HOLY FAMILY NURSING AND MIDWIERY TRAINING COLLEGE BEREKUM

A CLIENT/FAMILY CENTEED MATERNITY CARE STUDY

ON

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

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PREFACE

In the past, midwifery was the duty of the old women in the community. It didn't require any certificate or knowledge from books. It later became the duty of the traditional birth attendants and they were matured women from the community, who had been trained to have experiences in delivery and to identify problems for quick referral. Currently, midwifery has become the career of confident and qualified practitioners. Enough skills and knowledge from books have been impacted to these practitioners to enable them give holistic care to the client and the family.

The client/family centered maternity care study is an evidenced based care rendered to a client, her family and the community at large, during pregnancy, labour and puerperium. It includes assessment, diagnosis, management of problems identified and education to the mother and her family during pregnancy, labour and puerperium, to prevent any complications, regarding the expectant mother as a unique individual, including the well-being of her family. As the profession demands, client and family were assured of confidentiality of information obtained from them to compile this essay.

With the changing trends in midwifery, the client and family centered maternity care study as part of the student midwife curriculum helps the student midwife to use the new trends in midwifery like the use of the partograph in the management of stages of labour and continual care to the client and baby after delivery to ensure proper anagement of the puerperium using the nursing process.

The family centered maternity care study is a requirement that every final year student of the post basic midwifery program is supposed to undertake to satisfy the Nursing and Midwifery Council of Ghana towards the award of the registered midwifery certificate.

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I wish to express my sincere gratitude to the almighty God for how far he has brought me throughout the writing of this care study.

I am most grateful to my client and family for the information, cooperation and help giving me for this care study.

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My heartfelt gratitude goes to my dear husband, Mr. Teku Emmanuel for financial support during my training, my belove daughter Janina Teku Kyere, not forgetting my mother Ms. Bemma Pulina and my siblings for their support throughout my training and all who contributed in one way or the other towards my training. Also, to Rev. Joseph Adu Ayem Jnr for his prayers.

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LITERATURE REVIEW

Pregnancy

Fraser and Cooper (2009), pregnancy is the period of having developing embryo in the uterus and it the time when women and their partners are especially open to reflecting on their lifestyle and health care 0ptions. For health professionals, it provides an opportunity to help women learn how to use health care services effectively and to acquire information and skills that will enable them to have the best possible experience of birth and early parenting. The author also states that, during pregnancy the body systems undergo anatomical and physiological changes which are designed to support fetal growth and development. Some result in minor disorder such as constipation, fatigue and lower abdominal pains. Pregnancy has been divided into three trimesters. The first trimester is from conception to 13weeks of gestation. The second trimester starts from 14weeks to 26weeks during which the woman's body begins to adapt to the pregnancy. The third trimester is from 27weeks to 40weeks, a period when the foetus continues to grow and become mature for delivery. Changes occur this time due to specific hormones such as estrogen, progesterone and human gonadothrophin hormones. These changes nature the foetus and prepare the woman's body for labour. Antenatal care refers to the care given to pregnant women from the time that conception is confirmed to the beginning of labour and the care is aimed at monitoring the progress of pregnancy in order to support maternal health and normal fetal development. These aims include;

1. Developing a partnership with the woman

2. Recognising complications of pregnancy and appropriately referring women within the multidisciplinary team.

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3. Facilitating the woman to make an inform choice about methods of infant feeding and giving appropriate and sensitive advice to support her decision
4. Promoting an awareness, the public issues for the woman and her family
5. Offering education for parenthood with a plan program or an individual basis
6. Being an advocate for the woman and her family during her pregnancy, supporting her right to choose care that is appropriate for her own needs and those of her family. She states some common disorders during pregnancy includes; lower abdominal pains, frequency in micturition, headache, fatigue, backache and constipation.

Ghana Health Service (2008), pregnancy is confirmed from conception until the delivery of the baby. Antenatal care is the health care and education given during pregnancy. The objectives of antenatal include;

1. To detect and treat high risk conditions arising during pregnancy, whether medical, surgical or obstetric
2. To ensure safe delivery and postpartum health
3. To promote quality care, antenatal care services must be organized in such a manner as to provide comprehensive and individualized care. As much as possible all care activities eg. history taking, physical examination and treatment, should be provided by the care provider to the pregnant woman (focus antenatal care)
4. To help prepare the mother to breast feed successfully, experience normal puerperium and take good care of the child physically, physiologically and socially.

5. To promote and maintain the physical, mental and social health of mother and baby by providing education to pregnant women on nutrition, HIV/AIDS, birth preparedness and complication readiness.

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Tiran (2008), pregnancy is the condition of having a developing embryo or fetus within the body. It is the state from conception to the delivery of the fetus. The normal duration is 280 days, 40 weeks or (nine) 9 calendar months and 7 days counted from the first day of the last menstrual period or 265 days from conception. During this period, a physiological and psychological change occurs due to the effect of estrogen and progesterone which provide nutritive and protective environment for the developing embryo and also prepares the breast for lactation. The mother experiences frequency of micturition due to the effect of progesterone relaxing the detrusor muscles. Pregnancy has been divided into three. First, second and third trimester. First trimester is from conception to 13 weeks of gestation. Second trimester starts from 14 weeks to 26 weeks of gestation during which the woman's body begins to adapt to the pregnancy. Third trimester is from 27 weeks to 40 weeks of gestation where the woman assume a lumber curve position associated with back and waist pains.

Perry (2006) stated that, pregnancy is a period between conceptions till delivery of the baby, and there is a period of physical and physiological preparations 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 forty (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 form week one (1) to thirteen (13) weeks and the second from fourteen (14) to twenty-six (26) whereas the third trimester from twenty-seven (27) to

forty (40). Any pregnancy that advances from thirty eighth (38) to forty (40) weeks is considered to be at term.

Konar (2011), pregnancy is defined as when conception takes place as soon as there is ceasation of menstruation and lasts between 9 and 10 months and this period is divided into three sets of months. The first three months (first 12 weeks) is known as first trimester, the nest three month (13-28 weeks) following the first is the second trimester while the last three months (29-40 weeks) is known as the third trimester. The woman experiences the following changes throughout the trimesters; the breast become bigger/and tighter, there may be frequency of micturition, there may be saliva in the mouth more often, there may be morning sickness. She may like or dislike certain foods, fatigue, and slight pain in her lower abdomen. Digestion will slow down with some constipation and heart burns, she can feel more tightening of her abdomen with slight pain, her breast become heavier and contains slightly yellow fluid, she may feel more tired/have sleeping difficulty and in the last week, the head of baby descends into the pelvis (lightening).

Myles (2009), Pregnancy is confirmed, many physiological changes takes place in the body and return to its non-pregnant state during puerperium due to the effect of certain hormones namely progesterone and oestrogen. Even though these hormones have their own effect by causing the minor disorders that occurs during pregnancy, they are one way or the other an advantage for the mother and growing fetus since the f

etus depends solely on the mother for survival when in utero. variety of care that are rendered to expectant mothers and their entire family include history taking ,physical examination(head to toe examination and abnormal examination that is, inspection ,palpation and auscultation), laboratory investigation(urine, blood and stool), administration of routine drugs(folic acid ,ferrous Sulphate and multivitamin).The anatomical and physiological changes in the uterus play an essential role in pregnancy by protecting and supporting the fetus, placenta and amniotic time of labour it is able to contract regularly and forcibly to expel the fetus due to its unique properties of contractibility and elasticity.

Labour

Marshall and Raynor (2014), labour is the process by which the foetus, placenta, and its membranes are expelled through the birth canal. Normal labour is defined as low risk throughout, spontaneous in onset with the foetus presenting by the vertex, culminating in the mother and infant in good condition following birth. The author describes the three stages of labour, that is; first stage comprising of latent and active phase. The latent phase may take 6-8 hours in the first time mothers when the cervix dilates from 0cm to 3cm and the cervix canal shorten from 3cm long to less than 0.5cm long. The active phase of the first stage is the time when the cervix undergoes more rapid dilation. This begins when the cervix is 4cm dilated and in the presence of rhythmic contractions, is complete when the cervix is fully dilated (10cm). The transitional phase is the stage of labour when the cervix is from around 8 centimetres is dilated until it is fully dilated. Second stage is that of expulsion of the foetus. It begins when the cervix is fully dilated and the woman feels the urge to expel the baby. It is complete when the baby is born. Third stage is that of separation and expulsion of placenta and membranes, it also involves the control of bleeding. It last from the birth of the baby until the placenta and membranes have been expelled. She again states that in recent years, the pantograph has been widely accepted as an effective means of recording the progress of labour. It is a chart on which the salient features of labour are entered in a graphic form and therefore provides the opportunity for early identification of deviations from normal. The charts are usually designed to allow for recordings at 30 minutes interval and include: foetal heart rate, strength of contractions, frequency of contractions in terms of the number in 10 minutes, and 4 hours interval which include descent, maternal temperature, pulse, and blood pressure,

details of vaginal examinations, fluid balance, urine analysis, and drug administered.

Some presumptive signs of second stage include: expulsive uterine contractions, rupture of the fore waters dilation and gaping of the anus, show and appearance of the presenting part. Some positions used in delivery are squatting, kneeling, all fours or standing, left lateral position and upright position. The main movements in labour include; descent, flexion, internal rotation of the head, crowning, extension of the head, restitution, internal rotation of the shoulders and lateral flexion. The fourth stage is from complete expulsion of the placenta and membranes up to the first six hours following delivery and monitoring of the mother and baby.

Ghana Health service (2008), normal labour is defined as when there are regular, painful rhythmic contractions lasting at least 20 seconds (timed by a trained observer) occurring at a frequency of at least two contractions in every 10 (ten) minutes and with cervical dilation of at least 3cm. however in recent times active labour starts from 4cm. the first stage is form the onset of labour to full dilation of the cervix. This normally last up to 15 hours in multiple and 18 or 24 hours in primigravidas. Second stage begins from the full dilations of the cervix and when the woman feels the urge to expel the baby. It is complete when the baby is born. Third stage begins after the birth of the baby until the expulsion of the placenta and its membranes; it also involves the control of bleeding, signs that the woman may experience prior to labour includes show (pink mucous discharge from the vagina), engagement of the baby's head, more frequent Braxton Hicks contractions and a change in foetal movement. The hormone oxytocin is responsible for the strong regular contractions of labour which when released cause the uterus to contract. Labour contractions feel very different from Braxton Hicks contractions come regularly. Each one starts gradually,

builds up to a peak and then fades away. Typically when labour begins, contractions are short in length around 20 – 30 seconds long. As labour progresses contractions become gradually longer and stronger which dilates the cervix.

Tiran (2008) normal labour occurs spontaneously between 37 and 43 weeks gestation with a single foetus and is completed within 24 hours without maternal and foetal trauma. Physiology depends on the interactions between the uterus, maternal pelvis and fetus. During the first stage, cervical effacement and dilation occur, contractions are dominant; polarity facilities and contraction and retraction in the upper uterine segment. The second stage is from full dilation of the cervix until complete delivery of the baby. The third stage involves separation and expulsion of the placenta and membranes and control of haemorrhage. The fourth stage is from complete expulsion of the placenta and membranes up to the first six hours following delivery and monitoring of the mother and the baby. The author states that partograph is the graphical recording of labour progress obtained patterns of cervical dilation and descent of the presenting part in conjunction with records of maternal and foetal wellbeing.

Perry (2006) states that labour begins with the first uterine contractions, continues with hours of hard work during cervical dilation, birth of the baby and ends as the woman and her significant others begin the attachment process with the new born. He states further that three factors affect the process of labour and birth. These are the passenger which is the fetus and placenta, the passage which is the birth canal and the powers which is the contractions, position of the mother and physiological response. He further identifies the stages of labour as follows; the first stage of labour; this begins with the onset of regular uterine contractions, effacement, dilation of the cervix and progress in descent of the presenting part. The first stage of labour has been divided into three phases namely;

1. The latent phase where there is more progress in different of the cervix and little increase of descent. Cervical dilation is from 1cm to 3cm.
2. Active phase where there is more rapid dilation of the cervix and increased rate of descent of the presenting part. Cervical dilation is from 4cm to 10cm.

The transitional phase which is also incorporated in the active phase is from 8cm to 10cm. the second stage of labour; is the stage in which the infant is born. This stage begins with full cervical dilation (10cm) and complete effacement (100%) and ends with the baby's birth. He further explained that the second stage takes an average of 20 minutes for a multiparous woman and50 minutes for nulliparous woman but labour of up to 2 hours has been considered within the normal range for second stage. The third stage of labour; starts from the birth of the fetus until the placenta is delivered. He that, the placenta normally separates with the third or fourth strong uterine contractions after the infant has been born. The duration of third stage may be as short as 3 to 5 minutes although up to 1 hour is considered within normal limits. The fourth stage of labour lasts for 6 hours after delivery of placenta. It is the period of immediate recovery when homeostasis is re-established. It is important period of observation for complications such as bleeding.

Myles2006 states that, labour purely in physical sense may be described as the process by which the foetus, placenta and membranes are expelled through the birth canal. Labour has four stages. First stage comprises of latent and active phase. The latent stage may take 6—8 hours in primigravida. This begins when cervix is 3-4cm dilated and in the presence of rhythmic contraction, is complete when the cervix is fully dilated 10cm. The transitional phase is the stage of labour when the cervix is from around 8cm dilated until it is fully dilated. The second stage is that of the expulsion of the foetus. It begins when the cervix is fully dilated and the woman feels the urge to expel the baby. It is completed when the baby is born. The third stage is that of separation and expulsion of the placenta and membranes, it also involves the control of bleeding. It lasts from the birth of the baby until placenta and membranes are expelled. The fourth stage of labour is the sixth hours of observation of the

mother and baby. The partograph has been widely accepted as an effective means of recording the progress of labour. It is a chart on the salient features of labour are entered.

Puerperium

Myles (16th edition) states that, following the birth of the baby and expulsion of the placenta, the mother enters a period of physical and psychological recuperation. Puerperium starts immediately after delivery of the placenta and membranes and continues for six weeks. The general expectation is that by six weeks after the birth, a woman's body will have recovered sufficiently from the effects of pregnancy and the process of parturition. The difference between exercise and healthy activity verses rest, relaxation and sleep. Exploring each person's level of activity will encourage advice in relation to appropriate exercise and by association, nutritional intake and rest or relaxation and sleep. Undertaking regular pelvic floor exercise is of benefit to the woman's long term health.

Fraser and Cooper (2009) states that, following the birth of the baby and expulsion of the placenta, the mother enters a period of physical and psychological recuperation. Puerperium starts immediately after the delivery of the placenta and membranes and continues for six weeks. The overall expectation is that by six weeks after the birth of the baby, all the body systems will have recovered from the effects of pregnancy and return to their non-pregnant state expects the breast because of lactation.

Tiran (2008), states that puerpeium is the period following childbirth during which the maternal structures (uterus and organs) that took part in pregnancy are returning to their non-pregnant state, thus, a period of first day of birth to six weeks.

Ghana Health Service (2008), it states that puerperium is the period from the end of delivery to six weeks after delivery. Also, it says that, the purpose of post-natal care is to maintain the

physical and psychological wellbeing of the mother and child. This includes education to the mother on the care of her baby, detection, treatment or referral of any abnormalities for further management. The essentials of post-natal care are therefore;

1 Comprehensive screening to detect complication in both mother and baby.
2 Treatment of complication in the mother and baby.
3 Assessment and support for the infant feeding.
4 Malaria and anaemia prevention.
5 Health education and counselling.
6 Family planning counselling and services.
7 Immunization services for the mother and baby
8 Inspecting the pad for bleeding and lochia, its smell and quantity.
9 Palpating the uterus for signs of involution.
10 Inspection of the vulva and perineum for tears and swelling a pus.

Perry (2006) states that puerperium start from following delivery up to six weeks and lie enumerates that there are three types of lochia: **lochia rubra**: it is seen in the first three days and consists of blood serum, trophoblastic debris and may contain some small clots. It is the light red in colour. **Lochia serosa**: it is seen during the next 4-9days and consists of blood serum, leucocytes and tissue debris. It is pinkish in colour. **Lochia alba**: it is seen after10 days and consists of leucocytes deciduas epithelial cell and cervical mucus. It is white and continues for 10-14 days.

From the above definitions and explanations one can says puerperium is the period after the birth of the baby till six weeks of delivery management of the mother and baby to exclude puerperal sepsis, other complication and establishment of location.

WHY CLIENT WAS CHOSEN

Madam Konamah Hawa was met on10th may 2022 at Holy Famliy Hospital in Berekum East District. It was one of her usual antenatal visits to the Hospital. She was 36 weeks pregnant her antenatal records card was read thoroughly since it was the first reading, and realized that she was 30 years of age, gravida 3 para 2 alive and on interaction, client disclosed that her second delivery was a result of precipitates labour which led to born before arrival. She also disclosed that her pregnancy now was unplanned because she was not doing any family method. This informed the decision to choose her for the family centered maternity care study.

Introduction was made and directions to her house and phone numbers were exchange to enable me pay her visit to her home and a date was agreed.

CHAPTER ONE

ASSESSMENT OF CLIENT AND FAMILY

1.0 INTRODUCTION

This chapter deals with the assessment of client and family and it includes personal and social history, family history, medical and surgical history, menstrual history, past and presents obstetric history.

1.1 SOCIAL AND PERSONAL HISTORY

Madam Konamah Hawa, 30 years old woman comes from Mpatasie in Berekum East District in the Bono Region of Ghana, who also stays at Mpatasie in Berekum East District in the Bono Region. She is dark in complexion, speaks Twi and also understands English. She is about 165 centimeters tall. She attended school to J.H.S level and now she is a Trader.

She is happily married to Kyereh Samuel, a 36-year-old man who lives and works in Germany and their marriage is blessed with two children, a boy and a girl who are 16 years and 5 years old respectively. Madam Konamah Hawa and her husband are both Christians precisely, Presbyterian Church of Ghana, Trinity Congregation at Berekum. Next of kin is her mother by name Adjei Salamatu, and she also supports her physically and financially. According to Madam Konamah, her land lady by name Madam Kosua Kraa also support in catering for her and the unborn baby.

1.2 FAMILY HISTORY

Madam Konamah Hawa is the daughter of Mr. Adjei Mohammed and Madam Adjei Salamatu. According to her, there is no history of diabetes, hypertension, mental illness, sickle cell diseases or epilepsy in her family but there is history of multiple pregnancies. She also said there is no occurrence of congenital abnormalities like club foot, cleft lip and palate.

1.3 MEDICAL HISTORY

According to Madam Konamah, she has no disease like hypertension, liver diseases, cancer and kidney diseases. According to her, she has never been admitted to the hospital and has no allergic reaction to any known food or drugs and has never been transfused.

1.4 SURGICAL HISTORY

Madam Konamah said, she has never undergone any surgical operation and has not been involved in any road traffic accident that might have affected her pelvis or any of the reproductive organs and also never been transfused before.

1.5 MENSTRUAL HISTORY

On menstrual history, Madam Konamah said, she had her menarche at the age of fifteen, and she has regular menstrual cycle of 28 days with moderate bleeding which lasts for 4 to 5 days. According to her, she has no history of dysmenorrhea during menstruation.

1.6 LIFESTYLE AND HOBBIES

According to Madam Konamah, she wakes up every morning at 5:00 am, says her prayer as a Christian and goes about her morning hygiene of washing her face, brushing of her teeth, sweeping her room and her house compound if it her turn to do so and takes her bath. She then proceeds to preparing food for her children and also prepares them for school, she then goes to the market and sells her things. She picks her children from school when it is time and supervises them to do their home works. Supper usually ends around 6:00 pm. She enters her room after making sure her cooking utensils are washed and her kitchen neatly cleaned and goes to bed around 9:00 pm. Madam Konamah is a every sociable woman and enjoys having conversation not only with her husband on phone but also her mother and other people of her community. She does her laundry on Saturdays because she goes to church on Sundays. She neither smokes nor takes alcohol. Her favorite food is fufu with “werewere” soup.

1.7 PAST OBSTERIC HISTORY

Pregnancy, Madam Konamah said, her previous pregnancies occurred in 4th January, 2006 and 1st February, 2017 and were carried to term without any complication such as antepartum hemorrhage, pregnancy induced hypertension, abortion (either spontaneous or induced), and she attended antenatal clinic regularly at Berekum Holy Family Hospital scheduled until term. She added that she had three doses of tetanus toxoid injection during her previous pregnancies and also had three doses of Sulphadoxine Pyrimethamine (SP) during each of the previous pregnancy with the interval of one month apart as well as the routine drugs.

Labour, According to Madam Konamah, she delivered all her two babies at Berekum Holy Family Hospital and her second delivery nearly took place in a taxi before reaching the hospital, according to her the labour did not exceed 12 hours, also she had spontaneous vaginal delivery without any tears, lacerations, episiotomy or retained placenta at the Berekum Holy Family Hospital, the placenta was expelled shortly after the babies were born and they weighed 3.0 kilograms and 2.8 kilograms respectively. Their condition was satisfactory at birth and they were discharged 24 hours after delivery.

Puerperium According to her, she attended child welfare clinic where her babies had all their immunization on schedule against the childhood preventable diseases before one year and she registered them with the birth and death registry in Berekum. She did not experience any problems during puerperium such as postpartum hemorrhage, puerperal psychosis, or depression. On the issues of family planning, client said she has heard about family planning and had practiced a short-term method used Depo provera after her first delivery. According to her she also practiced exclusive breastfeeding in her previous deliveries and continued breastfeeding for 1 year 6 months before weaning. She did not continue with any family planning after her exclusive breastfeeding with her second child. She also said her mother and the land lady have been supporting her in all her deliveries.

1.8 PRESENT OBSTETRIC HISTORY

Madam Konamah, gravida 3 para 2 all alive started antenatal care on 8th November, 2021when she was 18 weeks pregnant. Her history was taken and the various examinations done on her. She said 9th 0ctorber 2021, was her last menstrual period, and her expected date

of delivery according to her ultrasound results was given as 2th February, 2022. Her vital signs were checked and recorded as follows Temperature 36.7 degrees Celsius, Pulse 81 beats per minutes ,Respiration 18 cycles per minute ,Blood pressure 120/60 millimeters of mercury, Weight 50.2 kilograms, Height 165 centimeters ,Other investigations carried out on her were recorded as follows ;Urine Routine examination no abnormality detected, Stool Routine Examination no abnormalities noticed. Hemoglobin level 13.8 grams per deciliter; Sickling negative ,Blood group O positive, Rhesus factor positive, Human Immunodeficiency Virus non-reactive , Glucose-6-Phospahate Dehydrogenase no defect, Veneral Disease Research Laboratory non-reactive. Physical examination was done and no abnormality was detected. Her gestational age was 18 weeks at booking. The symphysio fundal height measured 17 centimeters, presentation was not palpable and the fetal heart rate was not heard. She was put on the following drugs

Tablet folic acid 5milligrams daily for 30 days

Tablet fersolate 200milligrams daily for 30 days

Tablet Multivitamin 200milligrams daily for 30days

Client received 4th tetanus diphtheria (TD) injection on 8th November, 2021. She also received the first dose of Sulphadoxine-pyrimethamine (SP) on the 8th November, 2021 at the gestational age of 18weeks,During these visits, she did not encounter any problem. According to her, she had appetite and could eat at least three times a day. She said she only took the

routine drugs which were given to her at the facility; this was because she was told by the midwife not to buy drugs over the counter but to report any ailment to the health facility for medical attention. She added that she had a normal sleep pattern.She said she was educated on diet and nutrition and also to sleep under the insecticide treated bed net. The danger signs

of pregnancy such as bleeding, severe abdominal pains were explained to her. She was encouraged to visit the clinic monthly but to report and danger signs or illness for the necessary medical attention. In all, she made a total of 4 visits before she was met on the day of 10th may, 2022.

CHAPTER TWO

ANTENATAL CARE

2.0 INTRODUCTION

Chapter two deals with the care health professional give to clients during her antenatal periods. It includes first contact with client, antenatal home visits, subsequent visit to the clinic by client, and nursing care plan on problem identified during the antenatal period**.**

2.1 FIRST INTERRACTION WITH THE CLIENT.

Madam Konamah was first met on the 10th May, 2022 at around 9:40 in the morning when she visited the Holy Family Hospital Berekum for her usual antenatal care. She was 36 weeks plus 2 days pregnant and that was her fifth visit to the hospital. During the session, client disclosed that her second delivery nearly took place in a taxi on her way to the hospital, and also the items for delivery were not complete so Complication readiness was discussed with client, for her not to repeat herself again. This informed the decision to choose her for the family centered maternity care study.

The opportunity was taken to introduce myself to her as a student midwife from the Nursing and Midwifery Training College Berekum and why she was chosen for care study was explained to her and she accepted. She was assured that she would be assisted on all health related issues from that day till delivery and puerperium. She gladly accepted and promised that she would co-operate to make the exercise a fruitful one.

Her antenatal booklet was taken and glanced through; she was congratulated for her regular attendance. Explanation was given to her on every procedure that was to be carried on her and her consent sought. Her vital signs were recorded as follows; Temperature 35.6degrees Celsuis, Pulse 79beat per minute, Respiration 20 cycles per minute,

Blood pressure 100/70 millimeter of mercury, Hemoglobin level 12.7gram per deciliter, Weight 76kilograms

She was asked to empty her bladder and a specimen bottle was given to her to collect mid-stream urine was requested for urine analysis, but nothing abnormal was detected. She was sent to the examination room, assisted onto the couch. Hands were washed with soap under running water and dried with a clean towel she was examined from head to toe.

Head and Neck; Inspection of the hair and scalp was done; the hair was well kept, neatly braided with no dandruff and no ringworm. There was no swelling on her face. The eyes and conjunctiva were inspected for discharges, jaundice and pallor and none was present. There was no abnormality detected on the inspection of the teeth and tongue like dental caries. The mouth was inspected and no abnormalities were detected, her teeth and gums were clean and lips neither dried, cracked or inflamed. The neck was palpated and lymph, Nodes were absent.

Breast Examination; On the chest, the breast was almost of the same size and shape and no cracks, flat or inverted nipples were observed. Upon palpating the breast, no mass or enlarged axillary lymph nodes were detected, she was also reminded to care for and examine the breast by placing the hand of the examined breast at the back of her head and with the other hand in a circular motion palpate to feel for any lump in the breast. The secondary areola was present with a very prominent nipple in the center. Colostrum was present upon squeezing the areola indicating initiation of breast milk production. Madam Konamah was asked if she would like to breast feed exclusively as she did for the other children and she accepted lt. She was asked to report any abnormality on her breast when she notices it.

Upper extremities: were inspected for equality and no abnormalities were detected, like varicose veins. There was no pallor of the palms and nail bed. However, client's fingernails were found to be long and dirty. She was congratulated for keeping herself neat but was

however educated to keep her finger nails short and clean as they could serve as hiding place for micro-organisms which could contaminate food or cause infection to the perineal areas.

Lower extremities: she was examined for varicose veins, size, length and quality of the extremities and par for any pain in the calf but none was found, there was the presence of slight oedema and she confirmed that she experiences this when she sits or stands for long time. She was educated to elevate her legs when sitting or during sleep and avoid prolonged standing.

Abdominal examination

On inspection: the shape of the abdomen was oval and the size medium. There was no scar but few trace marks of straie gravidarium and linear nigra. Fetal movement was also observed.

Measurement of sympysio fundal height: standing at the right side of the client, hands were rubbed together generate warmth in other to prevent premature contractions. The zero mark of the tape measure was placed on the upper border of the fundus and extended along the contour of the abdomen along the midline to the symphysis pubis. The symphysio-fundal height measured 37 cm and the gestation was 36 weeks plus 2 days.

Fundal palpation: facing the head of the client, hands were warned by rubbing them together. The fingers were curved around the top of the fundus and it was noticed that the buttocks which was felt as a soft mass occupied the upper pole of the fundus.

Lateral palpation: both palms were placed on either side of the uterus between the symphysis pubis and fundus. One hand was used to stabilize the uterus and the other hand was used to examine. It was palpated from the midline of the abdomen to the lateral side of the abdomen and from the symphysis pubis to the fundus in a rotational manner. A smooth part indicating the back was located at the left side of the abdomen. The other side was also

stabilized and the same procedure was repeated and a rough part indicating the fetal was also palpated at the right side.

Pelvic palpation: facing the foot end of the client. She was asked to bend her knees slightly and breathe slowly through her mouth to relax the abdominal muscles. The palms were placed on either side of the uterus below the level of the umbilicus and fingers directed towards the symphysis pubis, with the thumbs almost meeting then a hard mass indicating the head.

Descent: to determine descent**,** the anterior shoulder was located then two fingers were kept over the anterior shoulder, with the right ulnar border placed just above the symphysis pubis and in between the anterior shoulder and the symphysis pubis. Five finger breaths were accommodated and descent was recorded as $5/5^{th}$. The lie was longitudinal with a cephalic presentation.

Auscultation: the fetoscope was rubbed in the palm to warm it and was then placed on the left side of the abdomen as the fetal back was located there. The ear was placed against the fetoscope and without the hands touching it, the fetal heart rate was listened to by comparing it with the maternal pulse on the radial artery. Fetal heart rate was counted for one minute and recorded as 120 beat per minute with good rhythm.

Vulva examination; Permission was sought to examine the vulva and hands were washed and dried. It was nicely shaved with no scars, oedema, varicose veins, and genital warts or bleeding, there were no discharges at the vulva. The labia majora were of the same size and shape. The clitoris was inspected and it was intact with no clitorectomy seen.

All findings were communicated to her and documented in her maternal health records book and she was thanked for her cooperation. She was helped out of the couch and dressed up. Hands were washed and dried with a clean towel. She was made comfortable on a chair.

Since she was not adequately prepared for delivery during her second pregnancy and never wanted a repetition of the situation, she was educated on preparations towards delivery. She was educated on how to estimate the expected date of delivery using her last menstrual period, and was also taught how to identify the EDD on the scan report. It was explained further that the EDD could be one week earlier or later and was encouraged to get ready by acquiring all needed item about one or two weeks to the EDD. She was given a list of all the needed items and was encouraged to acquire them early.

When asked if she had any concerns, she mentioned that she had Backache and heartburns. She was reassured and asked to cope with it.

In addition, she was educated on intake of nourishing diet to improve or maintain the hemoglobin level. She was educated on the danger signs of pregnancy and minor disorders. She was informed of my intended visit to her house. Her medications were served and they were as follows;

Tablets folic acid - 5milligrams daily for 7 days

Tablets paracetamol - 1 gram 3 times daily for 5 days

Tablets multivitamin - 1 gram three times daily for 7 days

Her next date for visit was communicated to her but to report if she experiences any danger sign.

2.2 FIRST ANTENATAL HOME VISIT

Madam Konama and her family were visited on 11th May, 2022 at 11:30am to access her general condition and meet the other family members as well as assess her home environment and offer appropriate education. I was warmly welcomed by client and her co-tenants. Client then introduced me to her landlord, Madam Kosua Kraa, and other members of the house. Generally, the condition of the house was satisfactory.it was inquire from client about the

backache and heartburns and she said it has subsided.Their source of drinking water is pipe born which is situated about 10 meters away from their house. They store their water in large containers provided with tight fitting lids. They were congratulated for keeping the environment clean and encouraged to keep it up. They have a dustbin but it however had no cover, education was then given to her on the health problems that can arise from an uncovered dustbin, such as cholera, dysentery. She was encouraged to cover her refuse to prevent flies and other insects from settling on it. She also showed me the final disposal site of the refuse, which was about 15 meters away from the house. Permission was then sought from client to use their wash room, and it was realized that the bathroom was unclean. I took the opportunity to educate members of the house the constantly clean their bathroom so as to prevent falling especially the pregnant woman and other older women in the house. Kitchen was scattered with cooking utensils and so members of the house were encouraged to arrange and cover utensils with napkins.

From the assessment, it can be said that Madam Konama and co-tenants are ready and willing to improve on their environmental hygiene. At the end of the assessment, she was asked about how prepared towards the delivery. Madam Konamah was ask if she has any problem, and she said she is having frequency of micturition and Waist pain which interrupt her sleep. She was reassured and the physiology was explained to her as due to pressure of the presenting part on the bladder, and pressure on the sacral nerves. Client was educated to reduce fluid intake such as natural diuretic like coffee especially before bed time, and sit straight with her back support with pillow have a chamber pot by her bed to reduce walking out of her bed room at night, empty her bladder immediately before going to bed. It was realized that her fingernails were cut short and were looking neat and was congratulated. The Landlord and the mother were encouraged to continue helping her and to allow her get some time to rest during the day.

Client and family were assisted to prepare for the birth and complication readiness that is, arranging for means of transport, blood in advance in case of the need for transfusion, and saving some money to cater for their needs during delivery. The mother assured me that transportation was not a problem since they have a family driver close to their house. The mother was encouraged to assist client acquire all the needed items before the next visit. She was educated on the true signs of labour and encouraged her to call me on my phone at any time she needed my help and was also encouraged to report to the hospital any time she encounters any problem. She was also taught how to perform the deep breathing and the Kegel exercises to strengthen the pelvic floor muscles

Health education was given on the benefits of exclusive breastfeeding that is to her the mother, the baby, the family and the nation as a whole as well as family planning, and they were encouraged to choose a method at six weeks postnatal review visit. She was encouraged to practice it after delivery, and she gladly accepted to do so. She was reminded of the date for the subsequent visit, was promised another visit before delivery. She was then thanked for her co-operation and permission was sought to leave.

2.3 SUBSEQUENT VISIT TO THE HOSPITAL

The client reported to the hospital on the 23rd May, 2022 at 9:30am. Client was welcomed and offered a seat and made herself comfortable. After 30 minutes relaxation, she was asked about the previous condition which is frequency of micturition and waist pain, she said both were better now. She was then taken through the normal processes and the following were the readings for the vital signs; Weight: 79.0 kilograms, Temperature 36.1 degrees Celsius, Pulse 80 beats per minute, Respiration 22 cycles per minute, Blood pressure 110/60mmHg, Urine for protein and glucose negative. Blood was also taken for hemoglobin level estimation and was recorded as 13.7gram per deciliter. After she had emptied the bladder, she was helped onto the examination bed/couch where privacy was ensured. Hands were washed with soap

and clean water and dried with a clean towel and physical examination was done on her under the midwife in-charge.

Her hair was examined and it was nicely platted with no dandruff and lice. The eyes, nose and ears were inspected for only discharges but no abnormality was detected. Her lips had no sore or cracks on them. Her upper and lower extremities were inspected and it was the upper limbs had no abnormality detected, and the oedema subsided. On abdominal examination, the abdomen was oval with linea nigra and straie gravidarum. Her gestation was 37 weeks symphysio fundal height was 37 centimeters. The lie was longitudinal, presentation cephalic, position right occipito anterior and the descent was $5/5^{th}$. On auscultation, the fetal heart was 130 beats per minute with good rhythm and volume. Fetal movements were present. After the examination, hands were washed and dried with clean towel; all findings were recorded in the antenatal record card and communicated to her.

Client was educated to have rest and sleep for at least four hours during the night and one hours during the day. She was again reminded on exclusive breastfeeding after delivery. According to laboratory investigation, her hemoglobin (Hb) level had reduced she was given hematinic and encouraged to continue with the good diet she has been taken so that she can improve her hemoglobin level. She was told to report anything unusual to the hospital anytime. Again, as part of the interventions for the knowledge deficit on family planning, she was introduced to a mother who practiced it to share her experience with her. Finally, she was congratulated for coming to the hospital and she was seen off.

2.4 SUBSEQUENT HOME VISIT

Client was again visited on the 30th May, 2022 about 2:10 pm. On arrival, the husband was at home and was happy I had made time to visit again. Greetings were exchanged and an enquiry about their health was made, and they were doing well.

The preparation for delivery was reviewed and they had bought all items and packed them nicely. They were congratulated. An enquiry was made about who was going to take care of the house and children when she goes to deliver and the mother gladly assured me she will take of care of that. She was again reminded on the true signs of labour such as appearance of "show" and painful regular rhythmic uterine contractions. She was asked to report to the clinic immediately any of these signs were noticed. The danger signs of pregnancy were made known to her as follows, bleeding per vagina, blurred vision, severe headache, oedema and excessive vomiting. Lastly, the need for exclusive breastfeeding for the six months of delivery and family planning were stressed and she agreed to practice it. The family was thanked and permission was sought to leave.

2.5 NURSING CARE PLAN ON ANTENAL

PROBLEMS IDENTIFIED

Client complained of:

1. Heartburns
2. Backacke
3. Frequency of micturition
4. Waist pain

SHORT TERM OBJECTIVE

1. Client heartburns will be reduced and cope with it throughout pregnancy
2. Client backache will subside and cope with it throughout pregnancy
3. Client will cope with frequent of micturition throughout pregnancy.
4. Client waist pain will reduce and cope with it througout pregnancy.

LONG TERM OBJECTIVE

Client will go through pregnancy, labor and puerperium successfully without any complication

ANTENATAL CARE PLAN

DATE/ TIME	NURSING DIAGNOSIS	OBJECTIVE/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
11/05/22 4:30pm	Heartburns related to the hormone progesterone relaxing the cardiac sphincter	Client's heartburns will be reduced and cope with it throughout pregnancy as evidenced by 1.Client action	1. Explain the physiology of heartburns to client. 2. Support client emotionally. 3. Educate client to eat in bits but at regular intervals 4. Educate client to wait at least 30 minutes after eating before going to bed. 5. Educate client to avoid the intake of	1. Physiology of heartburns was explained to client that it is due to the reflux of gastric content into the esophagus. 2.Client was supported emotionally. 3. Client ate in bits but at regular intervals. 4. Client waited for 30 minutes after eating before going to bed. 5. Client was educated to avoid the intake of fatty	11/05/22 9:30am	Goal fully met as client said her heartburns has reduced.	

			fatty and spicy foods.	and spicy foods			

ANTENATAL CARE PLAN CONTINUED

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES	NURSING ORDERS	NURSING INTERVENTIONS	DATE/ TIME	EVALUATION	SIGN
11/05/2022 9:30am	Backache related to pressure of the descending head on the sacral nerves.	Client backache will subside and cope with it throughout pregnancy as evidenced by; 1. Client action	1.Reassure client 2. Explain the physiology of backache to client 3. Educate client to support her back and side with a pillow when sleeping. 4. Encourage client to have rest and sleep 5. Encourage husband to perform sacral massage	1.Client was reassured 2. Physiology of backache was explained to client as pressure of the fetal head on the sacral nerves. 3. Client was educated to support her back and side with a pillow when sleeping. 4. Client was encouraged to have rest and sleep. 5. Client's husband was encouraged to perform sacral massage.	11/05/2022 10:00am	Goal fully met as evidenced by client verbalizing that her backache has subsided.	

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVE/OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN.
23/05/2022 9:30 am	Client will cope with frequent of micturition	Client will be able to cope with frequency of micturition within 24 hours as evidenced by client verbalizing	1.Reassure client. 2. Explain the physiology of frequency of micturition in the late pregnancy. 3.Educate client on effect of fluid with natural diuretics. 4. Encourage client to void when going to bed. 5. Encourage client to put	1. Client was reassured. 2. Physiology of frequency of micturition way explained to client and she understood. 3. Client took fluid that does not contain natural diuretics when going to bed. 4. Client emptied her bladder before going to bed.	23/05/2022 10:30am	Goal fully met as client verbalized the ability to cope with frequency of micturition.	

			chamber pot beside her bed during bed time	5. Client placed chamber pot beside her bed during bed time.			

DATE / TIME	NURSING DIAGNOSIS	NURSING OBJECTIVE/OUTCOME CRITERIA	NURSING ORDER	NURSING INTERVENTIONS	DATE / TIME	EVALUATION	SIGN.
23/5/2022 2:40pm	Waist pain related to pressure on the sacral nerves.	Client waist pain will reduce and cope with it client verbalizing.	1. Reassure client 2. Explain physiology of waist pains during pregnancy 3. Encourage client to wear low flat shoes 4.Educate client on mild exercise.eg walking 5. Serve clients with analgesics.eg tablets paracetamol 1g	1. Client was reassured. 2. The physiology of waist pain in pregnancy was explained and she understood. 3. Client wears low flat shoes 4. Client was seen walking around. 5. Client was served with 1g of paracetamol 3 times daily.	23/05/2022 2:40pm	Goal fully met evidenced by Client verbalized that her waist pain has reduced.	

CHAPTER THREE

LABOUR

3.0 INTRODUCTION

Chapter three deals with admission and management of labour which includes management of first, second, third and fourth stages of labour, immediate care of the baby at birth, examination of the placenta after birth, summary of labour notes, condition of baby and mother after birth, Condition of placenta and nursing care plan of labour on problems identified during the care.

3.1 ADMISSION AND MANAGEMNET OF THE FIRST STAGE OF LABOUR

Madam Konama Hawa reported to the maternity unit on the 31st May, 2022 at 10:15pm. She was accompanied by her mother. They were warmly welcomed and made comfortable with seats. Her facial expression and gait revealed that she was in pains. Client's antenatal booklet was collected and glanced through quickly to check for obstetric history. On history taking, she said she had a severe lower abdominal pains and uterine contractions which started around 6:00pm and show seen around 7:00pm. She was also asked if she had noticed any danger sign, example bleeding per vaginum but she responded no. She took porridge around 9: 00 pm with bread. She had no history of ruptured membranes and no medications were taken before reporting. She expressed fears of the outcome of labour, because according to her, the labour pains were more severe than the previous deliveries. She was reassured that she was in competent hands and everything would be well. She was also educated that the intensity of labour pains varied in different pregnancies.

Client and mother were reassured, and her mother was made comfortable at the waiting area while client was admitted into a comfortable bed. All procedures to be carried out during the

labour process were explained to her. She was informed that the various examinations to be carried out on her was about to begin, the procedure was explained and privacy was provided. Her general appearance was neat. Her vital signs were checked and recorded as below; Temperature 36.4 degrees Celsius Pulse, 86 beats per minute, Respiration 20 cycles per minute, Blood pressure 100/60 millimeters of mercury.

She was offered a bed pan to empty her bladder and was encouraged to urinate frequently to aid the descent of the fetal head. An amount 100 milliliters of urine was obtained and a sample of it tested negative to both protein and acetone. Client was assisted to undress and lie on the couch,Client complain of Anxiety and Fatique she was reassured and encourage to rest and do deep breathing exercise in between contraction.. Hands were washed under running water and dried with a clean towel and head to toe examination was done under the supervision of the midwife in-charge, and were no abnormalities were detected.

The hair was neatly styled with no lice or dandruff on the scalp. The eyes were clean; conjunctiva was slightly pale. The ears were clean with no discharges from nose; mouth and tongue were clean with a clean set of teeth and smooth lips, there no bad smell from the mouth. No lymph node, mass or distended vein at the neck. The size and the shape of the breasts were normal. The nipples were centrally situated at the breasts and were prominent. Client's breast was palpated starting from the axilla, exposing one breast at a time with the hand under the head no masses or lumps were noticed. There were no lumps at the axilla.

The upper extremities were of equal length, and no oedema was detected. The lower extremities were also inspected and palpated for oedema, equality, varicosity and pains in the calf muscles and no abnormalities were seen. The back was also examined and there were no rashes and sacral oedema.

Abdominal examination

On Inspection: the abdomen was oval in shape, moderate in size and no scars seen. **Measurement of sympysio-fundal height**: standing at the right side of the client, hands were rubbed together generate warmth in other to prevent premature contractions. The zero mark of the tape measure was placed on the upper border of the abdomen and extended along the contour of the abdomen along the midline to the symphysis pubis. The symphysio-fundal height measured 37centemeters.

Fundal palpation: facing the head of the client, hands were warned by rubbing them together. The fingers were curved around the top of the fundus and it was noticed that the buttocks which was felt as soft mass occupied the upper pole of the fundus.

Lateral palpation: both palms were placed on either side of the uterus between the symphysis pubis and fundus. One hand was used to stabilize the uterus and the other hand was used to examine. It was palpated from the midline of the abdomen to the lateral side of the abdomen and from the symphysis pubis to the fundus in a rotational manner. A smooth part indicating the back was located at the left side of the abdomen. The other side was also stabilized and the same procedure was repeated and a rough part indicating the fetal was also palpated at the right side.

Pelvic palpation: facing the foot end of the client. She was asked to bend her knees slightly and breathe slowly through her mouth to relax the abdominal muscles. The palms were placed on either side of the uterus below the level of the umbilicus and fingers directed towards the symphysis pubis, with the thumbs almost meeting then a hard mass indicating the head.

Descent: to determine descent**,** the anterior shoulder was located then two fingers were kept over the anterior shoulder, with the right ulnar border placed just above the symphysis pubis and in between the anterior shoulder and the symphysis pubis. Five finger breaths were

accommodated and descent was recorded as $3/5^{th}$. The lie was longitudinal with a cephalic presentation.

Auscultation: the fetoscope was rubbed in the palm to warm it and was then placed on the left side of the abdomen as the fetal back was located there. The ear was placed against the fetoscope and without the hands touching it, the fetal heart rate was listened to by comparing it with the maternal pulse on the radial artery. Fetal heart rate was counted for one minute and recorded as 142 beat per minute with good rhythm

Vagina examination: Permission was sought to do vaginal examination. She was asked her to lie on her side while hands were washed dried and surgical gloves put on. On inspection, the vulva was neatly shaved with no abnormalities such as vulva oedema, genital warts varicose veins detected. Vulva swabbing was done with five swabs soaked with savlon solution swabbing the labia majora first and then labia manora, separated the labia minora and the vestibule using swab per stroke and wiping from anterior to posterior. Using my right hand, the middle finger was inserted into her vagina firmly pressing downwards and then added the index finger to feel for condition of the vagina. The vagina was warm, moist and slippery, cervix was soft thin and 4 centimeters dilated. The presenting part was well applied to the cervix, membranes intact and there was no moulding at 10:30pm, the sacrum was well curved, the pubic arc was wide and the ischial spines blunt. Hands were removed and inspected with the liquor being clear. A fist was made and fitted at the intertuburtial diameter and it admitted four fingers. Client was made clean from all discharges and perineal pad was applied at the perineum. Gloves were removed and disposed into a bin. Hand washing was done again with soap and under running water and was dried with a clean towel.

The midwife in-charge was informed and she confirmed all findings. All findings were communicated to client and plotted on the partograph. After the examination, client was encouraged to empty her bladder frequently to aid the descent of the fetus and perform deep breathing exercise when there are contractions.

Subsequently, the fetal heart rate, uterine contractions, and maternal pulse were checked every 30 minutes. Temperature, descent, blood pressure, vaginal examination for moulding and fetal head were checked 4 hourly.

PREPARATION FOR BIRTH

In preparation, Madam Konama's mother was identified as the unskilled helper and she was told she would be called in case she is needed. The midwife in-charge served as the skilled helper to help assist in caring for the baby and supervise in the delivery as well. The emergency plan was reviewed which included the means of communication that is; telephone numbers of the referral hospital were available and a call was made to inform them about the labour. The ambulance driver was also informed since his services were also needed as a means of transportation to help seek advance care. The area for delivery was also prepared. The source of light was checked and a portable flash light was made available. Client was informed that windows and doors would be closed and curtains would be drawn down when the baby was about to be delivered to provide warmth and prevent the baby from losing heat. Hand washing and aseptic technique were observed to prevent infection. Client was informed that her hands and chest would be washed cleaned for skin to skin contact prior to second stage of labour. The resuscitation table was made clean and the equipment was checked to be adequate and functioning properly. Madam Konama and her mother were informed about the importance of such preparation. The emergency drugs and equipment's were checked and made available.

Madam Konama was reminded to lie on her left side to prevent supine hypotension syndrome. She was educated on her progress of labour using the dilatation board and possible outcome of labour such as safe delivery without complications. All information gathered was plotted on a partograph. After some time, client sacral massage was done and the physiology behind the pains was explained to her. She was encouraged to perform deep breathing exercise during contractions to minimize the pains. Water was frequently served to prevent dehydration and also she was given malt as an energy drink to enable her get energy. She was also sweating excessively; windows were opened for fresh air. She was then encouraged to urinate frequently to prevent prolong labour. She was also encouraged to breathe through her mouth when there were contractions and avoid pushing during contractions since the cervix was not fully dilated thus preventing oedematous of the cervix and also rest in between contractions. Client was educated on perianal hygiene because she was seen reusing fallen pad. She was encouraged to assume any of the positions used during labour were demonstrated to her.

At 11:45pm on the 31th May, 2022 the fetal heart rate was 146 beat per minute, uterine contractions was 4in 10 minutes lasting 40 seconds, Vital signs was checked and recorded as: Temperature 36.8 degree Celsius ,

Pulse 82 beats per minutes,

Respiration 20 cycles per minutes ,

Blood pressure 110/70 millimeter of mercury

The amount of urine passed was 150 milliliters and it was tested negative for protein, acetone and glucose. Membranes were intact. Vagina examination was done to rule out cord prolapse. The vagina was warm and moist and the cervix was 8 centimeters dilated and

the presenting part was well applied with descent $2/5^{th}$. Client was made comfortable in bed by cleaning discharges and a new perianal pad was applied. The trolley was set in preparation for delivery. The following items were set up.

Top shelf

1. **A sterile delivery pack containing:**

   Sterile cord scissors 2, Sterile artery forceps ,Sterile sheets ,Membranes pierce ,2 galipots containing sterile gauze and cotton respectively ,Sterile receiver for placenta Sterile cot sheet ,Cord clamps ,Bulb syringe

2. **Episiotomy tray containing:** Suture, Episiotomy scissors ,Xylocaine as an anesthetic agent ,Dissecting forceps ,Suturing forceps

   Bottom shelf

   Cot sheets , Oxytocin ,Perianal pad ,Identification band ,Sterile gloves ,Examination gloves ,Savlon ,Bed pan ,Measuring jug ,Fetoscope.

At 1:10am, Madam Konama was anxious about the outcome of the labour and was reassured she was in the hands of competent midwives.

At 1:40am, contractions were 4 in 10 lasting 48 seconds, fetal heart rate was 140 beats per minutes and maternal pulse was 88 beats per minute, membranes ruptured spontaneously and liquor was clear. Client said she has the urge to bear down and vagina examination done, cervix was 10 centimeters dilated and there was no cord prolapse. Descent was $0/5^{th}$ with moulding ++. The midwife in – charge was informed and she confirmed full dilatation of labour which marked the beginning of second stage of labour. The findings were documented on the partograph and client complained of backache. She was informed of full dilatation of cervix.

3.2 MANAGEMENT OF SECOND STAGE OF LABOUR

Every procedure to be conducted was explained to her and her consent sought. She was then asked to empty her bladder. Delivery trolley and infant resuscitation tray was also ready in the delivery room. Rubber apron was put on and face mask and boots worn, hands were scrubbed and dried with clean dried towel and sterile gloves put on. Client assisted to assume the dorsal position with the knees flexed. Cotton wool swabs soaked in antiseptic savlon solution were used to swab the upper thighs, pubis, vulva, and perineum, and the thighs and abdomen draped.

It was explained to Madam Konama that the baby would be delivered onto her abdomen to ensure provision of warmth and bonding between them. She was encouraged to push with contractions and rest in between. Perineal pad was applied at the anus to prevent any faecal matter from contaminating the delivery field, the anus and vulva started gaping. Client pushed with contractions and with good maternal effort the head appeared at the vulva, head advanced and fingers of my right hand over occiput to escape under the symphysis pubis thereby allowing the smallest diameter (parietal 9.5 centimeters) to distend the perineum.

As soon as the head crowned, she was asked to stop pushing and to breathe through the mouth to prevent rapid expulsive delivery of the head, and the rest of the head was delivered by extension.

The baby's face was cleaned; the eyes were also cleaned from inner outwards with sterile cotton wool. Cord around the neck was checked and there was none. Restitution and external rotation of the head indicating internal rotation of the shoulders took place. Hands were placed on each side of the head and the anterior shoulder delivered with gentle downward traction and posterior shoulder by upward traction. The mother was reminded that the baby would be delivered onto her abdomen. The rest of the body was delivered with lateral flexion

unto the mother's abdomen at 2:05am. A healthy Female baby was born and the baby cried immediately after birth.

IMMEDIATE CARE OF THE BABY

Immediately the head was delivered, sterile gauze was used to clean the baby's face, mouth and nose, neck was felt for cord around it the baby was delivered unto the mother's abdomen on a clean cot sheet and cleaned up off liquor and cot sheet changed.

The baby cried immediately after birth. The cord was clamped 3 centimeters away from the baby abdomen and second 2 centimeters away from the first clamp. The cord was covered with gauze and cut in between the two clamps to avoid splashing of blood. The first minute Apgar score was 8/10 and the 5^{th} minute Apgar score was 9/10. Baby was shown to the mother for identification of sex. An identification band was placed on the baby's wrist and it was bearing the name of the mother, sex and weight of the baby, date and time of delivery. The baby was put to breast to breastfeed and to aid bonding between the mother and the baby as well as th release of oxytocin to aid in contraction of the uterus

First minute Apgar score was 8/10. Appearance 2, Pulse heart rate 2, Grimace reflex 1 Activity muscle tone 1, Respiration 2 Fifth minute Apgar score was 9/10 Appearance 2, Pulse heart rate 2 Grimace reflex 2,Activity/ muscle tone 1 Respiration 2 weight 3.2kg.

3.3 MANAGEMENT OF THIRD STAGE OF LABOUR

The procedure was explained to Madam Konama and the uterus was palpated for undiagnosed twin, and there was none. Ten units of oxytocin were injected intramuscularly at the thigh to aid contraction of the separation of the placenta, the uterus was palpated and it was well contracted and the cord was re-clamped near the perineum with an artery forceps. The left hand was placed on the symphysis pubis of the mother for counter pressure to

prevent uterine inversion during removal of the placenta. The artery forceps was held and a gentle pull was made downwards and outwards direction following the line of the birth canal with steady controlled cord traction the placenta appeared at the vulva and the placenta and membranes were delivered with a twisting movement at 02:10 am.

The placenta was placed into a receiver and inspected quickly to detect retained products of conception. The placenta was quickly examined for its completeness and it was complete, the uterus was rubbed for contraction to expel clot and the vulva was cleaned.

The labia were parted, cleaned, examined and there were no laceration on the perineum. The vaginal walls and cervix were also inspected and there were no tears. Bed linen was changed and she was made comfortable.

EXAMINATION OF THE PLACENTA AND MEMBRANES

This is done to rule out any absence of lobes or fragment of membranes retained in utero so that prompt management can be done. It was done soon after delivery of the placenta under a good source of light and on a flat surface. The end of the cord was examined for number of blood vessels and it was two arteries and one vein. The cord was thick, strong and was covered with Wharton's jelly and centrally inserted into the placenta. The fetal surface looked shiny and bluish grey in colour and blood vessels radiating from the cord to the edges of the placenta.

Maternal surface looked dark red in colour, fitted together without any gaps and with no infarct. The cotyledons were also intact with no extra lobes. The placenta weighed 0.5 kilogram. The placenta decontaminated and discarded into a pit. Used instruments were immersed into 0.5% chlorine solution for 10 minutes; washing was done air dried and sterilized for the next procedure. Gloves were removed and discarded, hands washed with soap under running water and dried with clean towel.

3.4 MANAGEMENT OF THE FOURTH STAGE OF LABOR

In this stage, the mother and baby were assessed every 15 minutes for 2 hours, half hourly for the next 1 hour and hourly for the subsequent three hours. Madam Konama was encouraged to empty her bladder frequently to aid involution of the uterus and prevention post-partum haemorrhage. Madam Konama was encouraged to massage the uterus frequently to aid contraction. She was again educated to change her perineal pad when soaked and wash her hands before and after changing the pad with soap and water to prevent infection.

The mother's immediate post- delivery vital signs were as follows; Temperature 36.1 degrees Celsius, Blood pressure 110/60 milliliters of mercury, Respiration 20 cycles per minute ,Pulse 76 beats per minute. The uterus was palpated and it was well contracted and measured 16 cm. She was taught to massage the uterus. Relatives were allowed to see. Her lochia was red in color (rubra) and had a fleshy odour. She complained of lower abdominal pain and the in-charge was informed and she was served with 1g tablet of Paracetamol. She was educated that the pain was due to the uterine involution and educated on care of the perineum and how to fix baby to breast.

PREVENTION OF DISEASES

The following procedures were performed to prevent serious infection to the eye, cord and also prevent hemorrhagic disease of the newborn. Two (2) drops of chloramphenicol eye drop was instilled on each eye, the cord was dressed with sterile cotton and methylated spirit and vitamin K 1.0mg intramuscularly was given to the baby after head to toe examination was done. Baby skin was smeared with baby oil to provide warmth. Hands were washed with soap under running water and cleaned with dry towel.

EXAMINATION OF THE NEW BORN

The procedure was explained vividly to Madam Konamah, examination gloves were worn and the baby was examined head to toe to detect any deviation from normal at 8:00am. Baby was put on a covered flat surface and only the part to be examined was exposed. The head was examined for bulging and sunking of fontanelles, size, shape, laceration and caput succedaneum but no abnormality was detected. Head circumference was measured by encircling the head with tape measure from occipital protuberance to the supra orbital ridges and it measured 33cm and the baby's length was 50cm. The ear was examined for position, size, and patency. Eyes (conjunctiva) were also examined for pallor, sub conjunctiva hemorrhage and abnormal discharges but no abnormality was detected. The nose was also inspected for size, shape and nostrils checked to rule out deviated septum but everything was normal. The mouth was inspected for cleft palate, tongue tie, false teeth and suckling, rooting and swallowing reflexes were checked but everything was normal. The neck was examined for congenital goiter and swollen lymph nodes but there was none. The chest was inspected for shape, size and chest wall movement with respiration and respiration rate was 44 cycles per minute and the apex heart beat was also 140 beats per minute. Breasts were palpated for masses and nipple was checked for position and extra nipple and everything was normal. Examination of the upper extremities was done and hands were inspected for clubbing, extra or missing digits and webbing. Hands and arms were inspected for symmetry, movement and paralysis, and the palm for the number of palmer crease. Shape and colour of nail beds were inspected and reflexes (grasping, Moro) checked but were normal. The abdomen was examined the size and shape were normal. The cord was inspected but no bleeding was noted. The liver and spleen were palpated for enlargement and no abnormality detected.

SUMMARY OF LABOUR NOTES

Madam Konamah had a spontaneous vaginal delivery at 2:05 am to female baby on the 1st June, 2022. This was followed immediately by the delivery of the placenta and membranes at 2:10am and the approximate loss of blood was 140 milliliters.

Condition of baby at birth; Sex Female, Birth Weight 3.2 kilograms, Apgar score 8/10, 9/10, Full length 50 centimeters, Head circumference 33centimeters, Chest circumference 34 centimeters, Waist circumference 32 centimeters, Abnormalities None detected, General Condition Satisfactory

Condition of mother after delivery; Perineum intact, Blood loss 140 milliliters, Temperature 36.4degrees Celsius, Pulse 80 beats per minute, Blood pressure 100/60 millimeters of mercury, Respiration 20 cycles per minute, General Condition Satisfactory, Fundal height 16 cm.

Condition of placenta and membranes; Placenta and membranes completely expelled ,Length of cord 50 centimeters ,Weight of placenta 0.5 kilogram,Diameter of placenta 32 centimeters.

PROBLEMS IDENTIFIED

Client complained of:

1. Lower abdominal pains
2. Anxiety

3. Fatigue

4. Excessive sweat

SHORT TERM OBJECTIVES

1. Client will be able to cope with Lower abdominal pain till the end of labour.
2. Client's anxiety will resolve 1 hour after labour
3. Client will be relief from fatique within 1 hour after labour.
4. Client will be relief from excessive sweating by the end of labour.

LONG TERM OBJECTIVE

Madam Konamah will be able to go through labour and puerperium without any complication.

3.5 CARE PLAN NURSING CARE PLAN ON LABOUR

DATE/ TIME	NURSING DIAGNOIS	NURSING OBJECTIVE/OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTIONS	DATE/ TIME	EVALUATION	SIGN
31/01/2022 10:30pm	Lower abdominal pain related to decent fetal of head	Client will cope with lower abdominal pain throughout labour as evidenced by Client verbalizing.	1. Reassure client 2. Explain the cause lower abdominal pain to her. 3. Encourage her to empty her bladder frequently. 4.Encourage her to assume a comfortable	1. Client was reassured. 2. The cause of pains was explained to her and she understood. 3. Client emptied the bladder frequently to permit descent. 4. Client was assumed left lateral position	31/01/2023 2:30am	Goal fully met as client demonstrated quiet a relaxed facial expression.	

DATE/ TIME	NURSING DIAGNOIS	NURSING OBJECTIVE	NURSING ORDERS	NURSING INTERVENTIONS	DATE/ TIME	EVALUATION	SIGN
			and suitable position.				

31/05/20	Anxiety	Client's anxiety	1. Reassure client.	1. Client was reassured.	31/05/2022	Goal fully met as	
DATE/ 22 **TIME**	**NURSING DIAGNOSIS** related to unknown outcome of labour.	**NURSING OBJECTIVE /OUTCOME** will be resolved by end of labour as evidenced by **CRITERIA.** Client verbalizing.	**NURSING ORDERS** 2. Encourage client to express her fears. What is possible outcome of labour.	**NURSING INTERVENTIONS** 2. Client's was educate on the possible outcome of labour. 3. Procedure and outcome was	**DATE/ TIME** 3 ;00 am	**EVALUATION** client remained calm and verbalizing being allayed of	**SIGN**
10:30pm			3. Explain every procedure to client correctly in simple words. 4. Encourage client to ask question and answer. 5. Keep client informed on the progress of labour.	explained to the client in simple words 4. Question were answered in simple terms to client understanding. 5.Findings were communicated to client especially progress of labour.		anxiety.	

DATE/	NURSING DIAGNOIS	NURSING OBJECTIVE/OUTCOME	NURSING	NURSING	DATE/	EVALUATION	SIGN
29/05/2022 at 10:30pm	Excessive sweating related to process involved in labour	Client will be relieved of excessive sweating by the end labour as evidenced by client verbalizing.	1.Reassure client. 2.Ecourage client to do deep breathing exercise 3. monitor and do vital signs. 4.Encourage client to sips water. 5.Assess the amount and the colour of and urine output and record	1. Client was reassured 2.client engage in deep breathing exercise. 3.Vital signs were monitered and recorded. 4.Client was encouraged to sip water. 5. Amount and colour of urine produced were assessed and record.	30/05 2022 4:40am	Goal fully met as as client relaxed.	

TIME		CRITERIA	ORDERS	INTERVENTIONS	TIME			
30/05/2022 at 10:30pm	Fatique related to stress of labour.	Client will be relieved of fatique within 1 hour as evidence by Client verbalizing.	1.Reassure client. 2. Encourage client to rest. 3. Encourage client to continue deep breathing exercise. 4. Inform client on the proqgress of labour. 5. Encourage client to take oral fluids.	1. Client was reassured. 2. Client was encourage to rest in between contraction.. 3. Client was doing deep breathing during uterine contractions. 4. Client understood why theres progress of labour. 5. Client took sips of oral fluids.	31/052022 4:40am	Goal fully met as client verbalized relief of fatique.		

CHAPTER FOUR

PUERPERIUM

4.0 INTRODUCTION

The chapter consists of the management of the mother and baby during puerperium to detect any deviation from normal, which comprises care given on the day of delivery, subsequent care of the baby, examination of the baby, the post- delivery care, the various home visits and the first post clinic review visit and a nursing care plan. The chapter also has termination of care, summary and conclusion, appendices, bibliography and signatories.

4.1 DAY OF DELIVERY AND DISCHARGE (1st June, 2022)

They were made comfortable in bed and her baby placed by her side. Madam Konamah vital signs were checked and recorded as follows; Temperature 36.2 degrees Celsius, Pulse 80beats per minute Respiration 20cycles per minute, Blood Pressure 110/70 millimeters of mercury.

The uterus was palpated after she had emptied her bladder and the uterus was well contracted, fundal height measured 16 centimeters and lochia was red in color with moderate flow. Client was encouraged to urinate frequently since full bladder could lead to postpartum hemorrhage. She was also encouraged to breastfeed the baby exclusively and on demand. Client complained of After pain and she was reassured, client's mother was educated to gently apply warm compress to help relieve her of the pain. Client was also served with 1gm of paracetamol.

In addition, she was educated on frequent changing of perianal pads to prevent infection to the genital tract. She was also educated to drink enough nourishing fluid and eat nutritious diet containing vitamins and protein to help replace worn out tissue. Madam Konamah was served with a cup of warm beverage and later she was served with banku and palm nut soup. She ate with delight.

The baby was examined from head to toe in the presence of the mother without any abnormalities. Baby passed meconium and urinate signifying patency of the anus and urethra

Baby's vital signs were recorded as follows; Morning Temperature 36.5degrees Celsius, Apex beat 130beats per minute. Respiration 40cycles per minute. Evening Temperature 37.2degrees Celsius. Client and baby were allowed to rest.

SUBSEQUENT CARE OF BABY

Baby was observed closely for any abnormalities and deviation but nothing was detected. The baby had passed meconium and urine out and was cleaned up and could suckle well. The umbilicus was not bleeding. Chloramphenicol eye drops was instilled two drops into each eye to prevent eye infection, injection Bacillus Calmette Guerin (BCG) 0.05 milliliters was given on the right upper arm, and polio 0 2 drops was also given orally to prevent tuberculosis and poliomyelitis respectively on that same day of delivery. The mother was educated that there will be formation of nodule on the injection site which will heal leaving a scar, and that she should not panic or apply any medicine to it.

EXAMINATION OF THE BABY

Head to toe examination was done on the baby in the presence of her mother. Hands were washed with soap under running water before and after the procedure. Baby was put on a flat surface under good source of light. The baby was undressed and exposed and a quick assessment was done and covered and the part to be examined was exposed at a time to prevent heat loss

Physical examination:

The baby's general condition was satisfactory. Skin colour remained pink with no rashes, birth mark, bruises or peeling of the skin.

Head and neck; The head was in good shape and size, he had no wide sutures, edematous swelling, no bruises, eyes were free of yellowish discoloration, pallor or discharges or any conjunctival haemorrhage. The ears were in alignment with the eyes and were patent. The nose, mouth were inspected with no abnormality. Neck was without enlarged lymph nodes and rotated and flexed with no pain.

Chest examination; Chest was normal with good respiratory movement

The upper extremities were found to be of normal size with no extra or missing digits. Grasping, rooting, suckling, swallowing, Moro, cough and sneezing reflexes were all present when assessed. The abdomen had a normal shape and size and the umbilical cord vessels were not bleeding.

The lower extremities were equal with no abnormalities like tulips or webbing and no dislocation of hip noticed. There was no spinal bifida or protrusion of an organ at the back.

Genitalia: On inspection of the genitalia, the urethral opening was patent and she passed urine to confirm its patency. The anus was patent as the baby passed meconium.

The baby weighed 3.2 kilograms, head circumference was 33 centimeters, chest circumference 34 centimeters, full length 50 centimeters and waist circumference was 32 centimeters. Baby was redressed, wrapped and handed over to mother to feed. Hands washed and findings documented and communicate to her.

BABY'S FIRST BATH

Requirement:

Soap, sponge ,cream, powder, sterile cotton in gallipot, wrapper ,basin ,towels 1 big and 2 small ones, 2 cot sheet ,Apron ,Gloves A clean baby dress, cup and socks ,Mackintosh 2 jugs containing hot and cold water ,2 receptacles for used water and dirty linen A receiver for used swabs

Baby bath

After six hours (11:00am) the baby was bathed for the first time. The procedure was explained to the mother and all items for the bath were gathered. The baby was bathed with warm water. Bathing water was mix and tested with the elbow. The baby's face was clean with small damp towel the eyes were wiped from the inner canthus to the outward with a swab each. The baby's neck was supported on the left hand between the thumb and under the forefinger. The ears were plug with the thumb and middle figure so that water did not run through. The head was washed with sponge and soap taking care to remove all traces of blood from the hair and around the ears. The head was raised and dried.

Baby was kept on a flat table and towel was unwrapped exposed on areas to be bathed at a time. The baby's body was lathered with soap washed from front of the trunk to feet using a sponge and attention was paid to the skinfolds that is under the neck, axilla and groin. The back was turn with one arm supporting the chest and was wash to the feet, the baby's body was immersed in warm water and rinse thoroughly with the head and the shoulders supported on the left arm and the right hand was used to wash off soap from the body. The baby's body was wiped dry and attention was paid to the skin folds, baby was oiled and dressed. The cord was dressed with chlorhexidine and sterile cotton wool under aseptic technique and left open and no bleeding was noticed. The baby was handed over to the mother to be breastfed.

The conditions of mother and baby were satisfactory. Procedure for head to toe examination was explained to them, and mother and baby were examined but no abnormality was detected. Client's vital signs were checked and recorded as follows; Temperature 36.2degrees Celsius, Pulse 76beats per minute, Respiration 20cycles per minute ,Blood pressure 100/60millimeters of mercury

Fundal height was measured 14centimeters and well contracted. The lochia was red and moderate with no clots. Madam Konamah was served with warm water to bath and had her breakfast after

the examination. The baby had no abnormalities like eye discharges, bleeding cord, and he could suckle. He also passed urine and stool normally according to the mother. Baby's vital signs and weight were recorded as follows: Temperature 36.4degrees Celsius, Apex beat 138beats per minute Respiration 40cycles per minute ,Weight 3.1 kilograms.

Baby was topped and tailed and the umbilical cord was dressed with methylated spirit and a sterile cotton wool swab at 5:00pm. Baby was dressed, wrapped and given to the mother to breastfeed. Client and her mother in law were informed about their possible discharge that morning and her mother to help her in the care of the baby at home. Client was encouraged to eat well balanced diet such as, palm nut soup and fish or meat, beans and kontonmire soup served with fufu or banku. She could also take porridge with roasted ground nut and bread. Education was also given on nourishing fluids like milo drinks, mashed kenkey with roasted groundnut to encourage successful lactation and improved upon her hemoglobin level. Intake of fruits was also encouraged, and the husband was urged to do well and make sure nutritious food was available to her.

Madam Konamah was encouraged to maintain good personal and environmental hygiene by changing the pad whenever soiled and to bath twice a day. She should wash her hands before and after changing the pad, visiting the toilet and handling the baby to avoid cross infection. She must wash her clothing, underwear, and panties frequently and dry them on a drying line in the sun. The husband and mother were encouraged to help keep their environment clean as they did during the antenatal period. She was reminded on the importance of exclusive breastfeeding and was encouraged to feed on demand and to expel the air after feeding and informed that baby should be topped and tailed until cord goes off and keep the baby warm. She should change the napkins whenever soiled, clean buttocks, dry and apply Vaseline to prevent sore buttocks and nappy rashes. Mother was reminded on the importance of immunization and encouraged to take the baby to child welfare clinic for the rest of the immunizations. Rest and sleep was emphasized. She was

encouraged to sleep when baby is asleep so as to recover early from the strain and stress of pregnancy, labour, and puerperium. She was served with the following drugs:

Tablet Folic Acid 5 milligrams daily for 7days

Tablet Fersolate 200milligrams daily for 7 days

Tablet Multivitamin 200milligrams daily for 7 days

Tablet Paracetamol 1000milligrams three times for 7 days

She was encouraged to take her drugs as prescribed and to report any side effects immediately. They were discharged during rounds at about 6:00 pm. She had no bills to settle since she was ensured with the national health scheme and they were helped to pack their belongings. They were informed that they would be visited at home for one week to continue with the care, starting that day in the evening and then morning and evening for the second and third days, and then once daily for last four days.

4.2 FIRST DAY POST NATAL HOME VISIT (2nd DAY POST DELIVERY)

Madam Konamah and her baby were visited on 2nd June, 2022 in the morning at 7:30 am.

Both mother and baby looked healthy on arrival to their house. Greetings were exchanged, client was asked about her after pains and she said it has reduced and she even feels more comfortable now. She was informed of the procedures to be carried out. Hands were washed and dried. The baby was top and tailed and head to toe examination was done and no abnormality was detected. Baby passed meconium and urine during the procedure. The cord was also dressed with six sterile cotton wool swabs and chlorhexidine using aseptic technique; it was clean, dry and not offensive. The baby was dressed, wrapped and given to the client's sister. Madam Konamah 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 and symphysio

fundal height was 14 centimeters. The perineum was clean, dry and intact, lochia was small, red and not offensive. Mother's vital signs were checked and recorded as follows: Temperature 36.6 degree Celsius Pulse 82 bpm, Respiration 19 cpm, Blood pressure 120/80mmHg. Evening vitals Temperature 36.8 degrees Celsius, pulse 84bpm, Respiration 20cpm, Blood pressure 110/70mmHg.

The baby's vital signs and weight were also recorded as follows: Temperature 36.7 degree celsius, Heart rate 136 bpm, Respiration 40 cpm, Weight 3.1 kilograms, Cord Fresh. Evening vitals were checked as fellows Temperature 36.6 degree Celsius , Heart rate 137bpm,Respiration 45cpm, weight 3.1kilograme.

Baby was given to mother to breastfeed and baby was able to suckle well. Client was asked if she had any question or problem and she complained of inadequate sleep. She was reassured, encouraged to take naps in the afternoon and sleep whenever baby is asleep or whenever possible.

Madam Konamah was educated on danger signs of the newborn such as breathing difficulties, cyanosis, persistent vomiting, fever, crying weakly, refusal of baby to feed and yellowing of the palms of the hands and soles of the feet. Client and family were congratulated and permission was sought to leave. She was informed of the next home visit the next day.

In the evening at 4:30pm, client was paid a second visit that day. Client was at home with her mother. Client's husband has returned from church with their children. General health condition of mother and baby was good. Explanation was given to her that she and her baby were going to be examined from head to toe to determine any abnormality for prompt treatment. Client was examined from head to toe and nothing abnormal was detected. Breast was firm and lactating well; lochia was bright red and flow was small with no offensive odour. Her bowel movement was normal. Vital signs checked and recorded as: Temperature 36.5 degree Celsius**,** Pulse 80bpm**,** **Respiration** 20cp, Blood pressure 120/70mmHg

The baby was topped and tailed paying attention to skin folds around 4:50pm in the evening. He passed meconium and urine during the top and tail, the cord dressed with sterile cotton wool and chlorhexidine. Head to toe examination was performed with no abnormalities detected. The baby was weighed and wrapped nicely before feeding. The baby's vital signs were checked and recorded as: Temperature 36.2 degree Celsius, Heart beat 139bpm, Respiration 44cpm, Colour pink, Cord clean, Weight 3.1kg,

4.3 SECOND DAY POST NATAL HOME VISIT (2ND DAY POST DELIVERY)

On 3rd June, 2022 at 8:00 am, Madam Konamah was visited twice to assess her and her baby. On observation, the general condition of the family was good. An enquire was made about the sleep and client replied at day time so she is feel better. The procedures to be carried out were explained to her. The symphysio fundal height was 15 centimeters.

The perineum was inspected and it was clean, dry and intact with small bright red lochia which was not offensive. Her vital signs we checked and recorded as follows: Temperature 36.8-degree Celsius, Pulse 80 bpm, Respiration 18 cpm Blood pressure 110/70mmHg, Breast lactating, Fundal height 14cm.

Permission was sought to top and tailed and dress baby's cord but before that, head to toe examination was done and no abnormality was detected. Baby was top and tailed and cord was dressed nicely with six sterile cotton swabs and chlorhexidine and kept dry. Baby was wrapped in a cot sheet and given to mother for breastfeeding. Baby's vital signs and weight were checked and recorded as follows: Temperature 36.8 degree Celsius, Heart rate 130 bpm, Respiration 38 cpm, Cord clean, Colour pink, Stool meconium, Weight 3.0kg, Evening vitals were as fellows; Temperature 36.8degree Celsius, Heart rate 133bpm,Respiration 42cpm, cord clean colour pink , Stool meconium ,Weight 3.0kg

Madam Konamah was asked if she had any problem or questions and she complained of headache. ,She was reassured and she was advised to minimize house chores and clients support persons were encouraged to support in the care of the baby so that mother can sleep. She was also encouraged to sleep as soon as baby sleeps.

Client and family were thanked for their cooperation and permission was sought to leave and return the following day.

In the evening at 5:30 pm, client was paid a second visit that day. Client was at home with her mother. Client was asked about the husband whom she said her husband had gone to visit a neighbor in the next house. General health condition of mother and baby was good. Explanation was given to her that she and her baby were going to be examined from head to toe to determine any abnormality for prompt treatment. Client was examined from head to toe and nothing abnormal was detected. Breast was firm and lactating well; lochia was bright red and flow was small with no offensive odour. Her bowel movement was normal. Vital signs checked and recorded as;

Temperature 36.6 degree Celsius, Pulse 84bpm, Respiration 20cpm,

The baby was examined from head to toe and there was no abnormality detected. The baby was top and tailed. The cord was dressed with sterile cotton wool and chlorhexidine. The baby's vital signs and weight were checked and recorded: Temperature 36.9 degree Celsius, Heart beat 132bpm, Respiration 40cpm, Weight 3.0 kilograms, Cord clean

4.4 THIRD DAY POSTNATAL HOME VISIT (3RD DAY POST DELIVERY)

Madam Konamah was visited at home twice to check on how she and the baby were faring on 4th June, 2022 at 8:00 am. Greetings were exchanged and client headache was reviewed and she said is going gradually. Permission was sought to inspect her perineal pad. Her lochia discharge was pink serosa and not offensive. She also said she was able to have enough sleep now. Head to toe

examination was conducted and everything was normal. The uterus was firmly contracted and symphysio fundal height measured 12 centimeters. Vital signs were checked and recorded as; Temperature 36.8-degree Celsius, Pulse 84bpm, Respiration 18 cpm Blood pressure 120/80 mmHg.

Mother was asked to top and tailed the baby under supervision which she did very well with few lapses. Head to toe examination was done and everything was normal. Baby's cord was dressed with six cotton wool swabs and chlorhexidine and left to dry. The cord was not offensive and the baby passed stools and urine in which stools were brownish yellow in colour. The baby's vital signs and weight were checked and recorded as follows: Temperature 36.5-degree Celsius, Apex heart rate 134 bpm, Respiration 43 cpm, Weight 2.9kilograms,

Client was thanked for her cooperation and support. She was asked to take her routine drugs and also informed that; twice visit in the house changes to once visit from tomorrow. Permission was sought to leave.

Madam Konamah and family were visited 5:30pm. Greetings were exchanged and a seat was offered. On observation, the general condition was good. Perineal pad was inspected and the flow of lochia was small, bright red in colour with no offensive odour. Client complained of constipation and insomnia. Mother's vital signs were checked and recorded as: Temperature 36.5-degree Celsius, Pulse 86bpm, Respiration 19cpm, Blood pressure 110/80mmHg.

The baby was examined from head to toe and there was no abnormality detected. The baby was top and tailed. The cord was dressed with sterile cotton wool and chlorhexidine . The baby's vital signs were checked and recorded: Temperature 36.8degree Celsius, Heart beat 130bpm, Respiration 44cpm, Cord clean.

All the family members were reminded about changes in the visit to the house to once in a day and I thanked them.

4.5 FOURTH DAY POST NATAL HOME VISIT (4TH DAY POST DELIVERY)

Madam Konamah was visited again on 5th June, 2022 at 8:00 am. Mother, baby and family looked healthy on arrival. Client said she was relieved of her Constipation whiles taking 5 glass of water a day and some minimal exercise when she was asked about it. Baby had already been top and tailed by Madam Konamah's mother so head to toe examination was conducted and no abnormality was detected.

Baby's cord was dressed with six cotton wool swabs and chlorhexidine, it was dry and non-offensive and the stump was almost off. Head to toe examination was carried out on the mother and heaviness of the breast was detected as the mother experience pain when the left breast was touched and breast was warm and tensed. She was encouraged to continue breastfeeding and also taught on proper positioning and attachment. On palpation, the uterus was well contracted and the symphysio fundal height was 10 centimeters, perineum was clean and intact. Lochia was small, serosa and not offensive.

Her vital signs were checked and recorded as follows: Temperature 37.0 degree Celsius, Pulse 82 beats per minute, Respiration 20 cycles per minute, Blood pressure 120/80 mmHg, Fundal height 10 cm, Lochia serosa, Breast lactating.

The baby's vital signs and weight were checked and recorded as follows: Temperature 36.9 degree Celsius, Heart rate 128 beats per minute, Respiration 41 cycles per minute, Weight 2.9kilograms, Cord clean.

Client was asked of complaints and she complained of breast engorgement. Client was reassured and encouraged to continue with exclusive breastfeeding, express breast milk, massage breast gently before breastfeeding and apply cold compress on the left breast.

Mother was encouraged to ask questions. All findings were communicated to her and the necessary documentations were done. Client was thanked and permission was sought to leave.

4.6 FIFTH DAY POST NATAL HOME VISIT (5TH DAY POST DELIVERY)

On the 6th June, 2022, Madam Konamah was visited at 7:00 am. Mother and baby looked healthy on arrival.enquiry was made on breast engorgement while she said she continue the exclusive breastfeeding is subsided gradually. Baby was top and tailed by her mother, head to toe examination was done and no abnormality was detected. The cord was off and the stump was dressed with cotton wool swab and methylated spirit, it was dry and not offensive. Madam Konamah was also examined from head to toe and no abnormality was detected. On palpation, symphysio fundal height was 12cm. Perineum was clean and lochia was small and serosa in color and not offensive when inspected. Madam's vital signs were checked and recorded as: Temperature 36.6 degree Celsius Pulse 80 bpm, Respiration 18 cpm, Blood pressure 110/70 mmHg, Fundal height 8 cm, Breast lactating, Lochia serosa. Baby's vital signs were checked and recorded as: Temperature 36.6-degree Celsius, Heart rate 128 bpm, Respiration 40 cpm, Weight 2.9kilograms, Stool yellowish Baby was given to mother to breastfeed and baby's suckling was good. Mother was encouraged to continue with breastfeeding. Client was thanked and permission was sought to leave.

4.7 SIXTH DAY POSTNATAL HOME VISIT (6TH DAY POST DELIVERY)

On 7th June, 2022, Client and baby were visited at 8:00 am. Mother and baby looked happy on arrival and the whole family was doing well. Her husband was also fetching water for the family. Procedures to be done were explained to her, her permission was sought and she

consented. Head to toe examination was done for the baby and the mother and no abnormality was detected. The fundal height was 6cm. The perineal pad was inspected and lochia was scanty and brownish red in colour. Her vital signs were checked and recorded as follows: Temperature 36.9 degree Celsius, Pulse 86 bpm, Respiration 19 cpm, Blood pressure 120/80 mmHg, Fundal height 6 cm, Lochia serosa, Breast well lactating.

The baby was bathed and the umbilical stump was cleaned with cotton wool swabs and chlorhexidine. The cord stump was clean and dry with no offensive odour.

The baby looked healthy and active. His vital signs were checked and recorded as: Temperature 36.8 degree Celsius, Heart beat 130bpm, Respiration 38 cpm, Weight 3.0kilogram, Stool brownish -yellow.

Madam Konamah was asked if she had any problem and she said no. Client was informed about the termination of visits on the seventh day and permission was sought to leave after a short interaction.

4.8 SEVENTH DAY POSTNATAL HOME VISIT (7TH DAY POST DELIVERY)

On the 8th June 2022, at about 8:30 am, client was visited. Greetings were exchanged and a seat was offered. Baby and mother were doing well. Madam Konamah's mother bathed the baby under supervision and she did it perfectly after head-to-toe examination was done on both mother pain and baby and no abnormality was detected.The baby passed urine and stools during top and tail. The colour of the stool was bright-yellow. The fundal height was 4cm. The perineal pad was inspected and the lochia was scanty and brownish red in colour. The cord stump was dressed with chlorhexidine by Madam Konamah under supervision. The cord stump was clean, dry and not offensivhe. Mother's vital signs checked and recorded as follows: Temperature 36.8 degree Celsius, Pulse 84 beats per minute, Respiration 18 cycles per minute, Blood pressure 120/80 mmHg, Lochia serosa, Breast lactating, Fundal height 2 cm.

The baby's vital signs were: Temperature 36.7 degree Celsius, Heart rate 134 beats per minute, Respiration 40 cycles per minute, Weight 3.1 kilograms, Stool brownish - yellow Madam Konamah was encouraged to continue exclusive breastfeeding for six months, ensure personal and environmental hygiene as she always does. The importance of immunizing the baby against the preventable childhood diseases was also explained to her. She was reminded of her

visit to the clinic on the following day. Madam Konamah and her family expressed their heartfelt gratitude. They were thanked for their cooperation and also making the work easier. Permission was sought to leave.

4.9 FIRST POSTNATAL REVIEW VISIT

The first postnatal review visit was on the 10th June 2022. Client and her baby reported at the clinic at 8:00 in the morning accompanied by her mother. Their general appearance showed that they were in good health. They were welcomed and given seats. Madam Konamah Hawa was informed of the procedures to be carried out on her and baby and her consent sought. She was asked to empty her bladder, and a specimen of midstream taken for urine undress and assisted to lie on the couch. Head to toe examination was performed on her but no abnormalities were detected. Her hair was neatly braided, conjunctiva was normal as well as the mouth and the nose, and both upper and lower extremities were all normal. Her breasts were lactating well with no sores or cracks on the nipple. The fundus of the uterus was not palpable, lochia was examined and the colour had changed to creamy brown and it was scantly with no offensive smell. She was then helped to get from the couch**;** all findings were communicated to her and recorded as follows; Temperature 36.7 degrees Celsius, Pulse 80 beats per minute, Respiration 20 cycles per minute, Blood pressure 110/60 millimeters of mercury, Fundal height 10 centimeters, Hemoglobin 11.0 grams per deciliter, Urine no abnormality detected.

Madam Konamah was able to remember almost issues discussed on the education during the period of interactions, and was congratulated and lighter thrown on the few things that she could not remember. They were encouraged to call on report immediately to the clinic any time she had any problems or questions to ask on anything she did not understand. The baby was also examined from head to toe, but no abnormalities were detected. On general examination, the skin was pink with no rashes. The sutures and fontanels were normal with no swelling on the head. There was no discharge from the eye, nose and ears. The sclera was clear and conjunctiva was pink. She was educated to change soiled diapers frequently. The abdomen was soft and not distended, and

umbilicus was healed completely, the limbs, genital and the back were all normal. Baby's vital signs were checked and recorded as follows; Temperature 36.7 degrees Celsius, Pulse 138 beats per minute, Respiration 40 cycles per minute Weight 3.3kg.

Madam Konamah and the mother were reminded on the need to breastfeed the baby exclusively, on demand, and she was asked to demonstrate how to fix the baby correctly to the breast for effective breastfeeding and she did correctly, and was congratulated. She was further reminded to change baby's soiled diapers frequently to help half good sleep so that she can also sleep. She was also reminded of exclusive breastfeeding as an effective natural family planning method and encouraged to do the family planning at six weeks. She was encouraged to register the baby with birth and death registry before the child attains the age of one year and also have the baby circumcised as soon as possible. She was served with Multivitamin one tablet daily for 30 days. Madam thanked as for the care rendered to her. She was also thanked and escorted to the entrance of the facility. Explanation was given to madam Konamah on the need to be handed over to the midwife in charge for continuity of care on that same day. Explanation was made to her that the program was ending that day. Client was reassured of midwife in charges competency. Client was accompanied to her house and a seat was offered. Client and her family were thanked for their cooperation, information provided and mission was sought to leave.

4.10 SIXTH WEEK POSTNATAL TO THE CLINIC

According to the public health, the six weeks postnatal visit was made on 15th June, 2022 by client and her baby. Head to examination was done on both mother and baby but no abnormality was detected. The uterus was not palpable and no lochia drainage. Client weighted 69kilogram. The vital signs checked on mother were recorded as below; Temperature 36.7 degree Celsius, Pulse 76 beat per minute, Respiration 20 cycles per minute, Blood pressure 110/70 mmHg.

Client urine was tested for glucose and protein and was negative. Her hemoglobin level checked was 13.0 grams per deciliter. Baby looked normal on examination and the posterior fontanel was

closed. Baby weighed 3.5 kilogram. Baby's vital signs and weight were as follow: Temperature 36.9 degree Celsius, Apex heart beat 138 beat per minute, Respiration 42 cycles per minute. The client was handed over to the public health nurse at the facility for continuity of care. Baby was immunized with the following vaccines:

Vaccine	**Dosage**	**Route of Administration**
Polio	2drops	oral
Rotavirus	1.5mls	oral
Pneumococcal	0.5mls	intramuscular right thigh
DPT-HepB-Heb1	0.5mls	intramuscular left

Mother was reminded on family planning methods and she agreed to continue with Depo provera. Emphasis was also made on breastfeeding as advised. Client was also advised to report to any facility if she encounters any health-related problem. Client was then handed over to the midwife in charge for continuity of care. The midwife in charge was really appreciated for her cooperation.

3.11 NURSING CARE PLAN ON PUERPERIUM

PROBLEMS IDENTIFIED

Client complained of:

1. After pains
2. Headache
3. Inadequate sleep
4. Constipation
5. Breast engorgement

SHORT TERM OBJECTIVES.

1. Client after pain reduces within72 hours.

2. Client headache will subside within 24 hours

3. Client will be able to sleep at least3 hours within 24 hours.

4. Client will be able to empty her bowels at least once within 48 hours

5. Client breast engorgement will subside within 72hours.

LONG TERM OBJECTIVE

Client will go through puerperium without any complications

DATE/ TIME		NURSING DIAGNOSIS	NURSING OBJECTIVE	NURSING ORDERS	NURSING INTERVENTIONS	DATE/ TIME	EVALUATION	SIGN
03/06/2022 9:40am.		After pain related to involution of the uterus.	Client would be relieved of after pain within 72 hours as evidence by client verbalizing.	1.Reassure client. 2. Explain physiology of after pain to the client. 3. Encourage client to empty her bladder frequently. 4. Educate client to continue breastfeeding. 5. Serve-recommended analgesic.	1.Client was reassured. 2. Client was educated that after pain is a result of involution of the uterus. 3. Client emptied her bladder whenever she feels the urge. 4. Client was breastfeeding frequently. 5. Paracetamol 1g tds x 3 days was given served to reduce pain.	06/06/2022 at 9 :40am	Goal fully met client saying that her after pain was resolved. .	

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

31/05/2022 6:40 am	Headache related to inadequate sleep.	Client will be relieved of headache within 24 hours as evidenced by client verbalizing.	1. Reassure client 2. Encourage client's support person to help in the care of the baby. 3. Encourage client to rest and sleep during the day. 4. Check vital signs to rule out any complications. 5. Encourage client to rest in	1. Client was reassured. 2. Client's support person was helping in the care of the baby. 3. Client was resting during the day. 4. Vital signs were checked to rule out complications. 5. Client was encouraged to rest in between activities. 6. Client took 1 g paracetamol tds x 3 days.	01/06/2022 6:40 am	Goal fully met client verbalizing that she was relieved of headache.	

			between activities. 6. Encourage client to take the prescribed analgesic.				

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVE/OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTIONS	DATE/ TIME	EVALUATION	SIGN
02/06/2022 9:40 am.	Inadequate sleep related to breastfeeding in the night.	Client will be able to sleep at least3 hours within 24 hours as evidence by Client verbalizing.	1. Reassured client. 2. Encourage the client to have periodic rest during day when baby is asleep. 3. Educate partner and co-tenant to support client with house hold chores. 4. Encourage client to have a 5. Encourage client	1. Client was reassured. 2. Client was encouraged to have a periodic rest when baby is asleep. 3. Partner and co-tenant supported client in house hold chores and care of the baby. 4. Client was served with warm drink. 5. Visitors were limited.	3/06/2022 9:40 am	Goal fully met as client verbalizes that she has adequate sleep as indicated.	

			to sleep whenever warm drink before bed. 6.limit visitors				

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVE/OUT COME CRITERIA	NURSING ORDERS	NURSING INTERVENTIONS	DATE/ TIME	EVALUATION	SIGN
3/06/2022 8:40 am	Constipation related to hormonal influence during puerperium and inadequate intake of fluid and fiber diet during puerperium.	Client will be able to empty her bowel once within 48 hours as evidenced by client verbalizing	1. Reassure client. 2. Educate her on how her hormones cause constipation during puerperium. 3Encourage client to take adequate roughage ,vegetables and fruits diet. 4. Educate client to empty her bowel when she feels the urge. 5. Encourage client on frequent ambulation.	1. Client was reassured. 2. Client understand how hormones cause constipation during puerperium 3.Client was taking at least six glasses of water a day and ate a lot of fruit and vegetable. 3. Client took some minimal exercises roughage daily. 4. Client emptied her	5/06/2022 8:40 am.	Goal fully met as client verbalized being able to empty the bowels at least once a day	

				bowels whenever she has the urge. 5. Client was seen walking around.			

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVE	NURSING ORDERS	NURSING INTERVENTIONS	DATE/ TIME	EVALUATION	SIGN
03/06/2022 6:30 am.	Breast engorgement related to incomplete of empty of the breast.	Client will be relieved of breast engorgement of the breast with 48hours as evidenced by Client verbalizing	1. Reassure client . 2. Teach client on how to position and attach baby correctly to breast. 3. Educate client to apply cold compress to breast. 4. Encourage client to express excess milk. 5. Encourage client to breast feed on demand especially at night.	1. Client was reassured and she understood it. 2. Client was taught how to position and attach baby correctly to breast. 3. Client applied cold compress to breast. 4. Client expressed excess milk. 5. Client was breast feeding on demand.	04/06/2022 8:30am	Goal fully met as client verbalizing there is no sign of heaviness of the breast. .	

SUMMARY AND CONCLUSION

The family centered maternity care was given to Madam Konamah Hawa, a 30 old gravida 3 para 2 alive who was met at the Holy Family Hospital Berekum. She is a native of Mpatasie and also stays with the mother at Mpatasie in the Berekum East District in the Bono region of Ghana.

At first contact, which was on the 10th May 2020, she was 36 weeks plus 1 day pregnant. Various observations and general physical examinations including laboratory investigations were carried out to aid in her care. Client went through some minor disorders during pregnancy which were effectively managed, and her pregnancy was uneventful. She had a spontaneous vaginal delivery to a Female baby on the 1st June, 2022. The baby cried immediately after birth and weighed 3.2 kilograms and had an Apgar score of 8/10, 9/10 for the first and fifth minute respectively.

She was encouraged to attend child welfare clinic regularly to enable her complete her child's immunization schedule and to register her child with birth and death registry within one year of birth. Exclusive breastfeeding and family planning was also emphasized.

Madam Konamah Hawa and her baby had a successful puerperium were finally handed over to the Public Health unit for continuity of care.

My interaction with the client and her family during the period of writing this family centered maternity care has enabled me to identify the individual needs of an expectant mother and how to plan care that would help one go through pregnancy, labour and puerperium safely.

It has also given me the opportunity to put into practice all the theoretical knowledge acquired in classroom and also enabled me to care for client and her family in their own confinement.

Finally, it is my expectation that the knowledge and experience I gained during this period will enable me to render effective maternity service to all clients who would come under my care in order to reduce maternal and infant mortality and morbidity rate in Ghana.

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LIST OF APPENDICES

APPENDIX 1: COMPLETE DIAGNOSTIC INVESTIGATION

DATE	SPECIMEN	INVESTIGATION	NORMAL VALUES	FINDINGS	REMARKS
05/11/2021	Blood	Hemoglobin level	12 g/dl-16g/dl	13.7 g/dl	Normal
	Urine	Protein	Negative	Negative	Normal
	Urine	Sugar	Negative	Negative	Normal
07/1/2021	Blood	Voluntary counseling and testing on PMTCT	None reactive	None reactive	Normal
	Blood	Blood group	A, B, AB and O	O	Normal
	Blood	Rhesus factor	positive, negative	Positive	Normal
	Blood	Hepatitis B	Negative	Negative	Normal
	Blood	MPs	negative	Negative	Normal

	Blood	Sickling	negative		Normal
07/02/2022	Blood Urine Urine	Hemoglobin level Protein Sugar	12 g/dl-16g/dl Negative Negative	12.5 g/dl Negative Negative	Normal Normal Normal
02/03/2022	Blood Urine Urine	Hemoglobin level Protein Sugar	12 g/dl-16g/dl Negative Negative	12.5 g/dl Negative Negative	Normal Normal Normal
04/04/2022	Blood Urine Urine	Hemoglobin level Protein Sugar	12 g/dl-16g/dl Negative Negative	12.1 g/dl Negative Negative	Normal Normal Normal
02/05/2022	Blood Urine Urine	Hemoglobin level Protein Sugar	12 g/dl-16g/dl Negative Negative	11.7 g/dl Negative Negative	Normal Normal normal

16/05/2022	Blood Urine Urine	Hemoglobin level Protein Sugar	12 g/dl-16g/dl Negative Negative	10.8 g/dl Negative Negative	Normal Normal
23/05/2022	Blood Urine Urine	Hemoglobin level Protein Sugar	12 g/dl-16g/dl Negative Negative	11.4 g/dl Negative Negative	Normal Normal Normal

APPENDIX II

PHARMACOLOGY OF DRUGS FOR THE MOTHER

NAME OF DRUG	CLASSIFICA-TION	DOSAGE	ROUTE	ACTION AND USES	ACTUAL EFFECT	SIDE EFFECT	SIDE EFFECT EXPERIENCED
Tablet multivitamin	Vitamin Preparation	200 milligram once daily	Oral	Helps in formation of red blood cells and increase appetite	Increase appetite	Gastrointestinal disturbance	None

Tablet folic acid	Vitamin preparation	5 milligram once daily	Oral	Helps in formation of red blood cells and prevent neural tube defect.	Increase haemoglobin level	Nausea and vomiting	None
Tablet ferrous Sulphate	Haematenics	200 milligram	Oral	Helps in formation of red blood cells	Increase haemoglobin level.	Gastrointestinal disturbance	Dark stools
Tablet SulphadoxinePyrimethamine	Anti-malaria (prophylaxis)	3 tablets start at 16weeks/ after quickening and other 6 doses 4 weeks interval.	Oral	Treatment and prevention of malaria.	Malaria was prevented	Nausea, itching, weakness, insomnia and headache	Nausea
Tablet paracetamol	Analgesic and antipyretic	100 milligram 3 times daily for 3 days	Oral	Helps to reduce high body temperature and pain	Pain was reduced	Liver damage	None
Injection oxytocin	Oxytocic drug	10 units	Intramuscular	Stimulate contractions	Client had contractions	Vomiting and pressure	None

PHARMACOLOGY OF DRUGS FOR BABY

NAME OF DRUG	CLASSIFICATION	DOSAGE	ROUTE	ACTION AND USES	ACTUAL EFFECT	SIDE EFFECT	SIDE EFFECT EXPERIENCED

Vitamin k_1	Coagulant	1ml	Intramuscular	Production of prothrombin to prevent haemorrhage	Prevention of haemorragic diseases of the new born	None	None
Gentamycin eye drop	Anti-bacterial	2 drops	Instillation into the eye	To prevent infection of the eye	Prevention of eye infection	None	None
Oral polio vaccine	Antigen	2 drops	Oral	To stimulate the body to produce antibodies against poliomyelitis	Gives immunity against poliomyelitis	There may be diarrhoea	None
Bacillus calmette Guriene (BCG)	Antigen	0.05	Intradermal	To stimulate the body to produce antibodies against tuberculosis	Production of antibodies and prevention of tuberculosis	Blister formation at the injection site.	Blister formation
Penta 1	Antigen	0.5 mls	Intramuscular	To stimulate the body to produce antibodies against diphtheria, hepatitis B, tetanus, pertusis and haemophilus influenza B	Prevention of diphtheria, hepatitis B, tetanus, pertusis and haemophilus influenza B	Fever	Fever
Pneumococcal 1	Antigen	0.5 mls	Intramuscular	To stimulate the body to produce antibodies against pneumonia	Prevention of pneumonia	None	None

Rota virus 1	Antigen	1.5 mls	Intramuscular	To stimulate the body to produce antibodies against Rota virus	Prevention of diarrhea	None	None

ANTENATAL RECORDS

Date	**Temp e-raptu re/oC**	**Blood pressur e/mmH g**	**Urine protei n Sugar**	**Prese ntatio n**	**Fetal heart rate/b pm**	**Gestatio nal age**	**Fundal height**	**Descen t**	**Weight**	**Remarks**	**Treatme nt /advice**
05/11/2021	36.7	110/60	Negative	-	Positive	18wks	17cm	-	.70	Good	Tablet multivita min, folic acid, fersolate, SP1,
07/02/2022	36.8◦C	100/60	Negative	-	Positive	24wks	23cm	-	69,2	Well	Tablet multivita min, folic acid,

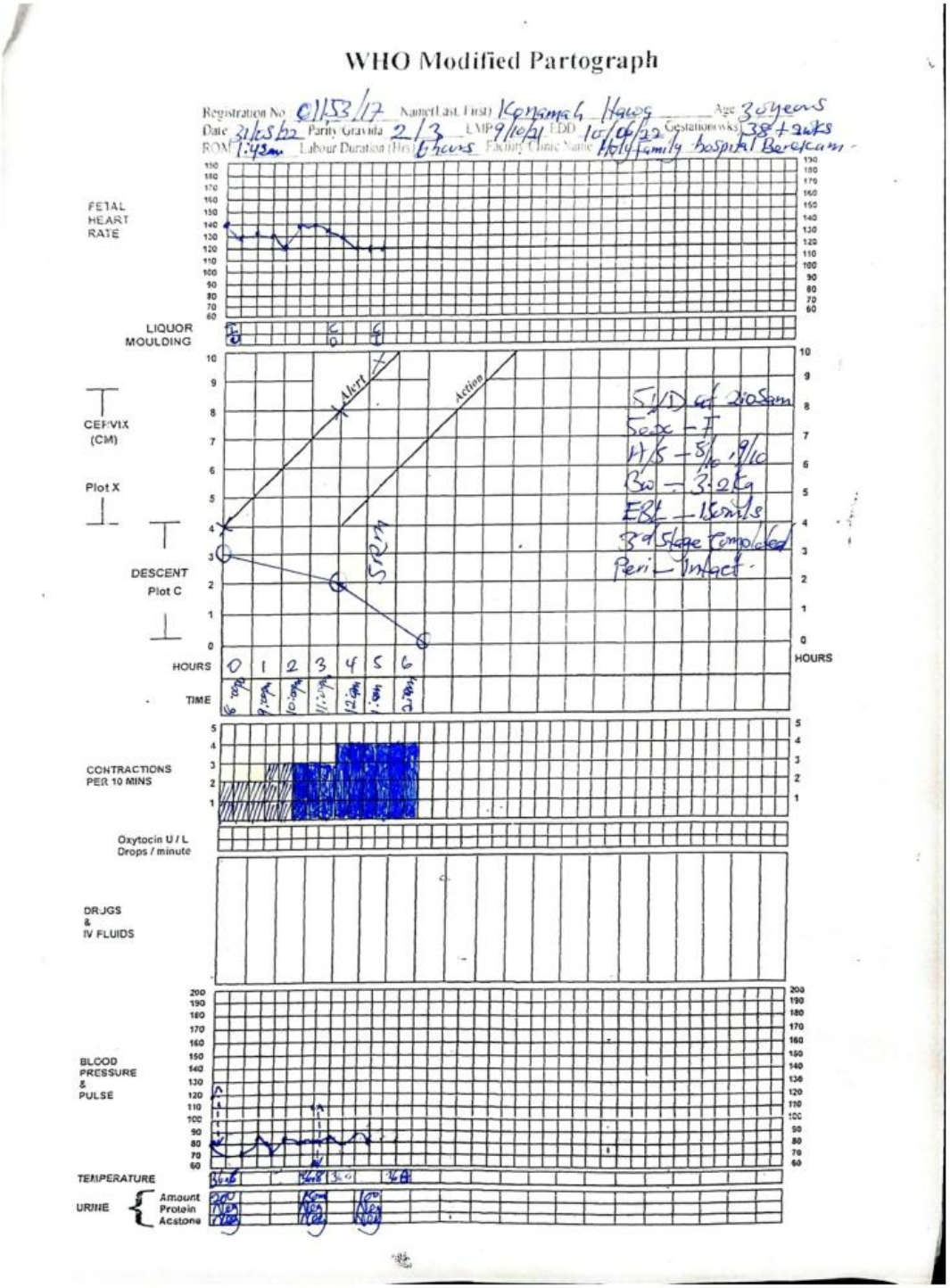
											fersolate, SP2.
2/03/2022	36.5◦C	110/70	Negative	Cephalic	Positive	28wks	27cm	-	69.8	Well	Tablet multivitamin, folic acid, fersolate, SP3
04/04/2022	37.2◦C	100/60	Negative	Cephalic	Positive	30wks	29cm	5/5	70	Well	Tablet multivitamin, folic acid, fersolate, SP4.

02/005/2022	35.6	100/70	Negative	Cephalic	134	34wks	33cm	5/5	71	Well	Tablet multivitamin, folic acid, Fersolate,
16/05/2022	36.1	100/60	Negative	Cephalic	130	36wks	36cm	5/5	73	Well	Tablet multivitamin, folic acid, fersolate
23/05/2022	36.4	110/70	Negative	Cephalic	138	37wks	37cm	5/5	75.8	Well	Tablet multivitamin, folic acid, fersolate

											advised on good nutrition

TD – tetanol Diphtheria

SP – sulfadoxine pyrimethamine


WHO Modified Partograph
Registration No 01153/17 Name(Last, First) Kanamah Hawa Age 30 years
Date 31/05/22 Parity Gravida 2/3 LMP 9/10/21 EDD 10/08/22 Gestation wks 38+2wks
ROM 1:45am Labour Duration (Hrs) 6hours Facility/Clinic Name Holy Family hospital Bereicam
FETAL HEART RATE
LIQUOR MOULDING
CERVIX (CM)
Plot X
DESCENT Plot C
Alert
Action
SROM
5/10 at 2:05am
Sex - F
A/S - 5/10, 9/10
BW - 3.2kg
EBL - 150mls
3rd Stage Completed
Peri - Intact
HOURS
TIME
CONTRACTIONS PER 10 MINS
Oxytocin U / L Drops / minute
DRUGS & IV FLUIDS
BLOOD PRESSURE & PULSE
TEMPERATURE
URINE
Amount
Protein
Acetone

.BOR NOTES

Client had a Spontaneous vaginal delivery to a alive female child with APGAR Score 8/10, 9/10.
Baby weight 3.2kg, HC 33cm and 4.5cm. 10unit of oxytocin given
Third Stage was completed, uterus was massage to expelled clot and well contract. Estimated blood lost was about 150mls
Baby and mother were both doing well.
Breast feeding was initiated.

Please circle or write responses

DELIVERY

DATE: 01/06 2022 TIME: 2:05am METHOD: (Spontaneous) / Vacuum Extraction / C/S / Other

PERINEUM: Intact / Episiotomy / Laceration

ANESTHESIA: None / Local / General

THIRD STAGE

Active Management: Yes / No · Medication: Time 2:8am Type/Dose 10unit of oxy

PLACENTA: TIME: 2:10am (Complete) / Incomplete

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

BABY

Weight: 3.2kg

Sex: Male / (Female)

Baby Position: (Vertex) / Breech / Other

APGAR

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

COMPLICATIONS OF MOTHER / BABY: (None) / Other: NAD

FOURTH STAGE MONITORING

Frequency	Time	B/P.	Pulse	Fundus	Bleeding	Bladder
Every 15 minutes first 2 hours	8:00pm	110/70mmHg	80	16cm	150mls	200mls
	8:15pm	110/60	82	Uterus well contracted	Negligible bleeding	Empty
	8:30pm	120/70	84			150mls
	8:45pm	110/60	82			Empty
	9:00pm	100/60	80			100mls
	9:15pm	120/60	84			Empty
	9:30pm	120/60	82			100mls
	9:45pm	110/60	80			Empty
Every 30 minutes For 1 hour	10:30pm	100/60	82			120mls
	11:00pm	110/70	80			

Birth Attendant Selina Asantewaa Addo Supervised By Janet Owusu Date 01/06/2022

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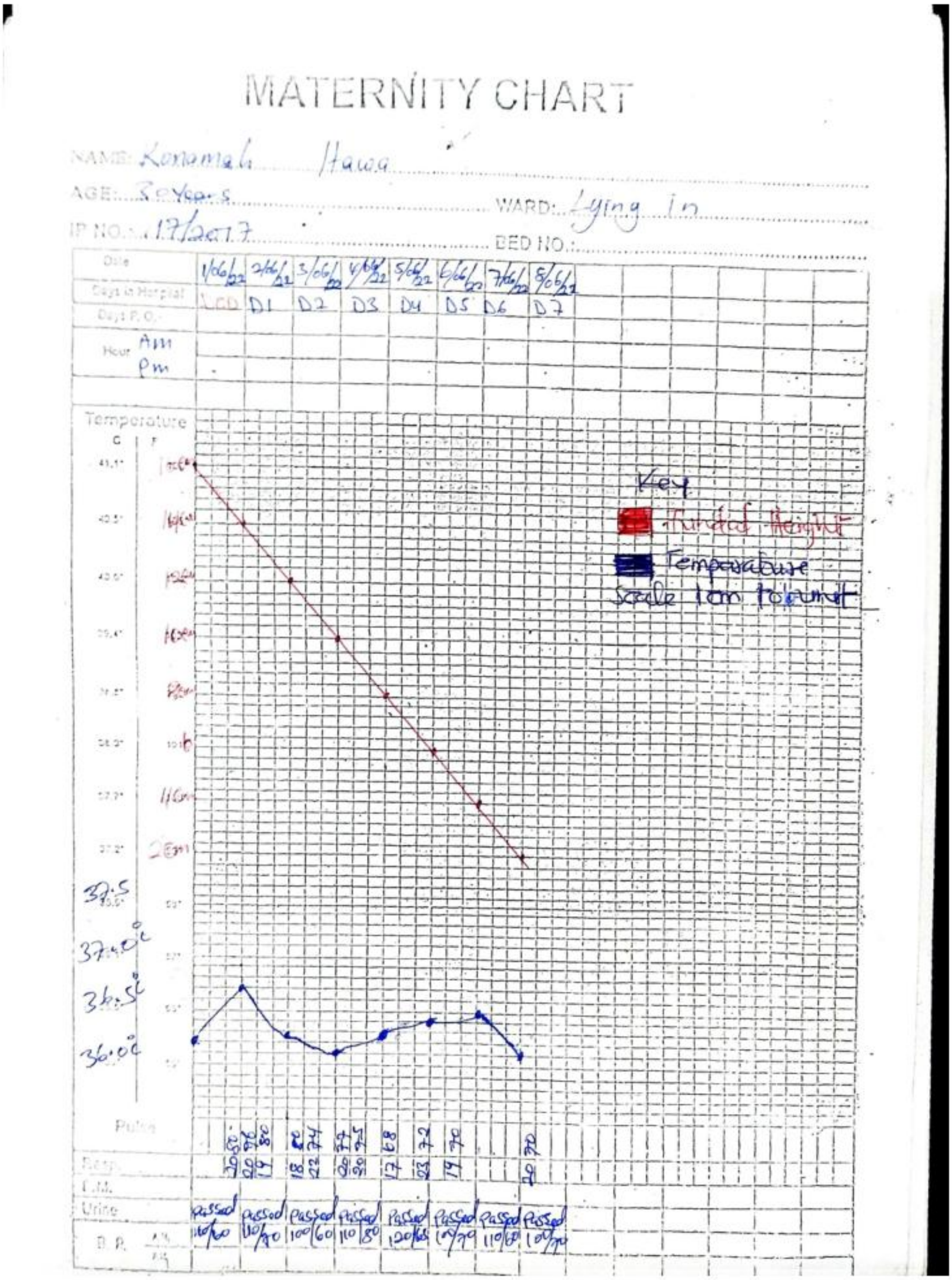
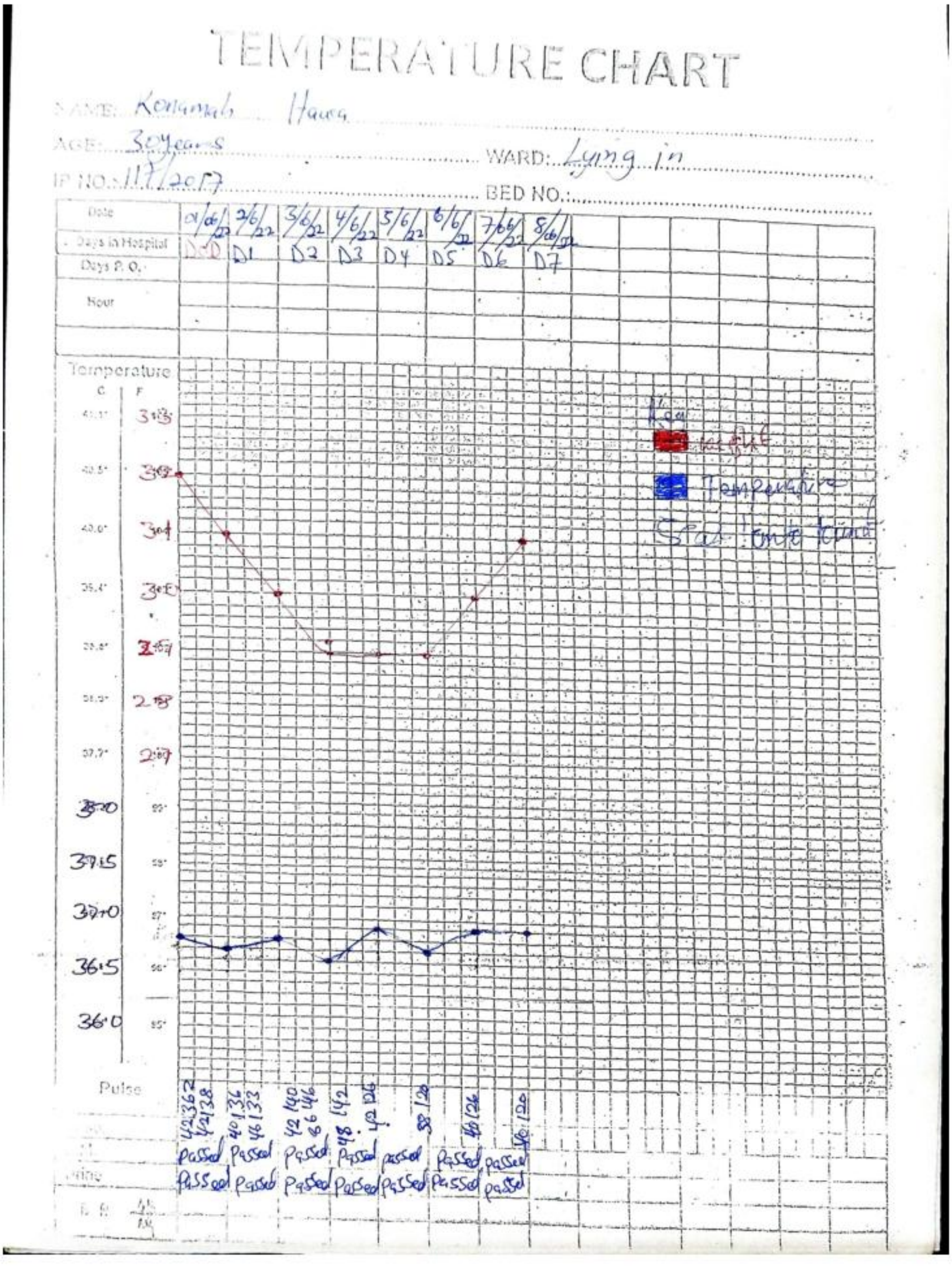

MATERNITY CHART
NAME: Konamah Hawa
WARD: Lying in
IP NO.: 17/2017
BED NO.:
Date
1/06/22 2/06/22 3/06/22 4/06/22 5/06/22 6/06/22 7/06/22 8/06/22
Days in Hospital
D1 D2 D3 D4 D5 D6 D7
Hour Am Pm
Temperature
Key
Fundal Height
Temperature
Scale 1cm to 1unit
Pulse
Resp.
Urine
Passed Passed Passed Passed Passed Passed Passed Passed
B.P.
110/70 100/60 110/80 120/65 110/60



TEMPERATURE CHART
NAME: Konamah Hawa
AGE: 30years
WARD: Lying in
IP NO.: 117/2017
BED NO.:
Date
Days in Hospital
Days P. O.
Hour
Temperature
Pulse

NEW BORN EXAMINATION FORM

Name: Baby [illegible] [illegible] Date of Assessment: 0/06/2022 Time: 2:50am

Date of Birth: 0/06/2022 Time of Birth: 2:05am Sex: ☐ M ☑ F Age at time of Assessment (days/hrs) ______

Astational Age: [illegible] ☐ [illegible] ☐ Mode of Delivery: ☑ Vaginal Assisted Vaginal C-Section

APGAR: 1min ☐ [illegible] 5min ☐ 9/10 Birth Weight: ☐ 3.2 kg ☐ Length: 50 cm Head Circumference: 33 cm

Temperature at time of Assessment: 36.8 °C Urine passed: (Yes) No Meconium passed: (Yes) No

Name of Assessor (Midwife/Doctor): [illegible] [illegible] Addo

1. Respiration

Rate [illegible]

- ☐ 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: 136bpm

- ☐ Normal (100-160)
- ☐ <100 *
- ☐ >160*

19. Femoral pulse

- ☐ Present
- ☐ Not palpable*

20. Abdomen

- ☑ Normal
- ☐ Distended*
- ☐ Scarphoid*
- ☐ Abdominal defect*
- ☐ Maases: ______
- ☐ Other ______

21. Back (spine)

- ☑ Normal
- ☐ Abnormal Swelling *
- ☐ Hairly patch over spine
- ☐ Abnormal dimple
- ☐ Abnormal curvature

22. Limbs

- ☑ Normal
- ☐ Abnormal ______

23. Genitalia

Male Genitalia

- ☑ Normal
- ☐ Undescended testes
- ☐ Abnormal meatus
- ☐ Hernia
- ☐ Other: ______

Female Genitalia

- ☑ Normal
- ☐ Fistula(meconium/urine through abnormal opening in vagina) *
- ☐ Large clitoria *
- ☐ Other: ______

24. Anus

- ☑ Patent
- ☐ Imperforate*

25. Resuscitation provided

- ☑ One
- ☐ Suction/stimulation
- ☐ Bag and mask
- ☐ Endotracheal Tube
- ☐ Ventilator/CPAP

26. Services provided

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

***May indicate severe disease that requires urgent referral**

Diagnoses (if known) ______

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

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

X

NEW BORN EXAMINATION FORM

Name: Baby Koromah Hawa Date of Assessment: 01/06/2022 Time: 2:50am
Date of Birth: 01/06/2022 Time of Birth: 2:05am Sex: ☐ M ☑ F Age at time of Assessment (days/hrs) ______
Astational Age 38+2/wk ☐ Mode of Delivery: ☑ Vaginal Assisted Vaginal C-Section
APGAR: 1min 8/10 ☐ 5min ☐ 9/10 Birth Weight: ☐ 3.2 kg ☐ Lenght 50 cm Head Circumference: 33 cm
Temperature at time of Assessment: 36.5 °C Urine passed: (Yes) No Meconium passed: (Yes) No
Name of Assessor (Midwife/Doctor): Salina Hsantewaa Addo

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

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

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

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

(5. Cord)
- ☑ Normal
- ☐ Red. draining pus
- ☐ Bleeding

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

7. Suck
- ☑ Good
- ☐ Weak
- ☐ Absent

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

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

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

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

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

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

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

16. Clavicle
- ☑ Normal
- ☐ Swelling/Fracture

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

18. Heart rate
Rate: 136bpm
- ☐ 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
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***May indicate severe disease that requires urgent referral**
Diagnoses (if known)______
Classification: (Overall assessment) [ ] Normal [ ] Baby with a Problem [ ] Danger Sign/ <1500g/ severe Jaundice
Plan: [ ] Routine Care[ ]Problem. Continue supportive in-patient care [ ] Urgent Referral / Advanced Care[ ] Discharge

NEW BORN CHART

Name: Baby Kanamah Hawa No. c/153/22 Birth Weight: 3.2kg

Sex: Female Mother's No. 117/2017 Length: 50cm

Nature of Delivery: Spontaneous Vaginal delivery Diagnostics: Healthy Baby

Date of Birth: 01/06/2022 Time: 2:05am Date of Discharge: 2/6/2022

Date	01/06/22		02/06/2022		03/06/2022		4/06/2022		5/06/2022		6/06/2022		7/06/2022		8/06/22			
No. of Days	DOD		D1		D2		D3		D4		D5		D6		D7			
Weight	3.2kg		3.1kg		3.0kg		2.9kg		2.9kg		2.9kg		3.0kg		3.1kg			
	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM
Temperature	36.8°C	36.6°C	36.7°C	36.5°C	36.8°C	36.5°C	36.5°C	36.5°C	36.8°C		36.6°C		36.8°C		36.5°C			
Stool	Passed	Passed	Passed	Passed	Passed	Passed	Passed	Passed	Passed		Passed		Passed		Passed			
Urine	Passed	Passed	Passed	Passed	Passed	Passed	Passed	Passed	Passed		Passed		Passed		Passed			
Remarks	Head / Neck / Trunk / Genitalia — No abnormalities detected.																	

SIGNATORIES

NAME OF CANDIDATE: SELINA ASANTEWAA ADDO

SIGNATURE.....

DATE....11-10-2022.....

THE MIDWIFE IN-CHARGE: NINA BAFFOWAA

SIGNATURE..... (Ag)

DATE: .....11-10-2022.....

THE SUPERVISOR: MS MARTHA KYEREMAA

SIGNATURE.....

DATE.....12-10-2022.....

THE PRINCIPAL:MS MONICA NKRUMAH

SIGNATURE.....

DATE.....12-10-2022.....

STAMP.....

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