HOLY FAMILY NURSING AND MIDWIFERY TRAINING COLLEGE,

BEREKUM

A CLIENT/FAMILY CENTERED MATERNITY CARE STUDY ON

MADAM GRACE YEBOAH

BY

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PREFACE

The practice of midwifery in the past focused mainly on the client in an effort to meet the client's needs. However, all the needs of client could not be met because they lacked family support. Again, Midwifery has undergone a lot of changes globally and nationally. These changes have brought the introduction of client and family centered maternity care concept. The concept of family centered maternity care is a systematic way by which a comprehensive maternity and nursing care is given to a pregnant woman and her family throughout pregnancy, labour and puerperium by the use of the nursing care process. The confidentiality of the client is ensured, client feels at ease to provide vivid history and discussions on confidential matters. This system gives the student midwife the opportunity to use all the knowledge and skills acquired during his/her training to give quality maternity care to the pregnant women and her family throughout the period of pregnancy, labour and puerperium.

The study also achieve enables the student midwife to identify and help client solve their health problems. To this, the student identifies the health problems, assess the client, set objectives, provide the necessary interventions, and evaluate the care to know if goals have been fully met at the end of the care.

The care study forms part of the academic exercise from the Nursing and Midwifery Council of Ghana which serves as a partial fulfillment towards the award of a professional midwifery certificate

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INTRODUCTION

The client and family centered maternity care study refers to all the midwifery care rendered to the expectant mother and her family throughout pregnancy, labour and puerperium. It entails every aspect of the woman's social, physical, spiritual and psychological wellbeing. The care is considered within the framework of the family and the community with the aim of preparing the pregnant woman to face labour, puerperium and to initiate lactation and subsequent care of the baby.

This particular care study is about Madam Grace, a 26 year old woman gravida 2 para 1 alive, she comes from Dormaa-Ahenkro in the Bono region of Ghana but currently stays at Wamnafo in the Dormaa East in the Bono Region. The care study started on the 27thof October 2021 at St. Mathew's Clinic Ampenkro in Dormaa East within Bono region of Ghana. The interaction started when I realized that Madam Grace did not breastfeed her child exclusively. That gave me the reason to take her as my client to educate her on the importance of exclusive breastfeeding and assist her go through labour and puerperium with no complication. During her 37weeks gestational age .After a comprehensive introduction to her, she was informed about the desire to choose her for the client/family centered maternity care study which she happily agreed. She was thanked for her cooperation and accepting the request.

Madam Grace was cared for during the antenatal period; visitation to her home was made to know her family, her surroundings and the community in which she lives. The client and her entire family were included in the care. The condition from the beginning till the end of the interaction was good and satisfactory. Madam Grace had a successful pregnancy, delivered spontaneously on 10th November, 2021 to an alive baby girl. She had a successful puerperium and was in good health. She was then handed over to the midwife in-charge at St. Mathew's Clinic for continuity of care on 23ed November, 2021.

This care study is in four chapters; chapter one talks about client's particulars such as social, family, obstetric, medical and surgical histories followed by chapter two which talks about the antenatal care rendered to Madam Grace throughout her pregnancy and chapter three is concerned with management of Madam Grace during

labour and finally chapter four is also about management of Madam Grace during puerperium. The chapter two, three and four has care plan attached to each. In addition is a summary and conclusion, bibliography as well as appendixes.

LITERATURE REVIEW

PREGNANCY

Tiran (2008) defined pregnancy as the process from conception to delivery of the foetus. Normal duration is two hundred and eighty days (280 days,40 weeks or 9 months and 7 days),counted from the first of the last normal period to delivery, or two hundred and sixty-five (265), from conception to delivery.

Marshall and Raynor (2014) stated that, during pregnancy the uterus plays a remarkable role by stretching and expanding to accommodate and nurture the growing foetus. She further states that the expansion and activation takes in the middle layer of the uterine wall, the myometrium, which is partly covered by an outer layer of the peritoneum .it also states that all changes that occur during pregnancy are due to the hormones.

King (2014) also stated that, the prenatal period is divided into trimester; First trimester is considered to be weeks 1 to 2 (12weeks) because organogenesis is completed at end of twelve weeks and the risk of spontaneous abortion is significantly reduced at times. Historically the second trimesters was considered to be 13 to 28weeks because prior to the introduction of modern neonatal intensive care technique 28 weeks was limited of viability. The third trimester extends from weeks 28 to 40. The term "postdate or post term" is typically used to describe a pregnancy beyond forty weeks (40).

According to king (2014) pregnancy is a time of profound anatomic and physiologic in a woman's body. In addition to the reproductive organs all maternal physiologic system make adaptations needed support the developing foetus and at the same time, maintain maternal homeostasis. Pregnancy last approximately two hundred and sixty-six days (266 days) or thirty, eight weeks (38week) from ovulation.

During pregnancy the oestrogen level also rise. The raised progesterone and oestrogen levels also cause some changes in the muscle layer and the

epithelium of the vagina such as thicker and viscous mucous helping to prevent ascending infection as well as enlargement of breast and other organs in the order to support foetal development and growth.

According to the Ghana Health Service (2008), the number of times a client needs to be seen during pregnancy may vary. For the uncomplicated pregnancy it is recommended that at least four ANC visit should be made according to the following schedule.

First visit; from onset of pregnancy up to sixteen weeks (16) gestation.

Second visit; from the 24th to 28th weeks of pregnancy.

Third visit; at 32nd weeks of pregnancy.

Fourth visit; at 36th week of pregnancy.

According to Dutta (2011), pregnancy last between nine and teen months. The duration of pregnancy is divided into three trimesters.

First semester 1st week – 13th week

Second trimester 13th week – 27th week

Third trimester 27th week –40th week

LABOUR

The World Health Organization (WHO) defines normal birth as follows:

- The birth is spontaneous in onset and low risk at the start of labour and remains so throughout labour and delivery.
- The infant is born spontaneously in the vertex position between 37 and 42 weeks of pregnancy.
- After birth, mother and infant are in good condition.

The stimulus for labour is unknown, but digitally manipulating or mechanically stretching the cervix during examination enhances uterine contractile activity, most likely by stimulating release of oxytocin by the posterior pituitary gland.

Normal labour usually begins within 2 weeks (before or after) the estimated delivery date. In a first pregnancy, labour usually lasts 12 to 18 hours on average; subsequent labour are often shorter, averaging 6 to 8 hours .(WHO 2008).

Marshall and Raynor (2014) stated that, traditionally three stage of labour are describe as the first, second and third stage. But this rather pedantic view, as labour is obviously a continuous process .it has been acknowledged that there are more than three stages of labour namely; the latent, active and transitional phase and these are not the only encompass specifics physical changes. But should also account for emotional effect observed in women during this time.

According to Annamma (2015) labour is divided into 4 stages;

1. The first stage; it that of dilatation of cervix .it begins with regular rhythmic contraction (true labour) and complete when the cervix is fully dilated and effaced.
2. Second stage; is the stage of expulsion of the fetus .it begins with dilatation of the cervix through till birth of the baby .it usually lasts 30minute in the multipara and 60 minutes in primigravida.
3. Third stage; starts from the separation and expulsion of placenta and membranes .it lasts from the birth of the baby through the delivery of the placenta with contraction and retraction of the uterus and control of haemorrhage.
4. The fourth stage; is the first 4 hours after delivery of the placenta. This is an arbitrary time during which, the vital signs must stabilize and any tendencies for immediate haemorrhage must be controlled. This is a critical period for every mother.

The Ghana Health Services (2008) mentioned specific objectives during labour and delivery and these include;

1. Proper management of the four stages of labour.

2. Early identification and proper management of complications.

According to Ghana Health Services (2008), partograph is the recommended tool for the World Health Organization (W.H.O), monitoring, documenting and managing labour.

Asha and Ameya(2017) concluded that competent use of the partograph can save maternal and foetal lives by ensuring that labour is closely monitored and that life-threatening complications such as obstructed labour are identified and treated. To address the challenges for using partograph among health workers, health-care systems must establish an environment that supports its correct use. Health-care staff should be updated by providing training and asking them about the difficulties faced at their health center. Then only the real potential of this wonderful tool will be maximally utilized.

W.H.O also stated some importance of partograph;

1. Provide guidelines on when labour is no longer 'normal 'and on the management for situations.

2. Gives a complete picture of the condition of the mother, baby and labour progress.

Annamma (2015) partograph is record of all the observations made on a woman in labour; the central feature of which is the graphic recording of the dilatation of the cervix as assessed by vaginal examination.

Marshall and Raynor (2014) active management of the third stage of labour (AMSTL); an active management policy usually includes routine prophylactic administration of

a uterotonic agent, either intravenously, intramuscularly or (occasionally) orally, as a precautionary measure aimed at reducing the risk of postpartum haemorrhage. It is applied regardless of the ass assessed obstetric risk status of the woman, and is usually undertaken in conjunction with clamping of the umbilical cord shortly after birth of the baby and delivery of the placenta by use of controlled cord traction.

From the above information, labour is when the uterus empties its content after 37 to 43 completed weeks.

PUERPERIUM

Marshall and Raynor (2014) stated that puerperium immediately after birth of the placenta and membranes and continue for 6weeks.

Ghana Health Service further stated the purpose and psychological wellbeing of the of the mother and child. Cares rendered during this period include;

1. Inspecting pad for bleeding and lochia, its smell and consistency
2. Giving education on family planning.
3. Inspection of vulva and perineum for tear, swelling and pus.

Dutta (2011) also defines puerperium as the period following childbirth which the body tissues, especially the pelvic organs revert back approximately to their pre pregnant state both anatomically and physiologically. He further explained that there are three types of lochia namely:

Lochia rubra: which consist of blood shreds of foetal membranes and decidua, vernix caseosa, lanugo and meconium. It is red in colour and it last for the first 1-4

days.

Lochia serosa: which consist of less red blood cells but more leucocytes, wound exudates, mucous from the cervix. It lasts for 5-9 days and it is pink or pale.

Lochia Alba: contains plenty decidua cells, leukocytes, mucous, cholestrin crystals fatty and granula epithelial cells. It lasts for 10-15 days and it is pale brown in colour.

Copper & Fraser (2009) states that, following the birth of the baby and expulsion of the placenta, the mother enters a period of physical and psychological recuperation. The puerperium, starts immediately after delivery of the placenta and membranes and continues for 6 weeks. The overall expectation is that by 6 weeks after the birth all the systems in the woman's body will have recovery from the effect of pregnancy and returned to their non-pregnant state. However, it is only comparatively recently that there has been any professional recognition or substantial interest in the diversity and extent of the morbidity experienced by woman in the week after childbirth. Some woman continue to experience problems related to childbirth that extend well beyond the 6 week period defined as the puerperium, and the possibility of longer duration is now accepted alongside the range of initial morbidity. It has been customary to refer to the first weeks after the birth as the postnatal period; defined in the UK as a period after the end of labour during which the attendance of a midwife upon a woman and baby is required, being not less than 10 days and for such longer duration is now accepted alongside the range of initial morbidity.It has been customary to refer to the first the birth as the postnatal period; defined in the UK as a period after the end of labour during which the attendance of a midwife upon a woman and baby is required, being not less than 10 days and for such longer period as the midwife considers necessary.

By no longer stating an endpoint in the time when midwifery care can still be made available to women, it is to be hoped that offering more flexibility to the provision of midwifery care will in time also make a positive difference to the experience of women and midwives of this aspect of midwifery care and services.According to veralls (2010) third edition puerperium is a period of six weeks following child birth during which the maternal uterus and other organs and structure are returning to their pre-pregnant state, lactation should be establish and new infant should be accepted in to the family.

Tiran (2008) defines puerperium as the six to eight-week period following child birth during which the uterus and other organs and structures are returning to the non-pregnant state. The women recover from the stress of pregnant and labour.

Mother and baby are discharge after twenty-four (24hours) that is when they are in good health. Mother assumes responsibilities for the care of the new born baby. Lactation and breast feeding are established, creating bondage between mother and baby.

During this period, the uterus involutes and traumatized areas of the genital tract heal. The care of the promotion of the physical wellbeing of the mother and baby though their normal regular postnatal visits. It also focuses on encouraging breastfeeding and promoting the development of good mother and child relationship. Throughout this period, the midwife encourages, supports and strengthens the mother in the thus enabling her to fulfill her role as a mother in the family. (Fraser & Cooper, 2009).

Initiation of breastfeeding is established, vitamin A supplement is given to the

mother, the baby is immunized with Bacillus Calmette Guerin (BCG) and polio O vaccine by a community health nurse, vital sign such as blood pressure, temperature, pulse and respiration are checked and recorded. Any abnormalities are reported to the in-charge.

Puerperium can also be defined as the period following childbirth during which the body tissue, especially the pelvic organs, revert approximately to the pre-pregnant state both anatomically and physiologically (Annamma Jacob 4th edition 2015)

WHY CLIENT WAS CHOSEN

On the 27th October, 2021 .Madam Grace was chosen as the client for the family centered maternity care study because of the opportunity gained to interact with her at 11:00am at St. Mathew's Clinic Ampenkro in the Dormaa East in Bono region.

During my interaction with her I realized that she did not practice exclusive breastfeeding for her child. I got to know this when she told me that she introduced her child to water and some light porridge after birth. In view of this I told her my intention to take her as my client for the care study, and to enable me educate her on benefit of exclusive breastfeeding and its benefit to her and her baby, as well as ensure she enter into labour without complication to herself, the newborn and the

entire family.

After a comprehensive introduction she was informed about the desire of using her for the client/family centered maternity care study which she happily agreed and promised to give me the necessary information needed for my study. It was her seventh antenatal visit and her gestational age was also 37weeks. She then gave me her phone number and direction to her house. She was finally thanked for her cooperation and introduced to the midwife in-charge, and promised of visiting her in her house

CHAPTER ONE

CLIENT'S PARTICULARS

1.0 INTRODUCTION

This chapter deals with the assessment of the client and her family, which involves a systematic collection of data from the client and her family. Information was acquired through observation, interview, medical records and antenatal records. This information helps the student midwife to provide holistic care for the client and her family taking into consideration the physical, psychological and spiritual needs.

1.1 PERSONAL AND SOCIAL HISTORY

Madam Grace, gravida 2 Para 1 alive is a 26year old lady who stays at Wamanafo, house number PT 163, but comes from Dormaa Ahenkro in the Bono region. Madam Grace is a trader who assist the husband in mobile money business and also sells phone accessories. Madam Grace is a Christian. She is married to Mr. Pattison Gyamfi who is also a Christian and a trader madam Grace completed senior High school and speaks Twi and English. Client has one Male child with Mr. Gyamfi called Kwabina who is three years of age and in Creche. Madam Grace is fair in complexion, weigh's 70kg, 158cm tall and neither smokes nor takes in alcohol. Madam Grace mentioned that her next of kin is her mother in-in-law.

1.2 FAMILY HISTORY

Madam Grace is the seventh child to Mr. Anthony and Late Madam Grace. Her father is a farmer and stays at Dormaa Ahenkro. Client has six siblings, two females and four male. There is no known history of asthmatic, heart disease, sickle cell disease, diabetes mellitus, liver cirrhosis, epilepsy, mental illness and congenital abnormalities in her family. However, she stated that there is a distant family member who is hypertension as well as history of multiple pregnancy. She said her

self and family seek for medical treatment and pray whenever they are not feeling well. She said all her family members who passed away died naturally.

1.3 MEDICAL HISTORY

According to Madam Grace, she has never had any chronic illness, like hypertension, heart disease, sickle cell disease, diabetes mellitus, liver cirrhosis, respiratory disorder, epilepsy, and anaemia. Client only said she sometimes suffers minor headache and pyrexia which she visits the clinic immediately to seek for medical treatment after which she gets well. She has no known allergy to food or any drug. She went on to say that she has not received any blood transfusion or donated blood before and has no known allergy.

1.4 SURGICAL HISTORY

Madam said she has never undergone any surgical procedure and also mentioned that she has never sustained any injury or road traffic accident that called for any abdominal or spine surgery or affected her pelvis or subsequent effect on pregnancy and labour. On examination, there was no scar indicating previous laparotomy such as caesarean section or appendectomy.

1.5 MENSTRUAL HISTORY

Madam Grace said she had her menarche at the age of 13 years and her menses lasts for 3 days during every month. She said she has a cycle of 28 days. Client also said she changes her pads twice daily indicating she has normal menstrual flow and has never experienced dysmenorrhea in her life. Her last menstrual period was 11th March, 2021 and her expected day of delivery was calculated as18th December 2021, but with the help of scan it was estimated to be 29th November, 2021.

1.6 HOBBIES AND LIFESTYLE

Madam Grace is a person who usually sleeps around 9:30pm and wakes up around 4:30am and prays before she does her household chores. Madam Grace sweeps the compound and disposes the rubbish off at the public refuge disposal. Client brushes her teeth and bath at least twice daily .So after her bath she prepares breakfast for her family and sends her son to school. Client also added that she goes to the market on Sundays since Sundays are their market days after church. Madam Grace mentioned that, she likes singing and dancing very well. Client said she prefers banku and okro stew with fried fish to other like rice and stew. Client does her laundry on Wednesdays and Saturdays after she is done with her general cleaning. Client added that she like watching television at her leisure time to watch movies. Client said she eats three times daily, but ever since she became pregnant she only eats on demand. Client also said that she prepares lunch at 1pm and supper at 4:30pm. Her husband now spends some time with her since she is pregnant. Client also said they all sit together and take their supper around 5:30pm and after praying in the evening she bath the kid and herself as well and go to bed. Client also mentioned that she empties her bowel every morning or evening and micturate whenever she has the urge to.

1.7 PAST OBSTETRIC HISTORY

Pregnancy

Madam Grace Gravida 2 Para 1 alive went through her pregnancy successfully without any complication. She had her first pregnancy in the year 2019 making the

interval between that pregnancy and this current one three years. Client also said during her pregnancy, she only experienced some minor disorders such as waist pain, lower abdominal pain, constipation, frequency of micturition, nausea and vomiting of which she reported to the clinic and they were explained to her as normal physiological changes in pregnancy which would resolve as pregnancy progresses and after delivery. Client also said she has never had any spontaneous or induce abortions and still births in her life. Her first pregnancy got to term. She has never suffered any pregnancy induced condition like gestational diabetes and pregnancy induced hypertension (pre-eclampsia). She also visited antenatal for six (6) times during her pregnancy and received all doses of sulphadoxinepyrimethamine as well as two doses of tetanus toxoid injection.

Labour

Madam Grace delivered her bouncing male child spontaneously at the clinic who was active and healthy at birth. She further stated that the duration for her delivery did not exceed 12hours. She also said she never had any perineal tear or been given episiotomy during her previous delivery. Client also added that she never experienced post-partum haemorrhage. Her placenta was delivered completely with no retained product of conception. Client also said her estimated blood loss was small. Her child never had any birth injuries, asphyxia or jaundice. The child was active at birth and healthy with birth weight of 3.0kg.

Puerperium

Madam Grace said she started breastfeeding him within the first hour after birth. She did not practice exclusive breastfeeding for her child; she started complementary feed after the 3 months for two years. She had a safer breastfeeding

with no complication. She added that her child did not have any abnormalities like cleft lip, extra digits or webbed digits. Her child was fully immunized against the childhood preventable diseases, such as diphtheria, measles, polio, tetanus, tuberculosis, and whooping cough. Her child never suffered any ill health. She herself did not experience any ill health such as puerperal psychosis, Anaemia and malaria. Client also did not experience problems like postpartum haemorrhage, puerperal pyrexia, puerperal sepsis, mastitis among others. In relation to family planning, client uses the natural family planning method thus the lactational amenorrhoea method. Client also stated that her family supported in taking care of the baby, herself and some of the household chores.

1.8PRESENT OBSTETRIC HISTORY

Madam Grace first visited the clinic on 17th June, 2021. Her gestational age was 20weeks, her last normal menstrual period was 11th March 2021 and her expected date of delivery was calculated as 18thDecember, 2021 but according to her scan, her expected date of delivery was given as 29th November, 2021. Her vital signs and laboratory investigations on that day were as follows;

Vital signs

Temperature………………... 36.3˚c

Pulse……………………….. 72bpm

Respiration………………… 20bpm

Blood pressure …………….110/60mmHg

Other assessments

Weight……………………….70kg

Height……………………….158cm

Lab investigations

Hb ……………………………… 11.8g/dl

Sickling ………………………… Negative (-)

Blood group ……………………… O(+)

Rhesus factor …………………….. Positive (+)

HIV………………………………. Negative (-)

HEP B…………….............. Negative (–)

VDRL……………………… Non-reactive

G6PD……………………… No Defect

Urine for pregnancy test …………. Positive (+)

Protein in urine ……………. Negative (–)

Glucose in urine……………. Negative (-)

Stool for ova………………No abnormality

On examination (head to toe), no abnormality was detected, fundus was 17cm and education on danger signs in pregnancy was given. She had no complains so was educated on the need to attend antenatal clinic regularly as scheduled. She was given her first dose of tetanus diphtheria (TD) injection. She was put on the following

drugs;

1. Capsule iron III one daily x 30

2. Tab multivitamins 200mg daily x 30

3. Tab folic acid 5mg daily x 30

4. Tab ferrous sulfate 200mg twice daily x30

She made her routine visits regularly, no abnormalities were detected, laboratory investigation ultrasound scan requested were carried out with no abnormalities recorded. She started her SP when she was 20 weeks pregnant and it was repeated at 4 weeks interval. All findings were recorded in her ANC card until she was met.

CHAPTER TWO

ANTENATAL CARE

2.0 Introduction

This chapter basically deals with the first encounter with the client during the antenatal period, client's subsequent visits to the antenatal clinic, subsequent antenatal home visits as well as the nursing care plan for client during the antenatal period.

2.1 FIRST CONTACT WITH CLIENT

Madam Grace was met for the first time on 27th October, 2020, when she was 37weeks pregnant which was her seventh visit to the antenatal clinic at St. Mathew's clinic around 11:00am. Introduction was made as a student midwife from Holy Family Nursing and Midwifery Training College, Berekum, who has been stationed at Ampenkro for eight weeks clinical and to write a care study on a chosen client. The desire to take her as a client was expressed to her and she agreed. All the procedures to be carried out on her were explained to her understanding and she agreed for them to be done. She was encouraged to ask questions when necessary and was also thanked for her co-operation. Her vital signs together with some lab investigations done on her were recorded below.

Temperature…………………36.1 degree Celsius

Pulse…………………………89 beats per minute

Respiration…………………..23 cycles per minute

Blood pressure………………98/70 millimeter of mercury

Weight ………………………76 kilograms

Hemoglobin level…………..12.5 grams per deciliter

Specimen bottle was given to her to collect midstream urine to be checked for the presence of protein and glucose by the use of a urine reagent strip and the test read negative. Permission was sought from her for head to toe examination to be performed and she consented. All the necessary requirements needed for the examination were gathered and sent to the examination room.

A tray comprising of the following items was set; sterile gallipot with sterile cotton wool swabs with a lid, receiver for used cotton wool swabs, tape measure, fetal stethoscope, a watch with a second hand, a pen and client's folder.

Privacy was provided using a screen and also drawing down the curtains to make her feel comfortable after explaining the procedures. Having emptied her bladder, permission was sought for head to toe examination to be carried out and she granted. She was assisted to undress and wrapped herself with a cloth. She was helped to lie on the examination couch. Hands were thoroughly washed with soap under running water and dried with clean towel. Client was asked to assume a dorsal position. Physical examination from head to toe was carried out under the supervision of the midwife in- change and the aim was to help detect any abnormality or deviation from normal for prompt management.

Head and neck examination

On examination of the head, her hair was nicely braided. Her hair was inspected for dandruff, cleanliness, alopecia (loss of hair) and lice, among others. The face for signs of oedema and chloasma but none was present and her eyes were also inspected for pallor of the conjunctiva, jaundice of the sclera, sunken eyes and discharges but the conjunctiva was pink in colour, sclera was clear and no sunken eyes or discharges. The nose and ears were inspected for growth, discharges or bleeding but there were none. The mouth was inspected and the lips were moist

without cracks, dryness and inflammations. Client was engaged in a conversation just for her to open her mouth for quick assessment of the mouth. The gums and tongue where pink without sores, lesions or bleeding. Her teeth were strong, whitish in colour with no odour from the mouth. Neck was also inspected and palpated for enlarged thyroid glands, enlarged lymph nodes and distended neck vein but there was none.

Breast examination

After explaining procedure, inspection proceeded with initial inspection of breasts. After exposing both breasts, the right breast was a little bigger than the left breast and breasts were normally situated with prominent nipples which were centrally placed. The breast looks hemispherical in shape. Primary and secondary areola was present with Montgomery's tubercle fairly distributed. Breast was inspected for rashes on the skin and nipple whether everted or inverted. Both breasts were palpated for lumps, enlarged axillary lymph nodes, but none was present. The nipple and areola were gently pressed, and colostrum was expressed and it was swabbed with a sterile cotton wool swab and smelt for bad odour, but it was not offensive and was shown to her. She was educated that the colostrum would serve as the first line of immunity and prevents allergies to the child and she was educated to feed the baby with it when delivered. Client was congratulated and educated to support the breast with a firm brassier with broad stripes. She was educated on the need for self-breast examination and encouraged to regularly examine her breast at least once in a month after her menses and if any abnormality is detected, she should report to the midwife or any other staff on duty. She was told she can examine her breast when bathing, lying down or standing in front of a mirror.

Extremities

Her upper limbs were of equal size and length. Client was asked if she had tingling and tightness of the fingers on making a fist and she said no. The palms were inspected for pallor, the nails including the capillary refill of the nail beds were checked and they appeared to be pink in colour. Madam Grace`s finger nails were trimmed neatly, short and with no extra digit.

On examination of the lower extremities, legs were palpated for oedema, tenderness of the calf muscle and none was present and also inspected for varicose vein which were absent and they were of equal size and length. Her toe nails were neatly trimmed and kept short.

Madam Grace was assisted to lie on the lateral side for examination of her spine but no abnormality such as oedema of the sacral region, scoliosis, kyphosis were detected and her vertebral column was normal without pain at the costovertebra angle.

Abdominal examination

Permission was asked to expose her abdomen for inspection after assisting her to lie on her back. The abdomen was examined to detect any deviation from normal standing on her right side. Items used for the examination were shown to her to allay fear.

On inspection, shape was ovoid, and the size corresponded with the gestational age, no striaegravidarum and lineanigra was seen from the symphysis pubis to the umbilicus and fetal movements were visible. No scars were seen on the abdomen.

Symphysio-fundal measurement commenced by first rubbing the palms together to generate warm in order to prevent stimulation of contractions. The zero end of the measuring tape was placed on the fundus of the uterus and the tape was extended

to the upper border of the symphysis pubis and the Symphysio-fundal height was 35centimeters and her gestational age was 37weeks.

On fundal palpation palms were placed on either side of the fundus with fingers curved around the fundus to detect what was occupying the fundus. A soft mass was felt indicating the buttocks.

On lateral palpation hands were placed on each side of the uterus, midway between the symphysis pubis and the fundus, the uterus was stabilized with one hand and examined with the other and the entire area from the abdominal midline to the lateral side and from the symphysis pubis to the fundus was palpated in a rotational manner. A smooth curve was felt which indicated the back at the right side of the abdomen, the process was then repeated on the left side of the abdomen and an irregular mass and movement were felt which indicated the limbs. The position was therefore right occipito anterior.

On pelvic palpation Madam Grace`s feet were faced and she was asked to flex her knees (legs) slightly and to breathe out slowly to relax the abdominal muscles. Palms were placed on either side of the uterus, with one palm just below the level of the umbilicus and fingers directed towards the symphysis pubis with thumbs almost meeting. A hard mass was felt which indicated the head and that the presentation was cephalic.

Descent of the head was assessed by locating the anterior shoulder and two fingers (left) were kept over the anterior shoulder and upper border of symphysis pubis was located. Placing the right ulna border just above the symphysis pubis and anterior shoulder, all the five fingers accommodated the area indicating descent was 5/5th above the pelvic brim.

Auscultation was done with fetal stethoscope; it was warmed by rubbing it in the

palm and placed on the right side of the abdomen where the back was located. Fetal heart rate was listened to without touching the fetal stethoscope. By the use of a breast watch, fetal heart beat was counted for one full minute while comparing it to the maternal pulse it was 136 beats per minute taking note of the volume and rhythm.

Vulva examination permission was sought from client to conduct vulva examination and she agreed. Client was asked to flex her knees and separate her leg. On inspection, it was realized that she had maintained a good personal hygiene and she was therefore commended. The vulva was clean and well shaved with no varicose veins, warts, oedema and no discharges or blood. She was assisted to lie on her side, sit up and got down from the couch and also assisted to dress up. She was made comfortable by offering a seat and she was thanked for her co-operation. Hand washing was done with soap under running water and dried with a clean towel.

Afterwards, all findings were communicated to her understanding and she was encouraged to ask questions which she said she had none. However when asked of her complaints, client complained of constipation. Madam Grace was reassured and educated to take in more fruits and also eat enough fiber diet such as cereals, whole grains, vegetables and fruits. Client was also educated that the pain was due to stress after ruling out other signs of malaria. Madam Grace was encouraged to rest in between work, have enough rest and to take her drugs as prescribed. . Her fifth dose of SP was given under direct observation therapy (DOT).

Client was also encouraged to report any abnormality to the hospital very early so that early treatment could be given to prevent further complications even when it was not yet time for her to come to antenatal clinic. She was also reminded about her next visit to the clinic as 2rd November, 2021. It was made known to her that a

visit would be paid to her house to discuss some important issues pertaining to her pregnancy which would be beneficial to her health and that of the fetus which she willingly agreed and gave her number and directions to her house.

Her medications given were as follows.

- Tablet Multivitamin 200mg daily for 7 days.
- Tablet Ferrous Sulphate 200mg daily for 7 days
- Tablet Folic Acid 5mg for 7 days.
- Tab paracetamol 1g tid for 3 days.

2.2 FIRST ANTENATAL HOME VISIT

The first visit to Madam Grace's house was 31st October, 2021. The aim of the visit was to observe the environment where she lives, her source of water and light, how well ventilated her room is and the number of people she shares her room with, where she attends to natures call, how she disposes her refuse and also how she relates with her family members and her co-tenants in the house. The journey was made by car and it is about fifteen minutes' drive from the health center.

PHYSICAL ENVIRONMENT

On arrival, it was realized that Madam Grace lives in a compound house with her co-tenants. A warm welcome and a seat were offered in her room. She was asked how

herself and the family were faring which she responded that they were all fine. She was asked whether she was doing something but she said she just finished with her chores. But her husband and child were not met in the house she said her husband had gone to work and the child had gone to play. Her curtains were neat with a mosquito trap gate in front of the door. Her room was neat with her things well arranged. She had adequate lightening and ventilation. She was congratulated and asked to keep it up. She added that in the night she lays a mat on the floor for the child to sleep and she and her husband share the bed. She was asked whether the child sleeps under an insecticide treated bed net but she said no since he sleeps on the floor. She was educated on the importance of sleeping under a treated insecticide net and advised to find a carpenter to put some nails on the wall and also get a conical shaped insecticide treated bed net from the health facility so that during the evening she could hang it for the child to sleep under and early the next morning she could remove it which she agreed.

However, they had a wooden bed with an insecticide treated net hanging loosely over it. She was advised to fold and pack the clean clothes nicely into their various bags and also not to hang any clothes whether dirty or neat on the cross bar since mosquitoes can hide in them and bite them at night. She was also advised to buy a laundry basket and keep the dirty clothes in.

A walk was taken around the house. It is a four bed room house built with cement blocks and roofed with aluminum sheets. It has a separate kitchen and wash room. Client cooks in her corridor whiles other tenants cook in the kitchen; she has a kitchen cupboard in which she has neatly arranged her utensils. There were no dirty dishes found in the kitchen. The toilet and bathroom was also well kept because it

was scrubbed on daily basis by occupants. A dustbin with a well-fitting lid was seen outside the house which she said they empty everyday into the public refuse dump which is some few meters away from their house. They fetch water from a nearby tap in their vicinity.

PSYCHOSOCIAL ENVIRONMENT

Madam Grace, her husband, her child and family have a cordial relationship with each other. Madam Grace has a warm and friendly relationship with her neighbors and other relatives who stay around their area. Client said she doesn't really have a lot of friends but with the few she has, she visits them at her leisure time and they also visits her sometimes. She is very joyful, freely and does not find it difficult to make new friends. Madam Grace also added that she has respect for all manner of people and neighbors. Clint also said she attend every social gathering like weeding, naming ceremonies, thanksgiving service and durbars, if only she knows the person and hears it. Madam Grace was congratulated and asked to keep it up.

Madam Grace was educated on the importance of maintaining good personal hygiene and encouraged to continue with her medication. Her layette was inspected and it was complete, however they were in separate polyethen bags. She was encouraged to pack the items in a single bag and identify a birth companion and have a purse with her insurance card and money in it. She was allowed to ask questions and appropriate answers were given. She complained of lower abdominal pain and heartburns which was explained to her as relaxation of the cardiac

sphincter of the stomach with reflux of acidic contents of the stomach into the lower oesophagus which is a normal physiology in pregnancy. She was thanked and permission was sought to leave. She was informed about the next visit on 7th November 2021.

2.3 SECOND ANTENATAL HOME VISIT

The second home visit to Madam Grace's house was on the 7th November, 2021 at 4:30pm. Client was met in the house chatting with some of her relatives who had visited her. They were greeted and a warm welcome was given and a seat offered. The wellbeing of the family was inquired and she said they were all doing well by God's grace.

The aim of the visit was to inquire about her health whether some changes have been made on how to keep and arrange her bedroom well and neat. Client was asked about her previous complains and she said was better now. Client was educated on birth preparedness and complication readiness that is, client should contact a taxi driver in case of emergency and get a blood donor .Her husband was her birth companion and she had pack her delivery items with a purse of money and her insurance card as well as antenatal book. She was then congratulated and asked to keep it up. Education on rest and sleep as well as true labour signs was given to her and she was told to report to the clinic anytime she sees any of the signs. Client was also encouraged to arrange with a taxi driver who would take her to the hospital when in labour. Client was educated on true sign of labour such as appearance of show, regular rhythmic contractions anytime she experience that she should not hesitate to come to the heath facility. Client was allowed to ask questions and

appropriate answers were given.

Client also complained of interrupted sleep due to frequency of micturition and backache. Client was educated to empty her bladder completely before going to bed and keep a chamber pot close to her to avoid walking long distance in the night to empty her bladder. Permission was sought to leave, she was thanked and reminded of her next visit date to the clinic.

2.4 SUBSEQUENT VISIT TO THE CLINIC

On the 9th November 2021, Madam Grace visited the clinic. She was warmly welcomed and a seat was offered to her. She was asked how she was faring and she said she was fine. Her weight checked was 82kg whiles her haemoglobin level was 12.5 grams per deciliter. Her vital signs were checked and recorded as follows;

- Temperature 35.7 degree Celsius
- Pulse 80 beats per minutes
- Respiration 18 cycle per minute
- Blood Pressure 110/70millimetre of mercury

Sample of her urine was taken and checked for protein and glucose and they were all negative. All procedures to be carried out on her were explained to her and privacy was provided. Hand washing was done with soap under running water and dried with a clean towel. Client was assisted onto the examination bed, physical examination was done from head to toe and everything was normal.

On abdominal examination, the abdomen was seen to be ovoid and medium in size.

Palpation was done and the fetal buttocks was located in the upper pole of the uterus whiles the back of the fetus was felt at the right side of the maternal uterus and the fetal limbs felt on the left side of the mother. The lie was longitudinal. The head occupied the lower pole and the descent checked was 5/5th. The Symphysio-fundal height was 37cm with a fetal heart beat of 146 beats per minute and gestational age 39 weeks

All findings were communicated to her after the procedure and she was thanked for her co-operation. Madam Grace was asked whether she had any complaint that day and she complained of backache. Client was reassured and told that the pain was as a result of the effect of the hormones progesterone and relaxin which relaxes the pelvic ligaments and muscles. Client was advised to maintain a straight back .She asked for permission to leave when even lifting light objects and also to get a hard board under her mattress for a firm back support and she was asked to come to the clinic for next visit on 17th November, 2021.

NURSING CARE PLAN

Nursing care plan is a document designed to render total individualized care to client and her family taking into consideration their needs. It involves identifying problems, analysing them, setting objectives and implementing interventions that will meet the set objectives.

PROBLEMS IDENTIFIED

Constipation-----------27/10/2021

Heartburns---------------------31/10/2021

Lower abdominal pain--------31/10/2021

Interrupted sleep--------------07/11/2021

Backache---------------------07/11/2021

SHORT TERM OBJECTIVES

1. Client will have free bowels movement within 48 hours.

2. Client will cope with reduced episodes of heartburns within 24 hours.
3. Madam Grace`s lower abdominal pain will reduce within 24 hours.
4. Client will have at least six (6) hours of sleep within 24 hours.
5. Client will have reduced episodes of backache within 24 hours.

LONG TERM OBJCETIVES

Madam Grace will go through pregnancy safely without any complications to the mother and baby

NURSING CARE PLAN FOR MADAM GRACE

Date /Time	Nursing Diagnosis	Nursing Objectives/out come criteria	Nursing Orders	Nursing Intervention	Date/ Time	Evaluation	Sign
27/10/2021 10:00am	Constipation related to increase progesterone level in the blood which causes relaxation of the smooth muscles of the colon there by causing decreased motility of the gut.	Madam Grace will have free bowel movement within 48 hours as evidence by; 1.Madam Grace verbalizing that she has been able to empty her bowel freely. 2. Client husband verbalizing that madam Grace empty her bowel freely.	1. Reassure client 2. Explain the physiology of constipation to her. 3. Educate client to eat enough roughage like vegetables and fruits. 4. Encourage the intake of fluids. At least 2000mls every day 5. Encourage her to respond to the urge of emptying the bowel to avoid reabsorption of water from the stools.	1. Client was reassured that she will empty her bowels freely. 2. She was told it was due to the effect of progesterone on her GIT. 3. Client was advised to eat enough roughage like fruits and vegetables. 4. Client was encouraged to take at least 2000mls of fluids everyday which is equivalent to four sachets of pure water. 5. Client was also encouraged to respond to the urge of emptying her bowel to avoid reabsorption of water from the stools.	29/10/2021 10:00am	Goal fully met as client said she moved her bowel freely.	YE

Date /Time	Nursing Diagnosis	Nursing Objectives/ outcome criteria	Nursing Orders	Nursing Intervention	Date/ Time	Evaluation	Sign
31/10/2021 4:00pm	Heart burns related to the relaxation of the cardiac spinchter of the stomach with reflux of acidic contents of the stomach into the lower oesophagus.	Client will cope with reduced episodes of heartburns within 24 hours as evidence by: 1. Client verbalizing that the intensity of heart burns has reduced. 2.Midwife observing that client Client is not complaining of heart burns anymore.	1. Reassure client. 2. Educate client on the causes of heart burns. 3. Encourage client to go to bed at least 30 minutes after meals. 4. Educate client to elevate the head end of the bed when sleeping. 5. Encourage Madam Grace to eat less spicy foods.	1. Client was reassured that the intensity of heart burns would reduce. 2. Client was educated that it was due to regurgitation of gastric content due to relaxation of the cardiac spinchter. 3. Client was encouraged to go to bed at least 30 minutes after meals. 4. Client was educated to use more pillows when sleeping to elevate the head end of the bed. 5. Madam Grace was encouraged to eat less spicy foods.	01/11/2021 4:00 pm	Goal fully met as the intensity of heartburns reduced.	YE

Date /Time	Nursing Diagnosis	Nursing Objectives/ outcome criteria	Nursing Orders	Nursing Intervention	Date/Time	Evaluation	Sign
07/11/ 2021 03:30pm	Lower abdominal pain related to excessive quickening.	Client's abdominal pain will be reduced within 24hours as evidence by client verbalizing that the pain has reduced. 2.Client husband verbalizing that client is coping with the condition	1. Reassure client. 2. Explain cause of lower abdominal pain. 3. Educate client to have enough rest and sleep. 4. Encourage client to drink adequate amount of water at least 8 glasses of water 5 .Administer prescribed analgesics.	1. Client was reassured that lower abdominal pain will resolve 2. Client was told it was due to decent of the fetal head into the pelvic brim 3. Client was educated to have at least two hours rest during the day and six hours at night. 4. Client was encouraged to drink at least 8 glasses of water every day 5. Tab paracetamol 1g was served as prescribed.	08/11/ 2021 03:30pm	Goal fully met as client said her headache resolved	YE

Date /Time	Nursing Diagnosis	Nursing Objectives/outcome criteria	Nursing Orders	Nursing Intervention	Date/Time	Evaluation	Sign
07/11/2021 3;30pm	Sleep disturbance related to frequency of micturition.	Client will have at least six (6) hours sleep within 24 hours as evidence by 1. Client verbalizing that she slept for at least six (6) hours. 2.Husband verbalizing that madam Grace had enough sleep	1. Reassure client that she will have adequate sleep. 2. Educate client on the physiology of frequent micturition. 3. Tell client to urinate before going to bed. 4. Educate client to limit the intake of fluid containing natural diuretics, such as caffeine 5.Educate client on the time to take her supper	1. Client was reassured of adequate sleep if interventions are followed. 2. She was educated that it was due to descent of the presenting part. 3. Client was told to urinate before going to bed. 4. She was also educated to limit the intake of fluids such as tea, caffeine at night. 5. Client was encouraged to eat her supper at least two hours before bedtime.	08/11/2021 3:30pm	Goal met as client reported that she slept for six hours.	YE

Date /Time	Nursing Diagnosis	Nursing Objectives/outcome criteria	Nursing Orders	Nursing Intervention	Date/Time	Evaluation	Sign
07/11/2021 3;30pm	Backache related to exaggerated lumbar curvature during pregnancy.	Client will have reduced episodes of backache within 24 hours as evidenced by; 1. Client verbalizing that her pain has reduced. 2.Midwife observing that client is comfortable	1. Reassure client 2. Educate client on the physiology of backache in pregnancy. 3. Advice client to wear low heels. 4. Educate client to support her back with pillow when sleeping or sitting. 5.Serve client prescribed analgesics, such as paracetamol	1. Client was reassured that her pain would subside. 2. Client was educated that pain was as a result of the effect of the hormones progesterone and relaxin which relaxes the pelvic ligaments and muscles. 3. Client was advised to wear low heels 4. Client was educated to support her back with pillow when sleeping or sitting. 5. Prescribed paracetamol 1g was served tid.	18/11/2021 3;30pm	Goal fully met. Madam Grace reported to the midwife that her back pains has reduced.	YE

CAPTER THREE

LABOUR

3.0 INTRODUCTION

This chapter describes the management of labour, the immediate care of the newborn, examination of the newborn and the care plans drawn for the management of the problems encountered during labour. The goal of care during labour and delivery is to ensure the most positive outcome mainly a healthy mother and baby.

3.1 ADMISSION AND MANAGEMENT OF FIRST STAGE OF LABOUR

Admission

On 10th November 2021, Madam Grace reported to the labour ward at St. Mathew's Clinic around 5:35pm with her husband with the complaints of waist and lower abdominal pain. Rapport was established and they were offered seats. Client was taken to the nurses' station for necessary information to be taken while glancing through her antenatal card. She was asked if she had experienced any danger signs like, bleeding from the vagina, leakage of liquor and persistent vomiting. Madam Grace replied that she had not seen any of the signs. Client appeared anxious and she was told that she was in competent hands and that she would have a safe delivery. History of her last meal, last bowel action and if she has taken any medication were taken.

Madam Grace said lower abdominal and waist pains started at 10:30am and also noticed the appearance of 'show'. Madam Grace's husband was reassured that everything was going to be alright .Madam Grace was sent to the examination room and assisted to change her clothing. Permission was sought to examine her and all

procedures were explained to her.

Client was then asked to pass urine and her urine measured 150mls,midstream sample was tested for albumin, sugar and acetone but the results were negative. She was assisted to lie on the couch and a quick examination from head to toe revealed no abnormality.

Her vital signs checked and recorded were as follows:

Temperature	-	36.7^{o}C
Pulse	-	90 beat per minute
Respiration	-	24 cycle per minute
Blood pressure	-	120/80 mmHg

Abdominal examination

Permission was asked to expose her abdomen for inspection after assisting her to lie on her back. The abdomen was examined to detect any deviation from normal standing on her right side. Items used for the examination were shown to her to allay fear.

On inspection, the shape of the abdomen was ovoid and straie gravidarum, lineanigra and fetal movement were noticed. No scars were seen on the abdomen.

Symphysio-fundal measurement commenced by first rubbing the palms together to generate warm in order to prevent stimulation of contractions. The zero end of the measuring tape was placed on the fundus of the uterus and the tape was extended to the upper border of the symphysis pubis and the Symphysio-fundal height was 37centimeters and her gestational age was 39weeks.

On fundal palpation palms were placed on either side of the fundus with fingers curved around the fundus to detect what was occupying the fundus. A soft mass was felt indicating the buttocks.

On lateral palpation hands were placed on each side of the uterus, midway between the symphysis pubis and the fundus, the uterus was stabilized with one hand and examined with the other and the entire area from the abdominal midline to the lateral side and from the symphysis pubis to the fundus was palpated in a rotational manner. A smooth curve was felt which indicated the back at the right side of the abdomen, the process was then repeated on the left side of the abdomen and an irregular mass and movement were felt which indicated the limbs. The position was therefore right occipito anterior.

On pelvic palpation Madam Grace`s feet were faced and she was asked to flex her knees (legs) slightly and to breathe out slowly to relax the abdominal muscles. Palms were placed on either side of the uterus, with one palm just below the level of the umbilicus and fingers directed towards the symphysis pubis with thumbs almost meeting. A hard mass was felt which indicated the head and that the presentation was cephalic.

Descent of the head was assessed by locating the anterior shoulder and two fingers (left) were kept over the anterior shoulder and upper border of symphysis pubis was located. Placing the right ulna border just above the symphysis pubis and anterior shoulder, the descent was $4/5^{th}$ above the pelvic brim and uterine contraction was 2 in 10 minutes lasting 20 seconds.

Auscultation was done with fetal stethoscope; it was warmed by rubbing it in the palm and placed on the right side of the abdomen where the back was located. Fetal heart rate was listened to without touching the fetal stethoscope. By the use of a

breast watch, fetal heart beat was counted for one full minute while comparing it to the maternal pulse it was 130 beats per minute taking note of the volume and rhythm.

Vulva examination permission was sought from client to conduct vulva examination and she agreed. Hand washing was done with soap under running water and dried with a clean towel and sterile gloves worn Madam Grace was asked to flex her knees and separate her leg. On inspection, it was realized that she had maintained a good personal hygiene and she was therefore commended. The vulva was clean and well shaved with no varicose veins, warts, oedema and no discharges or blood. The vulva was swabbed with savlon solution, using sterile swabs, the labia majora were swabbed with two sterile cotton wool soaked in savlon solution, the labia minora was also swabbed the same way and a single cotton wool soaked in savlon solution was used to swab the vestibule after which vaginal examination was carried out .

Client vagina felt moist, warm and distensible. The cervix was thin, soft, effaced and the presenting part well applied to it. The cervical dilatation was 5cm with membranes intact at 6:30pm. No moulding was felt. The sacral promontory was not reached, the sacrum was well curved and the ischial spines were blunt. A fist was placed in between the tuberosity and it admitted the fist. Client was cleaned after the examination and a clean perinea pad was applied to the vulva.

Client was tidied up and encouraged to lie on her left side. All findings were explained to her and reassured that labour was progressing well. All procedures were done under the supervision of the midwife-in-charge and recorded on a partograph.

Preparation for birth

A skilled helper was identified, that was the staff midwife on duty who was also supervising the delivery. She was made aware that her assistance may be needed if the need arose. The non-skilled helper was the client husband and he was also made aware that she would be called to help when needed. The phone number of the referring hospital was made available in case of any emergency and also a driver was informed that in case of emergency he would be called.

The delivery room was prepared for delivery; the room was made clean and warm by drawing the curtains closer, light were switch on, and touch light was also made ready in an event of light off. Hands were washed with soap and water and dried with clean towel. The client was also assisted to wash her hands, chest and abdomen with clean water and soap and dried with clean towel to prepare for skin to skin contact. Delivery set was available waiting to be set at appropriate time .Oxytocin and other emergency drugs like magnesium Sulphate were also made available.

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

Management of first stage of labour

The fetal heart rate, maternal pulse and uterine contractions were checked every 30 minutes, temperature, blood pressure, descent as well as vaginal examination was done 4 hourly and the results plotted on the partograph. She complained of tiredness and was reassured and encouraged to avoid screaming and perform deep breathing exercise when there are contractions. Again milo and biscuit was served and she

was stayed with; sacral massage was given and was also educated to breathe through her mouth. Client was reassured that labour was progressing well and was encouraged to pass urine frequently to prevent her bladder from being full, since this could impede descent of the fetus.

Client was asked to lie on her left lateral to prevent supine hypotensive syndrome or ambulate to enhance descent. She complained of thirst and dry throat. She was then encouraged to take sips of water to quench her thirst and to keep her mouth and throat wet.

At 10:30 pm, she was due for her next V/E. The procedure was explained to her and was asked to empty her bladder before doing the next examination. At this time the fetal heart rate recorded was 120beats per minute with good volume and rhythm. Descent of the fetal head was1\5th and uterine contractions were 4 in 10 minute lasting 40 seconds. On vaginal examination cervical dilatation was 9 cm with intact membranes and moulding was not felt

Her vital signs were checked and recorded as follows.

Temperature - 36.4^{o}C

Pulse - 79 beats per minute

Respiration - 20 cycles per minute

Blood pressure- 120/80 mmHg

All the findings were communicated to her and recorded on the partograph. She was reassured, encouraged to continue with the relaxation techniques and do deep breathing exercise. She was also given sips of water. She was cleaned with a wet

towel since she was sweating profusely.

The delivery trolley was set containing the following;

Top shelf

- Sterile scissors
- sterile gloves
- Two sterile artery forceps
- sterile drape
- sterile membrane pierce
- cord clamp
- Sterile episiotomy park containing scissors and suturing forceps
- sterile gallipots
- injection tray containing 10 units of oxytocin, vitamin k, syringe and needle

Bottom shelf

- Drum containing gauze and cotton wool
- chittle forceps
- jug for measuring the amount of blood loss
- urethral catheter and drainage bag
- examination gloves
- Identification band

Other items included sutures, lidocaine face mask, goggle, boots, plastic apron, baby's cot with cot sheets and baby's dress, bed pan, light source were brought closer

At 11:12pm she complained of severe bearing down sensations with the uterine contractions becoming more expulsive and frequent. The anus was gapping with the

perineum bulging. Vaginal examination was repeated, cervix was fully dilated with spontaneous rupture of membrane. Liquor was clear and there was no cord prolaps, moulding was ++ since the bones overlapped each other but easily separated. Foetal heart rate was 140bpm, contractions were 4:10 for 45 seconds, and descent was 0/5th. The midwife in-charge confirmed the findings.

3.2MANAGEMENT OF THE SECOND STAGE OF LABOUR

Madam Grace was transferred to the second stage room and she was asked to assume a comfortable position and she assumed a lithotomy position on the delivery bed at 11:18pm. What is expected of her during the delivery was explained to her. Client was assisted to lie in the dorsal position with knees flexed apart. She was reassured and every procedure to be done was explained to her. Protective clothing such as mackintosh apron, rubber boots and goggles were worn. Hands were washed with soap under running water and dried with sterile towel and sterile gloves were worn on both hands. The vulva and the upper thigh were swabbed with savlon solution and client draped with sterile towels. She was reminded that her baby will be delivered unto her abdomen to provide warmth and improve bonding. A clean perineal pad was applied to the anus to keep the delivery area clean. Madam Grace was encouraged to push with each contraction and rest in between contractions. The midwife in –charge checked the maternal pulse and fetal heart rate to ascertain the condition of both mother and fetus. This was done following uterine contractions to assess the recovery rate of the fetal heart rate after contractions and was recorded.

As labour progressed, the head advanced gradually and flexion was aided by gently

pressing the occiput downwards in other to allow the smallest diameter of the skull to distend the vulva and the perineum. Descent of the fetal head continued till crowning of the head occurred, Madam Grace was asked to stop pushing and pant at this stage to prevent rapid expulsion of the head which could lead to perineal tears and intracranial injury. The sinciput, face and chin swept the perineum and the head was slowly delivered by extension to prevent tear and injury to the baby. The eyes were cleaned with separate sterile swabs from the inner cantus of the eye outwards. The face was cleaned with gauze swabs. Cord was quickly felt for around the baby's neck but there was none.

The head was supported and restitution was allowed to take place and internal rotation of the shoulders as indicated by external rotation of the head. This brought the shoulders into anterior-posterior diameter of the pelvic outlet. Client was asked to push with the next contractions. Both palms were placed on either side of the baby's ear and gently pressed the head downwards to deliver the anterior shoulder which escaped under the symphysis pubis. The posterior shoulder swept the perineum and was delivered. The rest of the body was delivered by lateral flexion unto the mother's abdomen at 11:38 pm. An alive healthy female baby was delivered who cried soon after delivery. The baby was quickly cleaned from head to toe with a clean cot sheet and wrapped with another clean cot sheet while on her mother's abdomen after client confirmed the gender as a female. Client was congratulated for her efforts. The baby was moved to the mother's chest for skin-to-skin contact and covered them with a new sheet. Mother was informed that the baby was going to be there for an hour to improve bonding and initiate breastfeeding.

3.3 IMMEDIATE CARE OF THE BABY

The immediate care of the baby started as soon as the head of the baby was born. Different sterile gauze was used to clean the baby's eyes from inner cantus outwards. The face was wiped with gauze. The baby was dried thoroughly to keep the baby warm and stimulate breathing. The cord was clamped and cut in between two clamps at 2cm away from baby's abdomen and 3cm away from the first clamp. The baby was shown to mother to confirm the sex of the baby. Identification band was prepared with the mother's name, baby's sex, weight and date of birth and was tied around the baby's wrist. Baby was then cleaned and wrapped in a warm sheet with the head covered with a cap to prevent hypothermia.

The baby was put to breast to ensure the natural release of oxytocin to help with the contraction of the uterus, initiate lactation and promotion of bonding between mother and baby. The baby was then nursed with head turned to one side, in order to facilitate drainage of secretions to prevent aspirations.

3.4 ACTIVE MANAGEMENT OF THE THIRD STAGE OF LABOUR

After the cord separation, a sterile receiver was placed near the vulva in between the thighs to receive the end of the cord. Client's abdomen was palpated to rule out any second foetus in utero before 10 units of oxytocin was given intramuscularly by the midwife-in-charge to prevent any bleeding. The client was asked to empty her bladder which she said she had no urge. The left hand was placed on the fundus to feel for contractions. As soon as contractions were felt, the clamp was held with the right hand while the left hand was placed on the lower abdomen in the suprapubic area to push the uterus. The right hand which held the clamped cord , was used to

apply gentle downward traction in a downward and backward direction. Counter-traction was maintained with the left hand on the supra pubic area while traction was applied to the cord until the placenta was visible at the vulva. Both hands were used to receive the placenta at the introitus and placed in a bowl at 11:43 pm.

The uterus was massaged to maintain the contraction. Client was thought to massage her uterus and she was asked to feel the hardness of the uterus which indicated that the uterus was well contracted. This procedure was done every 15minutes for two hours making sure the uterus was firm, while blood loss was checked.

The placenta and membranes were examined quickly, and all the lobes were complete and healthy. The uterus was massaged and blood clots were expelled. Perineum, vaginal walls and cervix were examined under a light source and there were no tears.

The blood loss was approximately 200mls.Client was cleaned and a new perineal pad was placed at the perineum to make her comfortable in bed. Client was encouraged to change her pad and urinate frequently to prevent postpartum haemorrhage and infections. She was also educated on how it would help in the contractions of the uterus.

Madam Grace was congratulated for her cooperation. The delivery bed was cleaned and the equipment's used were decontaminated in 11:58 chlorine solution for 15 minutes and then washed in warm soapy water, rinsed under running water. The equipment's were put into the autoclave machine for sterilization and stored.

3.5 EXAMINATION OF PLACENTA AND MEMBRANES

After client was made comfortable in bed, the placenta was examined thoroughly in the sluice room. The maternal surface was examined in a cupped hand with no missing lobe, and membranes were intact. The cord was situated at the center of the placenta and there was one vein, two arteries in the cord and no abnormality was detected. The placenta was held by the cord allowing membranes to hang down. The membranes were spread out to aid in inspection. On examination; the chorion and amnion were intact. The fetal surface was smooth with shiny and bluish-grey in colour. The maternal surface of the placenta was red with complete lobes separated by grooves (sulci).

The placenta was discarded after decontaminating it. The instruments and equipment used were soaked in 0.5% chlorine solution and were removed after 10 minutes, washed and put in the autoclave after which the instruments were stored. Hands were dipped in 0.5% chlorine solution before discarding the gloves. Amount of blood loss was 200ml. Client was congratulated for the effort made.

3.6 MANAGEGEMENT OF FOUTH STAGE OF LABOUR

This is the period of six hours after delivery of the placenta during which both the mother and baby are under continuous observation in order to detect early complications, Madam Grace and her baby were monitored for six hours before transferring them into the lying-in-ward.

BABY

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

Head and neck examination

The procedure was explained vividly to Madam Grace, examination gloves were worn and the baby was examined head to toe to detect any deviation from normal. Baby was put on a covered flat surface and only the part to be examined was exposed. The head was examined for bulging and sunken of fontanels, 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 37cm and the baby’s length was 48cm. The ear was examined for position, size, and patency. Eyes (conjunctiva) were also examined for pallor, sub conjunctiva haemorrhage 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.

Chest examination

The chest was inspected for shape, size and chest wall movement with respiration and respiration rate was 45 cycles per minute and the apex heart beat was also 130 beats per minute. Breasts were palpated for masses and nipple was checked for position and extra nipple and everything was normal.

Upper extremities

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.

Abdominal examination

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 abnormalities were detected. With the lower limbs, no webbing, extra toes and club foot were found. The baby was turned prone with the head on one side and the spine was checked for swelling, spinal bifida and for missing vertebrae, but no abnormalities were noticed. On examination of the skin, the skin was pink and no abnormality found. The anus and the rectum were inspected for patency and no abnormality was detected since the baby had passed meconium and urine. The baby was weighed and it recorded 2.9kg. The temperature was checked and it was recorded as 36.5 degrees celcius.

Gloves were removed and disposed of. Hand washing was done and dried with clean towel. All finding were then communicated to the mother and documented .The baby was then classified as a normal baby and routine care initiated. The baby was wrapped in a warm dry sheet and was placed beside for her mother to breastfeed.

MOTHER

Client's vital signs as well as her uterus and lochia were checked 15 minutes for two hours, 30 minutes for an hour and hourly for three hours. Her vital signs were checked and recorded as follows:

Temperature - 36.6oC

Pulse - 86 beat per minute

Respiration - 20 cycle per minute

Blood pressure - 120/80 mmHg.

Madam Grace was asked to empty her bladder frequently in order to help contractions of the uterus. Client was served with warm beverage and also encouraged to establish bonding and to initiate and maintain lactation. She was educated on how breastfeeding enhances the release of oxytocin which would improve uterine contractions, drainage of lochia, control of haemorrhage and also as a form of family planning.

Madam Grace was examined from head to toe, her conjunctiva was pink and no abnormality detected. Uterus was well contracted and Symphysio-fundal height was 17cm, there was no active bleeding from the vagina. She was encouraged to report if she saw any profuse bleeding. She was asked to change her pad when soiled in order to prevent infection. The findings of all assessments carried out were within

the normal range. The baby was also monitored at the same interval to ensure that breathing was normal and the colour of skin was pink.

3.7 SUMMARY OF LABOUR AND DELIVERY

Date of delivery - 10th November, 2021

Time of delivery - 11:38pm

Type of delivery - Spontaneous Vaginal Delivery

Time of placental delivery - 11: 43pm

Duration of labour

1st stage - 6 hours 10 minutes

2nd stage - 20 minutes

3rd stage - 5 minutes

Total - 6 hours 35 minutes

Condition of baby

Apgar score at first minute - 8/10

Apgar score at fifth minute - 9/10

Sex of baby - female

Weight - 2.9 kg

Temperature - 36.5c

Head circumference - 37 cm

Full length - 48 cm

Meconium - Passed

Urine - Passed

Condition - satisfactory

Condition of mother

Temperature - 36.6^{o}C

Pulse - 86 beat per minute

Respiration - 20 cycles per minute

Blood pressure - 120/80 mmHg

Fundus - 17 cm

Lochia - Red (rubra)

Odour of Lochia - Non – offensive

Perineum - Intact

Condition - Satisfactory

Condition of placenta and membrane

Lobes and membranes - Complete and healthy

Maternal surface - Normal

Foetal surface - Normal

3.8 NURSING CARE PLAN ON LABOUR

PROBLEMS IDENTIFIED

1. Severe lower abdominal.
2. Anxiety.
3. Tiredness.
4. Thirst and dried throat
5. Profuse sweating.

SHORT TERM OBJECTIVES

1. Client will cope with lower abdominal pain within 2 hours and throughout labour
2. Client's anxiety will resolve within 30 minutes.
3. Client will regain her strength within 2 hours.
4. Clients thirst and dry throat will resolve within 10 minutes
5. Client will be comfortable within 10 minutes

LONG TERM OBJECTIVES

Client will go through labour and delivery successfully without complications to client and baby.

NURSING CARE PLAN TABLE B

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES/OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTIONS	DATE/ TIME	EVALUATION	SIGN
10/11/2021 6:10 pm	Lower abdominal pains related to physiology of labour.	Client will cope with lower abdominal pain within 2 hours and throughout labour as evidenced by; 1.client verbalizing that she is coping with labour pain 2. Midwife observing that client is coping with labour pain	1. Explain the physiology of labour pains to her. 2. Put client in a comfortable position 3. Encourage client to perform breathing and relaxation exercises 4. Provide diversional therapy 5. Perform sacral massage for client.	1. The physiology of labour pains was explained to her 2. Client was put in the left lateral position. 3.Client was encouraged to perform breathing and relaxation exercises 4. Client was stayed with and engaged in a conversation 5. Client's sacral region was massaged by her support person.	10/11/2021 8:10pm	Goal fully met as client said she was coping.	YE

DATE/TIM	NURSING	NURSING	NURSING	NURSING INTERVENTIONS	DATE/	EVALUATION	SIGN

E	DIAGNOSIS	OBJECTIVES/OUTCOME CRITERIA	ORDERS		TIME		
10/11/2021 6:00Pm.	Anxiety related to unknown outcome of labour.	Clients' anxiety will resolve within 30 minutes as evidence by; 1.Client verbalizing that she is no longer anxious. 2 Midwife observing that client is coping with each procedure	1. Reassure client. 2. Explain every procedure to be carried to client. 3. Allow her to ask questions and answer her tactfully. 4. Update client with progress of labour. 5. Allow support person to be with her	1. Client was reassured that labour will end safely. 2. Procedures like checking of vital signs, vaginal examination were explained to client. 3. Client was allowed to ask questions and answers were given tactfully. 4. Client was updated about progress of labour using the dilatation board after V/E. 5. Client's husband was allowed to be with her and massage her sacral region during contractions.	10/11/21 6:30Pm.	Goal fully met as client said she was no longer anxious.	YE

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVE/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
10/11/2021 7:10 pm	Fatigue related to advance state of labour.	Client will regain her strength within 2 hours as evidence by; 1.Client verbalizing that she is relieved of fatigue. 2.Midwife observing that client is comfortable in bed	1.Reassure client. 2. Encourage client not to scream during contractions. 3. Encourage client to continue with the relaxation technique. 4. Support client to perform deep breathing exercise during 5. Serve client with light diet	1.Client was reassured that she will regain her strength. 2. Client was encouraged not to scream during contractions. 3. Client was encouraged to continue with the relaxation technique. 4. Client was supported to perform deep breathing exercise during contraction. 5. Client was served with milo and biscuit/	10/11/2021 9:10 pm	Goal fully met as client verbalized she had been relieved of tiredness.	YE

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVE/OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
10/11/2021 9:30pm	Thirst and dry throat related to the process of labour	Clients thirst and drythroat will resolve within 10 minutes as evidenced by; 1.Client verbalizing she is no longer thirsty 2.Midwife observing that client is able to take a sip of water	1. Reassure client. 2.Explain the process of labour to client. 3. Support client to perform deep breathing exercise. 4. Give client sips of water. 5. Serve client with fluid diet.	1. Client was reassured that measures will be put in place to relieve her off the thirst and dry throat. 2. Process of labour was explained to client. 3. Client was supported to perform deep breathing exercise during contraction. 4. Client was given sips of water and ice to suck. 5. Client was served with cold milo drink.	10/11/2021 9:40pm	Goal fully met as evidenced by client verbalizing she does not feel thirsty and dry throat.	YE

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES/OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTIONS	DATE/ TIME	EVALUATION	SIGN
10/11/2021 10:00pm	Profuse sweating related to advanced stage of labour	Client will be comfortable within 10 minutes as evidenced by; 1.Client verbalizing that she is comfortable 2.Midwife observing that client is using clean towel to clean her face	1. Reassure client. 2. Wipe sweat off client's face and body with wet towel. 3. Serve client sips of water 4. Change client wet linen. 5. Assist client to take a shower	1. Client was reassured that measures will be put in place to help her maintain her personal hygiene. 2. Wet towel was used to clean client's face and body. 3. Clint was given sips of water at regular intervals 4. Client's soiled bed linen was changed. 5.Client was served with a bucket of water for bathing	10/11/2021 @ 7:10 pm	Goal fully met as evidenced by client looking clean and comfortable	YE

CHAPTER FOUR

PUERPERIUM

4.0 INTRODUCTION

This chapter talks about the management of puerperium thus the care rendered to both mother and baby after delivery. It begins immediately after the expulsion of placenta and membranes and control of hemorrhage and ends at the 40th day or six (6) weeks after delivery.

4.1 DAY OF DELIVERY

Before transferring Madam Grace and her baby to the lying-in ward they were both assessed carefully. She was made comfortable in an already prepared bed. Madam Grace's vital signs were checked and recorded as follows;

Temperature	36.5^0C
Pulse	80 beat per minute
Respiration	20 cycle per minute
Blood pressure	119/80 mmHg

On palpation the uterus was well contracted and the Symphysio-fundal height was 17cm above the symphysis pubis, lochia was small in amount and red in colour with no clots. She was advised to change her perineal pads frequently when soiled and to report any abnormal vaginal bleeding to the midwives on duty. Client was encouraged to urinate frequently since full bladder interferes with the contraction of the uterus with subsequent bleeding.

Madam Grace was encouraged to take in adequate fluid and eat a well-balanced diet

to help repair worn out tissues and promote growth. She was served with a cup of beverage. She was also educated on how to position and attach the baby to breast and observed as she breastfed the baby. The baby was examined from head to toe and no sign of injury was observed. The baby's weight was 2.9 kg, respiration was 44 cpm, and apex beat was 130 bpm.

4.2 SUBSEQUENT CARE OF THE BABY

After six hours of birth, Madam Grace was informed about the need for the baby to be bathed and she responded positively. The baby was then picked to be bathed in the presence of the mother so that education could be given during the procedure.

Requirement for Baby Bath

Top Shelf

- Methylated spirit in sterile galipot
- Sterile cotton wool swabs and gauze in a galipot
- Surgical gloves
- Sterile water in a galipot
- Baby's diapers
- Baby's dress
- Baby's towel and cot sheet to wrap the baby
- Baby's oil or Vaseline
- Baby's sponge
- Baby soap in a soap dish

Bottom Shelf

- Disposable gloves

- Jug of hot water
- Jug of cold water
- A bowl for mixing water
- Kidney dish for used gauze and swab
- A receptacle for used water
- Mackintosh apron

After picking all needed items, the cold and hot water were mixed and the temperature was tested with the elbow. The plastic apron was then worn; hands were washed with soap under running water and dried with clean towel. Gloves were then worn and the baby was placed on a protected flat surface, undressed and covered with the towel living the face. The eyes were cleaned with sterile cotton, dipped in sterile water from the inner canthus outwards and disposed into a receiver. The face was cleaned with a wet face towel. The nape of the neck was supported by the left palm and the ears were plugged with the thumb and index finger to prevent water from entering the ear. Mother's attention was drawn to this. The baby's head was washed in a circular motion with a soapy sponge after which it was rinsed out and dried with a towel. The baby was placed on a flat surface and the rest of the body was bathed (arms, chest and back), paying particular attention to the skin folds. The whole body was gently immersed in the bath of water with the head supported above the water level. Baby's body was dried with towel paying attention to the skin folds. Vaseline was applied all over the body of the baby to provide warmth. Gloves were removed, hands washed and dried. Sterile gloves were then put on. Cord was inspected for bleeding and there was no bleeding. Sterile cotton wool swabs and methylated spirit was used to dress the cord. One was used to hold the clamp and the cord was dressed aseptically with a cotton wool swab soaked in methylated

spirit from the base upwards to the cord clamp and left it opened to heal by dry gangrene. The baby was wrapped nicely to maintain the temperature. The baby's head was covered with a cap and dressed warmly to prevent heat loss and the baby was given to the mother to breastfeed in an effort to support breastfeeding. Mother was asked to fix the baby to breast by ensuring that she sat in a comfortable position, which meant the baby was attached well to breast and is sucking well. The mother was educated that the baby should be fed at least 8 to 12 times a day and exclusively for six months. Mother was educated on breast feeding problems such as cracked or sore nipples, breast engorgement and mastitis. She was asked to report to the clinic especially if the problem was not resolved and also signs of engorgement were noticed.

The baby's vital signs checked were recorded as follows:

Temperature	36.2ºC
Respiration	38cpm
Hear rate	138bpm

Mother's vital signs checked were recorded as follows:

Temperature	36.7ºC
Pulse	82bpm
Respiration	20 cpm
Blood Pressure	110/60mmHg

All findings were communicated to Madam Grace and all documentations were done.

4.3 FIRST DAY POSTNATAL (DAY OF DISCHARGE)

The first day after delivery was 11th November 2021. Madam Grace and baby slept soundly during the night and their condition remained satisfactory. Madam Grace woke up looking cheerful and healthy. She was served with warm water to bath at 8:00 am; her vital signs were checked and recorded as follows;

Morning

Temperature	36.3 ^{0}C
Pulse	80 beat per minute
Respiration	20 cpm
Blood pressure	120/80 mmHg

Client was examined from head to toe and no abnormality was detected. The breasts were heavy and colostrum was expressed. The uterus was firm and well contracted. Symphysio-fundal height was 16 cm above the symphysis pubis. Her vulva was inspected, the lochia was dark red in colour, flow was small and it was not offensive.

She was taught and supervised to do postnatal exercises. She was encouraged to keep the perineum clean and to use clean perineal pads to prevent infection. She

was also reminded to wash her hands before and after changing her perineal pad.

The importance of good personal hygiene was explained to her, in order to prevent puerperal sepsis and neonatal infections to the mother and her baby respectively. Exclusive breastfeeding was also encouraged and Madam Grace was advised to top and tail the baby until the cord was off. Hands were washed and dried with dry towel and baby examined from head to toe and no abnormalities were found. The baby was topped and tailed in the presence of the mother and the cord inspected for bleeding or any infection but there was none. Hands were washed and dried, sterile gloves worn and cord dressed with methylated spirit and left it open to dry. Mother was advised not to apply any hot compress or concoction on the cord to prevent infection of the cord. Baby's vital signs were checked and recorded as follows;

Morning

Temperature	36.6^0 C
Apex beat	132 beat per minute
Respiration	44 cycle per minute
Weight	2.9 kg

Baby was immunized with Bacilli Calmette Guerin (BCG) 0.05 mls and oral polio 'O' vaccine, 2 drops in the mouth to protect her against tuberculosis and poliomyelitis respectively.

After this, client was advised not to apply anything at the injection site but to continue the immunizations at the child welfare clinic when the child was six weeks old in order to protect her against the childhood diseases like measles, yellow fever, and pertusis among others. Mother and baby were declared fit by the midwife in-charge after all the examination. Client was informed about the discharge. She was

helped to pack her belongings and the following drugs were prescribed for the mother;

Tablet folic acid - 5mgdly x 14 days

Tablet Fersolate - 200bd x 14 days

Tablet Flagyl (Metronidazole) - 400mgtds x 7 days

Tablet paracetamol - 1gtds x 5 days

Capsule Amoxicillin - 500mgtds x 7 days

The drugs and dosages were explained to her and the need to take the drugs was stressed. Her NHIS card was used to settle her bills.

Madam Grace was advised on the importance of keeping the baby's cord clean and dry and to avoid the application of concoctions or unprescribed medications on it. She was educated on the importance of reporting to the clinic anytime they noticed danger signs like bleeding from the cord, offensive odour from the cord or high temperature of the baby.

Client was also educated to avoid applying hot water on the baby's fontanels and sutures. In order to prevent nappy rashes, she was advised to change the baby's napkins whenever soiled and also apply baby's oil on the buttocks.

Madam Grace was encouraged to sleep in mosquito net together with the baby to prevent malaria and advised to breastfeed the baby on demand. Her husband was also encouraged to help his wife to take care of the baby. Client was encouraged to have adequate rest and sleep. Client was reminded of visits to her house to continue the care for seven days. The family was seen off.

4.4 FIRST POSTNATAL HOME VISIT (SECOND DAY POST NATAL)

Madam Grace was visited on 11th November, 2021at 5:00pm with the aim to assess their general conditions and to detect early conditions that could be harmful to their health so as to give immediate treatment or refer to the hospital for further management. She was met at her house. Client had already taken her bath and finished brushing her teeth. Permission was sought to examine the baby. The baby was placed in her cot and head-to-toe examination was done without any problem. The baby was topped and tailed, hands were washed and new sterile gloves were worn, cord was inspected and dressed. The cord was not offensive and was quite dry. According to Madam Grace, her baby passed meconium and urinated. Baby's vital signs checked. Findings were recorded as follows;

BABY

Temperature	36.6 ^{0}C
Apex beat	132 beat per minute
Respiration	32 cycles per minute
Suckling	Good
Cord	Clean and dry
Colour	Pink
Stool	Meconium
Weight	2.9kg

Madam Grace was also examined from head to toe for any abnormality but none were present. The breasts were heavy and full with colostrum expressed. The uterus was well contracted and the Symphysio-fundal height was 15cm during abdominal palpation. She said she wanted to know more about family planning which she was educated on the various family planning methods. The lochia was red (rubra), small in quantity and not offensive. After the examination, all the findings were communicated to her. Vital signs were also checked. Findings were recorded as follows;

MOTHER

Temperature	36.4^0 C
Pulse	84 beat per minute
Respiration	22 cycle per minute
Blood pressure	120/70 mmHg
Breast	Lactating
Uterus	Contracted
SFH	15cm
Lochia	Rubra

Madam Grace was supervised to attach the baby to breast and baby was able to suckle well. Client was encouraged to make sure the baby empties one breast before giving the other breast to prevent engorgement and to make sure the baby takes adequate breast milk. Permission was then sought to leave and promised to visit them the next day.

4.5 SECOND POSTNATAL HOME VISIT (THIRD DAY POSTNATAL)

On the 12th November 2021, Madam Grace and family were visited in the morning and evening at 7:30 am and 4:30pm to access their condition of health. Client complained backache and severe abdominal pains when the baby suckles. She was reassured and encouraged to perform the postnatal exercise; for about ten to twenty minutes and also to continue the postnatal exercises to strengthen the pelvic floor muscles and also advised to breast feed the baby on demand as it helps in contraction thus involution of the uterus.

Client permission was sought to perform physical examination and check her vital signs. The Symphysio-fundal height was 15cm on abdominal palpation. On inspection of the vulva it was healthy and the flow of lochia was small and the colour was rubra. Permission was sought again to examine the baby. The baby was top and tailed and cord examined, it was clean and dry and dressing was done. Baby's vital signs were checked and recorded as ;

Baby	**Morning**	**Evening**
Temperature	36.5^{0}C	36.7^{o}C
Respiration	31 cycle per minute	35 cycle per minute
Apex beat	134 beat per minute	132 beat per minute
Weight	2.8kg	
Suckling	Good	Good
Cord	Clean and dry	Dry and clean
Colour	Pink	Pink
Stool	Meconium	Meconium

Mother's observations were checked and recorded as follows;

Mother	Morning	Evening
Temperature	36.6 ^{0}C	36.8^{o}C
Pulse	80 beat per minute	83 beat per minute
Respiration	20 cycle per minute	21 cycle per minute
Blood pressure	109/70 mmHg	110/60 mmHg
Breast	Lactating	Lactating
Uterus	Contracted	Contracted
SFH	15cm	15cm
Lochia	Rubra	Rubra

All the findings were communicated to the client and her family. Family planning education was reinforced and they promised to use a method after six weeks. They were congratulated for their cooperation and promised to visit the next day.

4.6 THIRD POST NATAL HOME VISIT (FOURTH DAY POST NATAL)

On the 13th November, 2021, at7:30am and 4:30pm. Client was visited again during the morning and evening to continue the care of the baby, the mother and the family. Baby was topped and tailed, cord dressed and the cord was dry and shrinking. Baby was well and suckled well on the breast on observation. She said her baby passed stools and urine. Both baby and mother were assessed and findings were recorded. Mother was also well, breast was lactating, uterus was well contracted and Symphysio- fundal height was measured 14cm. She was asked about her previous complains and she said she was coping.

Findings on both mother and baby were recorded as;

Baby	Morning	Evening
Temperature	36.4^0 C	36.3^0 C
Apex beat	130 beat per minute	133 beat per minute
Respiration	29 cycle per minute	28cycle per minute
Weight	2.7kg	
Suckling	Good	Good
Cord	Clean and dry	Clean and dry
Colour	Pink	Pink
Stool	yellowish	yellowish

Mother	Morning	Evening
Temperature	36.7^0 C	36.9^0C
Pulse	82 beat per minute	86 beat per minute
Respiration	22 cycles per minute	24 cycles per minute
Blood pressure	120/80 mmHg	110/70 mmHg
Breast	Lactating	Lactating
Uterus	Contracted	Contracted
SFH	14cm	14cm
Lochia	Rubra	Rubra

Madam Grace complained of sleeping disturbances as a result of night feeding.

Client was reassured and educated on the various positions she can assume during breastfeeding and also told to feed the baby on demand and to support the breast with a supportive brassier. They were promised to be visited again and thanked before leaving the house.

4.7 FOURTH POST NATAL HOME VISIT (FIFTH DAY POST NATAL)

On the 14th November, 2021, at 8:00am. Client was visited in the morning to continue the care of client and family. Mother and baby were in good condition when inquired but the husband had left for work. She added that the backache was resolving. Baby was topped and tailed, paying attention to the skin folds, cord dressed and the cord was almost off. Baby was well and suckled well on the breast on observation. She said her baby passed stools and urine. Findings after assessment were recorded.

Madam Grace was also assessed after explaining procedure to her and her emptying her bladder. Her Symphysio-fundal height was 13cm. Lochia was inspected and it was pink (serosa) in colour, odourless and small in flow. She was encouraged to do postnatal exercises, eat a well-balanced diet with more fruits and fluids, sleep under insecticide treated mosquito net with the baby to help promote and maintain adequate general health and prevent malaria. They were promised to be visited again and thanked before leaving the house. Findings on both mother and baby were recorded as;

Baby

Temperature	36.8^0 C

Apex beat	132 beat per minute
Respiration	29 cycle per minute
Weight	2.7kg
Suckling	Good
Cord	Almost off
Colour	Pink
Stool	Yellowish

Mother

Temperature	36.4^{0} C
Pulse	70 beat per minute
Respiration	20 cycles per minute
Blood pressure	120/80 mmHg
Breast	Lactating
Uterus	Contracted
SFH	13cm
Lochia	Serosa

4.8 FIFTH POST NATAL HOME VISIT (SIXTH DAY POST NATAL)

On the 15th November, 2021at 8:00am.Client and family were visited; Greetings were exchanged with client and her family after which a seat was offered in Madam

Grace's room. Hands were washed and dried after explanation of procedure. Client also stated that the cord fell off in the morning. The stump of the umbilical cord was cleaned with methylated spirit and left opened. No sign of infection such as redness was noted .Madam Grace complained of sleeping disturbance during physical examination. She was reassured and encouraged to put on a firm brassier and continue to breast feed the baby on demand. She was also encouraged to allow one breast to be emptied before the baby is attached to the other breast. No abnormality was detected on the mother and baby during the general examination except for the mother's breast engorgement. Client's Symphysio-fundal height was 12cm and lochia was serosa without any odour indicating that personal hygiene was maintained.

Findings after assessing both mother and baby were recorded as follows;

Mother

Temperature	36.8^0 C
Pulse	86 beats per minute
Respiration	20 cycles per minute
Blood pressure	110/70 mmHg
Breast	Engorged
Uterus	Contracted
SFH	12cm
Lochia	Serosa

Baby

Temperature	36.9^0 C
Apex beat	134 beat per minute
Respiration	33 cycle per minute
Weight	2.8kg
Suckling	Good
Cord	Off
Colour	Pink
Stool	Yellowish

They were congratulated for their cooperation and permission was sought to leave.

4.9SIXTH POST NATAL HOME VISIT (SEVENTH DAY POST NATAL)

On the 16th November, 2021.At 8:00 am Client and family were visited, hands were washed and dried. Procedure was explained to client after whom she went and emptied her bladder. The baby was examined from head to toe but nothing abnormal was detected in the presence of client .The stump of the umbilical cord was cleaned. The stump was healing nicely. Madam Grace said the breast felt a bit lighter. Baby's weight was checked and was recorded as 2.9kg. No abnormality was detected on the mother and baby during the general examination. Client's Symphysio-fundal

height was 11cm. On inspection, the lochia was creamy brown (Alba) with scanty flow and not offensive. Client was advised to have adequate rest and sleep during the day immediately the baby is asleep. All the findings were communicated to the client and her family. Family planning education was reinforced and she promised to use a method after six weeks.

Findings were recorded as follows;

Mother

Temperature	36.7^{0} C
Pulse	88 beats per minute
Respiration	24 cycles per minute
Blood pressure	120/80 mmHg
Breast	Lactating
Uterus	Contracted
SFH	11cm
Lochia	Alba

Baby

Temperature	36.5^{0}C
Apex beat	134 beat per minute
Respiration	32 cycle per minute
Weight	2.9kg
Suckling	Good

Cord	Off
Colour	Pink
Stool	Yellowish

Permission was sought to leave and client was told the next day was going to be the last visit.

4.10 SEVENTH POST NATAL HOME VISIT (EIGHT DAY POST NATAL)

On the 17th November, 2021 at 8:00 am Madam Grace and family were visited in the morning to access their condition of their health. Client's permission was sought to perform physical examination and vital signs on both mother and baby. The Symphysio-fundal height was 10cm on abdominal palpation. On inspection of the vulva it was clean and neat and the lochia was creamy brown with scanty flow and not offensive. The baby was examined and stump was clean and dry and dressing was done. Findings were recorded as follows;

Baby

Temperature	$36.9^{0}C$
Respiration	30 cycle per minute
Apex beat	134 beat per minute
Weight	3.0kg
Suckling	Good
Cord	Off
Colour	Pink

Stool	Yellowish

Mother

Temperature	$36.7^{0}C$
Pulse	80 beat per minute
Respiration	22 cycle per minute
Blood pressure	110/70 mmHg
Breast	Lactating
Uterus	Contracted
SFH	10cm
Lochia	Alba

All the findings were communicated to the client and her family. They were congratulated for their cooperation and told it was the last home visit. Madam Grace was reminded of her first postnatal visit to the clinic which fell on the 18th November, 2021. The need for registration of the child at the Births and Deaths Registry was emphasized. Client was encouraged not to hesitate to visit the clinic anytime she has any health problem before the date of appointment. Client complaints of constipation and she was encourage to eat enough roughage like vegetables and fruits. Client was advised to continue with exclusive breastfeeding of the baby for six months

Client's husband was encouraged to assist her in the household duties and caring of the baby to ensure adequate rest and sleep. The need for personal and environmental hygiene was stressed on and Madam Grace and family were thanked

for their co-operation and support. Permission was sought to leave.

4.11 FIRST POSTNATAL VISIT TO THE CLINIC

Madam Grace and her baby arrived at the clinic at 8:30 am for postnatal care on the 18th November, 2021 accompanied by her husband and her sister. Client was neatly dressed and looked cheerful. They were welcome and given a comfortable seat. Health educations on nutrition, immunization against preventable childhood diseases and family planning as well as care of the baby were given. Client was asked about her condition and that of the baby and client said they were doing well .Madam Grace said her baby was able to feed well and slept well. Madam Grace also confirmed that baby passed urine and stools regularly.

Permission was sought to examine the baby generally. The baby was taken and undressed and then wrapped with a clean cot sheet and placed on a flat surface for the examination in the presence of the mother. Baby's weight was 3.0kg. There were no discharges from the eyes, nose and ears. No discolouration of the mucus membranes, palms, eyes, conjunctiva and feet were observed during inspection. Baby's abdomen was not distended and the umbilical stump was completely healed. The baby's vital signs were checked and recorded as follows;

Temperature - 36.5^{0} C

Apex beat - 132 beat per minute

Respiration - 30 cycle per minute

The baby was neatly wrapped before she was given back to the clients' sister. The findings were communicated to the mother and thanked for the care. Madam Grace was advised to dress the baby with light clothes so as to prevent the rashes on the baby's skin.

Madam Grace was examined and her vital signs were recorded as follows;

Temperature	-	36.6 ^{0}C
Pulse	-	82 beat per minute
Respiration	-	20 cycle per minute
Blood pressure	-	120/80 mmHg

Permission was sought from to examine client from head to toe. The procedure was explained and she was asked to empty her bladder and midstream sample tested negative for protein and glucose. Privacy was provided after which hands were washed and dried and examination was commenced.

On inspection, it was observed that the conjunctiva was not pale, the nose was not discharging. The breasts were soft with no cracks or sore on the nipples. There was also no abdominal tenderness and the uterus was 6cm palpable. There was no drainage of Lochia on inspection. After that findings were communicated to her. Madam Grace was advised to ensure that the baby completes the immunization schedule. She was reminded of her second postnatal visit to the clinic. Baby was registered at the Births and Deaths Registry and client was handed over to the midwife in-charge for continuity of care. Madam Grace and her entire family were thanked for their co-operation and Support throughout this Study.

4.12 SECOND POST-NATAL VISIT TO THE CLINIC

Report from the midwife in-charge indicated that, client came to the clinic for six weeks postnatal visit on the 23rd December, 2021. They were warmly welcome and they all looked very healthy. General examination was conducted from head to toe as well as vital signs after her permission was sought. Her vital signs were checked and recorded as follows:

Temperature	36.4ºC
Pulse	78bpm
Respiration	20cpm
Blood Pressure	110/70mmHg

The under listed Laboratory investigations were carried out and recorded as:

Haemglobin	12.2 g/dL
Urine protein	Negative
Glucose	Negative

Head to toe examination was done on her with no abnormalities detected. She had not resumed her menses when asked. She was educated on the need to start a family planning method to prevent unwanted pregnancy.

Her baby was also examined from head to toe and no abnormalities were detected. On the head, the anterior fontanelle was palpated for pulsation and it was normal. The posterior fontanelle had closed. Vital signs were checked and recorded as

follows

Temperature 36.2ºC

Respiration 34cpm

Apex heart beat 134bpm

Weight 4.0kg

Madam Grace and her baby were handed over to the child welfare clinic and family planning unit for the six weeks immunization against diphtheria, pertussis, tetanus, haemophilus influenza and hepatitis B.

Client was encouraged to ask questions but she had none and made no complaints either. She was reminded on exclusive breastfeeding, rest and sleep, exercise and nutritious diet, which would help in lactation. She was finally referred to the public health nurse for continuity of care but report to the facility anytime she encounters any health related problem. She was thanked for her co-operation and understanding.

4.13 NURSING CARE PLAN DURING PUERPERIUM

PROBLEMS IDENTIFIED

1. 12/11/2021 Lack of knowledge on family planning methods.

2. 14/11/2021 Backache.

3. 15/11/2021 Sleeping disturbances.
4. 16/11/2021 after pains.
5. 17/11/2021 Constipation.

SHORT TERM OBJECTIVES

1. Client will gain adequate knowledge on family planning method within 2 hours.
2. Client's backache will reduce within 24 hours.
3. Client will have at least six hours sleep within 24 hours
4. Client's after pain will reduce within 24 hours.
5. Client will regain her normal bowel movement within 48hours

LONG TERM OBJECTIVES

Mother and baby will get a safe puerperium without any complication.

NURSING CARE PLAN

DATE/ STIME	NURSING DIAGNOSIS	NURSING OBJECTIVES/OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/TIME	EVALUATION	SIGN
12/11/2021 @8:00 am	Knowledge deficit on family planning methods related to inadequate information	Client will gain adequate knowledge on family planning methods within 2 hours as evidenced by 1.Client verbalizing that she will make a choice. 2. Client husband verbalizing the important of family planning	1. Reassure client 2. Educate client on family planning method. 3. Introduce client to different types of family planning methods and help her choose one. 4. Encourage client to practice family planning method. 5. Encourage client to ask questions	1. Client was reassured 2. Client was educated on family planning method during the puerperium 3. Client was introduce to the different types of family planning methods and was helped to choose one. 4. Client was encouraged to practice family planning method. 5. Client was encouraged to ask questions	13/11/21 10:00am	Goal was fully met as evidenced by client willingness to choose a method.	YE

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES/OUT COMECRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATIN	SIGN
14/11/2021 8:00 am	Backache related to poor feeding and sitting position	Client's backache will reduce within 24 hours as evidenced by client verbalizing a reduction of pain. 2.Mediwife observing that client ensure good posturing during breastfeeding	1. Reassure client. 2. Explain the causes of the backache to client. 3. Educate client on the proper use of body mechanics and good posture. 4. Educate client to assume correct position during breastfeeding	1. Client was reassured that pain will resolve 2. The causes of the backache were explained to client. 3. Client was educated on the proper use of body mechanics and good posturing. 4. Client was educated to straight with back supported when feeding baby. 5. Client was educated to bend from knees during household	15/11/2021 at 8:00am	Goal was fully met as client verbalized a reduced of backache.	YE

			5. Educate client not to bend down during household chores.	chores.				

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES/OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/TIME	EVALUATION	SIGN
15/11/ 2021 8:00	Sleep disturbance related	Client will have at least six hours sleep within 24	1. Reassure client. 2. Advice client to change baby's diaper	1. Client was reassured that adequate measures will be put in place to promote sleep.	16/11/ 2021 at	Goal was fully met as client	YE

am	to breastfeeding of baby at night	hours as evidenced by 1. Client verbalizing that she was able to sleep adequately 2.Client husband verbalizing that client had enough sleep	when wet before bed time. 3. Explain the importance of feeding on demand. 4. Explain the need for frequent night feeds. 5. Encourage family support.	2. Client was advised to change baby's diapers whenever wet 3. The importance of feeding baby on demand was explained to her. 4. The needs for frequent feeds at night of baby was explained to mother 5. Husband and sister were encouraged to support client.	1:00 pm	said she had adequate sleep.	

DATE/ TIME	**NURSING DIAGNOSIS**	**NURSING OBJECTIVES/OUTCOME CRITERIA**	**NURSING ORDERS**	**NURSING INTERVENTION**	**DATE/ TIME**	**EVALUATION**	**SIGN**
16/11/2021 7:30 am	After pains related to	Client's after pain will reduce	1. Reassure client. 2. Explain the cause	1. Client was reassured that pain will resolve	17/11/2021	Goal was fully met as	

	uterine contraction	within 24 hours as evidenced by 1.Client verbalizing a reduction in pain 2. Midwife met client in good condition	of pain to allay anxiety 3. Encourage client to void regularly. 4. Encourage client to feed baby on demand. 5. Serve analgesics as prescribed.	2. She was told it was due to contraction of the uterus that will enhance involution 3. Client was encouraged to urinate at least every two hours. 4. Client was encouraged to feed baby at least every 2 to 3 hours or frequently as demanded by baby. 5. Client was served with paracetamol as prescribed.	7:30 am	client verbalized a reduction in pain.	YE

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
17/11/2021 10:00 am	Constipation related to	Client will regain her	1. Reassure client.	1. Client was reassured that she will empty her bowels freely.	19/11/2021 10:00	Goal was met as client said	

	low fibre and fluid intake	normal bowel movement within 48hours as evidenced by 1.Client verbalizing that she has been able to empty her bowel freely. 2.Client sister verbalizing that client was able to empty her bowel freely	2. Explain the physiology of constipation to her. 3. Educate client to eat enough roughage like vegetables and fruits. 4. Encourage the intake of fluids. 5. Encourage her to respond to urge of emptying the bowel to avoid reabsorption of water from the stools	2. She was told it was due to the effect of progesterone on her gut. 3. Client was advised to eat enough roughage like fruits and vegetables. 4. Client was encouraged to take at least 2000mls of fluids everyday which is equivalent to four sachets of pure water. 5. Client was also encouraged to respond to urge of emptying her bowel to avoid reabsorption of water from stools.	am	she moved her bowel freely.	YE

SUMMARY AND CONCLUSION

This script is a family centered maternity care given to Madam Grace, a 26 year old gravid 2 Para 1 alive. She comes from Dormaa- Ahenkro and lives at Wamanafo. She was first met at the Antenatal clinic on the 27th October, 2021 at St. Mathew's Clinic Ampenkro, when she was 37 weeks pregnant .Various observations and examination including laboratory investigations were carried out to aid in the progress of normal pregnancy.

She experienced some minor disorders which were managed successfully. Madam Grace's labour and delivery were carefully managed without any complications and she had spontaneous vaginal delivery to an alive female infant who weighed 2.9kg on the 10th November, 2021, at St. Mathew's Clinic Ampenkro.

During this period, all complaints were taken into consideration and managed with the use of nursing process. No complications arose and goals set were achieved. She went through puerperium successfully where both mother and baby were finally handed over to the Midwife in charge of St. Mathew's Clinic on the 23ed November, 2021, for continuity of care.

This family centered maternity care given to Madam Grace has enabled me gain much experience about the importance of proper client management during pregnancy, labour and puerperium. It has also helped me to improve my skills as a student midwife in planning, interviewing, implementing, setting objectives and evaluating them to solve client's problem identified. As a result I will be able to give quality care to every woman who comes under my care.

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Tindal.

TABLE D

PHARMACOLOGY OF DRUGS

DRUG	CLASSIFICA-TION	DOSAGE OF DRUG	ROUTE	ACTION AND USES	SIDE EFFECTS OF DRUGS	REMARKS
Tablet Fersolate	Vitamin preparation	200 mg daily X 30 days	Oral	1. Helps in the formation of red blood cells. 2. Supplement the iron of the body. 3. Used in the treatment of iron deficiency anaemia.	1. Gastro intestinal upset and black tarry stool. 2.Nausea	1. Haemoglobin level increased. 2. Black tarry stool noticed.
Tablet Folic Acid.	Vitamin preparation	500 mg daily x 30 days	Oral	1. Helps in the formation of red blood cells. 2. Prevents neural tube defect. 3. Treatment for iron deficiency anaemia.	1. Gastro intestinal upset. 2. Nausea.	1. Haemoglobin level increased. 2. No reactions observed.
Tablet Multivite	Vitamin preparation	5 mg 2 daily x 14 days	Oral	1. Improvement of appetite. 2. Helps in red blood cell and bone tissue formation.	Nausea and vomiting.	No reaction observed

Tablet Vitamin B Complex	Vitamin preparation	200 mg 3 x daily x 7 days	Oral	Helps in metabolism of carbohydrate, protein and fat.	Abdominal discomfort.	No reaction.
DRUG	**CLASSIFICA-TION**	**DOSAGE OF DRUG**	**ROUTE**	**ACTION AND USES**	**SIDE EFFECTS OF DRUGS**	**REMARKS**
Tablet metronidazole	Anti protozoa	400 mg 3 x daily x 5 days.	Oral	Treatment of infection.	Gastrointestinal upset.	No reactions observed.
Tablet paracetamol	Anti pyretic and analgesic.	400 mg x 3 daily x 5 days.	Oral	1. Alleviates pain. 2. Reduce body temperature.	Prolong usage may damage the liver.	No reactions observed.
Injection Oxytocin	Oxytoxic drug	5 – 10 units	Intramus cular on the thigh.	Stimulates uterine contractions, controls bleeding, used for induction and augmentation of labour.	Uterine rupture if overdose is given. Nausea and vomiting.	None observed.

Tablet Sulphadoxine pyrimethamine-ne	Antimalaria	3 tablets stat at 16 weeks or quickening, repeat every 4 weeks till delivery	Oral	1. Therapeutic and prophylactic actions against malaria. 2.Attacks different stages of development of the malaria parasites 3. Maintains cidal serum	Vomiting, nausea, drowsiness and stomachache	None observed

PHARMACOLOGY OF DRUGS FOR THE BABY

NAME OF DRUG	CLASSIFICATION	DOSAGE	ROUTE	ACTION AND USES	ACTUAL EFFECT	SIDE EFFECT	SIDE EFFECT EXPERIENCED
Vitamin K	Antihaemorrh-agic vitamin.	0.5 – 1 mg	Intramuscular	1. Help in clotting of blood. 2.Helps to prevent haemorrhagic disease of newborn	Flashes of the face.	No side effect was observed.	Vitamin K
Chloramphenicol eye drop	Antibiotics	2-3drops	Instillation	To prevent eye infection	Eye was not infected	Increase risk of aplastic	No side effect observed

						anaemia	
Injection BaccillusCalmette Guerin (BCG)	Vaccine	0.05 mls	Intramuscular on the right upper arm.	Stimulate production of antibodies against tuberculosis	Small pustule which persist for some weeks and rise in temperature.	Blister observed.	None observed
Polio vaccine	Antigen	2 drops	Oral	Production of antibodies to prevent poliomyelitis	Under observation	There may be diarrhea	None observed

PHARMACOLOGY OF DRUGS FOR THE BABY CONTINUED

NAME OF DRUG	CLASSIFICATION	DOSAGE	ROUTE	ACTION AND USES	ACTUAL EFFECT	SIDE EFFECT	SIDE EFFECT EXPERIENCED
Pneumococcal 1	Antigen	0.5 ml	Intramuscular right thigh	Vaccinates neonate against pneumonia	Under observation	Redness at the sight of injection and fever.	None observed

Pentavalent 1 (5 in 1)	Antigen	0.5 ml	Intramuscular left thigh	Vaccinates neonate against diphtheria, pertussis (whooping cough), tetanus, hepatitis B, heamophilus influenza B	Under observation	Low grade fever	None observed
Rotavirus 1	Antigen	1.5 mls	Oral	Prevention of gastroenteritis	Under observation	None	None

APPENDIX II

Table F

LABORATORY INVESTIGATION

DATE	SPECIMEN	INVESTIGATION TYPE	FINDINGS	REMARK
17/06/2021	Blood	Groupings	(O)+	Normal
		Rhesus factor	(D) positive	Normal
		Haemoglobin level (Hb)	11.8 g/dl	Normal
		Hepatitis B (HBsAg)	Negative	Normal
		Sickling	Negative	Normal
		VDRL	Non-reactive	Normal

		Glucose 6 phosphate dehydrogenase (G6PD)	No defect	Normal
		HIV Status	Negative	Normal
	Urine	Protein	Negative	Normal
		Glucose	Negative	Normal
	Stool	Worm infestation	Negative	Normal
13/7/2021	Urine	Protein/glucose	Negative/negative	Normal
29/9/2021	Urine	Protein/glucose	Negative/negative	Normal

Date	Specimen	Investigation type	Findings	Remark
27/10/2021	Urine	Protein/glucose	Negative/negative	Normal
27/10/2021	Urine	Protein/glucose	Negative/negative	Normal
15/10/2021	Blood	Haemoglobin level (HB)	11 g/dl	Normal
		Hepatitis B (HBsAg)	None reactive	Normal
		PMTCT	None reactive	Normal
	Urine	Protein /glucose	Negative /negative	Normal

11/08/2021	Blood	Haemoglobin level	10.9 g/dl	Low
	Urine	Protein /glucose	Negative /negative	Normal
12//08/2021	Blood	Haemoglobin level	11.6 g/dl	Normal
	Urine	Protein /glucose	Negative /negative	Normal

APPENDIX III

ANTENATAL PROGRESS

Table E

Date	Temperature (°c)	WT (Kg)	BP. (mmHg)	Urine Protein / Glucose	Gestational Age in Weeks	Fundal height (CM)	Presentation	Descent	Fetal Heart Rate (Bpm)	Routine Medication	Complain, Treatment and Advise	Name & signature
17/06/2021	36.3	70	110/60	Negative / Negative	20	17	_	_	_	1st SP given and Routine drugs x30 days	No complains.	

14/07/2021	36.5	71	100/60	Negative / Negative	24	20	_	_	Present	2nd SP given and Routine drugs x30 days	No complains.	
11/08/2021	36.0	70	100/60	Negative / Negative	28	26	_	_	Present	3rd SP given and Routine drugs x30 days	No complains.	
15/09/2021	36.6	76	110/60	Negative / Negative	32	30	_	_	Present	Routine drugs x14 days	No complains.	

<table>
<tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>29/09/ 2021</td><td>37.0</td><td>76</td><td>100/70</td><td>Negative
Negative</td><td>34</td><td>32</td><td>Cephalic</td><td>5/5th</td><td>Present</td><td>Routine drugs x14 days</td><td>Leg cremps</td><td></td></tr>
<tr><td>15/10/ 2021</td><td>36.6</td><td>78</td><td>110/70</td><td>Negative
Negative</td><td>36</td><td>33</td><td>_</td><td>5/5th</td><td>137</td><td>4th SP given and Routine drugs x7 days</td><td>No complains.</td><td></td></tr>
<tr><td>Date</td><td>Temperature (°c)</td><td>WT (Kg)</td><td>BP. (mmHg)</td><td>Urine</td><td>Gestational Age in Weeks</td><td>Fundal height (CM)</td><td>Presentation</td><td>Descent</td><td>Fetal Heart Rate (Bpm)</td><td>Routine Medication</td><td>Complain, Treatment and Advise</td><td>Name & signature</td></tr>
</table>

27/10/2021	36.1	76	98/70	Negative / Negative	37	35	Cephalic	5/5th	136	5th SP given and Routine drugs x7 days	Headache	
02/11/2021	36.0	79	110/80	Negative / Negative	38	35	Cephalic	5/5th	141	Routine drugs x7 days	Backache	
09/11/2021	35.7^{0}c	82	110/70	Negative / Negative	39	37	Cephalic	5/5th	146	continue routine drugs	constipation	

INSECTICIDE T+REATED NET (ITN)			DATE SUPPLIED …………………………………………….			
INTERMITTENT PREVENTIVE TREATMENT (IPT) FOR	1ST DOSE SP*3TABS DIRECTELY OBSERVED	GESTATIONAL AGE IN WEEKS	2ND DOSE (1 MONTH) AFTER 1ST DOSE DIRECTELY	GESTATIONAL AGE IN WEEKS	3RD DOSE (1 MONTH) AFTER 2ND DOSE DIRECTELY	GESTATIONAL AGE IN WEEKS

MALARIA	TGHERAPY 17/06/2021	20weeks	OBSERVED TGHERAPY 14/07/2021	24 weeks	OBSERVED TGHERAPY 11/08/2021	28weeks

TETANUS IMMUNISATION	PREVIOUS TT		CURRENT TT	
	Ye[ ]	✔[ ] NO	DATE…………………….	DATE……………………………………

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

15/09/2021 4th dose of SP was taken at 32 weeks

27/10/2021 5th dose of SP was taken at 37 weeks.

SIGNATORIES

STUDENT'S MIDWIFE

NAME: YEBOAA ESTHER

SIGNATURE……………………………………

DATE: …………………………………….

THE MIDWIFE-INCARGE

NAME: MAD. IRENE AKOTO

DATE……………………………………………

SIGNATURE……………………………………

THE SUPERVISOR

NAME: MS. CELESTINE AHIAWORNU

SIGNATURE……………………………………

DATE……………………………………………

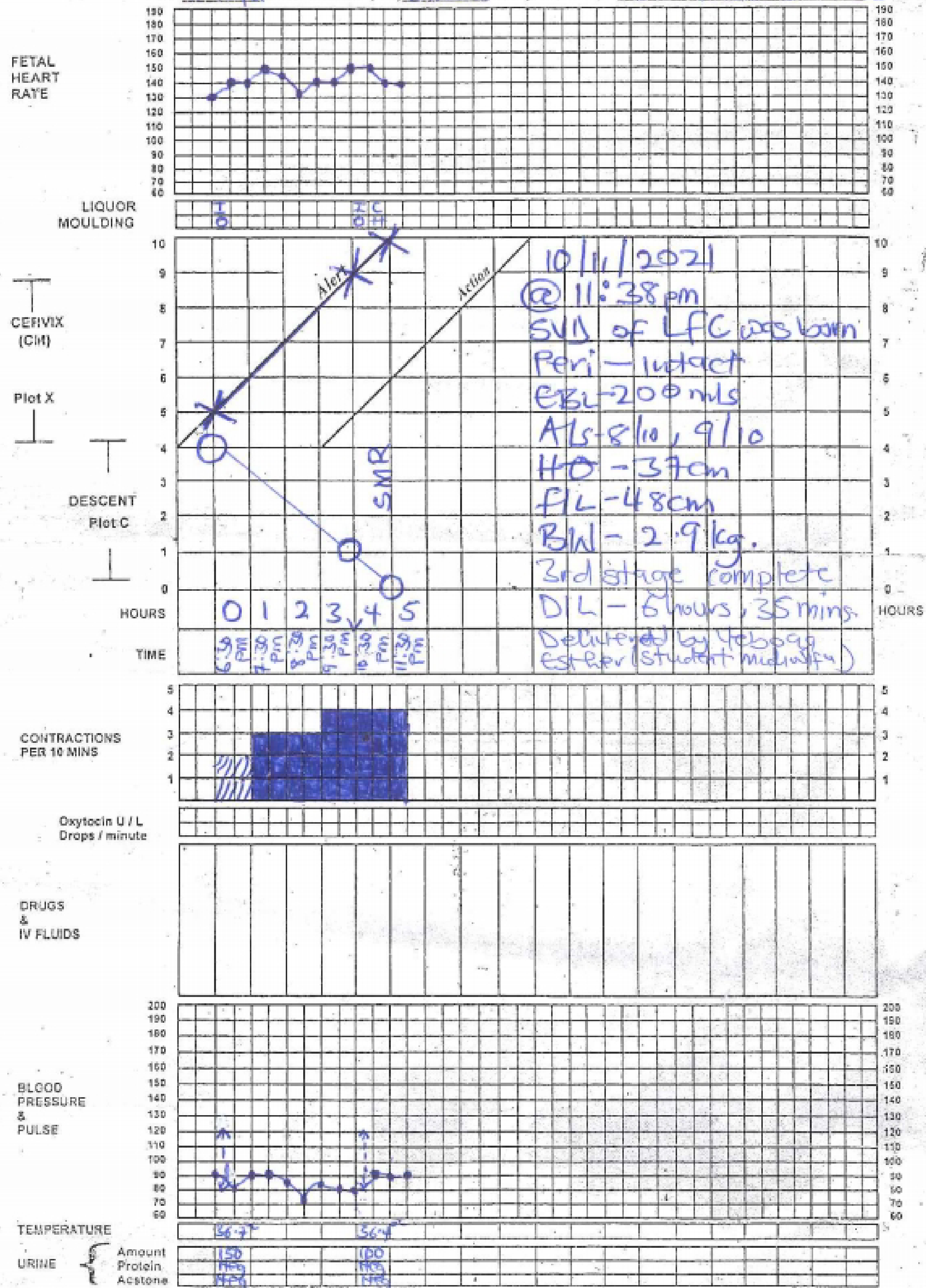
THE PRINCIPAL

NAME: MONICA NKRUMAH

SIGNATURE……………………………………

DATE……………………………………………

WHO Modified Partograph



Registration No.: 174/21 Name(Last, First) Yeboah Grace Age: 26years
Date: 10/11/21 Parity/Gravida 1, 2 LMP EDD Gestation(wks) 39 weeks
ROM: 11:12pm Labour Duration (Hrs) 6h, 35mins Facility/Clinic Name St. Mattiew's clinic

FETAL HEART RATE

LIQUOR
MOULDING

CERVIX (CM)
Plot X

DESCENT
Plot C

HOURS 0 1 2 3 4 5

TIME

Alert
Action

10/11/2021
@ 11:38pm
SVD of LFC was born
Peri – intact
EBL – 200mls
A/S – 8/10, 9/10
HC – 37cm
FL – 48cm
BW – 2.9kg.
3rd stage complete
D/L – 6 hours, 35 mins.
Delivered by Yeboah Esther (student midwife)

CONTRACTIONS PER 10 MINS

Oxytocin U / L
Drops / minute

DRUGS & IV FLUIDS

BLOOD PRESSURE & PULSE

TEMPERATURE 36.7°C 36.4°C

URINE Amount / Protein / Acetone: 150 Neg Neg; 100 Neg Neg

2

LABOR NOTES

Client G2 P1 at 11:38pm had spontaneous vaginal delivery to a live female infant at 11:38pm with Apgar score 8/10 for the first minute and 9/10 for the fifth minutes, third stage was completed by control cord traction and estimated blood loss was 200mls, skin-to-skin contact initiated for 30minutes. Cord and eye care done injection vitamin K given intramuscularly. Post delivery vital signs checked and recorded as BP-120/80mmHg, Temp-36.6, Pulse-56bpm, Respiration-20cpm. Both mother and baby are in good condition. Monitoring still ongoing.

Please circle or write responses.

DELIVERY

DATE: 10/11/2021 TIME: 11:38pm METHOD: (Spontaneous) / Vacuum Extraction / C/S / Other

PERINEUM: (Intact) / Episiotomy / Laceration

ANESTHESIA: (None) / Local / General

THIRD STAGE

Active Management: (Yes) / No   Medication: Time______ Type/Dose 10units of inj oxytocin

PLACENTA: TIME: 11:43pm (Complete) / Incomplete

BLOOD LOSS AMOUNT: 200mls (Small (Less than 250 cc))
Moderate (250-499 cc)
Large (more than 500 cc)
Significant for mother

BABY

Weight: 2.9kg

Sex: Male / (Female)

Baby Position: (Vertex) / Breech / Other

APGAR

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

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

	Frequency	Time	B/P.	Pulse	Fundus	Bleeding	Bladder
FOURTH STAGE MONITORING	Every 15 minutes first 2 hours	12:00am	120/80	56	17	Small	150mls
		12:15am	109/70	74	contracted	small	
		12:30am	110/70	89	well contracted	no bleeding	—
		12:45	119/80	70	well contracted	no bleeding	
		1:00am	101/60	64	well contracted	no bleeding	100mls
		1:15am	100/60	78	contracted	no bleeding	
		1:30am	118/60	80	contracted	no bleeding	—
		1:45am	120/80	75	contracted	no bleeding	
	Every 30 minutes For 1 hour	2:15am	110/70	83	contracted	no bleeding	100mls.
		2:45am	117/70	87	contracted	no bleeding	

Birth Attendant Yeboaa Esther assisted By Lydia Asubonteng (The midwife in-charge). Date 10/11/2021

LSS 4th Edition external review draft - © ACNM (to be published 2008)

MATERNITY CHART

NAME: Mad Grace Yeboah

AGE: 26 years WARD:

IP NO.: BED NO.:

Date	10/11/21	11/11/21	12/11/21	13/11/21	14/11/21	15/11/21	16/11/21	17/11/21
Days in Hospital	DD	D1	D2	D3	D4	D5	D6	D7
Days P. Q.								
Hour am		8:00	7:30	7:30	8:00	8:00	8:00	8:00
Hour pm	11:30							

Temperature

C F

→ Symphysis fundal height

→ Temperature scale Own limit

Pulse		[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Resp.		[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
B.M.	Passed	Passed	Passed	Passed	Passed	Passed	Passed	Passed
Urine	Passed	Passed	Passed	Passed	Passed	Passed	Passed	Passed
B.P.		120/90	120/70	109/70	120/80	120/80	110/70	110/70
	110/80							

NEW BORN EXAMINATION FORM

Name: Baby Akua Yeboah Date of Assessment: 10|11|2021 Time: 11:45pm
Date of Birth: 18|11|21 Time of Birth: 11:35 pm Sex: [ ] M [✓] F Age at time of Assessment (days/hrs) 1 hour
Astational Age [ ] 39 wks [ ] Mode of Delivery: [✓] Vaginal Assisted Vaginal C-Section
APGAR: 1min 8/10 5min [ ] 9/10 Birth Weight: [ ] 2.9 kg [ ] Length: 48 cm Head Circumference: 37 cm
Temperature at time of Assessment: 36.2 °C Urine passed: Yes No Meconium passed: Yes No
Name of Assessor (Midwife/Doctor): Yeboah Esther

1. Respiration
Rate 40
[ ] 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: 130
[✓] Normal (100-160)
[ ] <100 *
[ ] >160*

19. Femoral pulse
[✓] Present
[ ] Not palpable*

20. Abdomen
[✓] Normal
[ ] Distended*
[ ] Scarphoid*
[ ] Abdominal defect*
[ ] Maases: ____
[ ] Other ____

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

22. Limbs
[✓] Normal
[ ] Abnormal ____

23. Genitalia
Male Genitalia
[ ] Normal
[ ] Undescended testes
[ ] Abnormal meatus
[ ] Hernia
[ ] Other: ____

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

24. Anus
[✓] Patent
[ ] Imperforate*

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

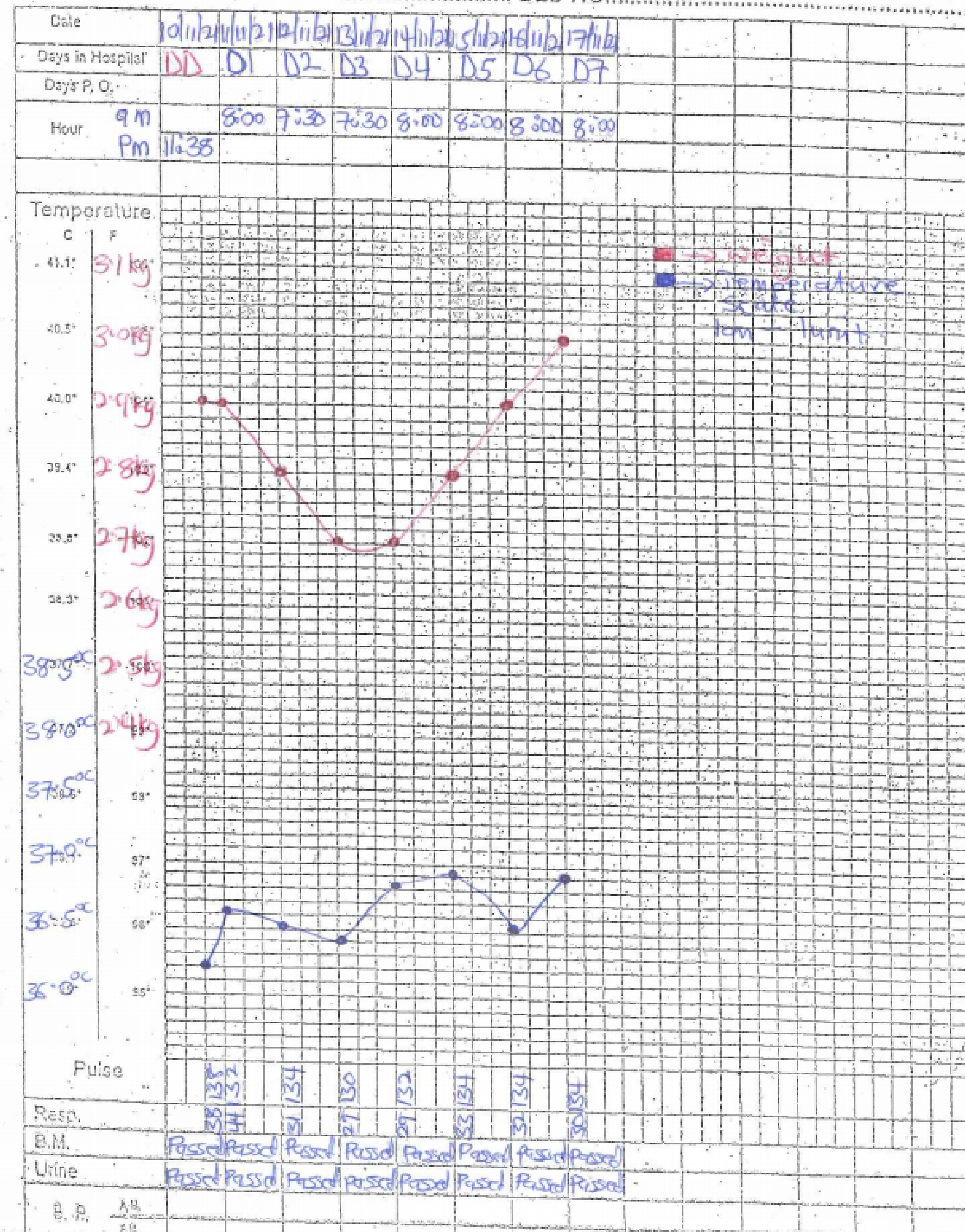
26. Services provided
[✓] Vitamin K1 given
[✓] Eye care provided
[✓] Cord care provided
[✓] Breastfeeding initiated
[✓] Breastfeeding established
[✓] Immunization (BCG/Polio)
[✓] BCG [✓] Polio Immunization
[✓] Antibiotics in mother
[ ] Antenatal corticosteroids

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

Diagnoses (if known) Term baby

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

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



TEMPERATURE CHART

NAME: Baby Akua Yeboah

AGE: Newborn WARD: Lying-Inn

IP NO.: BED NO.:

Date	10/11/21	11/11/21	12/11/21	13/11/21	14/11/21	15/11/21	16/11/21	17/11/21
Days in Hospital	DD	D1	D2	D3	D4	D5	D6	D7
Days P. O.								
Hour am		8:00	7:30	7:30	8:00	8:00	8:00	8:00
Hour pm	11:38							
Pulse	133	133	134	130	132	134	134	134
Resp.	38	47	31	27	29	33	32	30
B.M.	Passed	Passed	Passed	Passed	Passed	Passed	Passed	Passed
Urine	Passed	Passed	Passed	Passed	Passed	Passed	Passed	Passed
B. P. AM / PM								

NEW BORN CHART

Name: Baby Akua Yeboah No. .... Birth Weight 2.9 kg

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

Nature of Delivery Spontaneous Vaginal Delivery Diagnosis Term Baby.

Date of Birth 10th November, 2021 Time 11:38 pm Date of Discharge ....

Date	10/11/21		11/11/21		12/11/21		13/11/21		14/11/21		15/11/21		16/11/21		17/11/21							
No. of Days	DD		D1		D2		D3		D4		D5		D6		D7							
Weight	2.9kg		2.9kg		2.8kg		2.7kg		2.7kg		2.8kg		2.9kg		3.0kg							
	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	P
Temperature		36.2°C	36.6°C	36.6°C	36.5°C	36.7°C	36.4°C	36.3°C	36.8°C		36.9°C		36.5°C		36.9°C							
Stools		Passed	Passed	Passed	Passed	Passed	Passed	Passed	Passed		Passed		Passed		Passed							
Urine		Passed	Passed	Passed	Passed	Passed	Passed	Passed	Passed		Passed		Passed		Passed							

Remarks

Head
Neck
Trunk
Genitalia
Limbs

NAD

SIGNATORIES

STUDENT'S MIDWIFE

NAME: YEBOAA ESTHER

SIGNATURE...

DATE: 28/09/2022

THE MIDWIFE-INCARGE

NAME: MAD. IRENE AKOTO

DATE 29/09/2022

SIGNATURE...

THE SUPERVISOR

NAME: MS. CELESTINE AHIAWORNU

SIGNATURE...

DATE 28/09/2022

THE PRINCIPAL

NAME: MONICA NKRUMAH

SIGNATURE...

DATE 30th September, 2022.

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