HOLY FAMILY NURSING AND MIDWIFERY TRAINING COLLEGE

BEREKUM

# A CLIENT /FAMILY CENTERED MATERNITY CARE STUDY ON

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A CLIENT CENTERED MATERNITY CARE STUDY SUBMITTED TO THE NURSING AND MIDWIFERY COUNCIL OF GHANA IN PARTIAL FULFILMENT TOWARDS THE AWARD OF THE REGISTERED MIDWIFERY CERTIFICATE

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## PREFACE

The Practice of Midwifery in previous focused mainly on Client to meet the Client's needs. Moreover, all the needs of client cannot be achieved because they lacked family support. Again, Midwifery has undergone a lot of changes Globally and Nationally. These changes have brought the introduction of Client and family-centered maternity care concept. The concept of Family centered maternity care study is a systematic approach of rendering holistic midwifery care to gravide woman and her family throughout pregnancy, labour and puerperium base on a thoughtful understanding of the client as a unique individual with special problems and needs.

The family centered maternity care is mainly based on total nursing care in which the physical, psychological, spiritual, social, and rehabilitative aspect of the client is considered. It includes the expectant mother, her family and the community in preparing towards the impending arrival of a new family member.

The client and family centered maternity care study also helps students midwives to make good use of the new trends in midwifery like the use of partograph to monitor client in the first stage of labour and the continuity of care to the client after delivery. With this it also enables the student to practice the aspect of midwifery that deals with the client needs, the right of the clients in rendering quality and proper care to her satisfaction. It also helps the student to gain knowledge in the changes and management, ideals and practices in the clinics and maternity homes.

The confidentiality of the client is ensured and the client feels at ease providing vivid history and discussions on confidential matters. The care study offers the student midwife the opportunity to put all the knowledge and skills acquired during training into practice. It also enables student to detect health problems and solve their health problems.

Also, the family centered maternity care study helps to reduce maternal and neonatal morbidity and mortality. The client and family centered maternity care study is compiled into a document in partial fulfillment for the award of registered midwifery certificate by the Nursing and Midwifery Council of Ghana.

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## INTRODUCTION

The family centered maternity care is an academic work which gives the student midwife the opportunity to nurse a client throughout pregnancy, labour and puerperium using the knowledge and skill acquired during the 3-years training programme. The study also gave the opportunity to adopt approach to collect relevant problems after which would be evaluated to see if any objectives were achieved.

The study was conducted on madam Elizabeth Fosuaa a 20year old pregnant woman, gravida 2 para 1, during her pregnancy, labour and puerperium.

The interaction started when she visited the clinic on 14th November,2022. By this time she was 36 weeks +2days pregnant when she was met at the Antenatal clinic. After getting some personal information about her, her permission was sought to take her as a client so she could be nursed through pregnancy, labour and puerperium. She was introduced to the in-charge as a client to be used for the care study and permission was granted.

Thorough assessment and physical examination were done on her with vivid explanation of all procedures to her. She had normal pregnancy. Home visits were also carried out to assess her environment and community she lived. The family was involved in the care throughout the period. The interaction continued through her spontaneous vaginal delivery and finally ended on 22nd December, 2022. Mother and baby had a successful puerperal period and they were handed over to the Public Health Nurse for continuity of care in a healthy state after six weeks of care.

This write up are in four chapters outlined in this script.

Chapter One: Is the detailed information of the client's assessment and family which include the past and present obstetric History, social, medical, menstrual, lifestyle and hobbies.

Chapter Two: Also covers the first visit to the antenatal care which begins from the time of conception, subsequent antenatal visit to clinic, subsequent home visit and nursing care plan during antenatal till when the woman was due for delivery.

Chapter Three: Is about the admission and management of the various stages of labour, immediate care of the baby, subsequent care of the baby, summary of labour and nursing care plan during labour.

Chapter Four: Talks about the management of puerperium including first day post-delivery and discharge, postnatal visit to the hospital.

At the end of each chapter is a care plan drawn to solve problems encountered by client, summary, conclusion, bibliography and appendix. The client will be called Madam Fosuaa throughout this project.

# LITERATURE REVIEW

## PREGNANCY

Perry (2014), states that pregnancy is a period of physical and psychological preparation for birth and parenthood. According to him prenatal visit ideally begins soon after the first missed menstrual period to ensure good health of the expectant mother and the fetus. Normal pregnancy lasts for about 40weeks or 280 days and health care providers refer to early, middle and late pregnancy as trimesters. The first trimester lasts from week 1 through to 13, the second from week 14 through to 26, and the third from week 27 through to 40. Pregnancy is considered to be at term if advances to 38 to 40weeks.

Marshall & Raynor (2014) further explains that during pregnancy there are profound but predominantly reversible changes occurring in maternal homodynamic and cardiac function. These complex adaptations are necessary to

1. Meet evolving maternal changes in physiological function.
2. Promote the growth and development of the utero placental fetal unit.
3. Compensate for blood losses at the end of labour.

The heart is enlarged by chamber dilatation and a degree of myocardial hypertrophy in early pregnancy leading to a 10 -15% increase in ventricular wall muscles. The enlarging uterus raises the diaphragm upward and to the left to produce a slight anterior rotation of the heart on its long axis. It also increase in blood volume known as haemodilution, further explains that to accommodate increase oxygen requirement and physical impact of enlarging uterus

intricate changes occurring in respiratory physiology. The driving force for change in the respiratory stimulation effect of progesterone initiating hyperventilation by increasing sensitivity to carbon dioxide. Through lowering threshold at which the respiratory counter is stimulated. The lower ribs flare outwards prior to any mechanical pressure from the growing uterus. Changes are mediated by progesterone and relaxin which increase rib cage and elasticity by relaxing ligaments in a similar mechanism to that occurring in the pelvis.

Furthermore adaptation of the central nervous system is probably the least well understood compared to other body system. The hormonal fluctuations occurring throughout pregnancy may remodel the female brain increasing the size of neurons in some regions and producing structural changes in others. Oestrogen and progesterone readily enter the brain to act on nerve cells changing the balance between inhibition and stimulation. A pregnant woman's sleep pattern can be affected by both mechanical and hormonal influences.

The striking anatomical and physiological changes occurring in the urinary system are critical for optimal pregnancy outcome. In a healthy pregnancy the kidneys lengthen by up to 1.5cm and kidney volume increase by as much as 30%. The urethers become longer and are thrown in the single or double curves of various sizes. Dilated urethers with reduced peristalsis and mechanical obstruction by the enlarged uterus all contribute to urinary stasis leading to the

increase risk of urinary tract infection in pregnancy. The trogon becomes deeper and wider as pregnancy progresses leading to reduced bladder capacity. To compensate for this the urethra lengthens by about o.5cm and the bladder tone increase to help maintain continence in spite of the urinary incontinence can be troublesome in pregnancy. As the uterus enlarges the bladder becomes distorted and it is drawn upwards interiorly becoming an abdominal organ by the third trimester.

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

high oestrogen availability. The glycogen is metabolized to lactic acid by the lactobacillus acidophilus, (Doderlein's bacillus), and this leads to increase vaginal acidity.

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

According to Perry (2013), pregnancy is the period of physical and physiological preparation for child birth and parenthood. According to him, the expectant mother ideally should begin prenatal visit soon after the first missed menstrual period for early detection of complications and to ensure good health of the expectant mother and foetus. He also stated that normal pregnancy last for about fourty (40) weeks or two hundred and eighty (280) days and healthcare providers refer to early,

middle and late pregnancy as trimesters. The first trimester last from week one (1) to thirteen (13) weeks and the second from fourteen (14) to twenty-six (26) weeks whereas the third trimester from twenty-seven (27) weeks to fourty (40) weeks. Any pregnancy that advances from thirty-eight (38) to forty (40) weeks is considered to be at term.

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

## LABOUR

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

Marie (2013) defines labour as a series of events that takes place in the genital organs in effort to expel the viable products of conception out of the womb through the vagina into the outer world. Labour is called normal if it fulfills the following criteria; Spontaneous in onset. With vertex presentation. Without undue prolongation. Natural termination with minimal aids. Without having any complication affecting the health of the mother and/ or the baby. The features of true labour

signs are: Painful uterine contraction at regular intervals. ‘’Show’’. Progressive effacement and dilatation of the cervix. Formation of the’’ bag of waters’’. The events of labour are divided into four stages; first, second, third and fourth stage. First stage starts from the onset of true labour pain and ends with full dilatation of the cervix. Its average duration is 6 hours in multipara. Second stage starts from full dilatation of the cervix and ends with expulsion of the foetus from the birth canal. Third stage begins after the expulsion of foetus and ends with the expulsion of the placenta and membranes (afterbirth). Average duration is about 15 minutes in both multi and primigravidae. Fourth stage is the stage of observation after the expulsion of the afterbirth. Four factors are significant in the process of labour; that is the pelvis, passenger, powers and psyche. These are known as the four P’s.

Konar (2013) further stated that under bladder care; patient is encouraged to pass urine by herself as full bladder often inhibits uterine contraction and may lead to infection. If the woman cannot go to the toilet, she is given a bed pan. Privacy must be maintained and comfort must be ensured. If the patent fails to pass urine especially in late first stage, catheterisation is to be done with strict aseptic precautions.

Fraser & Cooper (2012) described labour as the process by which the foetus, placenta and membranes are expelled through the birth canal. It also explained that the first stage of labour can be divided into 3 stages namely: The latent phase which is prior to active phase of first stage of labour and may last for 6-8 hours in primigravida when the cervix dilates from 1cm to 3-4cm and the cervical canal shortens from 3cm long to less than 0.5 cm long. The active phase which is the time the cervix undergoes more rapid dilatation. This begins when the cervix is 3-4cm dilated and in the presence of rhythmic contractions, is completed when the cervix is fully dilated (10cm).The transitional phase which is the stage of labour when the cervix is from around 9cm dilated until it

is fully dilated (or until the expulsive contractions of second stage are felt by the woman). There is often a brief lull in the intensity of uterine activity at this time. Henderson and Macdonald (2011) further stated that in order to provide woman-centered care during labour, the midwife should: asses the needs and expectations of each individual woman regarding labour and birth.Plan care with each woman in labour, tailored to meet her specific needs and expectations. Put the care plan into practice. Evaluate the care given to measure its effectiveness. She also stated that, labour is divided into four (4) stages, these are: first stage which deals with the onset of painful rhythmic uterine contractions and dilatation of the cervix. Second stage which deals with full dilation of the cervix and expulsion of the fetus. Third stage is the delivery of the placenta, membranes and the control of haemorrhage. The fourth stage is when the mother and baby are being monitored for the first six hours after delivery.

According to the above definitions, it means labour is the process in which the fetus, the placenta and its membranes are expelled through the birth canal after 28 weeks of pregnancy

## PUERPERIUM

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

According to Marie (2013) puerperium is the period following childbirth during which the body tissues, especially the pelvic organs revert back approximately to the pre-pregnant state both anatomically and physiologically. The period is divided into; Immediate –within 24 hours. Early-up to 7 days, Remote –up to 6 weeks. Immediately following delivery, the uterus becomes firmer and retracted with alternating hardening and softening. At the end of 6 weeks, its measurement is almost similar to that of the non-pregnant state and it weighs 60 gram. The vaginal discharge for the first fortnight during puerperium is the lochia. The lochia originates from the uterine body, cervix and vagina. Depending upon the variation of the colour of the discharge it is named as: Lochia rubra (red) 1 -4 days. Lochia serosa (yellowish or pink or pale brownish) 5-9 days. Lochia alba (pale white) 10 -15 days. The average amount of discharge, for the first 5-6 days is estimated to be 250 ml.

## WHY CLIENT WAS CHOSEN

Madam Elizabeth Fosuaa was chosen as a client on 14$^{th}$ November, 2022 at Nkoranza Health Center during one of her usual antenatal visit. On interaction her antenatal card during her turn for examination, client's facial expression on observation was not cheerful. Client was

asked and she said that she had complained of constipation and after glacing through it was realize that she had complain for two consecutive times of her previous antenatal visits and still complaining. She explained that it was making her worried since she did not know the cause of this, She was reassured that she would be assisted with adequate management plan to get it under control. Physiology and education on the topic was provided. Introduction was made as a student from Holy Family Nursing and Midwifery Training College, Berekum, and was at the clinic for practical experience and wishes to use her for my care study. Permission was sought from her to be taken as a client for the care study which she accepted. All details of information and procedures involved in the study were explained to her and she gladly agreed and promised to give all the maximum cooperation. All the necessary particulars were collected. Appointment for home visit was booked, direction to her house was given and phone numbers were exchanged.

# CHAPTER ONE

# CLIENT PARTICULARS

## 1.0 INTRODUCTION

This chapter gives a preview on the various histories and information about the client, her family and the community in which she lives which includes social, family, medical, surgical, present obstetrical history and habit of daily living.

## 1.1 SOCIAL AND PERSONAL HISTORY

Madam Fosuaa a 20 year old gravida 2 para 1 alive, is a native of Techiman in the Bono-East Region of Ghana, but resided at New-Town in Nkoranza in the Bono-East Region. She is dark in complexion and weighs 55kg and 155cm in height. Her native language is Bono. According to Madam Fosuaa, she completed St. Francis R/C Junior High school in Techiman South of Ghana and she is now seamstress. She is married to Mr. Arhin Shadrack with one child, a male. Her husband is a Fashion designer (Tailer). They are both Christians and worship at Nkoranza church of Pentecost (Central). She speaks Bono. According to her, her next of kin is her husband, Arhin Shadrack. Madam Fosuaa lives in a compound house and relates well with her neighbours. According to her, they are financially sound and also her source of support through the period of pregnancy is the husband and the family.

## 1.2 FAMILY HISTORY

Mr. Kofi Opoku and Mrs. Hannah Twumwaa are Madam Fosuaa's parents. She is the first born of her parent's children among three siblings. Both parents come from Techiman in the Bono-East Region of Ghana and they speak Bono. According to Madam Fosuaa there is no history of Hypertension, Diabetes Mellitus, Sickle cell disease, Asthma and mental illness in her family.

They do not have any history of congenital abnormalities such as cleft lip or palate or heart disease in the family. She admitted that multiple pregnancies run through her family. Deaths in her family occur naturally.

## 1.3 MEDICAL HISTORY

According to Madam Fosuaa she has no history of medical condition such as hypertension, diabetes, hepatic disorders, kidney problems, pulmonary disorders among others. She has never been admitted to the hospital. Even though she sometimes suffers from certain illnesses, she is treated as an outpatient client whenever she reports to the hospital for treatment. Throughout her life, she has never reacted to any drug or a type of food. She is not on any lifelong medication. She has neither donated blood nor been transfused.

## 1.4 SURGICAL HISTORY

According to Madam Fosuaa, she has never received or donated blood, involved in any road traffic accident which could affect the adequacy of her pelvis nor undergone any surgical operation since infancy. None of her family members has ever undergone any surgical procedure.

## 1.5 MENSTRUAL HISTORY

Madam Fosuaa was 14 years when she had her menarche. Her regular menstrual cycle is 28 days; amount of blood loss is moderate each month and last for 5 days. She uses sanitary pad during the flow and changes it two times daily. Her last menstrual cycle was on 5$^{th}$ March, 2022. She has no history of dysmenorrhea. Her expected date of delivery was calculated to be 5$^{th}$ December, 2022. The ultrasound scan was also 8$^{th}$ December, 2022.

## 1.6 CLIENT'S HOBBIES AND LIFESTYLE

Madam Fosuaa usually goes to bed around 10:00 pm and wakes up around 5: 30 am. Routinely, morning devotion is the action she takes to give glory to Almighty God for his kind gesture and benevolence towards her life and her family. She does few household chores like sweeping, dusting and her husband baths her child. She then starts to prepare breakfast. She serves her child's meal after which her husband prepares her son for school. Since Madam Fosuaa is a seamstress, she also prepares for work after taking her bath and making sure everything is in order in the house. She goes to work and returns home at 3:00pm to prepare supper for the family. All these are done from Monday to Friday. On weekends, she does certain chores such as washing dirty cloths, scrubbing the house and goes to church on Sundays to pray. She sometimes assists her husband to iron their clothing. She prefers watching local movies and chatting with family. Banku with okra soup and fish is her favorite meal. She eats three times daily with fruit in between meals and takes in enough water and empties her bowel twice a day. Together with her family, they watch movies and have some fun until the day fades away. She neither smokes nor drinks alcohol.

## 1.7 PAST OBSTETRICAL HISTORY

### Pregnancy

Madam Fosuaa is Gravida 2 Para 1 alive, has no history of spontaneous or induced abortion. The interval between the first pregnancy and the current one was Three years. According to the Antenatal records, she never had problem during her pregnancies such as pre-eclampsia, pregnancy induced hypertension, ante partum hemorrhage, anaemia and gestational diabetes. She was a regular attendant at Antenatal session and took her fourth Tetanus dose. She took five doses of Sulphadoxine Pyremethamine and also received two doses of tetanus diphtheria in her pregnancy. The first child is three (3) years.

**Labour**

The mode of her first delivery was spontaneous vaginal delivery with no laceration at the perineum at Nkoranza Health Center on 26th of March, 2019. The outcome of labour was a live healthy male child (first child) with birth weight of 3.0kg and length of 47. The babies cried soon after birth. Postpartum complications such as postpartum hemorrhage, retained placenta, breast engorgement were not recorded and client confirmed not experiencing any complications. She stated that she did not suffer any complications after delivery. Madam Fosuaa exclusively breastfed her child for the first six (6) months and continued with supplementary feeds.

**PUERPERIUM**

The first child was fully immunized against the childhood preventable diseases. Much attention was given to her from her beloved husband and family during this period. She has never used any artificial family planning method but uses the natural family planning (calendar method). She attended the postnatal clinic as scheduled.

## 1.8 PRESENT OBSTETRICAL HISTORY

Madam Fosuaa reported to the antenatal clinic on 19th of May, 2022 with the last menstrual period on 5th of March, 2022. Upon this the expected date of delivery was calculated to be 12th of December, 2022 and the ultrasound was 15th December, 2022. Serving as a baseline for the comparison with the subsequent antenatal recording, the following laboratory investigations and vital signs were recorded on her booking visit:

Temperature 36.1 degree Celsius

Pulse 82 beats per minute

Respiration 22 cycles per minutes

| | |
|---|---|
| Blood Pressure | 107/70 millimeters of mercury |
| Weight | 55 kilograms |
| Height | 155 centimeters |

The results of the various laboratory investigations done were as follows

| | |
|---|---|
| Haemoglobin | 13.6 grams per deciliters |
| Sickling test | Negative |
| Blood group | O |
| Rhesus | Positive |
| Hepatitis B | Non-Reactive |
| VDRL | Negative |
| G6PD | No Defect |
| HIV status | Non-Reactive |
| Urine for protein and sugar | Negative |
| Gestational weeks | 11+1 weeks |
| Symphysio fundal height | Not palpable |

No abnormality was detected on Madam Fosuaa after carefully conducting head to toe examination. She complained of Waist pains. Madam Fosuaa was regular at antenatal clinic, and her complaints were addressed and scheduled for the next visit. Madam Fosuaa attended subsequent visit at the antenatal clinic and the routine care and drugs were given to her. She was served with the following routine drugs:

Tablet Ferrous Sulphate 60milligrams, one daily x 30 days

Tablet Folic Acid 5milligrams, one daily x 30 days

Tablet Multivitamin 200milligrams, one daily x 30 days

Client was routinely cared for and managed on routine drugs during the periods of her Antenatal Visit. All procedures were carried out on her appropriately with no abnormality detected. Client complied with all education given and took all her routine drugs until she was met and chosen for the study at 36 weeks plus 2 days gestation.

# CHAPTER TWO

# ANTENATAL CARE

## 2.0 INTRODUCTION

This chapter deals with the care given to the client during antenatal period. It includes the first contact with the client, antenatal home visit, subsequent visit to the Health Center and nursing care plan on problems identified.

## 2.1 FIRST CONTACT WITH THE CLIENT

On 14th Novermber ,2022 was the first time Madam Elizabeth Fosuaa was met. This took place at Nkoranza Health Center on her regular attendance to the antenatal clinic and this was her 9th visit and she was 36+2 weeks gestation. She was warmly welcomed and a seat was offered to her and enquiry about her health and that of her family was made. She had complained of constipation for two consecutive times of her previous antenatal visits and still complaining. Her antenatal book was collected and glanced through and then introduction was made to her as a student midwife from Holy Family Nursing and Midwifery Training College, Berekum who came to have clinical experience and then wish to use her for my care study. All details of information and procedures involved in the study were explained to her and she gladly agreed and promised to give all the information needed and the maximum cooperation. She was asked to empty her bladder after a specimen bottle was given to her and it was explained to her the need to obtain midstream urine, to check for ketone, protein and sugar. Vital signs were taken and the finding recorded in her antenatal book was as follows:

| | |
|---|---|
| Temperature | 36.2 degree Celsius |
| Pulse | 75 beats per minutes |

| | |
|---|---|
| Respiration | 22 cycles per minutes |
| Blood Pressure | 100/66 Millemetre of Mercury |
| Weight | 65kilograms |
| Height | 155centimeters |

The results of the various laboratory investigations done were as follows

| | |
|---|---|
| Hemoglobin level | 11.5 grams per deciliters |
| Hepatitis B | 65kilograms |
| Rhesus Factor | Positive |
| Blood Group | O |
| HIV | Negative |
| Sickle Test | Negative |
| G6PD | No Defect |
| Syphilis (VDRL) | Non –reactive |

**Urine testing**

After all these procedures, she was asked to empty her bladder and specimen bottle was given to her to collect mid-stream specimen of urine to test for urine glucose and protein.

Protective clothing like apron and gloves were worn. The quantity, colour, odour, smell and

sediments were noted. A chemically prepared strip was picked and dipped into the urine sample. The strip was immediately removed and the edge of the strip taped against side of the urine container to prevent spilling of urine onto the clothes. After one (1) minute, the stick was compared with the corresponding colour on the container. There was no change in color of the strip indicating a negative result when compared closely with the corresponding color chart on the container.

Findings were recorded and discussed with both midwife in-charge and client.

The procedure involved in physical examination was explained to her and she consented.

Privacy was provided by closing doors, nearby windows and curtains drawn and hand Washing was done.

**HEAD TO TOE EXAMINATION**

Head to toe examination was explained to her. The necessary equipment for the procedure were gathered and taken to the examination room. She was asked to sit on the bed and assisted to undress and wrap herself with cloth. she was helped to lie lateral and then assume a supine position on the examination couch. Hands were thoroughly washed with soap under running water and dry with clean towel under the supervision of the midwife-in-charge, the following examinations were carried out on Madam Fosuaa.

**Physical examination:** The examination was started on the client from the head and was supervised by the midwife-in-charge.

**Head and Neck:** On inspection, client's hair was observed to be neatly braided and appeared clean. Her face was also clean and no abnormality was detected. Her eyes were normal in color and in good condition. The ears were also in proper alignment with the eyes, the nose had patent nares. The mouth and teeth were very clean and in good condition, the lips were nicely kept with a lip balm applied to it, the tongue was kept clean. No abnormality was detected. As the procedure was on going, client was congratulated for having taken good care of herself. The neck was free from lymph nodes and goitre.

**Breast Examination:** Both breasts were exposed and inspected for the size and shape and the condition of the skin which had no abnormality. One breast was covered and she was asked to put the hand of the part to be examined under her head. The breast was palpated and there were no masses, lump, cracks or sore nipple. The nipple was squeezed gently, cleaned with dry cotton wool swab and was examined for blood and any abnormal discharge but it was normal. Same procedure was performed on the other breast and no abnormality was detected. Client was educated and taught how to perform self-breast examination.

**Upper Extremities;** after client was informed about the continuation of examination, Client was asked for tingling and tightness of the finger on making a fist, the hands and fingers were inspected for edema, extra digit, pallor of palms and nail bed for pallor and no abnormality was noted. The Client was informed about the next step and client was assisted into a left lateral position.

**Lower Extremities**; Madam Fosuaa was asked to lie on her back again for examination of the

lower extremities. There was no pain found in the calf, her toe nails were short and clean,

there was no varicose vein, extra digit or edema on the lower extremities. The. The legs were inspected for size and equality, nail bed for pallor and palpated for edema, tenderness in the calf muscles varicose veins, size and equality and no abnormality was noted.

**Back**: Her back was examined for any abnormalities of the spine and sacral region for edema

and for varicose veins of which no abnormality was detected. The skin was in good condition and costovertebral angle tenderness was absent.

**Abdominal examination.**

**Inspection**: The abdomen was inspected for scars, size, shape, striae-gravidarium, linear nigra and foetal movement. Linear nigra was present, the shape was ovoid with no scars, the size was average and there was fetal movement.

**Measurement of the Symphysio-fundal height:** The upper border of the symphysis pubis was located. For measuring the symphysio-fundal height, the zero mark of the measuring tape was placed on the upper border of the symphysis pubis and extended along the contour of the abdomen to the fundus. The symphysio-fundal height measured 35cm and the gestational age was 36+2 weeks.

**Fundal palpation**: The hands were rubbed together to make them warm in order not to Induce contractions. The palms were placed on either side of the fundus while facing the woman's head. Fingers were curved around the top of the fundus and a soft mass was felt, indicating that the buttocks were occupying the fundus.

**Lateral palpation**: The palms were placed on both sides of the uterus, midway between the symphysis pubis and the fundus. The uterus was stabilized with one hand and examined by the

other hand. The palpation was started from the abdominal midline to the lateral side of the abdomen and from the symphysis pubis to the fundus in a rotatory manner. The fetal back (the smooth part) was located at the right side of the woman's abdomen, and the limbs (the rough part) were at the left side.

**Pelvic palpation**: Facing the woman's feet**,** she was asked to flex her knees slightly and breath in and out slowly to aid in the relaxation of the abdominal muscle. The palms were placed on either side of the uterus just below the level of the umbilicus and fingers directed toward the symphysis pubis, thumbs almost meeting. Presentation was determined to be cephalic as a hard mass palpated with the lie being longitudinal.

**Descent**: The anterior shoulder was located 2.5cm below the umbilicus and with the ulna

border just above the symphysis pubis, five fingers occupied the space indicating descent of 5/5th above pelvic brim.

**Auscultation:** Fetal stethoscope was warmed by rubbing it in the palm. The fetal heart was auscultated by placing fetal stethoscope on the area where the back was located. The ear was placed against the stethoscope, making sure hands were not touching the stethoscope when the fetal heart beat was being counted. Comparing the rate with the maternal pulse and counting how many beats were heard for one minute, it was 140bpm with regular rhythm.

**Vulva examination:** Permission was sought from Madam Fosuaa to examine her vulva, which was granted. Hands were washed using aseptic techniques before the procedure. The woman was helped to relax onto the examination bed. She was made to bend her knees and was told to separate her legs gently. With the aid of a direct light, her inner thighs were touched gently before touching any of her genitals in order not to startle her. The labia, clitoris and perineum were inspected. The

skin was very smooth and clean and the pubic hair was free of nits and lice. The labia tissue felt soft and consistent on palpation. There was no swelling, redness, marks, rashes, pimples or sores. There were no abnormal discharges. No signs of fistulae were also observed. She was asked to bear down while holding the labia open to watch for any bulging of the anterior or posterior vaginal walls.

Madam Fosuaa was helped to dress up after the examination and all findings were explained to her. She was thanked for her understanding and cooperation. Hands were washed and dried and all findings were recorded in her antenatal book. She has no complains and she was educated on the need to have sex and birth preparedness and complication readiness. Permission was sought from Madam Fosuaa for home visit and it was granted and then directions to her house as well as her contact numbers were asked for. She was informed on the next antenatal visit which was on the 21st November, 2022. Routine drugs were served as follows;

1. Tablet Folic Acid 5 milligrams daily for 7days
2. Tablet Ferrous Sulphate 60 milligrams daily for 7days
3. Tablet Multivitamins 200milligrams daily for 7days

She was again reminded on the home visit and said goodbye to her.

## 2.2 FIRST ANTENATAL HOME VISIT

The first home visit to Madam Fosuaa's house was on the 19th November, 2022 at exactly 10:40am. The aim of the visit was to assess her home environment and to know how she is prepared toward birth. Greetings were exchanged and seat offered on arrival. She was in the house with her child and her family who were home due to the weakened. The husband was not yet back from work, thus the tailor. Madam Fosuaa lives in a chamber and hall room house built with blocks and

plastered with cement and also roofed with aluminum sheet. She lives with her husband and child. There is a pipe in her house and neighborhood, where she fetches water for domestic activities and stores it in a clean large blue barrel with a lid. Electricity is the source of power used in the house. She has a kitchen which is built with wood which was very clean and in a good condition. She gathers rubbish or waste in a container with a cover which she finally disposes every day into the public refuse dump. She was advised to always cover her dustbin to prevent flies from settling on uncovered food which could bring about diseases. The compound was very nice because it looked very neat and the surrounding was neatly weeded. There was no stagnant water and no gutters. She also said that the whole family was ready to accept the new born into the family. She was encouraged to introduce her child to the unborn child to prevent sibling rivalry. She was asked about the previous complained, she made about the constipation but said the constipation has subside due to frequently intake of fluid and fruit. She also complained of loss of appetite and she was educated to eat in bit but frequently and ensure oral hygiene. She was asked to continue with her routine drugs as prescribed. She promised to do as educated. She was encouraged to maintain the neatness in her compound. Before leaving, her layette was checked, she had already packed her bag with items like; sanitary pads, toiletries among others. In this bag included purse with money, insurance card and antenatal book. She was also educated on birth preparedness and complication readiness plan by asking her the person who would accompany her to the hospital to deliver as well as take care of the house during that same period and she replied saying her husband would take that responsibility. The permission to leave was sought and she was promised of another visit.

**Psychosocial Environment:** Madam Fosuaa, the husband, the child and family- in laws have a cordial relationship with each other, she has a warm and friendly relationship with the tenants,

other family members staying around the house and neighbours. Her friends most of the times visit her and also visits them at her leisure time. She is very free and likes to crack jokes. She has respect for humans and likes to make new friends.

After all interaction, Madam Fosuaa and her family were then appreciated for their warm reception and permission was sought to leave. The next visit scheduled and was then seen off by client.

### 2.3 SECOND ANTENATAL HOME VISIT

The second home visit was made on 23rd November, 2022 at 3:30pm. The visit was made purposely to check on the health status and educate Madam Fosuaa on birth preparedness and complication readiness plan. On arrival she was happy and gave and information about the previous complained her that the loss of appetite has subside and she can eat well. Client was doing well except that she complained of backache. She was therefore encouraged not to stand and sit for too long, she was also advised to let a family member assist in household chores, and also was reassured by explaining the physiology of backache in late pregnancy. She was educated on the true signs of labour such as rhythmic regular uterine contractions and show, and was told to give a call and report immediately to the clinic as soon as she sees any danger signs of pregnancy such as severe frontal headache, severe lower abdominal pains, bleeding per vaginum and excessive vomiting. She was thanked for her cooperation and reminded of her next visit to antenatal clinic on 28thNovember, 2022.Permission was sought to leave.

### 2.4 SUBSEQUENT VISIT TO THE CLINIC

On the 28th November, 2022 Madam Fosuaa reported at the facility as scheduled. she was warmly welcome, offered a seat and congratulated for her regular attendance. Her antenatal book was

collected and glanced through. All routine procedures to carried out were explained to her and her consent was sought. Her vital signs checked and recorded as follows.

| | |
|---|---|
| Temperature | 36.2 degrees Celsius |
| Pulse | 80 beat per minute |
| Respiration | 20cycle per minute |
| Blood pressure | 110/70 millimeter of mercury |
| Weight | 57 kilograms |

Client was asked to empty her bladder and urine was tested for the presence of protein and glucose which were both negative. She was then sent to the palpation room. she was assisted to position herself on the examination bed. After hand washing with antiseptic soap under running water and well dried with a clean dry towel, head to toe examination was done and no abnormalities was detected. On palpation, the gestation was 38weeks+2 days; Symphisio-fundal height was 37cm, lie longitudinal and position was left occipito-anterior, Presentation was cephalic, descent was was $4/5^{th}$, foetal heart rate was 140bpm on auscultation. she was then congratulated, asked to lie on her left side, sit and then get up from the examination bed. A sit was offered to her and findings where communicated to her. Client complains of heartburns and was then encouraged to eat in bit by bit and was asked to come to the facility in a week time if she had not delivered. she was not served with any of her routine drugs because the previous once has not finished. She was then thanked and seen off.

## 2.5 CARE PLAN DURING ANTENATAL PERIOD

## PROBLEMS IDENTIFIED DURING ANTENATAL

Madam Fosuaa complained of the following;

1. Constipation 7/11/22
2. Loss of Appetite 14/11/22
3. Backache 23/11/22
4. Heartburns. 28/11/22
5. Fatigue 30 /11/22

## SHORT TERM OBJECTIVES

1. Client will be able to pass stools once every 48hours.
2. Client will regain her appetite and take at least half of meal served within 48hours.
3. Client will cope with Backache throughout pregnancy within 48hours.
4. Client will be relieved of heartburns within 24hours.
5. Client"s fatigue will resolve within 72hours

## LONG TERM OBJECTIVES

Madam Fosuaa will go through pregnancy, labor and puerperium successfully without any complication to herself and her fetus.

**TABLE 2: NURSING CARE PLAN ON ANTENATAL CARE.**

| DATE/ TIME | NURSING DIAGNOSIS | NURSING OBJECTIVES /OUTCOME CRITERIA | NURSING ORDERS | NURSING INTERVENTION | DATE/ TIME | EVALUATION | SIGN |
|---|---|---|---|---|---|---|---|
| 07/11/22 at 10:00am | Constipation related to physiological changes during late pregnancy | Client will be able to pass stools once every 48 hours as evidenced by client verbalizing that she has resume normal bowel movements (twice daily). | 1. Reassure Client<br>2. Educate Client to take food rich in fiber.<br>3. Encourage Client to take at least 500mls of fluid everyday. | 1. Madam Fosuaa was reassured to allay any anxiety.<br>2. Madam Fosuaa was educated to take in food rich in fiber such as fruits and vegetables.<br>3. Client was encouraged to take at least 500mls of fluids per day. | 09/11/22 at 10:00am | Goal fully met as client verbalized she had resume normal bowel movement (twice daily). | Y.W.O |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  |  |  | 4. Encourage Client to engage in tolerable exercise such as walking. | 4. Madam Fosuaa was encouraged to engage in tolerable exercise such as walking . |  |  |  |

| DATE/ TIME | NURSING DIAGNOSIS | NURSING OBJECTIVE / OUTCOME CRITERIA | NURSING ORDERS | NURSING INTERVENTION | DATE/ TIME | EVALUATION | SIGN |
|---|---|---|---|---|---|---|---|
| 14/11/22 at 4:00pm | Alteration in Nutritional status less than body requirement (Loss of appetite) related to hormonal changes during late pregnancy. | Client will regain her appetite and take at least half of meal served within 48hours as evidenced by midwife observing it. | 1. Reassure client.<br>2. Educate Client to take foods in bits and in frequent interval.<br>3. Encourage her to practice Oral hygiene.<br>4. Encourage client to take vitamin supplements as prescribed. | 1. Client was reassured she would regain her appetite.<br>2. Madam Fosuaa was educated to take food in bits and in frequent interval.<br>3. She was encouraged to brush her teeth twice daily and rinse mouth with water before and after each meal.<br>4. She was encouraged to take in lots of fruits and vegetables. | 16/11/22 at 4:00pm | Goal fully met as midwife observed client taking half of meal served. | Y.W.O |

| DATE/ TIME | NURSING DIAGNOSIS | NURSING OBJECTIVE / OUTCOME CRITERIA | NURSING ORDERS | NURSING INTERVENTION | DATE/ TIME | EVALUATION | SIGN |
|---|---|---|---|---|---|---|---|
| 23/11/22 at 4:00pm | Acute Pain (Backache) related to pressure on sacral nerve. | Client will cope with backache within 48hours as evidenced by client making less pain complaint. | 1. Reassure client<br><br>2. Encourage client to avoid prolong sitting and standing.<br><br>3. Administer prescribed medications.<br><br>4. Encourage client's family to assist her with household chores. | 1. Client was reassured.<br><br>2. Client was encouraged to avoid prolong standing and sitting.<br><br>3. Prescribed analgesics were administered to client to relieve her of her pains.<br><br>4. Client's family were encouraged to help her with household chores. | 25/12/22 at 4:00pm. | Goal fully met as evidenced by client verbalizing that she can cope with backache and has less pain complaint. | Y.W.O |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | | 5. Encourage client to sleep on firm mattress. | 5. Client was encouraged to sleep on a firm mattress to provide comfort. | | | |

**TABLE 1.3: NURSING CARE PLAN ON ANTENATAL CARE CONTINUED**

| DATE/ TIME | NURSING DIAGNOSIS | NURSING OBJECTIVE | NURSING ORDERS | NURSING INTERVENTIONS | DATE/ TIME | EVALUATION | SIGN |
|---|---|---|---|---|---|---|---|
| 28/11/22 at 4:00pm | Heartburns related progesterone relaxing the cardiac sphincter causing reflux of gastric content into the oesophagus. | Client will be relieved of heartburns within 24hours as evidenced by client verbalizing she has been relieved of heartburns. | 1. Reassure Client<br><br>2. Explain the physiological reason of heartburns.<br><br>3. Educate client to reduce fatty and spicy foods. | 1. Madam Fosuaa was reassured.<br><br>2. Physiology of heartburns was explained to client that it is due the reflux of gastric content into the oesophagus.<br><br>3. Client was educated to reduce fatty and spicy foods. | 28/11/22 at 4:00pm | Goal fully met as evidenced by client verbalizing that has been relieved of heartburns. | Y.W. O |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | | 4. Educate client to eat in bits but a frequent interval<br><br>5. Educate client to go to bed early after eating. | 4. Madam Fosuaa was educated to eat in bits and a shorter interval.<br><br>5. Client was educated to sit for about an hour after eating before going to bed. | | | |

TABLE 1.3: NURSING CARE PLAN DURING ANTENATAL CONTINUED

| DATE / TIME | NURSING DIAGNOSIS | OBJECTIVE /OUTCOME CRITERIA | NURSING ORDERS | NURSING INTERVENTION | DATE/TIME | EVALUATION | SIGN |
|---|---|---|---|---|---|---|---|
| 30/11/22 at 9:00 am | Activity intolerance (fatigue) relatedto weight of the product of conception and inadequate rest. | Client's fatigue will subside and body comfort will be restored within 48 hours as evidenced by client verbalizing reduction in fatigue and improvement in the body comfort. | 1. Reassure client that fatigue will subside.<br>2. Encourage family members to help with house chores.<br>3. Encourage client to take up little work. | 1. Client was reassured of adequate support to reduce fatigue.<br>2. Family members were encouraged to help with the household chores.<br>3. Client was encouraged to take up little work that she can tolerate. | 2/12/22 at 9:00am | Goal fully met as client verbalized that fatigue was subside and improvement in body comfort. | Y.W.O |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | | 4. Teach client energy conservation techniques such as sitting rather than squatting or standing while washing.<br>5. Encourage client to have enough sleeping and rest. | 4. Client was taught energy conservation techniques such as sitting rather than standing and squatting while washing<br>5.Client was encouraged to have enough sleep and rest especially during the night. | | | |

# CHAPTER THREE

# LABOUR

## 3.0 INTRODUCTION

This chapter deals with admission and the management of labour which includes all the four stages of labour of the client, immediate care of the newborn, examination of the newborn and the care plan drawn for problems identified in labour.

## 3.1 ADMISSION AND MANAGEMENT OF THE FIRST STAGE OF LABOUR

### ADMISSION

During Night shift on the 1st December, 2022, Madam Fosuaa arrived at the labour ward at

03:00am accompanied by her husband and the mother in law. After her husband called on phone to give information about her wife experiencing lower abdominal pain and waist pain and was asked to come to the hospital. Assessment was done to assess the progress of labour before client

was taken through the admission process. History of labour was taken from client and she

said labour started around 11pm and she was experiencing mild waist and contractions, show

was noticed at home and the contractions became frequent. Madam Fosuaa said she had not

seen any trickling of water or blood but could feel increased fetal movements. Enquires were

made to know if she took any medications or herbs since the pain started but she answered no

and also said she ate Rice and Stew at 6:00pm before coming and

had a normal bowel movement when asked. Client was reassured of competent care to be rendered after which she was made comfortable in bed and privacy maintained. Client layette was arranged

by her bedside and she was encouraged to empty her bowel and bladder when she had the urge into a bed pan provided. Client was asking questions about the duration and outcome of labour and client was seen to be anxious. Madam Fosuaa was reassured of competent care to be given as well as education on procedures to be performed and the stages of labour. She was also reassured that she will not be left alone but the husband will be readily available for her. Her vital signs were checked and recorded as follows;

| | |
|---|---|
| Temperature | 36.2 degree Celsius |
| Pulse | 80 beat per minute |
| Respiration | 22 cycle per minute |
| Blood Pressure | 100/60 millimeter of mercury |

Privacy was provided and explanation was given on procedure for physical examination from head to toe. Consent was sought from client and she agreed. Madam Fosuaa was asked to empty her bladder and take a midstream urine to test for protein and acetone which when tested was negative for protein and glucose. Client passed 100mls of straw colored urine. Client was assisted to undress and cover herself with a piece of cloth and assisted onto the examination bed. Hands were washed under running water with soap and dried with clean dry towel. The head to toe examination was done under the supervision of the midwife in-charge. The hair, sclera, conjunctiva, nose, mouth, ears, neck were examined without any abnormality seen. The face was a bit tensed because of the painful contractions. The breasts

were firm on the chest with no engorgement or inversion of the nipples. The arms were proportionate in length, the nails were also short and clean. On her lower extremities, there was no varicose vein found on the legs. There was no pallor, edema nor jaundice. The hands were warmed again by rubbing them together.

**Inspection**; on abdominal inspection, the abdomen was globular in shape, there was linea nigra on the abdomen and no straie gravidanum or previous scar was observed.

**Measuring of the symphysio-fundal height; Symphysio** - fundal height was 38 centimeters with gestation of 38 weeks and 5 days.

**On fundal palpation**; the fundus was palpated and a soft mass was identified as the fetal buttocks.

**Lateral palpation;** was done to find the back and limbs of the fetus which revealed a smooth fetal back to be at the right side of the abdomen and limbs on the left side as it felt rough.

**On pelvic palpation;** the lie was longitudinal, position was right occipito-anterior, and presentation was cephalic.

Descent was determined by locating the anterior shoulder 2.5 cm below the umbilicus and symphysis pubis which admitted four fingers. Descent was four-fifth (4/5th) palpated above the pelvic brim.

**On auscultation;** the fetoscope was rubbed on the palm to warm it before placing it on the abdomen to listen to the fetal heart beat for a full minute which read as 128 beats per minute with regular rhythm and good volume.

The uterine contractions was timed for 10minutes and it recorded 3 in 10 minutes lasting 36 seconds approximately. There was no abnormal tenderness excluding enlargement of the liver and spleen.

**Vaginal examination**

Permission was asked to perform vaginal examination of which she agreed. Procedure for vagina examination was explained to her in order to promote comfort and seek her co operation. A sterile tray was set containing two gallipots, one containing savlon antiseptic solution, the other gallipot with sterile cotton wool swabs, a pair of surgical gloves and a receiver for used swabs and all was covered with a sterile towel. Privacy was ensured. Hands were washed with soap under running and dried with a clean dry towel. Client was then helped into a lithotomy position with her knees flexed and thighs apart. Examination gloves were worn and soiled pad removed, examined and discarded with the left hand. A pair of surgical gloves were worn. The vulva was well shaved. A sterile cotton wool swab was picked with the right hand dipped into the gallipot containing savlon solution. The swab was dropped from the right hand into the left hand and used to swab the labia majora and the minora using a

swab for each. With the left hand parting the minora, the last swab in the right hand was used to clean the vestibule from anterior to posterior. Client was informed that, the middle finger followed by the index finger will be put into her vagina to assess the condition of the vagina and cervix and that she will feel a bit uncomfortable. With the labia minora still separated, the right middle finger was inserted into the vagina gently but firmly pressing downward whilst the index finger was added into the vagina in order to relax the vagina wall and muscles.

On vaginal examination, the vagina was warm and moist, the sacrum was well curved, the ischial spines were blunt, the sacral promontory was not reached at 11cm and cervix was thin, soft, elastic and cervical os was 4cm dilated 3:10am. The presenting part was well applied to the cervix with intact membranes. Molding was not present. The pubic arch was wide, and the rectum was empty. On withdrawal of the fingers, observation was made on the examining fingers and they were clear and not offensive. The vulva was cleaned and a clean perineal pad was applied. Client was made comfortable in bed with the help of the midwife-in-charge. She was also encouraged to ambulate and to lie on her left when she fells tired, client was then informed about the findings and after this, all findings were recorded on the partograph. All instruments used were decontaminated in 0.5% chlorine solution. Hands were washed under running water with soap and dried with clean dry towel after the gloves were discarded.

## PREPARATION FOR BIRTH

In preparing for birth, helpers were identified including the skilled and unskilled personnel. The midwife in-charge was identified as the skilled personnel and the client's husband was identified as the unskilled personnel. The doctor on call was notified about the client"s admission. Emergency boxes (like PPH and Eclampsia) with their appropriate items were available. Client's mother-in-law was also asked to contact the taxi driver to be alert incase of referral. The area for delivery had been already cleaned. Client was encouraged to wash hands with soap under running water and dried with clean dry towel and she was informed that the windows will be shut and fans will also be put off to provide a warm environment for the baby when it is time for delivery of which she agreed. Room was well lighted and ventilated. Madam Fosuaa was also educated that the baby would be delivered onto her abdomen on a sterile towel and she will have to support the baby. She was also informed that her abdomen will be cleaned for skin to skin care with the baby. The resuscitation box had all the items needed such as a stethoscope, scissors, cord clamp, sucker, self -inflating bag and mask of different sizes. The self-inflating bag was tested to see whether it was functioning, also the radiant bulb was switched on to provide warmth to the cot. Other items like cot sheets were also made available. Referral centers and their numbers as well as ambulance. Delivery items were also

made available. Madam was encouraged to assume any position favorable to her. She was encouraged to assume a left lateral position to increase placental perfusion and prevent supine hypotension. She was encouraged to ambulate to aid in the descent of the fetal head. A bed pan was provided for her and was encouraged to urinate when she feels the urge to further aid in descent of the fetal head. Client was encouraged to take in water or any sweetened fluid to prevent dehydration. Client was served with 300mls of malt drink which was brought by the husband. Madam Fosuaa was reminded of the deep breathing exercises so as to conserve energy for the second stage. Sacral region was massaged during contractions to relieve her from pain. Client was continuously and closely monitored on the partograph throughout the first stage of labour, maternal and fetal conditions were recorded and labour progressed well. Client was monitored on the partograph as follows; fetal heart rate, uterine contractions and maternal pulse were checked every thirty (30) minutes. The cervical dilation, descent, membranes, moulding, blood pressure and temperature were checked every four (4) hours. Urine test for protein and acetone was done every four (4) hours. Client was reassured again of competent care to be rendered and all procedures were explained before their performance. All findings were communicated to her. At 4:10am fetal heart rate was 128bpm, contractions were 3 in 10 lasting for 36 seconds and maternal pulse was 85bpm. At 4:40am fetal heart rate was 130bpm, contractions were 3 in 10 lasting 32 seconds and maternal pulse was 75bpm. She was assisted to lie on her left and breathe through her mouth since she was complaining of severe waist pain. She

was reassured that she will soon have her baby and all discomforts will be resolved and a sacral massage was given to reduce the pain. She was encouraged to assume a favorable position and the physiology of uterine contraction was explained to her. At 5:10p m fetal heart rate was 129bpm contractions were 3 in 10 lasting 38 seconds, maternal pulse was 84bpm.The progress of labour was documented and then communicated to client. Client was sweating a lot and was cleaned with a wet towel. She was also given iced water to calm herself.

At 7:10am temperature was checked and recorded as 36.1˚C and blood pressure was 120/70mmHg, urine was taken to test for protein and acetone and they all showed negative and the amount of urine as 100mls and head descent was 2/5th. fetal heart rate was 136bpm, contractions were 3 in 10 lasting 41 seconds, maternal pulse was 87bpm. Client was due for vaginal examination. It was observed that client had removed pad onto bed. She was quickly made aware not to do that since she could be infected. She was encouraged to wash her hands with soap under running water and dried with clean dry towel and discard pad if fallen.

Vagina examination revealed cervical os 8cm dilated with membranes intact, moulding (0).

Progress of labour was communicated to her and she was reassured.

**Setting of trolley**

The trolley was set with the following instruments and items on top and button shelf and paying attention to sterility. It contained the following items;

**Top shelf**; which contain the sterile instrument that is the delivery pack and is made up of

- A sterile bowl for Savon solution
- Two artery forceps
- Two sterile towels
- Two dissecting forceps

 A HLD episiotomy pack containing;

- Episiotomy scissors
- Needle holder
- Dissecting forceps
- Receiver for placenta
- Sterile gauze swabs and cotton wool swabs in a gallipot
- Clean sucker.

**Bottom shelf** also contains

- Pre-packed sterile gloves
- Warm towels and blanket
- Perineal pads,
- Jug to measure blood loss
- Syringes and needles
- Cord clamp
- Baby identification band
- Antiseptic lotion
- Fetoscope

- Drainage bag and catheter
- A drug tray containing injection Oxytocin, Lidocaine, water for injection, injection
- vitamin K, and Chloramphenicol eye drop
- Two clean cot sheets.

Oxygen source and suctioning machine were all in good working condition.

At 9:10am, fetal heart rate was 133bpm, contractions were 4 in 10 lasting 46sec and maternal pulse was 92bpm. At 9:1

0am membranes ruptured spontaneously with clear liquor. Vaginal

examination was done to exclude cord prolapse and there was none, cervix was 10cm dilated with molding (++), descent was 0/5th, fetal heart rate was 136bpm, contractions were 4 in 10 lasting 49 seconds and maternal pulse was 85bpm. Client complained of bearing down and was encouraged to breathe through her mouth. The perineum was quickly examined, the vulva and anus were gaping, perineum was bulging and a trickle of blood was evident. Progress of labour was communicated to the midwife in-charge and the client that the cervix was fully dilated. All findings were explained to her and recorded on the partograph sheet. The midwife in charge confirmed full dilation of the cervix.

### 3.2 MANAGEMENT OF THE SECOND STAGE OF LABOUR

Madam Fosuaa had successfully passed through the first stage. Her cervix was fully dilated at 9:10am. The set trolley was pushed to the delivery bed. Protective clothing such as head gear, goggle, face mask, plastic apron and boots were worn. After hand washing, surgical gloves were put on to complete the sterility of the entire procedure. She was encouraged to assume dorsal position with the knee flexed as agreed earlier. The vulva was swabbed with the sterile cotton and savlon lotion. She was draped with 4 sterile towels; abdomen shouldn't be covered because you will deliver baby on it for skin to skin, under the buttocks as well as both thighs. Full dilation of the cervix was confirmed by the midwife on duty. A pad was applied to the perineum to prevent fecal content from entering the baby's face. She was reassured and encouraged to bear down with contractions and to rest in between contraction. After crowning, the birth of the head was controlled with the index and middle fingers placed on the fetal head to aid flexion to prevent perineal laceration. With extension, the sinciput, the face, and chin swept the perineum for the head to be born. After the delivery of the head, sterile gauze was used to wipe the eyes from the inner canthus outwards. The face, mouth and nose were also wiped. There was restitution followed by external rotation of the head indicating internal rotation of the shoulders occurred spontaneously. With both palms on each side of the baby's head, over the ears, a downward gentle pressure was applied towards the mother's perineum to deliver the anterior shoulder. The posterior shoulder was also delivered by upward movement towards the mother's abdomen. The trunk and the rest of the body were also delivered by lateral flexion onto the mother's abdomen at 9:30am.

### 3.3 IMMEDIATE CARE OF THE BABY

The immediate care of the baby starts from the delivery of the baby's head. The baby's eyes were cleaned from inner canthus out with sterile gauze. The liquor was cleaned from the baby's body

and the baby was covered with a warm dry cloth. The baby cried immediately and client was congratulated. The first minute APGAR score was assessed to be 8/10; baby was shown to the mother to identify the sex of the baby. A cap and baby's socks was put on as well as cloth for warmth. The cord was re-clamped tightly with a cord clamp 3 centimeters away from the baby's abdomen to prevent bleeding. An identification tag was put on the baby's hand. This tag bears the mother's name, sex, date and time of delivery. The fifth minute APGAR score was assessed to be 9/10. The baby was put skin to skin with mother with respiration monitored and breastfeeding initiated.

| **APGAR SCORE** | | **FIRST MINUTE** |
|---|---|---|
| Appearance | - | 2 |
| Pulse/heart rate | - | 1 |
| Grimace/reflex | - | 1 |
| Activity /muscle tone | - | 2 |
| Respiration | - | 2 |

| **APGAR SCORE** | | **FIFTH MINUTES** |
|---|---|---|
| Appearance | - | 2 |
| Pulse/heart rate | - | 2 |
| Grimace/reflex | - | 1 |
| Activity/muscle tone | - | 2 |

Respiration - 2

### 3.4 MANAGEMENT OF THE THIRD STAGE OF LABOUR

The management of third stage of labour is complete expulsion of the placenta and its membranes from the birth canal until all sources of hemorrhage are arrested. This begins immediately after the expulsion of the baby. Procedure involve in this stage was explained to client's understanding. Permission was sought before continuing with the third stage management. During the active management of the third stage, Madam Fosuaa's uterus was palpated through the abdomen to exclude the presence of second twin. Oxytocin 10units was injected intramuscularly on the upper outer thigh of the client. The cord was re-clamped with an artery forceps closer to the perineum. The left hand was put on the fundus to feel for contraction. As soon as contraction was felt, left hand was repositioned and placed on the suprapubic area with the palm facing the mother's abdomen. The uterus was pushed upward (counter pressure) to prevent inversion of the uterus. The right hand held the forceps and the cord. Gentle downward traction was put on the cord and repeated until the placental tissues were visible at the vulva. The placenta was cupped in both hands and gently turned in a twisting motion to deliver the membranes. The act prevented the tearing of the membrane.

The placenta was delivered completely at 9:40am and lobes were intact and it was placed in the receiver. Immediately, the fundus of the uterus was massaged through the abdomen until it was well contracted. Client was taught to be massaging her uterus from time to time. Blood clot was expelled from the uterus and the blood expelled measured 120mls. She was reassured and permission was asked to conduct examination to exclude any form of trauma to the cervix, vagina and the perineum. There were no cervical, vaginal, or perineal tears. All soiled materials were

removed and she was properly cleaned with savlon solution and made comfortable in a well laid bed. She was encouraged to empty her bladder regularly to ensure good contraction and to report any severe bleedings. The instruments were placed in a 0.5% chlorine solution for decontamination. She gave thanks to the Most High God. Other family members and her husband were also allowed to see Madam Fosuaa and her baby.

## 3.5 EXAMINATION OF PLACENTA AND MEMBRANES

Protective clothing was worn and a thorough inspection of the placenta and membranes was done in order to ensure no part of it has been retained during its delivery after it had been sent to the sluice room. The placenta was put in 0.5% chlorine solution to make it less infectious and it was held by the cord allowing the membranes to hang loosely downwards. The amnion was peeled from the chorion up to the umbilical cord and was fully viewed, the lobes fit together without any gap and edges also forming uniform circle at the maternal surface and this meant that there was no missing lobe, there was no white patches on the maternal surface, there was also no blood vessels radiating into the membranes which meant no succenturiate lobe. The cord was situated at the centre of the placenta with one vein and two arteries seen in the cord. There was no abnormality detected. The placenta was discarded after decontaminating it according to the protocol of the facility. The instruments and equipment used were soaked in 0.5% chlorine solution for ten minutes and washed, rinsed, dried and repacked for sterilization. Hands were dipped in chlorine solution before discarding the gloves.

## 3.6 MANAGEMENT OF THE FOURTH STAGE OF LABOUR

The fourth stage of labour begins right after delivery of the placenta, membranes as well as the arrest of bleeding until six hours after the delivery. During the fourth stage, the client and the baby were under close observation for early detection of postpartum complication that arose.

**Management of Mother**

Madam Fosuaa and baby were transferred to the lying-in ward after an hour observation. She was encouraged to continue breast feeding. Mother's vital signs were closely monitored every 15 minutes for 2 hours, every 30 minutes for an hour and every hour for three hours. The uterus was felt for contraction every 15 minutes to make sure it was well contracted. Her vital signs were recorded as follows**;**

| | |
|---|---|
| Temperature | 36.3degree celsius |
| Pulse | 80 beats per minutes |
| Respiration | 20 cycles per minutes |
| Blood pressure | 120/60 millimeter of Mercury |

Madam Fosuaa was also educated on how to feel for contraction and also massage her uterus. The symphysio fundal height was measured and recorded as 18cm**.** Mother was advised to report any severe bleeding observed. The lochia was red in color (rubra), moderate flow and had no odor. She took Porridge. Family members were also encouraged to visit Madam Fosuaa and the new born baby. The baby was observed for colour, breathing, bleeding from the cord and warmth but no abnormality was found. The baby was able to suckle the mother's breast.

**Prevention of disease (prophylaxis for the baby)**

The baby's eyes were cleaned with sterile cotton wool swab with normal saline from the inner to outer canthus and tetracycline eye ointment was instilled. The umbilical cord was dressed with six cotton wool swabs and Chlorhexidine gel. Vitamin $k_1$ (Phytomenadione) was given after the

examination. Hand washing was performed before and after handling of baby. This was done within the first 90 minute after birth to prevent infections such as ophthalmia neonatorium and hemorrhagic disease of the new born therefore the following treatments were given.

**Examination of the new born**

This is done within the first 90 minutes after birth. After washing hands and drying them, the procedure was explained to Madam Fosuaa. Disposable gloves were worn and the baby was examined in the presence of the mother in a clean, warm environment, with nearby windows closed and light switched on. Baby was placed on a covered flat surface with only the part being examined exposed systematically. Baby's general condition was stable. A detailed head to toe examination was carried out to determine any abnormality.

**The Head and Face:** The head was examined for softness/tension of fontanelles, size and shape, lacerations, caput succedaneum as well as intracranial hemorrhage 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 36cm. The eyes opened spontaneously when the baby was held in an upright position and the conjunctiva was clear. Eyes were also examined for colour, redness, discharge, placement and conjunctiva for hemorrhage 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 color and polyps which were all normal. The mouth was examined by pressing the angle of the jaw which opened the mouth and the tongue, gum and palate were inspected and there was no false tooth noticed. The palate was high arched, intact and the uvula centrally placed. There was no cleft palate or cleft lip, tight frenulum or tongue tie. Suckling, rooting and swallowing reflexes were checked and was present. The ears were inspected; the upper notch of the pinnae

was at the same level with the canthus of the eye. External auditory meatus was patent and the cartilage in the pinnae was checked for it softness. The shape and size was also noted and no abnormality was detected.

**Neck:** The neck was inspected and palpated with no swelling such as congenital goiter, enlarged lymph node, rotation and flexion were good.

**Chest and abdomen:** The chest was examined, the respiratory movement was regular and the respiratory rate was 46cpm. Breasts were palpated for consistency, masses, and the nipples for position and milk. The space between the nipples was noted and the nipples were in alignment. The abdomen was round with no bleeding from the umbilical cord and no signs of infection. The cord was examined and there was one vein and two arteries. The liver, spleen and bladder were palpated for size, tenderness and masses but no abnormality was detected. Apex beat was present and was recorded as 133bpm.

**Limbs and digits:** The length, movement and paralysis of the upper limbs were also noted. The digits were counted to be normal and separate to exclude webbing and the palm for the number of palmer creases. The shape and colour of the nail bed were inspected and reflexes (grasping, Moro) checked. Everything was normal. With the lower limbs, the leg and feet were inspected for symmetry, extra digits, webbing, movement, fare foot adduction, clubbed feet, knock-knees, bowed leg, tibia torsion and paralysis but no abnormality was found. The hip had no dislocation and the reflexes (knee jerk/ patella, plantar) were present. The feet were examined for any disability such as talips equinovarus. The axillae, elbow groin and popliteal spaces were examined without any abnormality detected.

**Back:** The spine was also examined with baby turned to one side. The back was palpated for swelling, dimpling, hairy patches to exclude spinal bifida and for missing vertebrae but no abnormality detected

**Genitalia and anus:** The urethra meatus was inspected for patency, foreign bodies and discharge. The anus was examined for patency and it was patent. The anus was also palpated for sphincter tone, masses, tenderness but it was normal. The baby passed meconium and urine

Baby's length was measured to be 49centimetres, weight was 3.3kg and temperature was 36.5◦C. In all, there was no abnormality detected. The baby was classified as normal and routine care of the baby continued. Gloves were removed and disposed aseptically before washing hands with soap under running water and dried with clean dry towel. The baby's was neatly wrapped. All findings were recorded.

| | |
|---|---|
| Temperature | 36.6 degree celsius |
| Apex beat | 128 beats per minutes |
| Respiration | 46 cycles per minutes |

Baby's condition was satisfactory. The baby and mother were transferred to the postpartum room for further monitoring.

Other assessments were recorded as follows;

| | |
|---|---|
| Sex | Female |
| Head circumference | 36 centimeters |
| Length | 49 centimeters |
| Weight | 3.3 kilograms |
| Abnormality | None detected |

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

**TABLE 2: APGAR SCORE**

| TIME | 1st min | 2nd min |
|---|---|---|
| **APPEARANCE** | 1 | 2 |
| **PULSE** | 2 | 2 |
| **GRIMACE** | 1 | 1 |
| **ACTIVITY** | 2 | 2 |
| **RESPIRATION** | 2 | 2 |
| **TOTAL** | 8/10 | 9/10 |

The general condition of the baby was satisfactory.

**Condition of mother**

Blood pressure 100/65 millimeters Mercury

Pulse 77 beats per minutes

Respiration 22 cycles per minutes

Temperature 36.4 degree celsius

Uterus contracted

SFH 18 centimeters

Lochia Rubra

| | |
|---|---|
| Condition | Satisfactory |

**Condition of placenta**

| | |
|---|---|
| Maternal surface | Normal (Dark red) |
| Fetal surface | Normal (Bluish grey) |
| Lobes and membranes | Complete and healthy |
| Blood Vessel | 2 Arteries, 1 vein |
| Cord situation | Central |

3.7 SUMMARY OF LABOUR

| | | |
|---|---|---|
| Time of delivery | | 9:30am |
| Time of placenta expulsion and membranes | | 9:40am |
| Type of delivery | - | spontaneous vaginal delivery |
| Estimated blood loss | - | 120mls |

**Duration of labour**

| | | |
|---|---|---|
| First stage of labour | - | 6hours |
| Second stage of labour | - | 10minutes |
| Third stage of labour | - | 10minutes |
| Total duration of labour | - | 6hours 20minutes |

## 3.8 CARE PLAN DURING LABOUR

**Problems identified during labor**

1. Lower abdominal pain 01/12/2022
2. Fatigue 01/12/2022
3. Possible perineal trauma
4. 
5. 01/12/2022
6. Anxiety 01/12/2022
7. Excessive sweating 01/12/2022

**SHORT TERM OBJECTIVES**

1. Client will cope and be relieved of lower abdominal pains within 24 hours by the end of labour.
2. Client will be relieved of fatigue within24 hours after labour.
3. Client will have intact perineum at the end of delivery.
4. Client anxiety will resolve within 24 hours by the end of labor.
5. Client will remain well hydrated and comfortable within 1 hour.

**LONG TERM OBJECTIVES**

Madan Fosuaa will go through pregnancy, labour and puerperium successfully without any complication to her and the baby.

**TABLE 3: NURSING CARE PLAN ON LABOUR**

| DATE/ TIME | NURSING DIAGNOSIS | NURSING OBJECTIVES/OUT COME CRITERIA | NURSING ORDERS | NURSING INTERVENTION | DATE/ TIME | EVALUATION | SIGN |
|---|---|---|---|---|---|---|---|
| 01/12/22 at 6:20am | Lower abdominal pain related to decent of fetal head. | Client will cope and be relieved with lower abdominal pains within 24 hours by the end of labor as evidenced by client`s actions. | 1. Reassure client and explain physiology of pain to her.<br>2. Explain the physiology of the pain to her.<br>3. Encourage client to practice deep breathing exercise.<br>4. Provide diversional therapy. | 1. Client was reassured and physiology explained to her.<br>2. The physiology of the pain was explained to the client.<br>3. Client was encouraged to practice deep breathing exercise.<br>4. Client was engaged in a conversation | 02/12/22 at 6:20am | Goal fully met as client verbalized that she was able to cope with the pain. | Y.W.O |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | | 5. Encourage ambulation | 5. Client was encouraged to walk around the bed. | | | |

**TABLE 3.1: NURSING CARE PLAN ON LABOUR**

| DATE/ TIME | NURSING DIAGNOSIS | NURSING OBJECTIVE | NURSING ORDERS | NURSING INTERVENTION | TIME/DATE | EVALUATION | SIGN |
|---|---|---|---|---|---|---|---|
| 01/12/22 at 07:00am | Fatigue related to pain and Stress of Labour | Client`s fatigue will be relieved within 24 hours after labor as evidenced by client`s actions | 1. Reassure client that she would be relieved of fatique.<br>2. Encourage client to do deep breathing exercise.<br>3. Monitor labour progress<br>4. Encourage her to have rest.<br>5. Give client oral fluid to hydrate her. | 1 Client was reassured that she would be relieved of fatique.<br>2. Client was encouraged to do deep breathing exercise<br>3. Partograph was used to monitor labor progression to avoid prolong labour.<br>4. Client was encouraged to have rest.<br>5. oral fluid (fruit juice )was given to hydrate . | 02/12/22 at 7:00am | Goal fully met as evidence by client's verbalizing that she feels less tired Midwife observing that client was active during labour . | Y.W.O |

| DATE/ TIME | NURSING DIAGNOSIS | NURSING OBJECTIVE | NURSING ORDERS | NURSING INTERVENTION | DATE/ TIME | EVALUATION | SIGN |
|---|---|---|---|---|---|---|---|
| 01/12/22 at 8:30am | Anxiety related to unknown outcome of labour. | Client anxiety will resolve within 24 hours by the end labour as evidenced by client`s behavior. | 1. Reassure client that is in the hands of competent staff.<br>2. Give feedback on every progress of labour.<br>3. Educate her on possible outcome of labour.<br>4. Encourage client to ask questions. | 1. Client was reassured that she was in the hands of competent staff.<br>2. Client was given feedback on the progress of labour.<br>3. Client was educated on possible outcome of labour.<br>4. Client was encouraged to ask questions and answers were given tactfully. | 02/12/22 at 8:30am | Goal fully met as client was seen relaxed in her bed and verbalized that she is relieved of anxiety. | Y.W.O |

|  |  |  |  |  |  |  |  |
|---|---|---|---|---|---|---|---|
|  |  |  | 5. Update client on the progress of labor. | 5. Client was updated on the progress of labour. |  |  |  |

| DATE<br>TIME | NURSING DIAGNOSIS | OBJECTIVES | NURSING ORDERS | NURSING INTERVENTION | DATE/<br>TIME | EVALUATION | SIGN |
|---|---|---|---|---|---|---|---|
| 01/12/22<br>at<br>9:00am | Potential for perineal trauma (over stretched and shiny perineum) related to delivery process. | Client will have an intact perineum after delivery as evidenced by midwife observing an intact perineum. | 1. Reassure client that she would have an intact perineum after delivery.<br>2. Confirm full dilatation of cervix before instructing client to push.<br>3. Deliver client skillfully using all the good mechanisms of second stage of labour.<br>4. Instruct client on when to push and when to relax. | 1. Client was reassured that she would have an intact perineum after delivery.<br>2. Cervix was fully confirm before client was instructed to push in other to prevent any tear.<br>3. Delivery was done skillfully using all the good mechanism during second stage of labour to prevent injury to the perineum.<br>4. Client pushed when she has the urge and relaxed in between contractions in other not to sustain tear. | 02/12/22<br>at<br>9:50am | Goal successfully met as evidenced by midwife observing an intact perineum after delivery. | Y.W.O |

|  |  |  |  |  |  |  |  |
|---|---|---|---|---|---|---|---|
|  |  |  | 5. Encourage client to adhere to all instructions given. | 5. Client was encouraged to adhere to all instructions given . |  |  |  |

TABLE 3.1: NURSING CARE PLAN ON LABOUR

| DATE/ TIME | NURSING DIAGNOSIS | NURSING OBJECTIVE | NURSING ORDERS | NURSING INTERVENTION | DATE/ TIME | EVALUATION | SIGN |
|---|---|---|---|---|---|---|---|
| 01/12/22 at 8:40am | Excessive sweating related to decrease glucose level in the blood | . Client will remain comfortable within 1 hour as evidenced by midwife observing that client feels comfortable and | 1. Reassure client.<br>2. Explain the cause of the perspiration.<br>3. Serve client cold water to drink at frequent interval.<br>4. Give ice cubes to client to sip<br>5. Mop the face and body of client with wet towel. | 1. Client was reassured of competent care to promote comfort.<br>2. The cause of the perspiration was explained to the client<br>3. Client took cold water frequently<br>4. Ice cube was given to the client to sip<br>5. Client's face and body was mopped with wet towel. | 01/12/22 at 9:40am | Goal met as client was observed to be comfortable and felt relaxed. | Y.W.O |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | not sweating excessively | 6. Improve ventilation . | 6. Windows were opened and fan put on | | | |

# CHAPTER FOUR

# PUERPERIUM

## 4.0 INTRODUCTION

This chapter provides information about the subsequent care given to the mother and her baby after delivery till six weeks postnatal.

## 4.1DAY OF DELIVERY

On Thursday,1st December, 2022. Madam Fosuaa had a spontaneous vaginal delivery with an alive female infant.

Both mother and baby were monitored every 15 minutes for 2 hours, 30 minutes for 1 hour and hourly for 3 hours. Madam Fosuaa and her baby were transferred to the lying-in ward for vigilant observation and they were made comfortable in bed with all observations recorded. Her health was enquired and the pains she complained during her labor had subsided. Madam Fosuaa was examined from head to toe before she took her bath and no abnormality was found. The lochia was red in color, moderate in quantity with no bad odor.

Findings from assessment of Madam Fosuaa and her baby were recorded as follows;

Mother's assessment

| | |
|---|---|
| Temperature/ | $36.3^{0C}$ |
| Pulse | 80bpm |
| Respiration | 20cpm |
| Blood pressure | 100/65mmHg |
| Symphysio fundal height | 18cm |

| Lochia | Rubra |
|---|---|

On palpation the uterus was well contracted and symphysio-fundal height measured 18cm just below the umbilicus. The lochia was red in colour and flow was moderate.Madam Fosuaa was asked to change her perineal pad when soiled to prevent ascending infection to the uterus and also empty her bladder to help involution of the uterus. She was advised to wash her hands before and after changing pad. She had her bath and kept warm with her baby in bed and encouraged on exclusive breastfeeding on demand. She was also advised to report any abnormal bleeding for prompt action to be taken. Madam Fosuaa was also educated on simple hand washing before and after touching and feeding the baby and after visiting the toilet. She was encouraged to take enough rest and sleep especially after breast feeding and put the baby to sleep to restore her energy. Madam Fosuaa complained of loss of appetite and was reassured it was temporal will subside with management. She was served with two tablets of paracetamol to relieve the after pains and was encourage to rest.

## 4.2 SUBSEQUENT CARE OF THE BABY

Six hours after the delivery of the baby, placenta and membranes, the baby was given a warm bath and he passed meconium and urine during her bath. The cord was inspected for bleeding and discharge but there was none. After that the baby was wrapped nicely in a warm towel and her findings from assessment was recorded as follows;

**Baby's vital signs**

| Temperature | $36.6^{0C}$ |
|---|---|
| Apex heart beat | 125bpm |

| | |
|---|---|
| Respiration | 42cpm |
| Weight | 3.3kg |

**BABY BATHING**

The baby was bathed after six hours observation with warm water and the cord dressed.

REQUIREMENTS

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

The procedure was explained to mother and a tray was set. The mother and the support person were made to observe the procedure. A plastic apron was worn and hands were washed with soap, water and dried with a clean towel. The water was mixed and the temperature was tested using the elbow. Sterile gloves were worn and baby was placed on a flat surface. she was undressed and wrapped in a big towel. The eyes were cleaned with cotton wool swabs soaked in clean water from inner canthus outwards. Her face was cleaned with damp face towel and dried. The nape of baby's neck was supported with one hand. Her ears were then plugged using two fingers of the hand and the head was washed with soapy sponge. With the body resting on the elbow and still supporting the nape, the baby was place at the edge of the bowl to rinse the soap off the head and dried. The baby was exposed; arms and front of trunk were washed paying attention to skin folds. The baby's back was turned with one hand supporting the chest and washed back down to feet paying attention to the skin folds. she was immersed in a bath of warm water with the head above the water and rinsed thoroughly. The baby was placed on a flat surface covered with clean sheet. The baby was dried by using a clean small towel paying attention to the skin folds. The cord was dressed by using sterile cotton wool swabs soaked in methylated spirit. The tip of the cord clamp was held with one sterile cotton wool swab and another was used to clean the base of the cord, the whole cord anteriorly and posteriorly each with a separate swab from the base upwards. The tip of the cord was cleaned with another swab and the cord was left exposed and the swab which was used to hold the cord clamp was used to clean it. The baby was dressed, wrapped and, given to mother to breastfeed. The waste materials were discarded according to infection prevention protocol. Mother was told that the baby will be topped and tailed till cord falls off. Gloves were removed and disposed of. Hands were washed with soap and water before handling the baby. Client was in a good condition after the procedure was carried out.

## 4.3 FIRST DAY POST DELIVERY AND DISCHARGE

The first day post-partum for Madam Fosuaa was 2nd December, 2022 at 7:30 am. She took a warm bath in the morning after her perineal pad was inspected for the presence of lochia which was small, no odor and red in color. She complains of after pain and she said, the pains were better now. Her consent was sought for head to toe examination. Everything was normal, breast was lactating well and uterus measured 17cm.

**Her vital signs were recorded as follows;**

| | |
|---|---|
| Temperature | $36.6^{0C}$ |
| Pulse | 84bpm |
| Respiration | 21cpm |
| Blood pressure | 120/60mmHg |
| Lochia | Rubra |
| Fundal Height | 17cm |
| Condition of the uterus | Contracted |
| Breast | lactating |

Madam Fosuaa complained of inadequate sleep during the night as a result of feeding her baby at night. She was encouraged to continue breastfeeding at night since it is important for the growth of her child and also sleep when the baby was asleep especially during the day time. Baby was

cleaned with warm water and cord was dressed with cotton wool swab soaked in methylated spirit. Baby was examined from head to toe in the presence of the mother and no abnormality was detected. Baby was reassessed and skin colour was pink, no cord bleeding and also baby was suckling well. Baby was dressed up neatly and the findings recorded as follows:

| | |
|---|---|
| Temperature | $36.5^{0C}$ |
| Apex heart beat | 127bpm |
| Respiration | 43cpm |
| Skin colour | pink |
| Weight | 3.2kg |
| Cord condition | clean dry |
| Cord bleeding | None |
| Suckling | Good |
| Stool colour | Meconium |

All findings were communicated to Madam Fosuaa. The baby was handed over to her to breast feed. This proved that what was taught during antenatal period was well understood. She was educated on healthy adequate nutritious diet to help in the production of more breast milk and improve her immunity, and help repair worn out tissues. Madam Fosuaa was again educated on good personal hygiene, post natal exercise and the various family planning methods. The essence of the exercise was to help the pelvic organs to return to their original position. She was informed

of her discharge. Furthermore Madam Fosuaa was encouraged to feed her baby on demand. She was also advised to register the baby at the birth and death registry.

Baby was given Bacillus Calmette Guerine (BCG) and polio “O” vaccine and mother was advised not to apply anything to the site in order to ensure effectiveness of the drugs. She was then asked to come with the baby to take the rest of the immunization at the time scheduled in order to prevent the baby from any of the childhood preventable diseases. Madam Fosuaa took fufu and chicken with salted beef soup after birth.

Client was served with the following drugs to send home:

| | | |
|---|---|---|
| Tab Ferrous Sulphate (tablet) | - | 200mg 1 daily for 30days |
| Tab Multivitamins (tablet) | - | 200mg 1 for daily for 30days |
| Tab Folic acid (tablet) | - | 5mg 1 daily by 30days |
| Tab Metronidazol | - | 400mg tid for 7days |
| Caps Amoxicilin | - | 500mg tid for 7days |
| Tab paracetamol | - | 1g tid for 7days |

She was informed of a visit to her house for a period of one week starting from the next day and she agreed. After settling her bill with national insurance, she was discharged.

### 4.4 FIRST POST NATAL HOME VISIT

Madam Fosuaa was visited in the house after delivery for the first time around 8:30am and 4:00pm on 3rd December, 2022. Greetings were exchanged and a seat was offered. The whole family was in good health and her previous complaints had gotten better, her loss of appetite had resolved and

after pains was better. Client was informed of the procedures to be carried out. Hands were washed and dried with a clean towel. Baby passed meconium and urine. Baby was examined from head to toe. No abnormality detected. Vital signs checked and recorded. The baby was cleaned. The cord was also dressed with cotton wool swabs and methylated spirit using aseptic technique; it was clean, dry and not offensive. The baby was then dressed properly and handed over to the client's mother-in-law who had come to assist the client after childbirth. Madam Fosuaa emptied her bladder and head to toe examination was done. The conjunctiva was examined and there was no pallor. The breasts were soft and lactating well. The uterus was well contracted with symphysio fundal height of 16cm. The perineum was clean, dry and intact, lochia was small red (rubra) and not offensive. Her vital signs checked and recorded during the morning and evening.

| Observation | Morning | Evening |
|---|---|---|
| Temperature | $36.5^{0C}$ | $36.3^{0C}$ |
| Pulse | 82 | 77 |
| Respiration | 23 | 20 |
| Blood pressure | 110/70 | 120/60 |
| Lochia | Rubra | Rubra |
| Fundal height | 16cm | 16cm |
| Condition of the uterus | Contracted | Contracted |

Baby was given to mother to breast feed. Baby was able to suck well. On assessment the baby's skin color was pink and there was no cord bleeding. Findings were recorded as follows;

| Observation | Morning | Evening |
|---|---|---|
| Temperature | 36.6$^{0C}$ | 36.7$^{0C}$ |
| Apex beat | 128bpm | 127bpm |
| Respiration | 44cpm | 41cpm |
| Skin colour | Pink | Pink |
| Cord condition | Clean and dry | Clean and dry |
| Cord bleeding | None | None |
| Suckling | Good | Good |
| Weight | 3.1 | 3.1 |
| Stool | Meconium | Meconium |

Madam Fosuaa was educated on family planning, danger signs in the newborn such as breathing difficulties, cyanosis, persistent vomiting and fever. Client and family were congratulated and permission was sought to leave and she was informed of the next home visit the next day during the evening visit.

### 4.5 SECOND POSTNATAL HOME VISIT

Madam Fosuaa was visited on the 4th December, 2022 around 8:30am and 5:00pm. Client and her baby were in good health. All procedures to be carried out on them were explained to her. Her perineal pad was inspected and lochia flow was small and red in color without bad odor before she took her bath. Madam Fosuaa was examined from head to toe and everything was normal, breast was lactating well. The symphysio fundal height was 15cm when measured. Her vital signs were taken and recorded as;

| Observation | Morning | Evening |
|---|---|---|
| Temperature | $36.2^{0C}$ | $37.2^{0C}$ |
| Pulse | 76bpm | 78bpm |
| Respiration | 21cpm | 20cpm |
| Blood Pressure | 110/62mmHg | 110/70mmHg |
| Lochia | Rubra | Rubra |
| Fundal height | 15cm | 15cm |
| Condition of the uterus | Contracted | Contracted |
| Breast | Lactating | Lactating |

Baby was then cleaned, she passed urine and meconium and was also examined from head to toe and nothing was detected. Her cord was dressed and was quite dry, no signs of infection were found.

The baby's vital signs and weight were checked and recorded as;

| Observation | Morning | Evening |
|---|---|---|
| Temperature | $36.6^{0C}$ | $36.8^{0C}$ |
| Apex heart beat | 129bpm | 125bpm |
| Respiration | 44cpm | 41cpm |
| Weight | 3.0kg | 3.0kg |
| Urine | Passed | Passed |

The mother was advised not to apply anything on the cord and encouraged to continue with post natal exercise and exclusive breast feeding. She was reminded of another visit the following day.

## 4.6THIRD POSTNATAL HOME VISIT

Madam Fosuaa was visited in the house for the third time at 8:30am and 5:30pm on the 5th December, 2022 to check up on how they were faring. They were doing well. Perineal pad was inspected. Lochia was small with red color. She took her bath after everything in the evening. Nothing abnormal was detected during head to toe examination. Symphysio fundal height was 14cm and findings from assessment were recorded as; Her vital signs were recorded as;

| **Observation** | **Morning** | **Evening** |
|---|---|---|
| Temperature | $36.5^{0C}$ | $36.2^{0C}$ |
| Pulse | 70bpm | 75bpm |
| Respiration | 19cpm | 20cpm |
| Blood Pressure | 110/60mmHg | 110/70mmHg |
| Lochia | Rubra | Rubra |
| Condition of the uterus | Contracted | Contracted |
| Breast | Lactating | Lactating |
| Fundal height | 14cm | 14cm |

No abnormality was found during head to toe examination. The cord was shrinking with no bleeding and was dressed with cotton wool with methylated spirit. She was dressed up and findings after assessment were checked and recorded.

All findings were explained to her understanding. She was once again reminded of next visit and was thanked for her cooperation. Baby's vital were checked and recorded as;

| Observation | Morning | Evening |
| --- | --- | --- |
| Temperature | $36.7^{0C}$ | $36.6^{0C}$ |
| Apex heart beat | 131bpm | 140bpm |
| Respiration | 40cpm | 42cpm |
| Weight | 3.0kg | 3.0kg |
| Urine | Passed | Passed |
| Cord condition | Clean and dry | Clean and dry |
| Suckling | Good | Good |

**4.7 FOURTH POSTNATAL HOME VISIT**

On 6th December, 2022 around 8:30am, client and family were visited as usual, greetings were exchanged and seat was offered and all family members were in good condition according to the mother. Head to toe examination was carried out and no abnormality was detected. Baby's cord was dressed with cotton wool swabs and methylated spirit, it was dry, not offensive and almost off. Head to toe examination was carried out on mother and no abnormality was detected. The Symphysio fundal height was 13 centimeters, perineum was clean and intact. Lochia was serosa, leucocytes and not offensive. The breast was lactating well. She also complained of backache and she was reassured and educated on other positions used in breastfeeding such as lying on her side to breastfeed and was also educated to support her back when sitting. Her vital signs were checked and recorded as;

The mother's vital signs were checked and recorded as;

| Observation | Morning |
|---|---|
| Temperature | $36.3^{o}$ C |
| Pulse | 70bpm |
| Respiration | 20cpm |
| Blood pressure | 110/75mmHg |
| Lochia | Serosa |
| Fundal height | 13cm |
| Condition of the uterus | Contracted |

The baby's vital signs was checked and recorded as;

| Observation | Morning |
|---|---|
| Temperature | $36.9^{0C}$ |
| Apex heart beat | 132bpm |
| Respiration | 46cpm |
| Weight | 3.1kg |
| Cord condition | Dry and clean |
| Stool colour | Meconium |
| Suckling | Good |

Mother was encouraged to ask questions. All findings were communicated to her and the necessary documentation was done. She was thanked and permission was sought to leave. She was reminded of another visit the next day.

## 4.8 FIFTH POST NATAL HOME VISIT

The 5th day postnatal visit was on 7th December, 2022 around 8:30am. Everybody in the family was fine and the environment was very clean. Madam Fosuaa's permission was sought for head to toe examination after taken her bath, inspection of lochia was done and the colour was pink (serosa) without any bad odour and the flow was moderate. Her vital signs were checked and recorded as;

| Observation | Morning |
|---|---|
| Temperature | $36.6^{0C}$ |
| Pulse | 72bpm |
| Respiration | 21cpm |
| Blood pressure | 110/70mmHg |
| Fundal height | 12cm |

On the fifth day, the symphysio fundal height was 12cm. The breast was lactating well. Examinations were done and everything was normal. The baby`s cord was off and healing well. Baby's vital signs were checked and recorded as;

| Observation | Morning |
|---|---|
| Temperature | $37.0^{o}$ C |
| Apex heart beat | 138bpm |
| Respiration | 46cpm |
| Weight | 3.2kg |
| Urine | Passed |

Mother was encouraged to continue good personal hygiene as well as that of the baby.

### 4.9 SIXTH POST NATAL HOME VISIT

0n 8th December, 2022 was the sixth home visit to Madam Fosuaa's house at 4:30pm. Client was doing well as well as baby and the entire family**.** Procedures to be done were explained to her. Head to toe examination was done on the baby and there was no abnormality detected. For the mother, Symphysio fundal height was11cm. The perineal pad was inspected and the flow was scanty and pink (serosa) in color and not offensive. Her vital signs were also checked and recorded as;

| Observation | Evening |
|---|---|
| Temperature | 36.1 °C |
| Pulse | 74bpm |
| Respiration | 19cpm |
| Blood pressure | 110/60mmHg |
| Fundal height | 11cm |

Head to toe examination was done and no abnormality was detected. The cord stump was clean, dry and not offensive. The baby was looking active and fine. Madam Fosuaa was asked to bath baby and clean the umbilical stump with cotton wool swab and methylated spirit under supervision and it was done well. The baby's vital signs were checked and recorded as;

| Observation | Evening |
|---|---|
| Temperature | 36.9 |
| Apex heart beat | 140bpm |

| | |
|---|---|
| Respiration | 42cpm |
| Weight | 3.3kg |
| Urine | Passed |

Madam Fosuaa was encouraged to continue with the exclusive breast feeding, exercise and the intake of nutritious diet for strong immunity and promotion of lactation. Madam Fosuaa and her family were thanked for their time and cooperation and were informed of the last home visit being the next day.

## 4.10 SEVENTH POSTNATAL HOME VISIT

The seventh day postnatal home visit was done on 9th December, 2022 at 8:30am. Greetings were exchanged with client and her family and a seat was offered in client's room. Mother and baby were both in a healthy condition. On examination, no abnormalities were detected. Her breast was lactating well. Symphysio- fundal height was 10cm. Inspection of the lochia was done and the colour was pink (serosa) normal flow without any bad odour. Madam Ameyaa said the baby has pass stool that morning before arrival.

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

| Observation | Morning |
|---|---|
| Temperature | $36.2^{0C}$ |
| Pulse | 80bpm |
| Respiration | 20cpm |
| Blood pressure | 115/70mmHg |

| Temperature | $36.2^{0C}$ |
|---|---|
| Fundal height | 10cm |

Baby was already bathed, head to toe examination was done and no abnormality was found on baby. The stamp was then dressed and the area was clean and dry.

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

| Observation | Morning |
|---|---|
| Temperature | $36.8^{0C}$ |
| Apex heart beat | 131bpm |
| Respiration | 43cpm |
| Weight | 3.4kg |
| Cord | Clean |
| Urine | Passed |

She was educated on the danger signs in baby like high body temperature, foul smell from the cord and the need to seek early care. She said, she appreciate that a lot, and she was thanked for her cooperation, she was reminded that, today was her postnatal visit to the clinic. Permission was sought to leave.

### 4.11 FIRST POST NATAL VISIT TO THE CLINIC

Madam Fosuaa arrived at the clinic with her baby accompanied by her sister on the 8th December, 2022. They were offered a seat and then asked about their health and they were fine including the

baby. All procedures to be carried out were explained to Madam Fosuaa. Her vital signs were checked and recorded. Her midstream urine specimen was collected and tested for protein and sugar but all were absent. Her haemoglobin level measured 12.4g/dl. Madam Fosuaa's weight was 66kg. She was helped to lie on the couch for a head to toe examination having emptied her bladder. On inspection the hair was well kept, there were no discharges from eye, nose, the conjunctiva was not pale, the sclera had no yellow discoloration and the mouth was clean. The ears were not discharging, neck was palpated for swollen lymph nodes but no abnormality was detected. The breast was examined and no abnormality was found and was lactating well with no engorgement. On abdominal examination, the uterus was not palpable and no enlargement of any abdominal organ. The vulva was inspected and there were no varicose vein, edema and bad odor. The Lochia was pale (serosa) in color with scanty flow and odorless. The extremities were free from any edema. All findings were communicated to her. Her vital signs were checked and recorded as follows;

Temperature $36.0^{0C}$

Pulse 76bpm

Respiration 20cpm

Blood pressure 120/70mmHg

Fundal height 11cm

The baby was also examined from head to toe and everything was normal. Baby's vital signs was checked and recorded as follows;

Temperature $36.7^{0C}$

| | |
|---|---|
| Apex heart beat | 135bpm |
| Respiration | 41cpm |
| Weight | 3.2kg |
| Urine | Passed |
| Stool | Yellowish Colour |

All the information was recorded in the post natal records. The mother was educated on good intake of well-balanced diet since this would improve her health status and also to produce more breast milk. She was also educated on family planning for her to have an informed choice so that during the six weeks post natal visit she could make a right choice. She was also advised to visit the child welfare clinic for the baby to complete all the immunization scheduled. She was thanked for her cooperation and also all the time spent together. She was very happy and was handed over to the midwife in-charge for continuity of care.

**4.12 SECOND POST NATAL VISIT TO THE CLINIC**

Madam Fosuaa visited to the facility at 9:30am on the 13th January, 2023. She came alone with her baby and they both looked nice and active. Every procedure to be carried out was explained to her. She was asked to empty her bladder and midstream urine was taken and tested for sugar and protein and the result was negative. Her haemoglobin level was 12.5gldl. Her vital signs were taken and recorded as follows;

| | |
|---|---|
| Temperature | $36.6^{0C}$ |
| Pulse | 88bpm |

Respiration 20cpm

Blood pressure 120/70mmHg

Baby's vital signs was checked and recorded as;

Temperature 36.7$^{0C}$

Apex heart beat 136bpm

Respiration 42cpm

Weight 4.2kg

Urine Passed

Stool Yellowish

Baby was given the due immunization at the Child Welfare Clinic by the midwife in charge. The baby was immunized against Pneumonia, Diphtheria, Pertussis, Tetanus, Hepatitis B, Hemophilus influenza B (5 in one vaccine).

The following vaccines were given:

| **Vaccine** | **Dosage** | **Route of administration** |
|---|---|---|
| Polio 1 | 2 drops | Oral |
| Rotavirus 1 | 1.5ml | Oral |
| DPT-HepB Hib | 0.5ml | Intra-muscular, left thigh |
| Pneumococcal 1 | 0.5ml | Intra-muscular, right thigh |

Madam Fosuaa and her baby were sent to the child welfare clinic for immunization as well as family planning unit after which they were handed over to the public health nurse for continuity of care.

## 4.13 CARE PLAN DURING PUERPERIUM

**PROBLEMS IDENTIFIED DURING PUERPERIUM**

Client complained of

1. After pain

2. Loss of appetite

3. Inadequate sleep

4. Backache

**SHORT TERM OBJECTIVES**

1. Client after pains will be relieved within 24 hours after labor.
2. Client will regain her normal appetite within 24hours
3. Client will sleep at least 6 hours within 24hours.
4. Client will be relived of backache within 24 hours after labor.

**LONG TERM OBJECTIVES**

Client will go through pregnancy, labor and puerperium successfully without any complication to her and the baby.

| DATE/ TIME | NURSING DIAGNOSIS | NURSING OBJECTIVES/ OUTCOME CRITERIA | NURSING ORDERS | NURSING INTERVENTION | DATE/ TIME | EVALUATION | SIGN |
|---|---|---|---|---|---|---|---|
| 01/12/22 at 9:00 am | After pains related to involution of the uterus. | Client's after pains will be relieved within 24 hours as evidenced by 1. Client verbalizing that the pain has resolve. | 1. Reassure client that pain is temporal<br>2. Encourage client to empty her bladder frequently.<br>3. Encourage client to continue breastfeeding the baby. | 1. Client was reassured<br>2. Client was encouraged to empty her bladder frequently.<br>3. Client was encouraged to continuously feed the baby on demand. | 2/12/21 at 9:00am | Goal fully met as client verbalized that her pain was relieved. | Y.W.O |

|  |  |  |  |  |  |  |  |
|---|---|---|---|---|---|---|---|
|  |  |  | 4. Explain the physiology of after.<br><br>5. Serve prescribed analgesic. | 4 Explain the physiology of after pains was explained to client.<br><br>5.Prescribed analgesic was served (tab paracetamol 1 gram tidx3) |  |  |  |

| DATE/ TIME | NURSING DIAGNOSIS | NURSING OBJECTIVE/ OUTCOME CRITERIA | NURSING ORDERS | NURSING INTERVENTION | DATE/ TIME | EVALUATION | SIGN |
|---|---|---|---|---|---|---|---|
| 2/12/22 at 8:00am | Backache related to exaggerated posture during pregnancy. | Client will be relieved of backache within 24 hours as evidenced by Client verbalizing that backache will resolve. | 1. Reassure client that, pain will relieve.<br><br>2. Teach client how to position herself when breast feeding.<br><br>3. Encourage client to wear well-fitting or supportive brassier.<br><br>4. Encourage client to attach baby properly during breastfeeding. | 1. Client was reassured that she will be relieved of the pains<br><br>2. Client was encouraged to support back with pillow when sitting to breastfeed baby.<br><br>3. Client was encouraged to wear well-fitting brassier<br><br>4.Client was encouraged to fix the baby properly to the breast | 3/12/22 at 8:00am | Goal fully met as client said her pain has stopped. | Y.W.O |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | | 5. Serve prescribed analgesics. (Paracetamol). | 5. Paracetamol 1g tid was served as prescribed. | | | |

| DATE/ TIME | NURSING DIAGNOSIS | NURSING OBJECTIVE /OUTCOME CRITERIA | NURSING ORDERS | NURSING INTERVENTION | DATE/ TIME | EVALUATION | SIGN |
|---|---|---|---|---|---|---|---|
| 4/12/22 at 8:00am | Loss of appetite related to stresses of labour | Client will regain her normal eating pattern within 24 hours as evidence by 1.Client verbalizing that she is able to eat. 2. Support person observing client | 1. Reassure client<br>2 Encourage client to practice oral hygiene to help increase her appetite.<br>3. Served client's favourite food. | 1. Client was reassured that she will gain her normal eating pattern.<br>2. Client was encouraged to brush her teeth at least twice daily to increaseher appetite.<br>3. Client was served with food with light soup and meat. | 5/12/22 at 8:00am | Goal fully met as client verbalizes that she is able to eat half meal severd. | Y.W.O |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | eats half of meal served. | 4. Served client's food attractively and plan diet with client<br>5.Administer vitamin supplement | 4. Client's food was served attractively by garnishing the food.<br>5.Vitamin supplement such as folic acid, multivitamin were administered. | | | |

| DATE/ TIME | NURSING DIAGNOSIS | NURSING OBJECTIVE/OUTCOME CRITERIA | NURSING ORDERS | NURSING INTERVENTION | DATE/ TIME | EVALUATION | SIGN |
|---|---|---|---|---|---|---|---|
| 6/12/22 at 8:00am | Sleeping pattern disturbance (Insomnia) related to night breast feeding. | Client will sleep at least 3 hours sleep at night and 2 hours in the day within 24hours as evidenced by client verbalizing it. | 1. Explain the importance of night breast feeding to her.<br>2. Encourage her to feed the baby on demand.<br>3. Encourage her to sleep when baby is asleep.<br>4. Encourage relatives to support her. | 1. Importance of night breast feeding was explained to her.<br>2. Client was encouraged on the essence of feeding on demand.<br>3. She was encouraged to sleep when baby was asleep.<br>4. Her relatives were encouraged to help her. | 7/12/22 at 8:00am | Goal fully met as evidenced by client verbalizing that, client can sleep. | Y.W.O |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | | 5. Encourage client and family members to reduce the number of visitors. | 5. Client was encouraged to rest enough during the day. | | | |

## TERMINATION OF CARE

Madam Fosuaa and her family were made aware on the first time of interaction that the care would be terminated during the postnatal review visit where she and her baby would be handed over to the public health nurse in- charge for continuity of care.

Madam Fosuaa and her family were able to go through pregnancy, labour and puerperium successfully through all the education and care given to them. After examination both client and baby were handed over to the public health nurse for continuity care. Profound gratitude was expressed to the client and the family for their total cooperation. They were also grateful for the care and support.

## SUMMARY AND CONCLUSION

The study was carried out on Madam Fosuaa a 20year old woman who was gravida 2 Para 1 alive. She was met at Nkoranza Health Center (labour ward) on 14th November, 2022 during antenatal session and pregnancy was 36 +2 gestational weeks. She was in good health when we met.

The cordial relationship that existed among the client, family and staff of the clinic aided to educate them on personal, environmental health, maintenance as well as other health related issues. She had successful antenatal period and entered labor on the 1st December, 2022. She was monitored throughout the stages of labour to resolve all her problems by the use of nursing process and she delivered spontaneously of a healthy baby girl on 1st December, 2022 at 9: 30am Mother and baby were discharged a day after delivery in good condition on the 2nd December, 2022.

Mother and baby were visited for seven days after delivery. They were monitored until they were handed over to the community health nurses for continuity of care in good health. Our interaction ended after one week of postnatal care.

In conclusion, the care has helped the student midwife to gain knowledge and experience. It is an effective means of monitoring pregnancy, labor, delivery and puerperium. This helps to promote a good relationship between the student midwife, the client and the family

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APPENDIX I

| DATE | WEIGHT (KG) | BLOOD PRESSURE | URINE FOR PROTEIN AND SUGAR | GASTATION IN WKS | FUND AL HEIGH T | PRESEN TATION | DESCENT | FETAL HEART RATE | COMPLAINS | TREAT MENT | REMARK |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 19/05/22 | 55kg | 107/7o | Neg/Neg | 11weeks+1day | - | - | - | - | No complains | Routine drugs | well |
| 17/06/22 | 56kg | 97/63 | Neg/Neg | 15weeks+1day | 15cm | - | - | - | No complains | Routine drugs | good |
| 15/07/22 | 57kg | 93/58 | Neg/Neg | 19+1weeks | 21cm | varible | - | - | No complains | Routine drugs | well |
| 12/08/22 | 58kg | 115/67 | Neg/Neg | 23weeks+1day | 22cm | Cephalic | - | 134bpm | Loss of appetite | Routine drugs | good |
| 10/9/22 | 59kg | 97/62 | Neg/Neg | 27weeks+1day | 25cm | Cephalic | - | 138bpm | No complains | Routine drugs | well |

| 10/10/22 | 60kg | 105/66 | Neg/Neg | 31weeks+2days | 30cm | Cephalic | - | 134bpm | No complaints | Routine drugs | good |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 24/10/22 | 61kg | 99/60 | Neg/Neg | 33weeks+4days | 32cm | Cephalic | $5/5^{th}$ | 137bpm | No complaint | Routine drugs | well |
| 7/11/22 | 64 | 96/69 | Neg/Neg | 35weeks+5days | 33cm | Cephalic | $5/5^{th}$ | 138bpm | No complaints | Routine drugs | Good |
| 14/11/22 | 65 | 98/66 | Neg/Neg | 36weeks+2days | 34cm | cephalic | $5/5^{th}$ | 148bpm | Back pains | Routine Drugs | Good |
| 21/11/22 | 67 | 99/59 | Neg/Neg | 37 weeks+2 | 36cm | cephalic | $5/5^{th}$ | 135 | Waist pains | Routine Drugs | Good |
| 28/11/22 | 63 | 91/61 | Neg/Neg | 38weeks+2 | 38cm | Cephalic | $4/5^{th}$ | 138 | Waist pain | Routine Drugs | Well |
| | | | | | | | | | | | |

## APPENDIX II

**COMPLETE DIAGNOSTIC INVESTIGATION**

| DATE | SPECIMEN | INVESTIGATION | NORMAL VALUES | FINDINGS | REMARKS |
|---|---|---|---|---|---|
| 19/05/22 | Blood | Haemoglobin | 11-16g/dl | 13.6g/dl | Normal |
| | | Blood group | A, B, AB, O | O | Normal |
| | | Rhesus factor | Positive/Negative | Positive | Normal |
| | | Sickling | Negative | Negative | Normal |
| | | G6PD | Reactive/Non-reactive | Non-reactive | Normal |
| | Urine | Protein | Negative | Negative | Normal |
| | | Glucose | Negative | Negative | Normal |
| 17/6/22 | Urine | Protein | Negative | Negative | Normal |
| | | Glucose | Negative | Negative | Normal |
| 12/8/22 | Urine | Protein | Negative | Negative | Normal |
| | | Glucose | Negative | Negative | Normal |
| 09/09/22 | Urine | Protein | Negative | Negative | Normal |

| | | Glucose | Negative | Negative | Normal |
|---|---|---|---|---|---|
| 10/10/22 | Urine | Protein<br><br>Glucose | Negative<br><br>Negative | Negative<br><br>Negative | Normal<br><br>Normal |

## COMPLETE DIAGNOSTIC INVESTIGATION CONTINUED

| DATE | SPECIMEN | INVESTIGATION | NORMAL VALUES | FINDINGS | REMARKS |
|---|---|---|---|---|---|
| 24/10/22 | Urine | Protein | Negative | Negative | Normal |
| | | Glucose | Negative | Negative | Normal |
| | Blood | Hemoglobin | 11-16g/dl | 11.6g/dl | Normal |
| 07/11/22 | Urine | Protein | Negative | Negative | Normal |
| | | Glucose | Negative | | Normal |
| 14/11/22 | Urine | Protein | Negative | Negative | Normal |
| | | Glucose | Negative | Negative | Normal |
| | Blood | Haemoglobin | 11-16g/dl | 11.3g/dl | Normal |
| 28/11/22 | Urine | Protein | Negative | Negative | Normal |
| | | Glucose | Negative | Negative | Normal |

## APPENDIX III

**PHARMACOLOGY OF DRUGS USED (MOTHER)**

| NAME OF DRUGS | CLASSIFIC-ATION | DOSAGE | ROUTE OF ADMINIST-RATION | ACTION & USE | ACTUAL EFFECTS | SIDE EFFECT OF DRUGS | SIDE EFFECT EXPERIENCED |
|---|---|---|---|---|---|---|---|
| Tablet ferrous sulphate | Iron supplement | 200 milligram once daily | Orally | Proper formation and functioning of red blood cell. | Hemoglobin level increase | Diarrhea and black stool. | None |
| Tablet folic acid | Vitamin preparation | 5 milligram daily once daily | Orally | It helps in iron absorption of iron. | Increase formation of red blood cells | Nausea and vomiting | None |
| Tablet multivitamin | Vitamin preparation | 200 milligram once daily | Orally | Increased appetite. Helps in the formation of red blood cell | Increase appetite. | Gastro intestinal disturbances | Constipation |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Tablet sulphadoxine pyrimethamine | Malaria prophylaxis | 3 tablets start at 16weeks/ after quickening and repeated at 4 weeks interval till delivery. | Orally | Treatment and prevention of malaria | Prevention of malaria | Nausea, itching, dizziness, vomiting. | None |

**PHARMACOLOGY OF DRUGS CONTINUED**

| NAME OF DRUGS | CLASSIFIC-ATION | DOSAGE | ROUTE OF ADMINIST-RATION | ACTION & USE | ACTUAL EFFECTS | SIDE EFFECT OF DRUGS | SIDE EFFECT EXPERIENCED |
|---|---|---|---|---|---|---|---|
| Injection tetanol | anti-tetanus | 0.5 milligram | Subcutaneously | Helps in the prevention of tetanus | Client protected against tetanus | slight fever and chills | None |
| Injection oxytocin | Oxytocic drug | 10 units in 1milligram | Intramuscularly | Increase uterine contraction and controlling of bleeding. | Increase uterine contraction and controlling of bleeding. | Hypotension and hyper stimulation of the uterus | None |
| Tablet Paracetamol | Analgesic and antipyretic | 100 milligram 3 times daily | Orally | Helps to reduce increased body temperature and pain | Pain was reduced | Liver damage | None |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Capsule vitamin A | Group A vitamin supplement | 200,000 units for 2 days | Orally | Growth development and proper sight | Normal vision and healthy skin | Vomiting | None |

**PHARMACOLOGICAL DRUGS USED (BABY)**

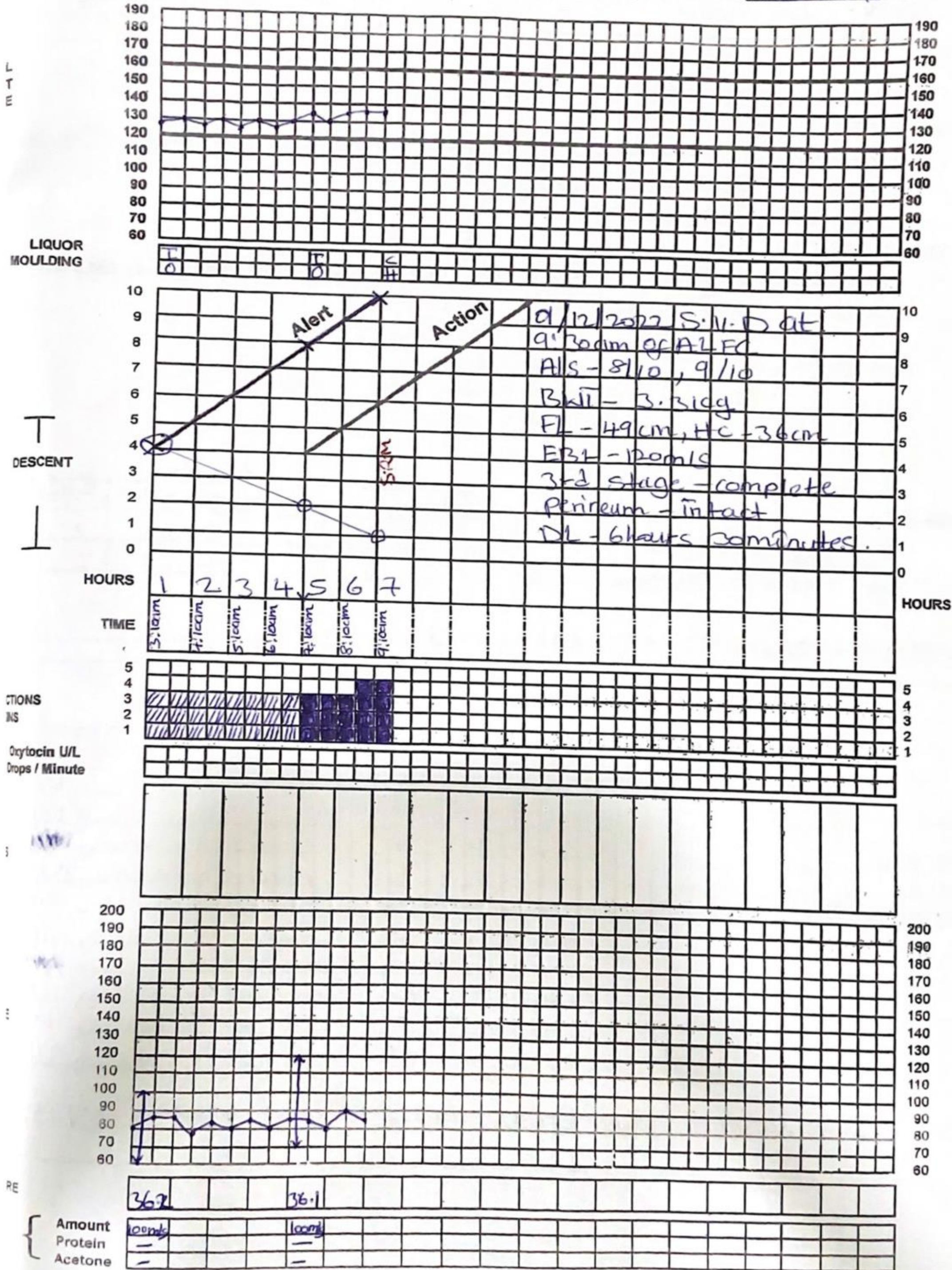
| DRUGS | CLASSIFI-CATION | DOSAGE | ROUTE | ACTION AND USE | ACTUAL EFFECTS | SIDE EFFECTS | SIDE EFFECT EXPERIENCED |
|---|---|---|---|---|---|---|---|
| Vitamin k | Group K vitamins | 0.5 milligram | Intramuscularly | Production of prothrombin. Aids in clotting | No bleeding | None | None |
| Chloramphenicol eye drop | Antibiotics | 2 drops | Instillation | To prevent infection | Infection of the eye was prevented | None | None |
| Oral polio vaccine 0 | Antigen vaccine | 2 drops | Orally | Production of antibodies | Baby is under observation | There may be diarrhea | None |
| Injection Bacillus | Antigen vaccine | 0.05 milliliter | Intradermal | Production of antibodies and | Baby is under observation | Blister formation | None |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Calmette Guerin | | | | prevention of tuberculosis | | | |

**PHARMACOLOGICAL DRUGS USED CONTINUED**

| DRUGS | CLASSIFI -CATION | DOSAGE | ROUTE | ACTION AND USE | ACTUAL EFFECTS | SIDE EFFECTS | SIDE EFFECT EXPERIENCED |
|---|---|---|---|---|---|---|---|
| Pentavalent(5 in 1) vaccine | Antigen | 0.5milliliter | Intramuscularly | Stimulate the production of antibodies against Diphtheria, Tetanus, haemophilus, influenza, hepatitis B, pertussis | Low grade fever | None | None |
| Pneumococcal vaccine 1 | Antigen | 0.5milliliter | Orally | Stimulate the production of antibodies against streptococcal infection | Redness at the site of injection and fever | None | None |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Polio vaccine 1 | Antigen vaccine | 2 drops | Orally | Production of antibodies against poliomyelitis | Baby is under observation | There may be diarrhea | None |
| Rotavirus vaccine 1 | Antigen Vaccine | 1.5milliliter | Orally | Immunity against rotavirus | Baby is under observation | Vomiting | None |


WHO Modified Partograph
Registration No. 651/22 Name (Last, First) Fosuna Elizabeth Age 23yrs
Date 01/12/2022 Parity/Gravida 1 / 2 LMP 5/03/22 EDD 15/12/22 Gestation (wks) 38weeks5days
ROM (Time, Date) Labour Durable (Hrs) 6½ Facility/Clinic Name Nkwanza Health center
LIQUOR
MOULDING
DESCENT
Alert
Action
01/12/2022 S.V.D at
9:30am of A/LFC
A/S - 8/10, 9/10
BWT - 3.3kg
FL - 49cm, HC - 36cm
EBL - 120mls
3rd stage - complete
perineum - intact
DL - 6hours 30minutes.
HOURS
TIME
Oxytocin U/L
Drops / Minute
36.2
36.1
Amount
Protein
Acetone

LABOR NOTES

Labour progressed and client had spontaneous vaginal delivery to an alive female Neonate at 9:30am, Apgar Score 1st minute 8/10, 9/10 for the 5th minute. Placenta and membranes were completely delivered at 9:40am. Uterus messaged to expel blood clot of about 120mls. Perineum was intact. Baby was examined thoroughly and no abnormalities detected. Mother was cleaned and skin to skin contact and breastfeeding was initiated.

Please circle or write responses.

DELIVERY

DATE: 01/12/2022 TIME: 9:30am METHOD: (Spontaneous) / Vacuum Extraction / C/S / Other

PERINEUM: (Intact) / Episiotomy / Laceration

ANESTHESIA: (None) / Local / General

THIRD STAGE

Active Management: (Yes) / No · Medication: Time 9:31am Type/Dose injection oxytocin 10units

PLACENTA: TIME: 9:40am (Complete) / Incomplete

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

BABY

Weight: 3.3kg

Sex: Male / (Female)

Baby Position: (Vertex) / Breech / Other

APGAR

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

COMPLICATIONS OF MOTHER / BABY: None / Other: ________

FOURTH STAGE MONITORING

| Frequency | Time | B/P. | Pulse | Fundus | Bleeding | Bladder |
|---|---|---|---|---|---|---|
| Every 15 minutes first 2 hours | 10:00am | 120/60 | 80 | 18cm | 120mls | 100mls |
| | 10:15am | 115/70 | 85 | contracted | No active bleeding | Nill |
| | 10:30am | 120/75 | 79 | contracted | No active bleeding | Nill |
| | 10:45am | 110/65 | 84 | contracted | No active bleeding | Nill |
| | 11:00am | 100/70 | 88 | contracted | No active bleeding | Emptied |
| | 11:15am | 110/80 | 64 | contracted | No active bleeding | Nill |
| | 11:30am | 100/62 | 82 | contracted | No active bleeding | Nill |
| | 11:45am | 120/75 | 78 | contracted | No active bleeding | Nill |
| Every 30 minutes For 1 hour | 12:15pm | 110/65 | 80 | contracted | No active bleeding | 110mls |
| | 12:45pm | 115/70 | 72 | contracted | No active bleeding | Nill |

Birth Attendant Yeboah Wiafe Ophilia (student Midwife) Date 01/12/2022

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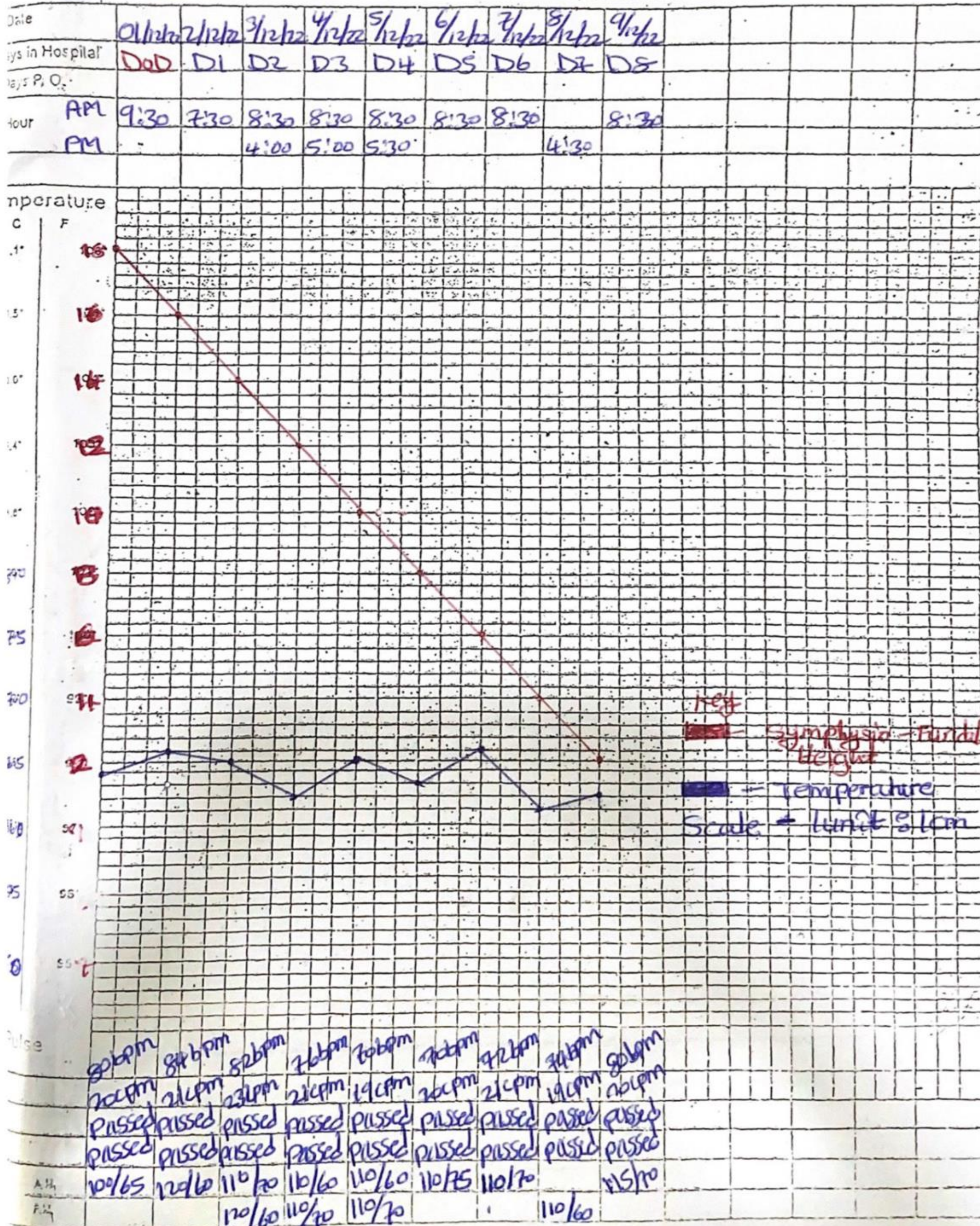
# MATERNITY CHART

NAME: Elizabeth Fosuaa

AGE: 20years WARD: labour ward

NO.: 651/22 BED NO.: 2



| Date | 01/12/22 | 2/12/22 | 3/12/22 | 4/12/22 | 5/12/22 | 6/12/22 | 7/12/22 | 8/12/22 | 9/12/22 |
|---|---|---|---|---|---|---|---|---|---|
| Days in Hospital | DoD | D1 | D2 | D3 | D4 | D5 | D6 | D7 | D8 |
| Days P. O. | | | | | | | | | |
| Hour AM | 9:30 | 7:30 | 8:30 | 8:30 | 8:30 | 8:30 | 8:30 | | 8:30 |
| Hour PM | - | | 4:00 | 5:00 | 5:30 | | | 4:30 | |
| Pulse | 80bpm | 84bpm | 82bpm | 76bpm | 70bpm | 70bpm | 72bpm | 74bpm | 80bpm |
| | 20cpm | 21cpm | 23cpm | 21cpm | 19cpm | 20cpm | 21cpm | 19cpm | 20cpm |
| | passed | passed | passed | passed | passed | passed | passed | passed | passed |
| | passed | passed | passed | passed | passed | passed | passed | passed | passed |
| A.M. | 100/65 | 120/60 | 110/70 | 110/60 | 110/60 | 110/75 | 110/70 | | 115/70 |
| P.M. | | | 120/60 | 110/70 | 110/70 | | | 110/60 | |

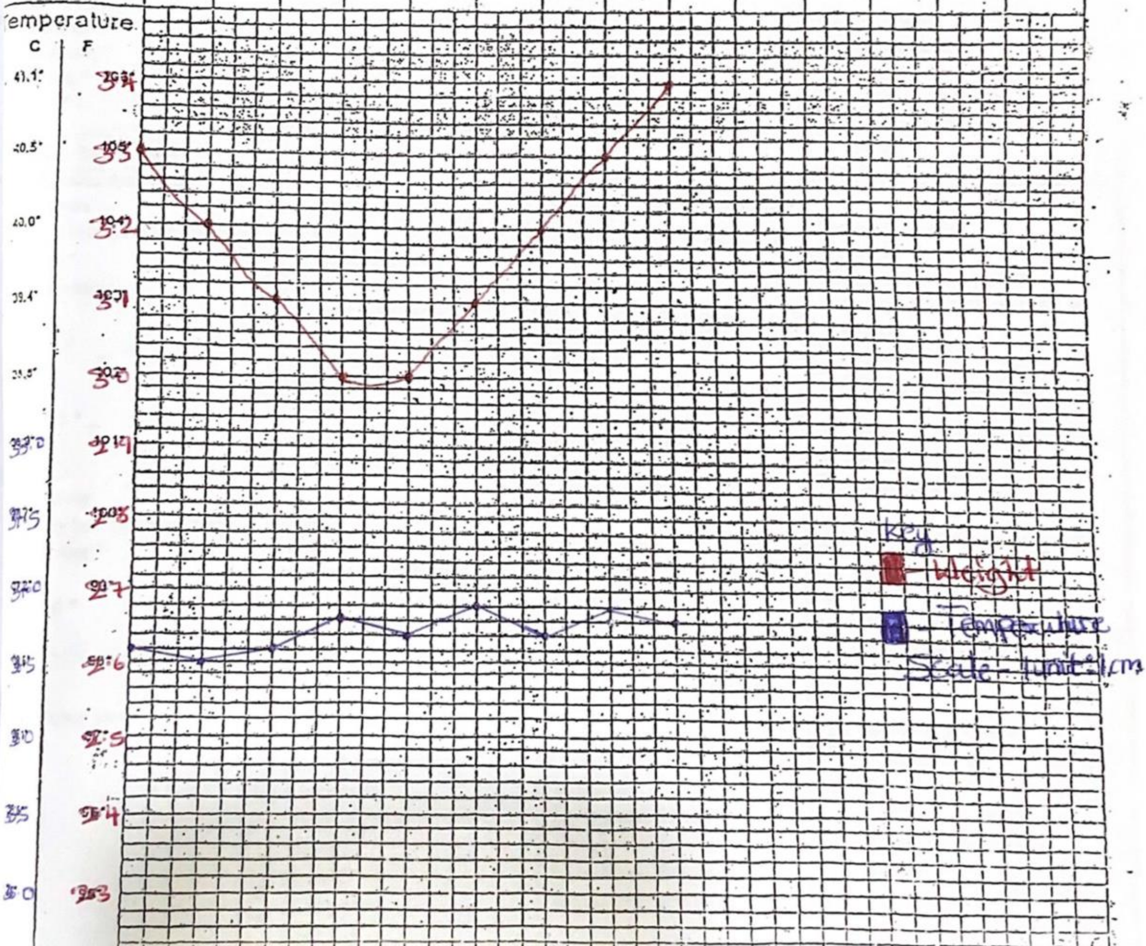
# TEMPERATURE CHART

NAME: Baby Yaa Fosuaa

AGE: New ...... WARD: labour

NO.: 651/22 ...... BED NO.: 2

| Date | | 1/12/22 | 2/12/22 | 3/12/22 | 4/12/22 | 5/12/22 | 6/12/22 | 7/12/22 | 8/12/22 | 9/12/22 | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Days in Hospital | | DOD | D1 | D2 | D3 | D4 | D5 | D6 | D7 | D8 | | | | | |
| Days P. O. | | | | | | | | | | | | | | | |
| Hour | AM | 9:30 | 7:30 | 8:30 | 8:30 | 8:30 | 8:30 | 8:30 | | 8:30 | | | | | |
| | PM | | | 4:00 | 5:00 | 5:30 | | | 4:30 | | | | | | |




| Pulse | 130bpm | 127bpm | 128bpm | 129bpm | 131bpm | 132bpm | 138bpm | 140bpm | 131bpm |
|---|---|---|---|---|---|---|---|---|---|
| | 142cpm | 143cpm | 144cpm | 144cpm | 140cpm | 146cpm | 146cpm | 142cpm | 143bpm |
| | passed | passed | passed | passed | passed | passed | passed | passed | passed |
| | passed | passed | passed | passed | passed | passed | passed | passed | passed |
| A.M. | | | | | | | | | |
| P.M. | | | | | | | | | |

## NEW BORN EXAMINATION FORM

Name: Baby Yaa Fosuaa Date of Assessment: 02/12/2022 Time: 7:30am

Date of Birth: 01/12/2022 Time of Birth: 9:30am Sex: [ ] M [✓] F Age at time of Assessment (days/hrs) 22hrs

Astational Age 38 [ ] weeks [ ] days Mode of Delivery: [✓] Vaginal Assisted Vaginal C-Section

APGAR: 1min 8/10 5min 9/10 Birth Weight: 3.2 kg [ ] Lenghth: 49 cm Head Circumference: 36 cm

Temperature at time of Assessment: 36.5 °C Urine passed: Yes No Meconium passed: Yes No

Name of Assessor (Midwife/Doctor): Yeboah Ntiafe Ophilia

**1. Respiration**
Rate 43cpm
- [ ] 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: 127bpm
- [ ] 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) Normal 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

...me: Baby Yaa Fosuaa Date of Assessment: 01/12/2022 Time: 10:30am
...e of Birth: 01/12/2022 Time of Birth: 9:30am Sex: [ ] M [x] F Age at time of Assessment (days/hrs) 30mins
...ational Age 38 weeks + 5 days Mode of Delivery: [ ] Vaginal Assisted Vaginal C-Section
...GAR: 1min 8/10 5min 9/10 Birth Weight: 3.3 kg [ ] Length: 49 cm Head Circumference: 36 cm
...mperature at time of Assessment: 36.6 °C Urine passed: Yes No Meconium passed: Yes No
...me of Assessor (Midwife/Doctor): Yeboah Ndiaye Ophilia

**Respiration**
...e 46cpm
Rate < 30 b/m *
Rate < 60 b/m *
30-60 b/m
Retractions *
Grunting *
Stridor *

**Activity/Movemnet**
Spontaneous symmetric movements
Reduced/Absent Movement in ≥1 limb *
No Movement

**Tone**
Normal
Floppy *
...creased *

**Colour**
...k all over
...k body but blue hands/feet
...e all over *
...e *
...ndiced *

**Cord**
Normal
...raining pus
...eding

...
...rmal
...ll *
...ent *

**7. Suck**
- [x] Good
- [ ] Weak
- [ ] Absent

**8. Head swelling**
- [ ] Caput succedaneum
- [ ] Cephalhaematoma
- [ ] Subgaleal hemorrhage
- [x] No swelling

**9. Sutures**
- [x] Normal
- [ ] Overlapping
- [ ] Fused
- [ ] Widely Separated *

**10. Fontanel**
- [x] Normal
- [ ] Sunken *
- [ ] Raised *
- [ ] Wide (>5cm)*

**11. Eyes**
- [x] Normal
- [ ] Subconjunctival bleed
- [ ] White pupil or cornea
- [ ] Eye discharge
- [ ] Other

**12. Ears**
- [x] Normal (size / shape/position).
- [ ] Abnormal: ______

**13. Mouth**
- [x] Normal
- [ ] Cleft palate
- [ ] Cleft Lip
- [ ] Other: ______

**15. Neck**
- [x] Normal
- [ ] Swelling
- [ ] Webbed
- [ ] Other: ______

**16. Clavicle**
- [x] Normal
- [ ] Swelling/Fracture

**17. Chest**
- [x] Normal (Shape/movement)
- [ ] Abnormal ______

**18. Heart rate**
Rate: 133bpm
- [x] Normal (100-160)
- [ ] <100 *
- [ ] >160*

**19. Femoral pulse**
- [x] Present
- [ ] Not palpable*

**20. Abdomen**
- [x] Normal
- [ ] Distended*
- [ ] Scarphoid*
- [ ] Abdominal defect*
- [ ] Maases: ______
- [ ] Other ______

**21. Back (spine)**
- [x] Normal
- [ ] Abnormal Swelling *
- [ ] Hairly patch over spine
- [ ] Abnormal dimple
- [ ] Abnormal curvature

**22. Limbs**
- [x] Normal
- [ ] Abnormal ______

**23. Genitalia**
**Male Genitalia**
- [ ] Normal
- [ ] Undescended testes
- [ ] Abnormal meatus
- [ ] Hernia
- [ ] Other: ______

**Female Genitalia**
- [x] Normal
- [ ] Fistula(meconium/urine through abnormal opening in vagina) *
- [ ] Large clitoria *
- [ ] Other: ______

**24. Anus**
- [x] Patent
- [ ] Imperforate*

**25. Resuscitation provided**
- [ ] One
- [x] Suction/stimulation
- [ ] Bag and mask
- [ ] Endotracheal Tube
- [ ] Ventilator/CPAP

**26. Services provided**
- [x] Vitamin K1 given
- [x] Eye care provided
- [x] Cord care provided
- [x] Breastfeeding initiated
- [x] Breastfeeding established
- [x] Immunization (BCG/Polio)
- [x] BCG [x] Polio Immunization
- [x] Antibiotics in mother
- [ ] Antenatal corticosteroids

...ndicate severe disease that requires urgent referral
...ses (if known) Normal Baby
...ation: (Overall assessment) [x] Normal [ ] Baby with a Problem [ ] Danger Sign/ <1500g/ severe Jaundice
...Routine Care[ ]Problem. Continue supportive in-patient care [ ] Urgent Referral / Advanced Care[ ] Discharge

# NEW BORN CHART

Name: Baby Yaa Fosuaa No: 651/22 Birth Weight: 3.3kg

Sex: Female Mother's No: 651/22 Length: 49cm

Nature of Delivery: Spontaneous Vaginal Delivery Diagnosis: Term baby

Date of Birth: 01/12/2022 Time: 9:30am Date of Discharge: 02/12/2022

| Date | 01/12/2022 | | 02/12/2022 | | 3/12/2022 | | 4/12/2022 | | 5/12/2022 | | 6/12/2022 | | 7/12/2022 | | 8/12/2022 | | 9/12/22 | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| No. of Days | DOD | | D1 | | D2 | | D3 | | D4 | | D5 | | D6 | | D7 | | D8 | | | | | |
| Weight | 3.3kg | | 3.2kg | | 3.1kg | | 3.0kg | | 3.0kg | | 3.1kg | | 3.2kg | | 3.3kg | | 3.4kg | | | | | |
| | AM | PM | AM | PM | AM | PM | AM | PM | AM | PM | AM | PM | AM | PM | AM | PM | AM | PM | AM | PM | AM | PM |
| Temperature | 36.6°C | | 36.5°C | | 36.6°C | 36.7°C | 36.6°C | 36.8°C | 36.7°C | 36.6°C | 36.9°C | | 36.7°C | | | 36.9°C | 36.8°C | | | | | |
| Stools | passed | | passed | | passed | passed | passed | passed | passed | passed | passed | | passed | | | passed | passed | | | | | |
| Urine | passed | | passed | | passed | passed | passed | passed | passed | passed | passed | | passed | | | passed | passed | | | | | |
| Remarks | Head<br>Neck<br>Limbs<br>[illegible] } No Abnormality detected | | | | | | | | | | | | | | | | | | | | | |

## SIGNATORIES

**THE STUDENT MIDWIFE**

NAME: YEBOAH WIAFE OPHILIA

DATE:......7TH JULY, 2023......................

**MIDWIFE- IN- CHARGE (NKORANZA HEALTH CENTER)**

NAME: GRACE SEKYERAA

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

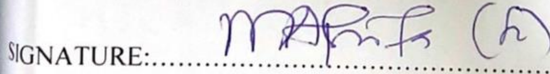
**SUPERVISOR**

NAME: MARTHA KYEREMAA

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

**PRINCIPAL**

NAME: MONICA NKURMAH



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