She was thanked for her cooperation. The stages and true signs of labour were explained to her. That is first, second, third and fourth stages also show, painful rhythmic uterine contractions respectively. Madam Twumwaa was educated to report to the clinic if she sees any of these signs.

She was served with below routine drugs;

- Tab Ferrous Sulphate 200mg 1daily for 30 days
- Tab Folic acid 5mg 1daily for 30 days

She gave me directions to her house and contacts were exchanged so that she can be visited at home. Madam Twumwaa having agreed to be used for the study, arrangement was made to visit her house on the 16th of August, 2023 She was thanked and seen off to the entrance.

2.2 FIRST ANTENATAL HOME VISIT

On the 16th of August, 2023 at 3:30pm Madam Twumwaa was visited at home. The main goal was to visit where she lives and also talk about birth preparedness and complication readiness plan. The house was far from the clinic. Madam Twumwaa was very glad for the visit. Seat and a glass of water were offered after which interaction with her started. Introduction was made once again. The house is built with blocks and roofed with aluminum sheets. There are three rooms in the house of which Madam Twumwaa and her husband occupies one. The house is painted green from the outside and white inside. Their surroundings were neat. The used water from the bathroom drains through a canal into a small gutter purposely created for the draining water and is poured out. She brought out the Items for delivery for inspection and it was neatly arranged and complete. She was congratulated for purchasing all the necessary items for the impending labour and she was advised to add her National Health Insurance and keep some amount of money that will be needed for some things during the period of labour, which may not be settle with the NHIS.

Madam Twumwaa was educated on the signs of labour, and the process of labour. She was also educated on the intake of a well- balanced and nutritious diets, the importance of having enough rest, lifting of light loads instead of heavy ones and wearing of loose cloths and low heel shoes as well. She was educated on the essence of practicing exclusive six months breastfeeding and environmental and personal hygiene education was also given. Her husband arrived just as the discussion was about to be concluded and he was educated on the signs of labour and also the

danger signs that when he sees from his wife that he must rush her to the hospital immediately. He was encouraged to give a helping hand to reduce tiredness and promote adequate rest and sleep. She was informed about the next visit which was on the 19th August, 2023. Permission was sought to leave. She was very grateful .She was thanked for her co-operation and willingness to adhere to the pieces of advice given.

2.3 SECOND ANTENATAL HOME VISIT

On the 19th August, 2023, Madam Twumwaa was visited as she was promised. A cheerful welcome was given by the client. After pleasantries were exchanged, It was inquired how she is doing and the foetus as well. She was asked if she had been feeling some foetal movements and she said yes, enough of them. She complained of constipation, profuse vaginal discharge and frequency of micturation but she was reassured and explained to her the physiological changes that occur in pregnancy and she was told it will disappear soon after delivery. Enquiries were made to know if the vaginal discharge was offensive or itchy but she said it was not offensive and itchy, so she was encouraged on good perineal hygiene and the use of panty liners and also washing and drying panties in the sun or ironing them.

Madam Twumwaa was reminded on the true signs of labour. She was thanked for her cooperation. Permission was sought to leave

2.4 SUBSEQUENT VISIT TO THE ANTENATAL CLINIC

Madam Twumwaa reported to the antenatal clinic on 21st August, 2023 around 10:00am. She was helped through the normal routine procedures and her vital signs were checked and recorded as follows; Temperature 36.5^{o}C,Pulse 80bpm,Respiration 21cpm,Blood pressure 120/70mmHg,Weight 64 kg.

Madam Twumwaa was asked to empty her bladder; midstream urine sample was tested for protein and glucose which were trace and negative respectively. She was helped onto the examination couch and privacy was ensured. General examination was carried out under the supervision of the midwife in-charge and no abnormalities were found. On abdominal examination symphysio–fundal height was 37cm, her gestational age 38weeks, lie was longitudinal and presentation was cephalic with a descent of 5/5th above the pelvic brim. On lateral palpation, the position was right occipito-anterior. On auscultation; the fetal heart rate was 147bpm with regular rhythmic and good volume.

All findings were communicated to her and recorded in her antenatal book. She was asked to continue her routine drugs and report to the facility if she sees any signs of labour.

2.5 NURSING CARE PLAN DURING ANTENATAL PERIOD

Problems Identified During Antenatal Period

1. Lower Abdominal Pain-16th August 2023.
2. Waist Pains-16th August 2023.
3. Constipation-19th August 2023.
4. Vaginal Discharge -19th August 2023.
5. Frequency of Micturation-19th August 2023.

SHORT TERM OBJECTIVES

1. Client will cope with lower abdominal pains throughout pregnancy.

2. Client waist pain will reduce and cope with it throughout pregnancy.
3. Client will be to move her bowel at least once in 48 hours.
4. Client will cope with vaginal discharge throughout pregnancy.
5. Client will cope with frequency of micturation throughout pregnancy.

LONG TERM OBJECTIVE

Client will go through pregnancy, labour and puerperium successfully without any complication to mother and the foetus.

NURSING CARE PLAN FOR PREGNANCY

DATE / TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTIONS	DATE / TIME	EVALUATION	SIGN
16/08/23 at 10.00am	Lower abdominal pains related to descent of the foetal head.	Client will cope with lower abdominal pains throughout pregnancy as evidenced by client verbalizing that her pain has reduced.	1. Reassure client that her pain would subsided after intervention. 2. Explain the cause of lower abdominal pains to client. 3. Encourage client to reduce household activities. 4. Encourage client to wear low heel shoes.	1. Client was reassured that her pain would be subsided. 2. Client was thought that the pain is due to pressure on the bladder and nerves of the pelvis. 3. Client reduced household activities. 4. Client wore ow heeled shoes throughout pregnancy.	16/08/23 at 10.00am	Goals fully met as client verbalizing that the abdominal pains has been reduce.	

			5. Encourage client's sister to help client with household chores.	5. Client's sister helped client with household chores like sweeping and washing.			

NURSING CARE PLAN FOR PREGNANCY

DATE / TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTIONS	DATE / TIME	EVALUATION	SIGN
16/08/23 at 10:00am	Waist pain related to relaxation of the pelvic joints due to actions of pregnancy hormones.	Madam Twumwaa's waist pain will reduce and cope with throughout pregnancy as Client verbalizing that she is being familiar with the waist pain.	1. Reassure client that she will be relieved of waist pain. 2. Encourage her to always bend on the knee and not from waist. 3. Teach husband on how to do sacral massage for Madam Twunwaa. 4. Encourage her to take enough rest in between activities. 5. Administer prescribed analgesic (Paracetamol 1g).	1. Client was reassured that she will be relieved of waist pain. 2. She should bent from the knee and not from the waist. 3. Husband did sacral massage for client. 4. She took enough rest in between activities. 5. Prescribed analgesics were administered. (Paracetamol 1g).	17/08/23 at 10:00am	Goal fully met as client verbalizing that the pains is reduce.	

NURSING CARE PLAN FOR PREGNANCY

DATE / TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTIONS	DATE / TIME	EVALUATION	SIGN
19/08/23 at 10:00am	Constipation related to activity of progesterone causing decreased peristalsis and relaxation of the smooth muscles of the large	Client will able to move her bowel at least once in 48 hours as by Client verbalizing that she was able to pass stools (twice daily) and also stating that she is relief of	1. Reassure Madam Twumwaa that she will have a free bowel. 2. Explain the physiology of constipation to her. 3. Encourage client to take at least 8 glasses of water daily.	1. Client was reassured that she will have free bowel. 2. The physiology of constipation was explained to the client 3. Client took about 8 glasses of water daily.	19/08/223at 10:30am	Goal fully met as client verbalizing that she was able to pass stools.	

	bowel during pregnancy.	discomfort of constipation.	4 .Educate client on the intake of roughages. 5. Encourage her to perform both active and passive exercises such as dancing and walking.	4. Client took a lot of roughages such as vegetables and fruits. 5. Client performed active and passive exercises such as dancing and walking.			

NURSING CARE PLAN FOR PREGNANCY

DATE / TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES /OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTIONS	DATE / TIME	EVALUATION	SIGN
19/08/23 at 8:00am		Client will cope with the profuse vaginal discharge throughout pregnancy. Evidence by client verbalizing that she is coping and midwife	1. Reassure client that the discharge will reduce. 2. Explain the physiology of vaginal discharge to client. 3. Encourage client to wear cotton panties to allow aeration. 4. Encourage client to practice good personal hygiene to avoid the incidence of genital tract infections.	1. Client was reassured that the discharge will reduce. 2. Client was taught that it was due to hormonal influence on the vagina. 3. Client wore cotton panties to allow absorption and aeration. 4. Client practiced good personal hygiene like washing her panties regularly and	20/08/23 at 8:00am		

		noting that client is not complaining.	5. Instruct client to change panties frequently. 6. Encourage client to dry panties in the sun if possible or iron them before using.	taking good care of the perineum 5. Client applied panty liner all the time 6. Client dried panties in the sun or ironed them to reduce the rate of infections when it was possible.			

NURSING CARE PLAN FOR PREGNANCY

DATE / TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES /OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTIONS	DATE / TIME	EVALUATION	SIGN
19/08/23 at 10:00am	Frequency of micturition related to the growing uterus exerting pressure on the bladder.	Client will cope with frequency of micturation throughout pregnancy. Midwife observing that client complains less of the	1. Reassure client and remind her of the physiology of the frequency of micturition. 2. Encourage her to lean forward when voiding to help empty her bladder. 3. Encourage her to urinate immediately she has the urge.	1. Client was reassured and reminded the frequency of micturition is due to pressure on the bladder. 2 .She leaned forward when voiding. 3. Client urinated immediately when she has the urge.	19/08/23 at 1:00pm	Goal fully met as client verbalizing that the amount of micturition has be reduce.	

		frequent voiding.	4. Educate her on the use of panty liners. 5. Educate client on how to tightening the muscles (kegel exercise) around her vagina and anus.	4. Client used panty liners.\ 5. Client understood what was taught on how to tighten the muscles around the vagina and anus.			

CHAPTER THREE

LABOUR

3.0 INTRODUCTION

This chapter describes the management of labour, the immediate and subsequent care of the newborn and care plans drawn for the management of the problems encountered during the labour.

ADMISSION AND MANAGEMENT OF LABOUR

3.1 ADMISSION OF CLIENT

On the 31st August, 2023 Madam Twumwaa called that she was experiencing lower abdominal Pain which started around 5:00am and also saw 'show' around 7:50am, and thus she was on her Way to the labour ward. She arrived at the facility around 8:20am in the company of her Mother. They were welcomed and offered seats. Her facial expression indicated that she was in pain. Her antenatal card was collected and glanced through quickly. On enquiry, she said she ate banku and okro stew last evening. She complained of lower abdominal pains and was assure that it will stop after delivery. The physiology was explained to her that it was due to contractions of the muscles of the uterus and pressure on the cervix.

Her bed was prepared and she was assisted into a warm comfortable bed. Procedures were explained to her and provided with privacy by closing the door. She was served a bed pan to empty her bladder. Mid-stream urine was taken and tested for glucose and protein which were all negative. The urine passed was 190mls. Vital signs were checked and recorded as follows;

Blood pressure 127/79 millimeters of mercury

Pulse 77 beats per minutes

Respiration 24 cycles per minutes

Temperature 36.6 degrees Celsius

After procedure was explained and permission was sought to conduct physical examination on client, she was helped unto the couch, hands were washed with soap under running water, dried with clean towel. Client was examined from head to toe and no abnormality detected

ABDOMINAL EXAMINATION

On inspection: Client's abdomen was globular in shape, presence of striae gravidarum and linear nigra but there was no previous surgical scar observed.

On palpation: Client's abdomen was palpated and Symphysio-fundal height measured at 38cm With gestational age of 38weeks plus 2days, lie was longitudinal, presentation was cephalic, and Descent was 4/5th palpable abdominally and position was right occipito anterior, fetal heart rate was 149beat per minute, contractions were 2 in 10 lasting between 20 seconds 25 seconds. Also, there was presence of fetal movement.

Client was helped to assume a lithotomy position. Hands were washed and dried and surgical gloves worn. Her vulva was inspected for vaginal war h was touched first to alert her and the middle finger of the dominant hand was inserted into the vagina and the index finger was added to access the dilatation of the cervix.

She was admitted and her information recorded in the admission and discharge book and daily ward state. She was then given orientation to the bathroom, toilet, admission room and delivery room, she was also introduced to other staff to make her familiar with the ward environment.

At 9:30am the cervix and vagina were examined for warmth and softness. On examination, the cervix was well effaced and dilatation was 2cm. The sacral promontory was not reached; ischia spines were blunt and had a wide pubic arch indicating that her pelvis was adequate. Hands were removed following the curve of carus and fist was made between the ischia tuberosity and all four

(4) Knuckles were accommodated around 1pm another vaginal examination was done and dilatation was 4centimeters and membranes were intact. After the procedure, she was cleaned and perineal pad was applied to the vulva. She was educated to change perineal pad when soiled and also wash and dry hands before touching the perineal pad. The gloved hands were inspected and the gloves were removed by inverting them inside out and inspected before disposal in a plastic waste container. Hands were washed and dried with clean towel. She was encouraged to ambulate and lie laterally on her left side when she gets tired. She was made comfortable. Findings were explained to client and was encouraged to ask questions. All findings were recorded on a partograph as; uterine contraction was 2 in 10 minutes lasting above 27 seconds, maternal pulse 75 beats per minutes, fetal heart rate145 beats per minutes with good volume, blood pressure 127/78 millimeters of mercury, temperature 36.6degrees Celsius, urine output was 140mls. Urine was tested for protein and glucose and was all negative, membranes intact and no molding. Descent was 4/5th

Client's mother was reassured and informed that Madam Twumwaa was in true labour. She was assisted to remove items for the delivery

3.2 PREPARATION FOR BIRTH

A helper was identified, both skilled and unskilled helper. The skilled helper was the midwife in Charge of the facility whose duty was to supervise the delivery help in case of resuscitation and the unskilled helper was client's relative (mother). The duty of client relative was to provide emotional support to the client and also to run errands in case client needs food or blood donation. The emergency plan was reviewed.

The delivery room was prepared for delivery; the room was made clean and warm, lights were Switch on, and touch light was also made ready in an event of light off. Hands were washed with

soap and water and dried with clean towel. Delivery set was available waiting to be set at appropriate time. Oxytocin and other emergency drugs like magnesium sulphate and ergometrine were also made available.

Resuscitation area was made ready by switching on the light to keep the place warm if needed, all equipment such as ventilation bag and mask, stethoscope needed to help baby breath were assembled and tested for proper functioning.

MANAGEMENT OF THE FIRST STAGE OF LABOUR

Client was encouraged to lie on the left lateral position because it keeps baby's weight from applying pressure to the large vein (inferior vena cava) that carries blood back to the heart from the feet and legs. She was also encouraged to ambulate to aid fetal head descent and also for contractions to be effective. Subsequently, her pulse, contractions, and fetal heart rate were checked every 30 minutes, temperature and urine output were monitored two hourly, then blood pressure, on vaginal examination, cervical dilatation and fetal head descent done four hourly were recorded on the partograph. The partograph is attached to the write up as an appendix.

She was educated to change her perineal pad frequently and wash hands with soap and water before and after handling the perineal pad to prevent infections. She was educated not to bear down prematurely but do the deep breathing exercise that she was taught whenever she was in pain.

Client was encouraged to adhere to any instructions given during labour as it would help her deliver safely. She still complained of lower abdominal pains and was continuously reassured that it would soon be over. Madam Twumwaa was served yam and kontomire with fish and drank about 500mls of water. She also had a bottle of chilled malt which she was sipping intermittently. Client was rolling on the floor due to pains and was told to stop rolling on the floor to prevent her from getting infections. She was then reassured that the labour would soon be over. Client was complaining of

waist pains, and the sacral region was massaged and she was encouraged that the pain will stop after delivery. Client was noticed inserting her fingers into the vagina and also did not wash her hands after changing the pad. She was educated to always wash her hands and not to insert fingers into the vagina.

Client was noticed to be sweating, a clean dry cloth was used to wipe the sweat off her face and the nearby windows were opened to provide fresh air and was reassured that labour will soon be over.

At 4:00pm uterine contraction was 3 in 10 minutes lasting above 41 seconds, maternal pulse 80 beats per minutes, fetal heart rate140 beats per minutes with good volume, blood pressure 127/80 millimeters of mercury, temperature 36.4 degrees Celsius, urine output was 100mls. Urine was tested for protein and glucose and was all negative. On vaginal examination the cervical dilatation was 8 cm with membranes intact and no moulding. Descent was 1/5th .The delivery trolley was set gradually instrument needed for the delivery was assembled, a cot was prepared for the baby as well as a source of light was made available to assess the baby if needed.

The delivery trolley was cleaned and a sterile delivery pack with other clean items were made available on both top and bottom shelf.

Top shelf contained sterile items as follows

- 2 Artery forceps
- 4 Drapes
- Cord scissors
- Gallipot with sterile cotton wool swabs
- Episiotomy set (artery forceps, dissecting forceps, episiotomy scissors, suturing forceps)
- Cord clamp (removed from cover)

Lower shelf contained

- Chettle forceps and its container
- Identification band
- Baby dress
- Cot sheets
- Injection tray containing oxytocin, vitamin k, syringe and needle
- Fetoscope
- Local anesthesia
- Antiseptic lotion
- Jug for measuring blood loss
- Disposable gloves
- Catheter and drainage bag
- Mackintosh
- Sterile gloves in its pack
- Receiver for used swabs
- Perineal pad
- Toilet roll
- Dettol and soap
- Bowl of water with bulb syringe
- Bedpan
- Clock
- Drum containing sterile gauze

The membranes ruptured spontaneously at 6:00pm, on vaginal examination, and liquor was clear with no cord prolapse, moulding was two plus (++), the cervical os was also fully dilated that is 10 cm and descent was 0/5th with clear liquor confirmed by the midwife in-charge.

The pulse was 95 beats per minute with a temperature of 36.2 degree Celsius, 100 mls of urine Was emptied which read negative to both acetone and protein. Contractions were 4 in 10 minutes lasting above 52 seconds. Foetal heart rate was 141beats per minute. BP 120/80.

The client was also assisted to wash her hands, chest and abdomen with clean water and soap and Dried with clean towel to prepare for skin to skin contact.

The delivery trolley was readily available and the e instrument needed for the delivery was assembled, a cot was already prepared for the baby as well as a source of light was made available to assess the baby if needed.

3.3 MANAGEMENT OF SECOND STAGE OF LABOUR

Madam Twumwaa was transferred from the labour room to the delivery room where she was assisted to position herself in a lithotomy position. A gown, mackintosh apron, masks and boots were worn. After that, hands were washed with soap under running water and they were dried. Sterile gloves were worn. The midwife in-charge who was supervising, checked the foetal heart rate and maternal pulse after each contraction. The vulva, perineum, pubis and the inner thighs of the client were swabbed with gauze soaked in savlon solution and client was draped with a clean towel. A clean perineal pad was applied over the anus to prevent faecal matter from contaminating the delivery field. Client was encouraged to push with just contraction to prevent exhaustion and rest in between contractions. Client was given oral fluid and reassurance and encouragement during each contraction was provided. Her perineum was shiny and over stretched, so she was told to follow the instructions so that tears would be prevented. Fingers of the right hand were placed

on the advancing head to aid flexion in order to allow the smallest diameter to distend the perineum. Descent of the foetal head continued till it crowned. As soon as the baby's head crowned, she was asked to pant and give only small pushes with contraction to prevent rapid expulsion of the foetal head which could result in perineal tears and intra cranial injury. The sinciput, face and chin swept, the perineum and the head was delivered by extension. The mouth and nose were gently cleaned with sterile gauze. The eyes were wiped with sterile cotton wool swab from the inside out as well as the face. The neck was quickly felt for cord around it. The mother was reminded that the baby would be delivered unto her abdomen whiles waiting for restitution and external rotation of the foetal head. This was accompanied by internal rotation of the shoulders. With palm on each side of the baby's head, client was asked to push with the next contractions. The anterior shoulder was delivered by downwards traction on the head and the posterior shoulder swept the perineum to be delivered. The rest of the body was delivered by lateral flexion unto the mother's abdomen at 6:40pm, baby cried lustly immediately after birth.

3.4 IMMEDIATE CARE OF THE BABY

This commenced as soon as the head of the baby was delivered. The eyes were cleaned with a sterile swab from the inner canthus out. The mouth and nose were also cleaned with sterile gauze to enhance patent airway. The umbilical cord was clamped about 2 centimetres away The baby was dried and placed on the mother's abdomen to continue skin to skin and both were covered with a warm cot sheet to maintain warmth and prevent hypothermia .The baby's Apgar score was assessed at the first and fifth minutes were 8/10 and 9/10 respectively.

APGAR SCORE

TIME	COLOUR	BREATH	HEART	TONE	REFLEX	TOTAL

1st MINUTE	2	2	2	1	1	8/10
5th MINUTE	2	2	2	2	1	9/10

3.5 MANAGEMENT OF THIRD STAGE OF LABOUR

Client still in the lithotomy position, the clamped and cut end of the cord was placed in a receiver in between the thighs nearer to the perineum to receive the placenta, membranes and blood loss after putting on a new sterile gloves. Cord was reclamped closer to the perineum and the cord with the artery forceps were held with the right hand. The left hand was placed on the fundus to check for contractions. With contractions, the hand was repositioned just above the symphysis pubis with the palm facing the woman's umbilicus. The uterus was pushed in an upward direction to serve as counter traction to prevent inversion of the uterus. The cord and the forceps were also held firmly at the same time and a downward steady traction was applied. The steady traction on the cord and the counter traction on the uterus was maintained until the placenta became visible at the vulva. The placenta was cupped by both hands and twisted gently to reduce pressure on the fragile membranes. The placenta and membranes were delivered completely at 1:30am.A quick examination of the placenta was done to make sure that there were no retained products. The placenta was placed in a receiver for a thorough examination to be done later. The uterus was massaged to expel clots the perineum was cleaned and gauze was used to wrap two fingers of each hand to inspect the vagina and cervix but no tear or lacerations were detected. Client was taught how to massage the uterus and was asked to feel for the contracted uterus. She was educated to

change the pad when soiled, urinate frequently and report immediately when there is excessive bleeding. Madam Twumwaa was cleaned off the liquor and blood with a clean pad after the examination. A new perineal pad was applied at the vulva and she was made comfortable. She was asked to cross her legs to keep the perineal pad in position. Client was monitored at the second stage room for an hour before transferring to the lying-in. During that time baby was put to breast to improve lactation and to help in contraction of the uterus and also to improve bonding between mother and baby.

3.6 EXAMINATION OF THE PLACENTA AND MEMBRANES

The placenta was sent to the sluice room for thorough examination. The cord was situated at the middle of the placenta with two arteries and a big vein in the cord with no knot. The maternal surface of the placenta was intact with no missing lobe and was also checked for infarcts and it was dark maroon in colour. The membranes were examined for any blood vessels, and both the chorion and the amnion were separated to check whether they were intact and they were. The foetal surface was shiny grey in colour and translucent, intact with no abnormality. Blood clots from the maternal surface were added to the blood loss. Blood loss measured was 150 millilitres. After the examination the instruments were decontaminated in 0.5% chlorine solution for 10 minutes. The instruments were removed, washed, rinsed, dried and made ready for sterilization.

She was asked to urinate when she had the urge for the uterus to contract and was told that if she should feel any changes, she should not hesitate to report. She expressed gratitude for the patience and care and she was in turn thanked for her cooperation.

3.7 PREVENTION OF DISEASES

Cord was dressed with Chlorhexidine gel. Injection 1mg of vitamin K was given intramuscularly to prevent bleeding disorders. Tetracycline Hydrochloride 1% ointment was applied on each eye to prevent eye infections. Hands were washed under running water with soap and dried with a clean towel. Mother was also given vitamin A and was educated to wash her hands before and after breastfeeding the baby. She was further encouraged to breastfeed baby on demands at least (8-12 times per day).

3.8 EXAMINATION OF THE NEW BORN

The procedure was explained to Madam Twumwaa then hands were washed with soap and water and dried with a clean towel. Disposable gloves were put on and the baby was examined in the presence of the mother in a clean, warm environment, where nearby windows were closed. Baby was put on a covered flat surface and only the part to be examined was exposed. The general condition of baby was checked to be normal. A detailed head to toe examination was carried out to detect any abnormality. The head was examined for bulging fontanelles, size and shape, oedematous swelling that is caput succedaneum and lacerations, but no abnormality was detected. Head circumference was measured by encircling the head with a tape measure from the occipital protuberance to the supra-orbital ridges and it measured 32cm. The ear was examined for alignment, shape, size and patency and the cartilage in the pinna was checked for its softness. Eyes were also examined for colour, redness and conjunctiva haemorrhage but no abnormality was found.

The nose was inspected for size and shape and examined for deviated septum but the septum was normal. The nostrils were inspected for patency and discharges and the mucosa for colour and polyps. For the mouth, the little finger was used to feel the palate for any submucosa cleft then the gum was checked for presence of false teeth and the tongue for tongue tie and no cleft lip was observed. No abnormalities were detected. Sucking, rooting and swallowing reflexes were checked and found present.

The neck was examined for congenital goiter, swelling, growth and rigidity of the neck but no abnormality was present. The chest was inspected for shape and the chest wall for movement and expansion. Breasts were palpated for lumps and the nipple was checked for position and witches' milk and everything was normal. Apex beat was present (132 bpm).

Examination of the upper extremities was done and the hands were inspected for clubbing, extra or missing digits, nails over growth and webbing. Hands and arms were inspected for symmetry, movement and paralysis, and the palm for the number of palmer creases. Shape and colour of nail beds were inspected and reflexes (grasping, moro) checked. Everything was normal. The abdomen was inspected and the size and shape was normal. The cord was inspected for bleeding and signs of infection and two arteries and a vein were found. The liver, spleen, and bladder were not palpable, no tenderness and masses but no abnormality was detected.

The genitalia was examined, and they were well developed thus the vulva and the urethral meatus for location, and they were all in their rightful position. The anus was patent on palpation, while the baby also passed meconium and urine. With the lower limbs, the legs and feet were inspected for extra digits, webbing, symmetry, movement, clubbed feet, paralysis, but no abnormality was found. The hip had no dislocation and the reflexes (knee jerk/patella, plantar) were present. The baby was turned on his back with the head turned on one side and the spine was checked for

swelling, dimples or hairy patches (spinal bifida), and for missing vertebra, meningomyelocele, but no abnormalities were detected. On examination of the skin, there was no abnormality found. The gloves were removed and disposed off, hands were washed and dried with clean dry towel. Findings were then communicated to the mother and documented as well.

3.9 MANAGEMENT OF THE MOTHER AND BABY

Madam Twumwaa and her baby were transferred into the lying-in room, made comfortable and also congratulated for her co-operation. Uterus was felt if contracted. The uterus measured 17cm and her vital signs together with bleeding were monitored every 15 minutes for 2 hours, 30 minutes for 1 hour, 1 hourly till the end of the 6 hours. The baby's condition was checked alongside with monitoring of the mother. There was no bleeding from the cord and no other abnormality was detected. The first post-delivery vital signs were checked and recorded as follows; and the rest recorded on the partograph. Temperature 36.3 degree Celsius, Pulse 81 beats per minute,Respiration 22 cycles per minute,Blood pressure 120/80 millimeters per mercury. She was advised to empty the bladder frequently to prevent postpartum complications such as postpartum haemorrhage. She was educated on personal hygiene and exclusive breastfeeding.

3.10 CONDITION OF MOTHER

Blood pressure - 120/70 millimeters per mercury

Fundal height - 17 centimeters

Uterus - Contracted

Lochia - Red (rubra)

Urine output - 100mls

Mother's condition was good.

3.11 CONDITION OF BABY

Sex	-	Female
Birth weight	-	2.9 kilograms
Length of the baby	-	48centimeters
Head circumference	-	34 centimeters
Apgar Score		
First minute score	-	8/10
Fifth minute score	-	9/10
Meconium	-	Passed
Urine	-	Passed

Baby's condition was very good.

3.12 DURATION OF LABOUR

Duration of first stage	-	5hours 47mins
Duration of second stage	-	30minutes
Duration of third stage	-	6minutes
Total duration of labour	-	6 hours 10 minutes

3.13 NURSING CARE PLAN ON LABOUR

PROBLEMS IDENTIFIED

1. Lower abdominal pain
2. Anxiety

3. Fatigue

4. Possible perineal trauma

5. Waist pain.

SHORT TERM OBJECTIVES

1. Client will cope with lower abdominal pain within 2 hour and released after delivery.
2. Client will be relieved of anxiety within 30minutes after labour.
3. Client's fatigue will resolve within 30minutes after labour.
4. Client will have intact perineum at the end of the deliveries

LONG TERM OBJECTIVE

Client will go through labor and Puerperium successfully and deliver an alive baby without complications to both mother and baby.

NURSING CARE PLAN ON LABOUR

DATE /TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE /TIME	EVALUATION	SIGN
31/08/23 At 8:10pm	Lower abdominal pain related to strong expulsive uterine contractionn	Client will cope with lower abdominal pain within 2 hours after delivery as evidenced by Client verbalizing she is coping with the pain.	1. Reassure Madam Twumwaa and explain physiology to her. 2. Provide diversional therapy. 3. Encourage client to adopt a comfortable position. 4. Encourage and supervise client to practice deep breathing exercise during uterine contraction. 5. Give Madam Twumwaa a sacral massage to relieve pain.	1. Madam Twumwaa was reassured and told that it is due to the uterine contractions. 2. Client was engaged in conversation during labor. 3. Client adopted a comfortable position like lying in a left lateral position to reduce pain. 4. Deep breathing exercises were performed. 5. Sacral massage was given to Madam Twumwaa when there were contractions.	31/08/23 at 10:00am	Goal fully met as client verbalizing that pain is relieved.	

NURSING CARE PLAN ON LABOUR

DATE /TIME	NURSING DIAGNOSIS	NURSING OBJECTIVE/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE /TIME	EVALUATION	SIGN
31/08/23 at 8:30pm	Anxiety related to unknown outcome of labour.	Client will be relieved of anxiety within 30minutes as evidenced by client verbalizing that she is no more anxious of the outcome of labour Midwife observing calm	1. Reassure client that she is in the hands of competent staff. 2. Explain the physiology of the stages of labor to client. 3. Allow client to ask questions and answer them	1. Client was reassured that she was in the hands of competent staff so labour will be successful without any complications. 2. The physiology of the stages of labour was explained to client in simple terms. 3. Client asked questions and appropriate answers were given. 4. Findings were communicated to client about the progress of labour	31/08/23 at 9:00pm	Goal fully met as client expressed a relaxed face and verbalized that she is relieved.	

			tactfully.				
		tone in client's speech.	4. Communicate findings to client. 5.Introduce client to other staffs	such as cervical dilatation and descent. 5. Client was introduced to other staffs.			

NURSING CARE PLAN ON LABOUR

DATE /TIME	NURSING DIAGNOSIS	NURSING OBJECTIVE/OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE /TIME	EVALUATION	SIGN

31/08/23 at 8:30am	Waist pain related to descent of the fetal head.	Client will be to cope with waist pain within 30minutes after delivery as evidenced by client verbalizing that she no longer has waist pain. Midwife observing client coping with waist pains.	1. Reassure client that she would be relieved of waist pain. 2. Encourage client not to sit for a very long period. 3. Give sacral massage to relieve her of pain. 4. Explain the physiology of waist pain to client. 5. Encourage deep breathing exercise along contraction.	1. Client was reassured that she would be relieved of waist pain. 2. Client sit for short period and walked around. 3. Sacral massage was given to client to relieve her of pain. 4. Client was enlightened the waist pain is due to pressure on the sacral nerves and give of the pelvis. 5. Madam Twumwaa was assisted to perfom deep breathing exercises.	02/09/23 at 9:00am	Goal fully met as client verbalizing that she is relieved from her waist pain.	

NURSING CARE PLAN ON LABOUR

DATE /TIME	**NURSING DIAGNOSIS**	**NURSING OBJECTIVE/OUTCOME CRITERIA**	**NURSING ORDERS**	**NURSING INTERVENTION**	**DATE /TIME**	**EVALUATION**	**SIGN**

31/08/23 at 8:30am	Fatigue related to pain and stress of labor.	Client tiredness will resolve within 30minutes after labour as evidence by: Client verbalizing that she feels less tired.	1. Reassure client that she would be relieved of fatigue. 2. Encourage client to rest in between uterine contractions. 3. Explain to her why she feels tired and be sure she understands and allow her to ask questions and answer them tactfully.	1. Client was reassured that she would be relieved of fatigue. 2. Client was seen resting in between uterine contractions to prevent further exhaustion. 3. Education on fatigue was given to client and she knew it was normal for her to be tired during labor. 4. Client was seen practicing deep breathing exercise.	02/09/23 at 9:00am	Goal fully met as evidence by Madam Twumwaa verbalizing that she feels no tired.	

			4. Encourage client to practiced deep breathing exercise. 5. Hydrate Client orally.	5. Oral fluid (water) was given to client to hydrate her.			

NURSING CARE PLAN ON LABOUR

DATE /TIME	NURSING DIAGNOSIS	NURSING OBJECTIVE/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE /TIME	EVALUATION	SIGN
31/08/23 at 8:30am	Potential for perinea trauma (over stretched and shiny perineum) related to delivery process.	Client will have an intact perineum at the end of delivery as evidence by midwife observing an intact perineum.	1. Reassure client that she would have an intact perineum after delivery. 2. Confirm full dilatation of cervix before instructing client to push. 3. Deliver client skillfully following the mechanisms labour.	1. Client was reassured that she would have an intact perineum after the delivery. 2. Cervix was confirmed fully dilated before client was instructed to push in other to prevent any perineal tears. 3. Flexion was maintained until head crowned. Also client was asked to pant for head to be delivered slowly.	31/08/23 at 1:30pm	Goal fully as midwife observed an intact perineum after delivery.	

			4. Instruct client on when to push and when to relax. 5. Encourage client to adhere to all instructions given.	4. Client pushed when she has the urge and relaxed in between contractions in other not to sustain tears. 5. Client was encouraged to adhere to instructions given.			

CHAPTER FOUR

PUERPERIUM

4.0 INTRODUCTION

This chapter consists of the care given to the mother and the baby from the day of delivery till the second postnatal visit (six weeks postpartum).

4.1 DAY OF DELIVERY

Madam Twumwaa came to Constance Maternity Clinic labour wad around 5:40pm on the 31st August 2023. She had a supervised vaginal delivery around 6:40am to a baby girl with Apgar score 8/10, 9/10 within the first and fifth minutes respectively. 10units of oxytocin was injected intramuscularly on her thigh after delivery of the baby. Placenta and membranes were completely deliverd by control cord traction around 1:30am. Estimated blood loss was 150mls.

She was made comfortable in bed with her baby and was allowed to rest in the labour ward for about an hour for observation. She was later sent to the fourth stage room and made comfortable for six hours with close observation and monitoring. Breastfeeding was initiated. The mother's vital signs, contraction of the uterus and lochia were monitored every 15minutes for the first hour, 30 minutes for the next two hours and hourly for the next three hours.

Physical examination was carried out on the mother to rule out any abnormality. The purpose of head to toe examination was explained to her. She agreed and Madam Twumwaa was examined from head to toe and no abnormality was detected. Client was taught to do postnatal exercises such as the Kegel's exercise and encouraged to ambulate early to prevent thrombosis formation and

severe abdominal pains and also to empty her bladder frequently, change her perineal pad frequently and must wash her hands after changing each pad and report quickly in case of heavy bledding. She was served with a warm milo and observatons continued. The symphysio fundal height was measured to be 18 centimeters. Temperature 36.4ºC, Pulse rate 80bpm , Respiratory rate 20cpm, Blood pressure 120/70mmHg.

Baby was examined from head to toe and no abnormality was detected. The skin colour was pink, respiorations were normal and baby could suckle and there was no bleeding from the cord. The baby was then given vitamin k 1mg intramuscular injection to prevent any bleeding tendencies. Madam Twumwaa was encouraged to eat good, nutritious and balanced diet, adequate intake of fluids, more fruits and roughages to enhance bowel movement and to help repair all worn out tissues. She was again encouraged to rest and sleep and exercise especially the abdominal and kegel. She was then informed of possible discharge the following day which was on 1st September, 2023

SUBSEQUENT CARE OF THE BABY

4.2 EXAMINATION OF THE BABY

A detailed head to toe examination was carried out to detect any abnormality. The head was examined for bulging fontanelles, size and shape, oedematous swelling that is caput succedaneum and lacerations, but no abnormality was detected. Head circumference was measured by encircling the head with a tape measure from the occipital protuberance to the supra-orbital ridges and it measured 34cm.

The ear was examined for alignment, shape, size and patency and the cartilage in the pinna was checked for its softness. Eyes were also examined for colour, redness and conjunctiva haemorrhage but no abnormality was found.

The nose was inspected for size and shape and examined for deviated septum but the septum was normal. The nostrils were inspected for patency and and congestion and the mucosa for colour and polyps and they were all normal. For the mouth, the little finger was used to feel the palate for any submucousa cleft then the gum was checked for presence of false teeth and the tongue for tongue tie and no cleft lip was observed. No abnormalities were detected. Sucking, rooting and swallowing reflexes were checked and found present. The neck was examined for congenital goiter, swelling, growth and rigidity of the neck but no abnormality was present. The chest was inspected for shape and the chest wall for movement and expansion. Breasts were palpated for lumps and the nipple was checked for position and witches' milk and everything was normal. Apex beat was present 132 bpm.

Examination of the upper extremities was done and the fingers were inspected for clubbing, extra or missing digits, nails over growth and webbing. Hands and arms were inspected for symmetry, movement and paralysis, and the palm for the number of palmer creases. Shape and colour of nail beds were inspected and reflexes (grasping, moro) checked. Everything was normal. The abdomen was inspected and the size and shape was normal. The cord was inspected for bleeding and signs of infection and two arteries and a vein were found. The liver, spleen, and bladder were not palpable, no tenderness and masses but no abnormality was detected.

The genitalia was examined, and they were well developed thus the vulva and the urethral meatus for location, and they were all in their rightful position. The anus was patent on palpation, while the baby also passed meconium and urine. With the lower limbs, the legs and feet were inspected

for extra digits, webbing, symmetry, movement, clubbed feet, paralysis, but no abnormality was found. The hip had no dislocation and the reflexes (knee jerk/patella, plantar) were present. The baby was turned on his back with the head turned on one side and the spine was checked for swelling, dimples or hairy patches (spinal bifida), and for missing vertebra, meningomyelocele, but no abnormalities were detected. On examination of the skin, there was no abnormality found. Baby's vital signs were checked and the findings were communicated to the mother and documented as follows:Head circumference 34 centimeters,Length 48 centimeters,Weight 3.2kilograms,Apex beat 140 beats per minute,Temperature 36.0 degree Celsius,Respiration 40 cycles per minute.

4.3 BABY'S FIRST BATH

Baby had her first bath after 6 hours of birth. Mother was informed that baby was going to be bathed so should come and observe so that she could do same after discharge. Items to be used for the procedure were assembled. y's diaper, baby's dress, baby's towel and cot sheet to wrap the baby, baby's sponge, baby's oil or **Top shelf contained**; Sterile cotton wool swabs and gauze in a gallipot,Sterile water in a gallipot, baby's Vaseline, baby's soap in a soap dish**. Lower shelf contained**; disposable gloves, methylated spirit, jug of hot water, jug of cold water, a bowl for mixing water , kidney dish for used gauze and swab, a receptacle for used water, mackintosh apron. A clean dry cot sheet, Chlohexidine gel for cord dressin, 2 basins for the water and a jug.

Baby was kept on a safe place while the water for the bathing was mixed and the temperature was tested using the elbow. Plastic apron was put on, hands were washed and a sterile gloves worn. Baby was placed on a flat surface, the cot sheet was opened and baby was undressed and upon a

quick glance, baby had no abnormalities. The eyes were cleaned with sterile cotton wool swabs soaked with normal saline from the inner canthus outwards. The face was cleaned with wet towel and dried. While supporting the nape of the neck, the ears were plunged with the thumb and index finger to prevent water from entering the ears. The head was then washed with a mild soap and water. The hair was rinsed and dried with a clean towel. The rest of the body was washed with soapy sponge and water, paying attention to the skin folds of the armpit, groin and buttocks. Baby's back was washed by supporting the chest with the arm. The baby passed meconium and urine indicating that urethra and anus were patent. The baby was then immersed into a basin of water with head above water level and thoroughly rinsed. She was then placed on a big towel and dried with a small towel paying attention to the skin folds. Baby oil was smeared on the body and vaseline on the hair and combed. She was then dressed and wrapped in a dry cot sheet but the cord was exposed. Baby's cord was dressed using chlohexidine gel and exposed for some time for it to dry.

Madam Twumwaa was also taught good position and attachment of the baby to breast. After that baby was placed beside the mother to breastfeed. The mother was educated not to apply cow dung and other items on the cord with the exception of chlohexidine gel that will be given to her.

4.4 FIRST DAY POST DELIVERY (DAY OF DISCHARGE)

The first day post-natal was 1st September, 2023. Mother and baby were seen in the lying- in ward at 7:30am to find out how they were doing. Greetings were exchanged and Madam Twumwaa was asked about how they were doing and she said they were both doing very well, except that she had lower abdominal pains (after pains) while breast feeding the baby. She was reassured and educated on the physiology of the after pain that is a normal physiology thus the suckling of the baby triggers

the release of oxytocin which causes uterine contractions and therefore causes lower abdominal pains. She was given paracetamol 1g to reduce the pain. Madam Twumwaa also complained of less sleep because the baby cried a lot during that night. She was advised to attend to the baby whenever she cries in the night and have enough sleep when the baby is asleep. She was urged to change baby's diapers when soiled. She had already emptied her bladder so a puerperal assessment was then made on her. The hair was inspected for dandruff and lice, conjunctiva was inspected for sign of anaemia and jaundice but they were all absent. The breasts were lactating slightly. The uterus had contracted and the symphysio fundal height measured 18cm. The perinea pad was inspected and the Lochia was red (rubra), with moderate flow and there was no offensive smell. She was given capsules vitamin A 200,000IU to take and another one for the next day.

Madam Twumwaa's vital signs were checked and recorded as follows; Temperature 36.5 degree Celsius, Pulse82beat per minute, Respiration 22 cycles per minute, Blood Pressure 120/70 millimeters per mercury. Baby's vital signs Temperature 37.1 degree celcsius, Apex beat 130bpm, Respiration 40cpm, weight 3.15kg. Mother was educated not to apply hot compress on baby's head with the intention of closing the fontanels, it was explained to her that the fontanels closes naturally. Baby's cord was dressed with chlorhexidine gel.

The baby was given Bacilli Calmette Guerin (BCG) 0.05ml intradremal on the right upper arm for protection against tuberculosis and two drops of oral Polio vaccine against polimyelitis. The mother was asked not to rub the injection site. She was told that there could be a tissue reaction over the area, a scar formation later indicating that the child had been immunized against tuberculosis effectively. The opportunity was taken to prepare them towards discharge in the presence of her relatives and her haemoglobin checked to be 12.1g/dl. Madam Twumwaa and family were encouraged to come back to the hospital for the 7^{th} day postnatal for assessment to

ensure no abnormality has risen within this period. They were also told to report to the facility quickly if they notice any abnormality with the baby or the mother. Client was also told to register the baby at the birth and death unit and complete all the immunization schedules at the Child

Welfare Clinic. Routine drugs were collected and served. The client was on the National Health Insurance Scheme so no bills were settled.

She was assisted by her sister, to pack her belongings. Prescribed drugs were given to her for the subsequent days as below;

Tablet paracetamol - 1g tds for 3/7

Tablet folic acid - 5mg daily for 7/7

Tablet Multivitamin - 200mg tds for 7/7

Capsules vitamin A - 200,000 IU for the next day

The dosage and time for taking the drugs were explained to her and she was educated to take them as ordered. Madam Twumwaa was also told that she would be visited for one week to check on her condition and that of the baby and continued with their care. She was discharged home at 11:00am and was escorted with her items into a car brought in by her husband. They were reminded of the visit to their house and bid them farewell.

4.5 FIRST DAY POST NATAL HOME VISIT (On the 2nd SEPTEMBER, 2023)

Madam Twumwaa was visited in her house in the morning at 5:30am as scheduled. On arrival, greetings were exchanged with a warm welcome. She was neatly dressed and had already set the place for the baby to be bathed; the baby was then toped and tailed. The vital signs of the baby was

checked and then she was bathed and dressed nicely. The cord was dressed with the chlohexidine gel.

Madam Twumwaa was also examined from head to toe and there were no abnormal changes but she complained of back pain. The fundal height measured 16cm. The perineum was inspected and was found to be cleaned, lochia was red (rubra) with moderate amount of flow. Her vital signs were taken and recorded as; Temperature 36.2 degree Celsius, Pulse 78beat per minutes, Respiration 21cycle per minutes, Blood pressure 110/70mmHg.

Baby was not pale and was able to suckle well. Baby's vital signs were taken and recorded as follows; Temperature 36.5 degree Celsius, Pulse 120 beats per minute, Respiration 44 cycles per minute, weight 3.15kilograms. Madam Twumwaa was encouraged to exclusively breastfeed the baby on demands and observe baby's crying and sleeping pattern and change in stool. She was also advised to keep the baby warm and dry always. She was assured to be visited in the evening. Mother and baby were seen in their house looking healthy. Greetings were exchanged where they offered a seat and enquiries were made about their wellbeing and mother said they were doing well. Permission was sought from the mother in order to examine her and the baby. Hands were washed and the mother was examined from head to toe and everything was normal. Baby was also examined from head to toe and no abnormality was found. Vital signs for both mother and baby were taken and recorded as below; Temperature was 36.8celcius, pulse was 80bpm, respiration was 21cpm, blood pressure was 110/70mmHg and Fundal height was 16cm. Baby's vital signs were checked and recorded as follows; Temperature was 36.0, pulse was 137bpm, respiration was 36cpm and weight was 3.15kg.

4.6 SECOND DAY POSTATAL HOME VISIT

On the 2nd September, 2023 around 6:20am, Madam Twumwaa was visited as promised the previous day. Greetings were exchanged and a seat was offered. Enquiries were made about their general condition and she said they were doing well but client complained of pain on both breast. The procedure of head to toe examination was explained to her, permission was sought and she was examined head to toe. During the examination the breast was observed to be heavy and engorged which she admitted that it was painful and has caused her headache. She was told that it was as a result of improper attachment and incomplete emptying of the breast. She was encouraged to always wake the baby up to feed her and also proper positioning of the baby to breast allowing her to empty one breast at a time before changing to another breast.

Fundal height was measured and recorded as 14cm above the symphysis pubis. Perineal pad was inspected and lochia and was red with no offensive smell and with a moderate flow. Her vital signs were checked and the findings were communicated to her and was recorded as; Temperature 36.5^{o}c, pulse 81bpm, respiration 21cpm, blood pressure 120/70mmHg. Hands were washed and the baby was examined from head to toe and no abnormality was detected. Client's perrmission was sought to top and tail the baby and permission was granted. The mother was asked to observe the procedure so as to be able to do it her herslf afterwards. Baby was topped and tailed and the cord was dressed with the Chorhexidine gel and the cord was exposed to dry. The baby passed urine and a drak green stool. Her vital signs were checked and recorderd as follows;Temperature 36.5^{o}c,respiration 41cpm,weight 3.1kg,pulse 132bpm. Madam Twumwaa was encouraged to do postnatal exercises, eat a well-balanced diet and have enough sleep and rest. She was also encouraged to practice exclusive breastfeeding which if properly done can be used as a family

planning method (LAM). She was encouraged to ask any questions if she has but she said no. Enquiry was made about the previous complains and she said she was doing fine. Her sister and the husband were asked to help client in her activities and also in the care of the baby. Permission was sought to leave and promised to come back in the evening was made.

At 6:20am, client was visited. On arrival, she was breastfeeding the baby and had assume a good posture with the baby properly attached to the breast. Lactation was well established and she was congratulated as it will help reduce breast engorgement. Client's home environment was noticed to be neat and she was congratulated for the good work done. She was examined and her perineal pad was inpsected for the lochia and the flow was moderate and it was still rubra. Her vital signs were checked and recorded as; Temperature 36.8^{O}C, Pulse 80bpm, respiration 21cpm, blood perssure 110/70mmHg. The baby's vital signs were checked and recorded as Temperature 37.0, respiration 40cpm pulsee 129bpm. She was top and tailed and the cord was dressed and exposed to dry. The cord was dried and non-offensive on inspection. Madam Twumwaa was educated to eat adequate diet to help in the production of breast milk and also to enable her recover quickly from stress of pregnancy and labour. She was encouraged to take enough water to avoid constipation. Enquiries were made about the previous complains and she said she was doing better.

Permission was sought to leave.

4.7 THIRD DAY POSTNATAL HOME VISIT

On the 3rd of September, 2023 a third day post-delivery visit was made to Madam Twumwaa's house at 7:30am in the morning. Mother and baby were doing well. Permission was sought to inspect Madam Twumwaa's perineal pad and the lochia was red (rubra) without any offensive

smell. Head to toe examination was also done and everything was normal. Breasts were heavy and breast milk was flowing freely. Mother was encouraged to breastfeed the baby frequently to prevent the breast from engorging and also attach the baby well to the breast to prevent cracks in order to prevent sore nipples and infection of the breast. Symphysio fundal height was measured 12cm. The baby was top and tailed, assessed and general condition was good and no abnormality was present. The cord was neatly dressed and was dry without bad any odour. The baby also passed brownish yellow stools and she passed urine as well. Mother and baby's vital signs were checked and recorded as Temperature 36.6^{o}C, pulse 80bpm, respiration 20cpm, blood pressure 120/60mmHg. Baby vitals were Temperature 36.9^{0}C, pulse 137bpm, respiration 46cpm, weight 3.05kg

At 7:30pm, both mother and baby were visited. Nothing abnormal was detected during the examination. Madam Twumwaa complained of interrupted sleeping pattern because baby normally cries at night. She was reassured and encouraged to breastfeed baby well before bed time and to change the baby's soiled napkins. She was reminded on exclusive breastfeeding and feeding on demand, maintenance of personal hygiene, eating of fruits and highly nutritious diet and warm sit baths. Husband was encouraged to care for the baby at night so that mother could have adequate sleep. Mother and baby's vital signs were checked and recorded as Temperature 36.9^{0}C, pulse 82bpm, respiration 22cpm and blood pressure 110/70mmHg. Baby vitals were temperature 37.5^{o}c, pulse 137bpm, and respiration 42 cpm. Permission was sought to leave and Madam Twumwaa was very grateful and appreciated the care that was given to them very much.

4.8 FOURTH DAY POSTNATAL HOME VISIT

Madam Twumwaa and her baby were visited again on the 4th September, 2023 in the morning at 7:30am to continue with the postnatal care. They were physically examined and nothing abnormal was detected. Lochia was pink (serosa) on inspection, with no odour and breasts were lactating. Head to toe examination was done and everything was normal. Symphysio fundal height measured 10cm. Baby had been bathed already on arrival, so the general examination commenced. No abnormality was found. The cord was neatly dressed and had shrinked with no evidence of infection. The baby passed urine and dark yellow stools. Mother and baby's vital signs were checked and recorded as follows Blood pressure 120/70mmHg, Temperature 36.7^0C, Pulse 80bpm, respiration 21cpm. Baby vitals were Temperature 36.8^0C, pulse 133bpm, respiration 43cpm and weight was 3.0kg. After the assessment everything was found normal. Permission was sought to leave and Madam Patricia granted the permission to leave in the absence of question. She was very overwhelmed with the numerous visits. She was thanked for her co-operation as always. Mother and baby were visited again in the evening and they were all doing good. Mother was doing better on inspection and her vital signs were found within the normal range as well. Upon the assessment of the baby it was observed that there was some heat rashes over the baby's body, which was as a result of warm room temperature, client was advised to ensure enough ventilation by opening windows, dress baby with light clothes and always keep baby dry as much as possible. Madam Twumwaa vitals were Temperature 36.4^oC pulse 85bpm, respiration 20cpm, blood pressure 120/70mmHg. Baby vitals were temperature 36.5oC, pulse 135bpm, and respiration 47 cpm. Permission was sought to leave and client was very grateful and appreciated the care that was given to them very much.

4.9 FIFTH DAY POSTNATAL HOME VISIT

The fifth day postnatal home visit was on 5th September, 2023. at 7:30am to continue with the post-natal care. Hands were washed and dried and the baby was examined after seeking mother's permission. No abnormality was detected on examination. The heat rashes on the baby were sloughing off. The baby was then bathed and neatly dressed. The cord had fallen off during the night as said by the mother. The umbilicus was inspected for bleeding or any abnormality but none was found. The stump of the umbilicus was dressed with the chlorhexidine gel and it was kept dry. With an advice from the midwife in charge dusting powder was applied on the baby's skin. Client and her family were reminded about the termination of care on the seventh day and ther was sadness written on their faces butbthey were assured that it is the official termination but they would be visited from time until the clinical period is over.

Mother and baby's vital signs were checked and recorded as follows respectively: Temperature 36.6^{O}C, Pulse 80bpm, Respiration 20cpm, Blood Pressure 120/70mmHg,Funda height 8cm.Baby vitals were Temperature 36.9^{O}c,Pulse 133bpm,Respiration 49cpm and Weight 3.0kg. Madam Patricia was reminded of the next visit and she said she was very grateful so the opportunity was taken to leave.

4.10 SIXTH DAY POSTNATAL HOME VISIT

The sixth day postnatal home visit was made on the 6th of September, 2023 at 7:30am. A warm welcome was given and a seat was offered. Enquiry was made about the wellbeing of the mother and the baby and they were all doing good. Permission was asked to examine both mother and the baby. Hands were washed and dried and the examination of the mother commenced and no

abnormality was detected. On abdominal examination the fundal height was 6cm; perineal pad was pinkish on inspection, she was congratulated on good perineal care.

Her vital signs were monitored as: Temperature 36.4oc, Pulse 78bpm, Respiration 19cpm

Blood pressure 120/80 mmHg .Head to toe examination was done and no abnormality was found. During the examination, it was realized that the cord had fallen off. The skin rashes had dried off completely. Baby's vital signs were checked. Baby was then bathed. Vital signs are as follows; Temperature 36.5 celcius, Apex heart beat 128bpm. Respiration 48cycle per minute and weight 3.05kg. Client was reminded about the termination of care on the seventh day and also about the birth registration of the baby. It was explained to her the need to complete all immunizations on the baby. Permission was sought to leave.

4.11 SEVENTH DAY POSTNATAL HOME VISIT

The sixth day postnatal home visit was made on the 7th of September 2023 at 7:30am. A warm welcome was given and a seat was offered. Enquiry was made about the wellbeing of the mother and the baby and they were all doing good. Permission was asked to examine both mother and the baby. Hands were washed and dried and the examination of the mother commenced and no abnormality was detected. On abdominal examination the fundal height was 4cm;perineal pad was pinkish on inspection, she was congratulated on good perineal care. Her vital signs were monitored as:Temperature 36.5^{o}c ,Pulse 78bpm ,Respiration 19cpmBlood pressure 120/80 mmHg and Fundal height 4cm.

Head to toe examination was done and no abnormality was found. During the examination, it was realized that the cord had fallen off. The skin rashes had dried off completely. Baby's vital signs were checked. Baby was then bathed. Vital signs are as follows;Temperature 36.9^{o}c

Apex heart beat 128bpm ,Respiration 50cpm and weight 3.1 kg. It was explained to her the need to complete all immunizations on the baby. Permission was sought to leave.

4.11 SEVENTH DAY POSTNATAL (FIRST POSTNATAL VISIT TO THE CLINIC)

Madam Twumwaa and her baby together with her husband reported at the hospital on 7th September, 2023 accompanied by her husband. Mother and baby looked healthy and cheerful. They were welcomed to the postnatal site and a seat was offered to them to listen to a health talk on immunization against the preventable childhood disease, exclusive breastfeeding and family planning.

After the talk client and baby were taken to the examination room to be examined. Procedure was explained to the mother. With permission from mother head to toe examination of the baby was done, she was undressed and wrapped in a clean cot sheet and was put on a flat surface in the presence of the mother. Hands were washed and dried. The fontanels and sutures were examined for any bulging fontanels or widening sutures but there were none. The eyes, nose and ears were examined and no abnormalities were detected. Baby had no rushes or bruises on the skin. The abdomen was soft, not distended, and the umbilical stump was completely healed. The extremities and the back were also examined and there were no abnormalities.

Baby's weight was 3.1kg and her vital signs checked and recorded as follows: Temperature 37.0°C, Pulse rate 142bpm, Respiratory rate 48cpm. All findings were communicated to mother and recorded. Mother said the baby has good bowel movement and breastfeeds well. Madam Twumwaa was asked to empty her bladder for physical examination after the procedure has been explained to her. She was assisted onto the examination couch and privacy was provided. Hands were washed and dried. On inspection, client's hair was clean and nicely braided, her conjunctiva

and sclera were pink without any pallor or jaundice, she was engaged in a conversation so as to examine the mouth, the lips were moist and there was no offensive smell from the mouth. The neck had no palpable nodes. The breast was heavy with milk dripping; lactation was well established. The upper and lower extremities were examined without oedema and her back was normal. The lochia was scanty and creamy white (Alba). The abdomen had almost returned to normal. The fundus was palpable and measured 4cm. She was helped to dress up after the examination. Findings were communicated to her and documented. She was encouraged to honour all appointments to the child welfare clinic.

Madam Twumwaa was advised to maintain good personal and environmental hygiene in the care of herself, the baby and the entire family as well. She was asked to continue the postnatal exercises. Client was reminded of the six weeks postnatal visit to the clinic. Client's vital signs and other observations were made and was recorded as; Temperature 37.0^{O}C, Pulse 80bpm, Respiration 20cpm, Blood Pressure 116/75mmHg, Symphisio fundal height 4cm, Haemoglobin 12.7g/dl and Weight 61kg. Protein and Sugar were checked and they were both negative. Client was congratulated for proper care of herself and the baby.

4.13 SECOND POSTNATAL VISIT TO THE CLINIC

According to the midwife In- Charge, on the 6th of october, 2023 Madam Twumwaa came to the facility for six weeks postnatal visit. They were warmly welcomed and they both looked healthy. General examination was conducted on the client from head to toe with her permission and everything was normal by then. Her vital signs were checked and recorded as; Temperature 36.5^{o}C, Pulse 80 bpm, Respiration 20cpm, Blood pressure 120/70 mmHg,Haemoglobin 13g/dl and Weight 94kg. Madam Twumwaa's urine was checked for protein and sugar and it was negative

for both, fundus was not palpable and no lochia observed. The baby was examined from head to toe and no abnormality was found. The following immunizations were given to the baby;

Vaccine	**Dosage**	**Route of Administration** OPV
1	2 drops	Oral
DPT-HepB+Hib 1	0.5ml	Intramuscular, left thigh
Pneumococal 1	0.5 ml	Intramuscular, right thigh
Rotavirus 1	1.5ml	Oral

Baby's vital signs and other observations were checked and recorded as:Temperature 36.2degree Celsius, Respiration 24 cpm. Mother was encouraged to continue with the breastfeeding exclusively for 6 months to inhibit ovulation and prevent infection or any disease to the baby and maintain growth and development. Client was congratulated for taking good care of the baby as seen in the baby's weight gain. 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 the immunizations and continuity of care.

4.12 TERMINATION OF CARE

Client was told about the end of the care given to her from pregnancy, labour and some few days during her postnatal period. It was explained to her earlier that the care study will be brought to an end a week after her delivery but that does not end the care in reality. Madam Patricia was handed over to the Public health nurse and informed her about the completion of the immunizations and continuity of care. Both maternal and child health record books of client and baby were handed over to the public health nurse. She welcomed Madam Twumwaa with a smile. Client was reminded about family planning services and where she could get access to them.

She was advised to report to the facility immediately she recognizes any abnormality in her condition as well as the baby for early management and prevention of any complications that may arise out it. She was encouraged to take good care of herself and the baby. Client was reminded of the registration of the baby within 21 days. She was promised to be called regularly to see how both of them are doing. Happily good bye to each other were exchanged. Client and her husband expressed an overwhelmed appreciation for the support received during Pregnancy, Labour and Puerperium

NURSING CARE PLAN DURING PUERPERIUM

PROBLEMS IDENTIFIED

31st AUGUST, 2023

1. After pains
2. Interrupted sleeping pattern during the night.
3. Back pain.
4. Fullness of Breast.

SHORT TERM OBJECTIVES

1. Madam Twumwaa will be relieved of after pain within 48hours.
2. Client will have at least 3hours' sleep within 24hours.
3. Client's backache will subside within 72 hours.
4. Client's breast engorgement will resolve within 72hours.
5. Client fatigue will subside within 24hours.

LONG TERM OBJECTIVE

Mother and baby will pass through puerperium without any complications.

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVE/OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
31/08/23 at 7.30am	After pain related to involution of the uterus.	Madam Tumwaa's after pain will resolved within 48hours as evidenced by Client verbalizing the pain has reduced. Relatives observing that client is relieved of pain by her facial expression during breastfeeding	1. Reassure client that she would be relieved of after pain. 2. Explain the physiology of the after pain to client. 3. Encourage client to continue breastfeeding the baby on demand. 4. Encourage client to empty her bladder frequently. 5. Serve Client with prescribed analgesics.	1. Client was reassured that she is in competent hands. 2. Client understood that after pain is due to contractions of the uterus. 3. Client was breastfeeding baby on demand. 4. Client was emptied her bladder frequently. 5. Client was served with analgesics (Paracetamol 1g).	02/09/23 at 7:30am		

NURSING CARE PLAN ON PUERPERIUM

NURSING CARE PLAN ON PUERPERIUM

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVE/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN.
31/08/23 at 8:00am	Interrupted sleep related to baby crying at night.	Client will be able to sleep 3 hours as evidenced by client stating that she gets adequate sleep at night.	1. Reassure the client that it is normal during the first few days. 2. Encourage her to sleep during the day when baby is asleep. 3.Advice client to ensure that baby is well fed and dried before putting her to bed 4. Encourage the husband to assist her in the care of the baby.	1. Client was reassured that when milk comes in it will normalized. 2. Client was sleeping during the day timewhen baby is sleeping. 3. Client ensured that baby is well fed before putting her to bed	31/08/23 at 11:00am	Goal was fully met as verbalizing that she is can sleep.	

				4. Client's husband assisted her in the care of the baby.			

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVE/OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN

NURSING CARE PLAN ON PUERPERIUM

31/08/23 at 8:00am	Heaviness of breast (breast engorgement) related to inadequate emptying of breast.	Client's breast engorgement will resolve within 72 hours as evidenced by Client verbalizing that she is relieved of breast engorgement The midwife observing the	1. Reassure client and explain the physiology of breast engorgement. 2. Teach her on how to fix baby correctly to the breast. 3. Demonstrate to client how to correctly position herself when breastfeeding. 4. Encourage client to empty	1. Client was reassured and was taught that it is due to increased blood supply and inability of the baby to suckle well. 2. Client was taught how to fix baby correctly to the breast. 3. Demonstration was done to client on how to position baby during breastfeeding. 4. Client was encouraged to empty one breast before the other	03/09/23 at 8:00am	Goal fully met as verbalizing that she is relieved of breast engorgement	
		absence of breast heaviness and warmth.	one breast before the other. 5. Encourage client to continue breastfeeding the baby exclusively	5. Client was encouraged to continue breastfeeding the baby exclusively.			

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVE/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN.

NURSING CARE PLAN ON PUERPERIUM

31/08/23 at 8:00am	Back pain related to poor feeding techniques.	Client's backache will subside within 72 hours as evidenced by client verbalizing that her backache has subside.	1. Reassure client that she would be relieved of backache. 2 Explain the physiology of backache to the client. 3. Encourage client to adopt a good posture when breastfeeding the baby. 4. Teach client other positions in breastfeeding. 5 Encourage client to apply warm compress to her back.	1. Client was reassured that she would be relieved of backache. 2. Client became enlightened that backache may be due to poor posture. 3. Client was encouraged to adopt a straight back posture when breastfeeding her baby. 4. Client used other positions in breastfeeding such as lying down. 5. Client applied warm compress to her back.	03/09/23 at 8:00am	Goal fully met client verbalizing that she is relieved of backache.	

SUMMARY AND CONCLUSION

This script is a Family Centered Maternity Care, given to Madam Twumwaa, a 34years old woman gravida 2 Para 1 alive. She lives in Nkrankwanta in the Bono West Region. She was met at Constance Maternity Clinic when she was $37^{+}1$ weeks pregnant. Various observations, examinations and Laboratory investigations were carried out to aid in her care. Madam Twumwaa went through pregnancy with some minor disorders which were managed successfully.

Madam Twumwaa's labour and delivery were managed carefully without any complications. She had a spontaneous vaginal delivery to an alive female infant with birth weight of 2.9 kg on the 31st August, 2023 at 6:40am who cried immediately after birth.

Madam Twumwaa's puerperium was successful, mother and baby were visited at home and finally handed over to the Public Health Nurse for further management on 7th September, 2023. The Family Centred Maternity Care has afforded me the opportunity to identify the various needs of the expectant woman during pregnancy, labour and puerperium.

The knowledge and experience acquired will be translated to other expectant mothers, their families and the community members during my practice as a midwife.

In conclusion, the client/family centred maternity care study has exposed the writer to situation where the knowledge received in the classroom has practically been demonstrated on the client and family from pregnancy to puerperium. This has also enhanced the ability to perform them and render them to any pregnant woman in the course of practice wherever to help reduce maternal and infant morbidity and mortality.

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APPENDIX I

COMPLETE DIAGNOSTIC INVESTIGATION

DATE	SPECIMEN	INVESTIGATION	NORMAL VALUES	FINDINGS	REMARKS
17/08/23	Blood	Haemoglobin	12.0-16g/dl	12.0g/dl	Normal
		Blood group	A, B, AB, O	O	Normal
		Rhesus factor	Positive/Negative	Positive	Normal
		Sickling	Negative	Negative	Normal
		HIV status	Negative	Negative	Normal
	urine	Protein	Negative	Negative	Normal
		Glucose	Negative	Negative	Normal
21/08/23	Urine	Protein	Negative	Negative	Normal
		Glucose	Negative	Negative	Normal
	Blood	Hemoglobin	11.0-16g/dl	12.0g/dl	Normal
26/08/23	Blood	Haemoglobin	11.0-16g/dl	12.0g/dl	Normal
	Urine	Protein	Negative	Negative	Normal
		Glucose	Negative	Negative	
15/08/23	Urine	Protein	Negative	Negative	Normal
		Glucose	Negative	Negative	Normal
	Blood	Hemoglobin	11.0-16g/dl	12.0g/dl	Normal

COMPLETE DIAGNOSTIC INVESTIGATION CONT'D

DATE	SPECIMEN	INVESTIGATION	NORMAL VALUES
22/08/23	Urine	Protein	Negative
		Glucose	Negative
	Blood	Hemoglobin	11.0-16g/dl
29/09/23	Urine	Protein	Negative
		Glucose	Negative
	Blood	Hemoglobin	11.0-16g/dl
		(Repeated)	
3/09/23	Urine	Protein	Negative
		Glucose	Negative
	Blood	Hemoglobin	11.0-16g/dl
3/10/22	Urine	Protein	Negative
		Glucose	Negative
	Blood	Hemoglobin	11.0-16g/dl
9/08/23	Urine	Protein	Negative
		Glucose	Negative
	Blood	Hemoglobin	11.0-16g/dl
17/08/23	Urine	Protein	Negative
		Glucose	Negative
	Blood	Hemoglobin	11.0-16g/dl

APPENDIX II:

PHARMACOLOGY OF DRUGS (MOTHER)

NAME OF DRUG	CLASSIFICATION	DOSAGE	ROUTE	ACTION AND USES	ACTUAL EFFECT	SIDE EFFECT	SIDE EFFECT EXPERIENCED
Tablet multisite	Vitamin preparation	200 milligram once a day	Oral	Increases appetite, helps in the formation of red blood cells.	Appetite increased	Gastrointestinal disturbance	None
Tablet folic	Vitamin preparation	5 milligram	Oral	Proper formation and function of red blood cells.	Haemoglobin level increased	Nausea and vomiting	None
Tablet ferrous Sulphate	Hematinic	200 milligrams once daily	Oral	Aids in red blood cell production.	Increased hemoglobin level	Dark stool, diarrhea and constipation	None

APPENDIX II

PHARMACOLOGY OF DRUGS FOR THE MOTHER CONTINUED

NAME OF DRUG	CLASSIFICATION	DOSAGE	ROUTE	ACTION AND USES	ACTUAL EFFECT	SIDE EFFECT	SIDE EFFECT EXPERIENCED
Tablet Sulfadoxinepy -rimethamine	Anti -malaria and prophylaxis(given between 16 weeks or after quickening and 36 weeks)	3 tablets stat at 16 weeks and repeated at a 4 week interval till delivery	Oral	Prevention of malaria	Prevented malaria	Nausea, itching, headache, dizziness	None
Capsule Amoxicillin	Antibiotic	500 milligram three times daily for five days	Oral	Prevention of infection	Infection was prevented	Nausea and vomiting	None

PHARMACOLOGY OF DRUGS FOR THE MOTHER CONTINUED

NAME OF DRUG	CLASSIFICATION	DOSAGE	ROUTE	ACTION AND USES	ACTUAL EFFECT	SIDE EFFECT	SIDE EFFECT EXPERIENCED
Injection oxytocin	Uterotonic	10 units	Intramuscular	To control bleeding and aids in uterine contraction	Effective uterine action and control of bleeding achieved.	Vomiting, rise in blood pressure, uterine spasm	None
Tablet paracetamol	Analgesic and Antipyretic	1 gram stat	Oral	To relieve pain and fever	Pain relieved	Prolong use causes liver damage	None

APPENDIX III

PHARMACOLOGY OF DRUGS FOR THE BABY

NAME OF DRUG	CLASSIFICA-TION	DOSAGE	ROUTE	ACTION AND USES	ACTUAL EFFECT	SIDE EFFECT	SIDE EFFECT EXPERIENCED
Vitamin k	Group K vitamin	1ml	Intramuscular	Production of prothrombin	Prevented bleeding	Bleeding prevented	None observed
Chloramphenicol eye drop	Antibiotics	2-3drops	Instillation	To prevent eye infection	Eye was not infected	Increase risk of aplastic anemia	No side effect observed
Injection Bacillus Chalmette Guerin	Antigen	0.05 ml	Intradermal	Production of antibodies to prevent tuberculosis	Under observation	Blister formation, slight fever and pain	Blister formation
Polio vaccine	Antigen	2 drops	Oral	Production of antibodies to prevent poliomyelitis	Under observation	There may be diarrhea	None observed

PHARMACOLOGY OF DRUGS FOR THE BABY CONTINUED

NAME OF DRUG	CLASSIFICATION	DOSAGE	ROUTE	ACTION AND USES	ACTUAL EFFECT	SIDE EFFECT	SIDE EFFECT EXPERIENCED
Pneumococcal 1	Antigen	0.5 ml	Intramuscular right thigh	Vaccinates neonate against pneumonia	Under observation	Redness at the sight of injection and fever.	None observed
Pentavalent 1 (5 in 1)	Antigen	0.5 ml	Intramuscular left thigh	Vaccinates neonate against diphtheria, pertussis (whooping cough), tetanus, hepatitis B, heamophilus influenza B	Under observation	Low grade fever	None observed

Rotavirus 1	Antigen	1.5 mls	Oral	Prevention of gastroenteritis	Under observation	None	None

APPENDIX IV

ANTENATAL CHART

Date	**Weight**	**Blood Pressure(mmHg)**	**Urine (protein and sugar)**	**Haemo-globin level (g/dl)**	**Gestati--onal age (weeks)**	**Fun--dal height (cm)**	**Presentation**	**Descent (th)**	**Foetal heart rate (bpm)**	**Complains**	**Treatment and advice**	**Rem-arks**
17/08/23	92	110/70	Negative Negative	12.0	6	-	-	-	-	No complains	Tablet folic acid, multivitamin, Fersolate, Advise on good nutrition, insecticide treated net given.	Healthy

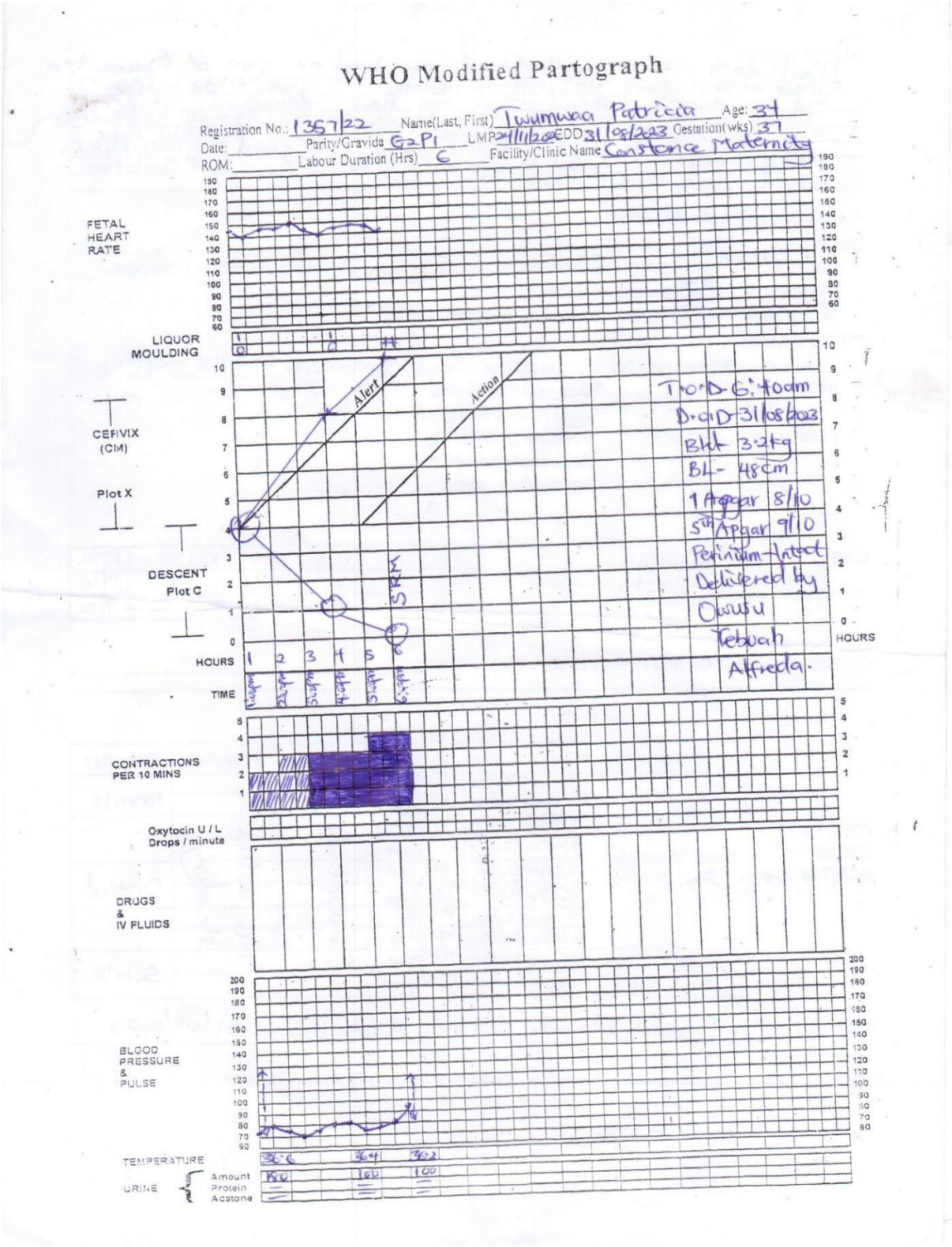
21/08/23	94	110/60	Trace Negative	12.1	10		-	-	+	No complains	Tablet folic acid. Fersolate Iron	Well

26/08/23	96	100/60	Negative Negative	12 .1	14		-	-	+	No complains	Folic Acid, Multivitamin, Fersolate, Iron. She was educated to take more fluids, fruits and vegetables	Well
15/08/23	98	110/60	Negative Negative	12.0	18	16	-	-	+	No complains	Routine drugs served,1st dose of SP given under DOT and educated on personal hygiene	Healthy
5/8/23	100	100/60	Negative Negative	12.0	24	18	-	5/5	+	Lower abdominal pain	Routine drugs served,2nd dose of SP given under DOT, Paracetamol 1g for 5days was served and educated on rest and sleep	Well

13/08/22	102	120/60	Negative Negative	12.0	28	2\4	-	5/5	+	No complains	Routine drugs served,3rd dose of SP given under DOT	Well
22/08/23	104	110/70	Negative Negative	12.0	34	30	Cep halic	5/5	+	No complains	To continue with routine drugs served, 4th dose of SP was given under DOT.	Well
29/08/23		100/60	Negative Negative	12.3	36	34	Cep halic	5/5	140	Lower abdominal pains and waist pains.	Routine drugs served 5th dose of SP was given under DOT. Client was educated to minimize frequent bending and also encouraged to wear low heeled shoes. Analgesics were served to client for the relieve of pain.	Neat
11/08/23		120/70	Negative Negative	12.3	37	35	ceph alic	5/5	140	No complains	Routine drugs served.	

19/08/23	106	120/70	Trace Negative	12.3	38+2	36	Cep halic	5/5	147	No Complains	Routine drugs served.	Healthy

APPENDIX IV


WHO Modified Partograph
Registration No.: 1357/22
Name(Last, First) Twumwaa Patricia
Age: 34
Date:
Parity/Gravida G2P1
LMP 24/11/2022
EDD 31/08/2023
Gestation(wks) 37
ROM:
Labour Duration (Hrs) 6
Facility/Clinic Name Constance Maternity
FETAL HEART RATE
LIQUOR MOULDING
CERVIX (CM)
Plot X
DESCENT Plot C
Alert
Action
HOURS
TIME
CONTRACTIONS PER 10 MINS
Oxytocin U / L Drops / minute
DRUGS & IV FLUIDS
BLOOD PRESSURE & PULSE
TEMPERATURE
URINE
Amount
Protein
Acetone
T+D 6:40am
D.o.D 31/08/2023
BWt 3.2kg
BL- 48cm
1 Apgar 8/10
5th Apgar 9/10
Perinium-Intact
Delivered by
Owusu
Tebuah
Alfreda.

LABOR NOTES
Client G2P1 with 37 gestational age had an SVD at 6:40am to a female alive infant IM oxytocin 10units was given to the mother and on palpation second twin was not diagnosed Skin to skin contact was ensured. Active third stage of labour was successfully complete through CCT Essential care was done for the baby and the baby was clean very well. client was sustained no fear. Baby and Mother are in good condition and made them comfortable in bed.

Please circle or write responses.

DELIVERY

DATE 31/08/2023 TIME: 6:40am METHOD: (Spontaneous) / Vacuum Extraction / C/S / Other

PERINEUM: (Intact) / Episiotomy / Laceration

ANESTHESIA: (None) / Local / General

THIRD STAGE

Active Management: Yes / No ·Medication: Time 6:40am Type/Dose 10 units oxytocin

PLACENTA: TIME: (Complete) / Incomplete

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

BABY

Weight: 3.2kg

Sex: Male / (Female)

Baby Position: (Vertex) / Breech / Other

APGAR

Time	Color	Breath	Heart	Tone	Reflex	TOTAL
1min	2	2	2	1	1	8/10
5min	2	2	2	2	1	9/10

COMPLICATIONS OF MOTHER / BABY: None / Other:

FOURTH STAGE MONITORING

Frequency	Time	B/P.	Pulse	Fundus	Bleeding	Bladder
Every 15 minutes first 2 hours	9:00am	120/70	80bpm			10am/s
	9:15am	120/70	81bpm			
	9:30am	110/70	78bpm			
	9:45am	120/80	79bpm			
	10:00am	120/68	86bpm			Emptied
	10:15am	110/80	76bpm			
	10:30am	120/70	90bpm			
	10:45am	120/60	92bpm			
Every 30 minutes For 1 hour	11:00am	110/70	78bpm			5am/s
	11:30am	120/70	80bpm			

Birth Attendant Owusu Deborah Afreda Assisted Date 31/08/2023

MATERNITY CHART

NAME: Twumwaa Patricia.

AGE: 34years WARD:

IP NO.: 1357/22. BED NO.: 4

Date	31/08/23	1/09/23	2/09/23	3/09/23	4/09/23	5/09/23	6/09/23	7/09/23
Days in Hospital	D0	D1	D2	D3	D4	D5	D6	D7
Days P. O.								
Hour								
Temperature C / F								
Pulse								
Resp.								
B.M.								
Urine	Passed	Passed	Passed	Passed	Passed	Passed	Passed	
B. P.	120/70	110/70	120/70	120/60	120/70	120/70	120/80	120/80
		110/70	110/70	110/70	120/70			

NEW BORN EXAMINATION FORM

Name: (Baby) Twimwaa Patricia Date of Assessment: 31/08/2023 Time: 7:20am
Date of Birth: 31/08/2023 Time of Birth: 6:40am Sex: ☐ M ☑ F Age at time of Assessment (days/hrs) 1day
Astational Age ☐ 37+1 ☐ Mode of Delivery: ☑ Vaginal Assisted Vaginal C-Section
APGAR: 1min 8 ☐ 10 5min ☑ 10 Birth Weight: ☐ 3.7 kg ☐ Length: 48 cm Head Circumference: 34 cm
Temperature at time of Assessment: 36.0 °C Urine passed: Yes No Meconium passed: Yes No
Name of Assessor (Midwife/Doctor): Owusu Deborah Afriyie

1. Respiration
Rate 40cpm
☐ Rate < 30 b/m *
☐ Rate < 60 b/m *
☐ 30-60 b/m
☐ Retractions *
☐ Grunting *
☐ Stridor *

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

3. Tone
☑ Normal
☐ Floppy *
☐ Increased *

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

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

6. Cry
☑ Normal
☐ Shrill *
☐ Absent *

7. Suck
☑ Good
☐ Weak
☐ Absent

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

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

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

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

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

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

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

16. Clavicle
☑ Normal
☐ Swelling/Fracture

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

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

19. Femoral pulse
☑ Present
☐ Not palpable*

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

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

22. Limbs
☑ Normal
☐ Abnormal _____

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

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

24. Anus
☑ Patent
☐ Imperforate*

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

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

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

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

NEW BORN EXAMINATION FORM

Name: (Baby) Twumwaa Patricia Date of Assessment: 01/09/2023 Time: 7:22am
Date of Birth: 31/08/2023 Time of Birth: 6:40am Sex: ☐ M ☑ F Age at time of Assessment (days/hrs) 1 day
Astational Age ☐ 37+1 ☐ Mode of Delivery: ☑ Vaginal Assisted Vaginal C-Section
APGAR: 1min 8 10 5min 9 10 Birth Weight: ☐ 3.2 kg ☐ Length: 48 cm Head Circumference: 34 cm
Temperature at time of Assessment: 36.0 °C Urine passed: (Yes) No Meconium passed: (Yes) No
Name of Assessor (Midwife/Doctor): Owusu Yeboah Alfreda

1. Respiration
Rate 40cpm
☐ Rate < 30 b/m *
☐ Rate < 60 b/m *
☐ 30-60 b/m
☐ Retractions *
☐ Grunting *
☐ Stridor *

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

3. Tone
☑ Normal
☐ Floppy *
☐ Increased *

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

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

6. Cry
☑ Normal
☐ Shrill *
☐ Absent *

7. Suck
☑ Good
☐ Weak
☐ Absent

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

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

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

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

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

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

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

16. Clavicle
☑ Normal
☐ Swelling/Fracture

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

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

19. Femoral pulse
☑ Present
☐ Not palpable*

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

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

22. Limbs
☑ Normal
☐ Abnormal _____

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

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

24. Anus
☑ Patent
☐ Imperforate*

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

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

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

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

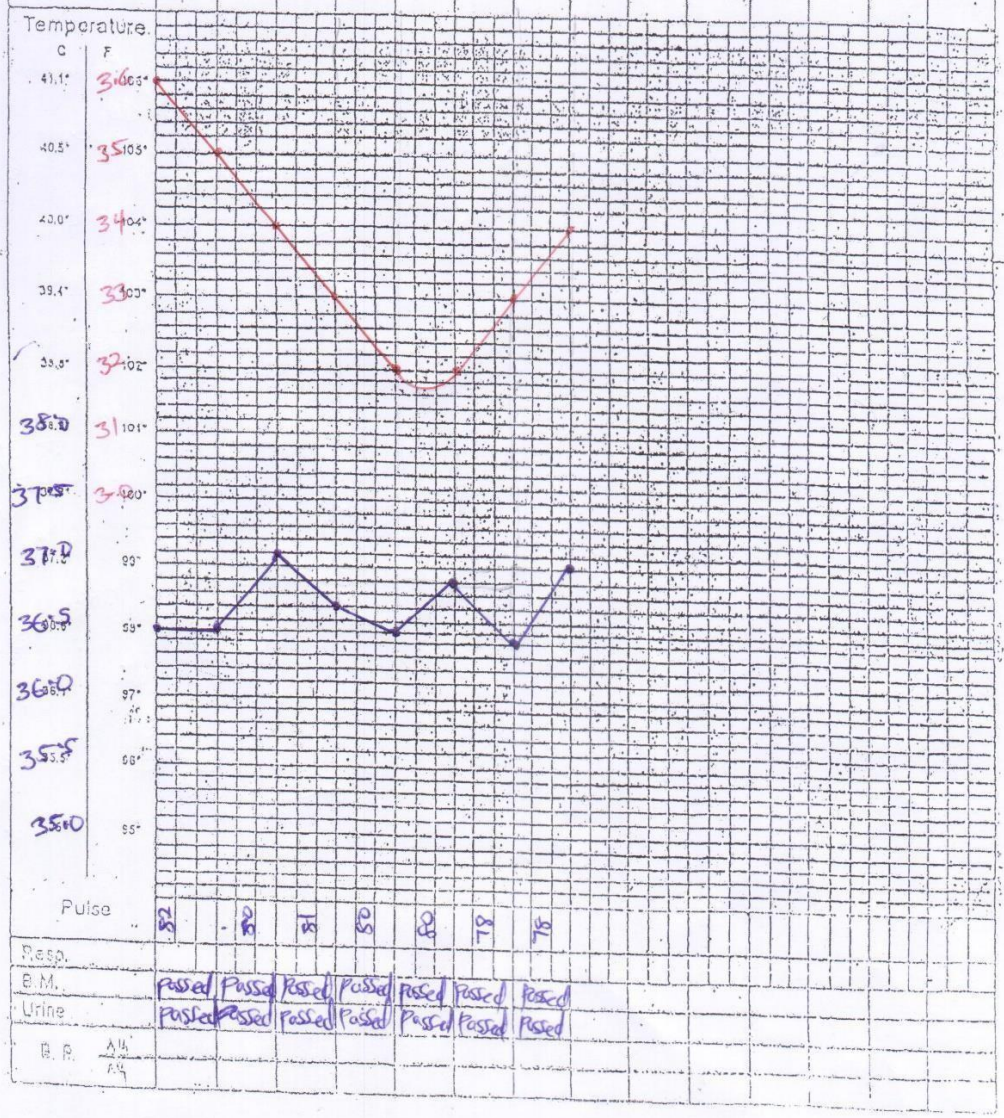
TEMPERATURE CHART

NAME: Baby of Twumwaa Patricia

AGE: 34 years. WARD: Lying-in

IP NO.: 1357/22 BED NO.: 4

Date		1/09/23	2/09/23	3/09/23	04/09/23	05/09/23	6/09/23	7/09/23	
Days in Hospital	AD	D1	D2	D3	D4	D5	D6	D7	
Days P.O.									
Hour AM	7:30	5:30	6:30	7:30	7:30	7:30	7:20	7:30	
PM	11:00		7:00	7:30					
Temperature C / F									
Pulse									
Resp.									
B.M.	Passed	Passed	Passed	Passed	Passed	Passed	Passed		
Urine	Passed	Passed	Passed	Passed	Passed	Passed	Passed		
B.P.									



NEW BORN CHART

Name: (Baby) Twumwaa Patricia ..... No: ..... Birth Weight: 3.2kg .....

Sex: Female ..... Mother's No: ..... Length: 48cm .....

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

Date of Birth: 31st August, 2023 ..... Time: 6:40am ..... Date of Discharge: 7st September 2023

Date			01/08/2023		02/08/2023		03/08/2023		04/08/2023		05/08/2023		06/08/2023		07/08/2023							
No. of Days	D.O		D1		D2		D3		D4		D5		D6		D7							
Weight	3.2kg		3.15kg		3.1kg		3.0kg		3.0kg		3.0kg		3.0kg		3.1kg							
Temperature	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM
	36.0°C		37.1°C		36.5°C	36.0°C	37.0°C	36.9°C	37.5°C	36.8°C	36.5°C		36.5°C		36.9°C							
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 Trunk Limbs Genitalia > No abnormalities detected.																					

SIGNATORIES

NAME OF STUDENT

NAME: OWUSU YEBOAH ALFREDA

SIGNATURE: .....

DATE: ..... 7TH JUNE 2024

THE MIDWIFE IN CHARGE (CONSTANCE MATERNITY HOME AND CLINIC)

NAME: KUNYO PATRICIA

SIGNATURE: ..... (FOR)

DATE: ..... 7TH JUNE 2024 .....

THE SUPERVISOR

NAME: MARTHA KYEREMAA

SIGNATURE: .....

DATE: ..... 7TH JUNE 2024 .....

THE PRINCIPAL

NAME: MONICA NKRUMAH

SIGNATURE: .....

DATE: ..... 07/06/2024 .....

PRINCIPAL
HOLY FAMILY NURSING AND
MIDWIFERY TRAINING COLLEGE
BEREKUM