HOLY FAMILY NURSING AND MIDWIFERY TRAINING COLLEGE,

BEREKUM

A CLIENT/FAMILY CENTERED MATERNITY CARE STUDY

ON

MADAM ISSAKA RASHIDA

BY

TANG BAYELE SANDRA

4122220147

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

(DIPLOMA)

TABLE OF CONTENT

PREFACE

Client/Family centered maternity care study is a systematic way of administering midwifery care to a pregnant woman and her family throughout pregnancy, labour and puerperium. The Client/ Family Centered Maternity care study also helps the student midwife to use new trends in midwifery like the partograph which is recommended and tested by the World Health Organization (WHO) in the management of labour. The active management of third stage of labour was also introduced to limit the occurrences of postpartum hemorrhage. The Client/Family centered maternity care study helps the student midwife to put into practice the Safe Motherhood initiative which has been adopted in order to help reduce the maternal mortality among pregnant women to improve the quality of health care through antenatal, labour and postnatal periods. The Client/Family centered care study is a required study that every final year student of Registered Midwifery programme is supposed to undertake to satisfy the Nursing and Midwifery Council to help contribute to the award of professional certificate in Registered Midwifery. To achieve these aims, the client, family and the community are all involved in the preparation towards the newborn. It is also necessary to establish good rapport, use a holistic care approach so that client's problems and minor disorders are solved through education, counseling and early measures taken to prevent complication. .

ACKNOWLEDGEMENT

To the almighty God, giver of life, knowledge, wisdom and understanding all glory, honor and praises are unto his name for the success of this care study. I would like to express my indebtedness to the Principal, Miss Monica Nkrumah for granting me such an opportunity, the tutors and staffs of Holy Family Nursing and Midwifery Training College Berekum for their support throughout my three years studies in the college. My profound gratitude also goes to my supervisor Mrs. Monica Boakye for her time, knowledge and support given to me. I would also express my appreciation to Madam Issaka Rashida the client I chose and her families for their acceptance and humble cooperation to make this care study a success. May the almighty God protect and bless them all. I thank the midwife in charge of Amantin Health Center Ms. Jennifer Ayambire and midwife Kate Authur for always being there for me throughout my care study and her concern, Miss Margaret Awoonor,, Miss Regina Adjei and to all the health team members at Amantin Health Center, for various support and encouragement towards the success. Special thanks to Rev Fr. Richard Baatabe and my lovely mother Mrs. Diana Nyarko for their hard work and the investment of their money in my education up to this level, to my sweet brother Tang Hillary Derry also for the motivation and encouragement, and special thanks to Mr. Ibrahim Alhassan for his hard work and support and also to all my relatives for their prayers and numerous advice, God bless you all. My sincere gratitude goes to authors and publishers of the various books used as references. To all who contributed in diverse ways, may the Almighty God richly bless them.

INTRODUCTION

The family centered maternity care study is a study about the nursing care given to the expectant mother, her unborn baby and her family as well. The student midwife puts into practice knowledge acquired in the classroom to care for the pregnant woman and her family in solving any identified problem in the course of the interaction throughout pregnancy, labour and puerperium

The Client/ Family centered maternity care study was carried out on Madam Issaka Rashida, a 24-year-old, Gravida 2 Para 1A ,Her gestational age was 37 weeks and 3 days pregnant who was nursed during the community midwifery practical experience at Amantin Health, during pregnancy, labour and puerperium. Madam Rashida was first met on the 14th August, 2023 when she came for antenatal follow up. She was in good health. Introduction was made to client and permission was sought if she could be used for the study which she accepted without reluctance. She was visited at home to assess her environment and community in which she lives. For the purpose of this study, Madam Rashida will be used throughout the study. Madam Rashida's problems identified during pregnancy, labour and puerperium were managed by the use of the nursing process. She delivered a healthy baby boy safely and managed properly during puerperium without any complication.

There are four (4) chapters outlined in this script that helped in caring for the mother and the baby.

Chapter One talks about client's particulars and various histories.

Chapter Two; outlines the care given to the client during antenatal period and home visits made to her residence.

Chapter Three**;** is the care given to the client during labour and its management.

Chapter Four; entails the care given to client during puerperium. The various histories taken and care given to client is to establish rapport and mutual relationship between the client and family so that client can voice out her sentiments without restraint and go through her pregnancy, labour and puerperium safely without complication. vi A care plan was drawn to identify problems and management given with the use of nursing

process at the end of each chapter. Summary and conclusion, bibliography, signatories as well as various appendices like antenatal records, laboratory records and pharmacology of drugs for both mother and baby are all included.

LITERATURE REVIEW

PREGNANCY

It is a period of having a developing embryo in the uterus and it is a time when women and their partners are especially open to reflecting on their lifestyles and healthcare options.

According to Mayes (2011), confirmation of pregnancy is established by a detailed history and a clinical examination based on the signs and symptoms of pregnancy, resulting from the physiological alteration in the body's system and organs. These include amenorrhea, breast changes and tenderness, nausea and vomiting and then increased frequency of micturition. These signs and symptoms become obvious to the woman as her pregnancy advances.

According to Davis (2022), conception to about the 12th week of pregnancy marks the first trimester. The second trimester is weeks 13 to 27 and the third trimester starts about 28 weeks and lasts until birth. Women gain weight all over their bodies while they are pregnant.

Fetal weight accounts for about 7 1/2 pounds by the end of pregnancy. The placenta, which nourishes the baby, weighs about 1 1/2 pounds. The uterus weighs 2 pounds. A woman gains about 4 pounds due to increased blood volume and an additional 4 pounds due to increased fluid in the body. A woman's breasts gain 2 pounds during pregnancy. Amniotic fluid that surrounds the baby weighs 2 pounds. A woman gains about 7 pounds due to excess storage of protein, fat, and other nutrients. The combined weight from all these sources is about 30 pounds (Davis, 2021).

Marie Elizabeth (2013) defines pregnancy as when the woman’s egg and a man’s sperm cell unite to form zygote. The duration of pregnancy has traditionally been calculated by the clinicians in terms of 10 lunar months or 9 months and 7 days or 280 days or 40 weeks, calculated from the first day of the last menstrual period. This is called menstrual or gestational age. It is divided into 3 trimesters, a period of three months in each trimester. The first trimester begins from the fertilization of the ovum to 12 weeks of gestation. The second

trimester begins from the 13th week to the 24th week of pregnancy. The third trimester starts from the 25th week to the 40th week. General check-up is done at interval of 4 weeks up to 28 weeks; at interval of two weeks up to 36 weeks and thereafter weekly till the expected date of delivery. Ideally this should be more flexible depending on the need, and the convenience of the patient. .

King, (2014) pregnancy is a time of profound anatomic and physiologic changes in a woman's body. In addition to the reproductive organs, all maternal physiologic systems make adaptations needed to support the developing foetus and at the same time, maintain maternal ix homeostasis. Pregnancy last approximately two hundred and sixty-six days (266) or thirty eight weeks (38) from ovulation. The antenatal period is into trimesters, first trimester is considered to be weeks 1 to 12 (12weeks) because organogenesis is completed at the end of twelve weeks and the risk of spontaneous abortion is significantly reduced at time. Historically, the second trimester was considered to be weeks 13 to 28 weeks were limit of viability. The third trimester extends from 29 to 40 weeks. The term 'post-date' or post term is typically used to describe a pregnancy beyond forty weeks (40).

The World Health Organization (WHO) envisions a world where "every pregnant woman and newborn receives quality care throughout the pregnancy, childbirth and the postnatal period" (Tunçalp, et al., 2019). Antenatal care (ANC) can be defined as the care provided by skilled health-care professionals to pregnant women and adolescent girls in order to ensure the best health conditions for both mother and baby during pregnancy (World Health Organization, 2016). According to the World Health Organization (2016), the components of ANC include: risk identification; prevention and management of pregnancy-related or concurrent diseases; and health education and health promotion.

ANC reduces maternal and perinatal morbidity and mortality both directly, through detection and treatment of pregnancy-related complications, and indirectly, through the identification of women and girls at increased risk of developing complications during labour and delivery, thus ensuring referral to an appropriate level of care (World Health Organization, 2016). In addition, as indirect causes of maternal morbidity and mortality, such as HIV and malaria infections, contribute to approximately 25% of maternal deaths and near-misses (9), ANC also

provides an important opportunity to prevent and manage concurrent diseases through integrated service delivery (World Health Organization, 2016). Through this form of preventive health care, women can learn from skilled health personnel about healthy behaviors during pregnancy, better understand warning signs during pregnancy and childbirth, and receive social, emotional and psychological support at this critical time in their lives. Through antenatal care, pregnant women can also access micronutrient supplementation, treatment for hypertension to prevent eclampsia, as well as immunization against tetanus (United Nations Children's Funnd (UNICEF), 2022).

LABOUR

Konar (2011) states that, labour is a series of event that takes place in the genital organ in an effort to expel the viable products of conception out of the womb through the vagina into the outer world. The date of onset of labour is very much unpredictable to foretell precisely the exact date of onset of labour. It not only varies from case but even in different pregnancies of the same individual. Conventionally events of labour are divided into four stages: First stage starts from the onset of true labour pains and ends with full dilatation of the cervix. It is in other words, the ‘cervical stage’ of labour. Its average duration is twelve hours (12) in primigravida and six hours (6) in multipara. Second stage starts from the full dilatation of the cervix (not from the rupture of the membranes) and ends with expulsion of the fetus from the birth canal. It has got two (2) phases thus the propulsive phase starts from full dilatation up to the descent of the presenting part to the pelvic floor and the expulsion phase is distinguished by maternal bearing down efforts and ends with delivery of the baby. Its average duration is two hours (2) in primigravida and thirty minutes (30) in multipara. Third stage begins after expulsion of the fetus and ends with expulsion of the placenta and membranes (after-births) and control of haemorrhage. Its average duration is about fifteen minutes (15) in both primigravida and multipara. The duration is, however, reduced to five minutes (5) in active management. Fourth stage is the stage of observation for at least one hour (1) after expulsion of the after-births. During this period, general condition of the patient and the behaviour of the uterus are to be carefully monitored. Under bladder care, patient is encouraged to pass

urine by herself as full bladder often inhibits uterine contraction and may lead to infection. If the woman cannot go to the toilet, she is given a bed pan. Privacy must be maintained and comfort must be ensured. If the patient fails to pass urine especially in late first stage, xi catheterization is to be done with strict aseptic precautions. Under rest and ambulation, if the membranes are intact, the patient is allowed to walk about. This attitude prevents venacava compression and encourages descent of the head. Ambulation can reduce the duration of labour; analgesia can improve maternal comfort. The transition from the first stage to the second stage is evidenced by the following features:

• Increasing intensity of uterine contractions.

• Urge to defecate with descent of the presenting part.

• Complete dilatation of the cervix on vaginal examination.

Varneys (2014) describes the onset of labour as the occurrence of regular painful contractions that promote dilatation of the cervix. Contractions that occur at regular intervals with increasing frequency, duration, and intensity are hallmark of labour. There are four stages of labour that has being established; the first, second, third and fourth stages. The first stage of labour starts with cervical dilatation which begins with regular rhythmic uterine contractions until the cervix is fully dilated. During this stage, enquiry is to be made about the onset of labour pains or leakage of liquor if any through general and obstetrical examinations including vaginal examination are to be carried out and recorded. Records of antenatal visits, investigation reports and any specific treatment given if available are to be reviewed. There is an assessment of progress of labour and partograph recording. The second stage of labour begins with the expulsion of the foetus from the birth canal, it starts when the cervix is fully dilated and the woman has the urge to expel the foetus and ends when the foetus is born. The third stage of labour is the complete expulsion of the placenta and its membranes as well as the arrest of haemorrhage. The fourth stage of labour is 6 hours after the delivery of the placenta and membranes and continues with close monitoring of the client and baby.

Myles (2014) states that, labour purely in physical sense, may be described as the process by which the fetus, placenta and membranes are expelled through the birth canal. Labour has xii four stages. Stage one comprises of latent phase and may last 6 to 8 hours in primigravidae. This begins when the cervix is 4cm dilated and in the presence of rhythmic contractions, progressively dilates to 10cm or full dilatation. Second stage of labour is the expulsion of the foetus. It begins when the cervix is fully dilated and the woman has the urge to expel the baby. There is stretching of the clitoris, gaping of the anus and bulging of the perineum. Labour completes when baby is born. In multigravida women, it last 15-30 minutes. Third stage begins after the expulsion of foetus and ends with the expulsion of the placenta and membranes (afterbirth). The fourth stage is a period of careful observation of the mother made to assess excessive bleeding and the firmness of the contracting uterus immediately after the third stage of labour and it last for six hours after delivery of the placenta.

The National Safe Motherhood Service Protocol (2008) states that normal labour begins with a regular painful uterine contraction lasting at least twenty (20) seconds (timed by a trained observer) occurring at a frequency of at least two contractions in every ten minutes and with cervical dilatation of at least 3 centimeters. Signs that women may experience prior to labour includes show (pink mucous discharge from the vagina), engagement of the baby's head. The hormone oxytocin is responsible for the strong regular contractions of labour which when released cause the uterus to contract. Labour contractions feel very different from Braxton Hicks contractions that women experience during pregnancy but the most important difference is that labour contractions come regularly. Each one starts gradually, builds up to a peak and then fades away. Typically, when labour begins, contractions are short in length around 20 – 30 seconds long. As labour progresses contractions become gradually longer and stronger which dilates the cervix National Safe Motherhood Protocol (2008), labour is a physiologic process during which the products of conception (the fetus, membranes, umbilical cord, and placenta) are expelled outside the uterus. Normal labour begins when there are regular painful contractions lasting at least 20 seconds occurring at a frequency of at least two contractions in every 10 minutes. xiii There are four stages of labour describe as follows; First stage; this start from the onset of labour till the cervix is fully dilated and is accompanied with painful rhythmic regular uterine contractions. It lasts for 6 to 10 hours in

multigravidas and 12 to 14 hours in primigravida. Partograph is used to manage the first stage of labour (during the active stage). Second stage; this starts from full dilatation of the cervix (10cm) to the expulsion of the baby through the birth canal. It usually lasts up to 30 minutes in multiparous women and 60 minutes in primigravida respectively. Third stage; this stage starts after delivery of the baby and ends with delivery of the placenta. It marks the separation and complete expulsion of the placenta and its membranes from the birth canal as well as control of bleeding after the expulsion. Fourth stage; it is the first six hours following the birth of the placenta. It deals with vigilant observation of both mother and baby immediately after third stage of labour till the first six hours after delivery.

PUERPUERIUM

National Safe Motherhood Service Protocol (2008) states that the postnatal period is the period that starts from the end of delivery of the placenta and membranes and control of hemorrhage to six weeks after delivery. The purpose of postnatal care is to maintain the xiv physical and psychological wellbeing of the mother and child. Postnatal care includes education of the mother on the care of her baby, detection and treatment or referral of any abnormalities for further management. The essential components of postnatal care are therefore:

1. Comprehensive screening to detect complications in both mother and baby.

2. Treatment of complications in mother and baby.

3. Assessment and support for infant feeding.

4. Malaria and anemia prevention.

Some common discomforts of postpartum period in mothers are listed as after pains, perineal pain, bowel and urinary changes, stretch marks, fatigue, sleeplessness, breast engorgement backache, headache, hemorrhoids and mood changes in the first week. Those associated with the newborn are caput succedaneum, tongue tie, rashes and vomiting after feeds.

The major causes of death in this period are infections, hypertensive complications, haemorrhage and thrombo embolism of which predisposing factors includes:

1. Conditions or complications during the antenatal period.

2. Complications of labour, related to duration of labour and mode of delivery.

Konar (2011) states that, puerperium is the period following childbirth during which the body tissues, specifically the pelvic organs reverse back approximately to the pre-pregnant state both anatomically and physiologically. This begins as soon as the placenta is expelled and last for approximately six weeks when the uterus becomes regressed to the non-pregnant size called involution, the period is arbitrarily divided into(a) immediate-within 24 hours;(b) early-up to 7 days and remote-up to 6 weeks. In its anatomical consideration, the uterus immediately following delivery becomes firm and retract with alternate hardening and softening. At the end of six weeks, the weight of the uterus is almost similar to that of the non-pregnant state and weighs about sixty (60) grams. The physiological consideration of involution is most marked in the body of the uterus where the changes occur in the muscles, blood vessels and endometrium.

Dutta (2013) puerperium is the period following childbirth during which the body tissues especially the pelvic organs reverse back approximately to the pre- pregnant state. The period is arbitrarily divided into (a) immediate –within 24 hours; (b) early –up to 7 days and (c) remote- up to 6 weeks. In this book, the principles in management of puerperium are;

1. To restore the health of the mother.

2. To prevent infections.

3. To take care of the breast, including promotion of breast feeding.

4. To motivate mother for contraception

Marie Elizabeth (2013) describes puerperium as the period following childbirth during which the body tissues, especially the pelvic organs reverse back approximately to the prepregnant state both anatomically and physiologically. The period is divided into;

- Immediate –within 24 hours
- Early- up to 7 days
- Remote –up to 6 weeks

Immediately following delivery, the uterus becomes firmer and retracted with alternating hardening and softening. At the end of 6 weeks, its measurement is almost similar to that of the non-pregnant state and it weighs 60 grams. The lower uterine segment becomes thin, flabby and collapsed structure. The cervix contracts slowly; the external os admits to fingers for the few days but by the end of the first week, narrows down to admit the tip of a finger only. The external os never revert back to the nulliparous state. During puerperium the number of muscles fibres is not decreased but there is substantial reduction in the myometrial cell size. The arteries are constricted by contraction of its wall and thickening of the intima followed by thrombosis. New blood cells grow in the thrombi. Soon after birth it takes a long time (4 to 8) for the vagina to involute. The vaginal discharge for the first fortnight during puerperium is the lochia. The lochia originates from the uterine body, cervix and vagina. Depending upon the variation of the colour of the discharge it is named as: lochia rubra (red) 1 -4 days, lochia serosa (yellowish or pink or pale brownish) 5- 9 days, lochia alba (pale white) 10 - 15 days. The average amount of discharge, for the first 5-6 days is estimated to be 250 ml. With all definitions and changes it can be deduced that puerperium is the period from birth to 6 weeks of delivery.

According to Marshall and Raynor (2014), After the birth of a baby and expulsion of the placenta, the mother enters a period of physical and psychological preparation and this period, called the puerperium starts immediately after delivery of the placenta and membranes and continues for a period of 6 to 8 weeks. Puerperium is a period after childbirth where the uterus and other organs and structures which were affected by pregnancy returns to their non-gravid state. This period is also divided into three;

1. Immediate puerperium: this is the first 24 hours after delivery.
2. Early puerperium: is between the second and the seventh day after delivery.
3. Late puerperium: this is the period from the second week to the sixth week after childbirth.

During this time a number of physiological and psychological changes take place which are;

The reproductive organs return to the non-pregnant state.

1. Lactation is established
2. Bounding between infant and parents is also established

The mother recovers from the stresses of pregnancy and delivery, and assumes responsibility for the care and nurture of her infant. The main aim of management during puerperium is to;

1. Manage minor disorders in both mother and baby.
2. Counsel and teach on nutritional needs of the puerperal mother.
3. Counsel, teach and encourage the mother to breastfeed exclusively for six months and how to properly fix baby to breast.
4. Counsel and teach mother on importance of rest and sleep, ambulation and exercise as well as family planning.

The transition to parenthood involves major adjustments within a family and some mothers will welcome and actively seek help and support from a midwife during the postnatal period, but some women, for a range of reasons, may not. Women from different cultural backgrounds may have traditions that conflict with the current management of postpartum care consider that they already have sufficient skills and experience. Not being able to speak or understand English may also prevent a woman from seeking help. Although a visit to the home might have been planned, there will also be times when women are not at home when the midwife visits. It is important to keep in mind individual circumstances and whether these might have any bearing on a no-access visit. For example, parents with a disability such as hearing loss or poor mobility might not hear a doorbell. It is, therefore, important to make arrangements for contact to be made by alternative means (e.g. using a visual alarm or telephone to alert the woman of the visit beforehand). The midwife needs to recognize situations where

the mother perceives she has different priorities from those routinely provided by the healthcare services (Marshall & Raynor, 2014).

WHY CLIENT WAS CHOSEN

On the 14th August, 2023, 24years old Gravida 2 Para 1A was met at Amantin Health Center. She had come for the 5th antenatal clinic visits as booked by the midwife. Her gestational age was 37 weeks and 3 days pregnant. On arrival at the clinic, client was not looking cheerful and when she was approached she complain of having leg cramps which she did not experience in the previous pregnancy. Decision was made to use her and support her, she was reassured to allay fear and anxiety. The midwife in charge was notified and she also gave her approval for client to be chosen. Self-introduction was made as a student midwife from Holy Family Nursing and Midwifery Nursing Training, Berekum. The intension was made known to her and she consented, direction to her house and phone number was taken and promised to visit client.

CHAPTER ONE

1.0 INTRODUCTION

This chapter is about assessment of the client and her family which involved gathering of data. 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 social and personal, family, social, surgical, hobbies and lifestyle, past obstetric and present obstetric history.

CLIENT'S PARTICULARS

1.1 PERSONAL AND SOCIAL HISTORY

Madam Issaka Rashida a Gravida 2 Para 1^{A} is a 24 years old woman who stays at Dauda Akura but comes from Larabanga in the Upper West Region, a native of Bosanga. She weighed 67.2 kilograms and she is 1.6 meters (m) tall and dark in complexion. Her educational level is Senior High School (S.H.S) because her parents were financially incapacitated. Madam Rashida is unemployed. She is married to a noble man Mr. Issaka Abulai who is a fitting and also a Muslim. She lives in apartment house with her husband. There are three (3) completed rooms in the building in which they reside with their neighbor who lends a helping hand to client when less busy. Madam Issaka Rashida speaks Twi, English and Bosanga. Client's next of kin is her beloved husband Mr. Issaka Abulai who is a devoted and a responsible man. She does not indulge in any harmful social habits like smoking and drinking.

1.2 FAMILY HISTORY

Madam Rashida is born to Mr. and Mrs. Basiru Bansey and Maliatu. Both her father and mother lives at Amantin in the Bono East Region. Client says her siblings reside in different places because of marriage and job opportunities and are healthy. According to Madam Rashida, there are no known histories of hypertension, heart disease, sickle cell disease, diabetes mellitus, liver cirrhosis, epilepsy, mental illness and congenital abnormalities are in her family. She also added that, there are no known congenital abnormalities such as missing digits, extra digits, cleft palate, cleft lip, imperforate anus and spinal bifida among others in the family. Client stated that her family seek for medical treatment and prays whenever they are not feeling well. There is no history of multiple pregnancies. She said all her family members who passed away died naturally.

1.4 SURGICAL HISTORY

She said she has never undergone any surgical procedure. She also mentioned that she has never sustained any injury or road traffic accident that called for any abdominal or spine surgery to affect her pelvis. On examination, there was no scar indicating previous laparotomy such as caesarean section, appendectomy among others.

1.5 MEDICAL HISTORY

Client said she has never been transfused with blood. Also, client has never been admitted to the hospital. She receives medical treatment as an outpatient when she suffers minor illness or buys drugs from a licensed chemical seller when she falls sick. Client has never donated blood neither has she been transfused. Madam Rashida has no medical condition such as hypertension, sickle cell, diabetes, asthma, glucose-6 phosphate dehydrogenase (G6PD) defect, mental and heart diseases. She has never had any allergic reaction to any food or drug.

1.6 MENSTRUAL HISTORY

Madam Rashida has a regular menstrual cycle of 28 days. Client had her first menstruation at age 16. Her menstrual flow is moderate, last for 6 days and experiences dysmenorrhea for the first day. She uses sanitary pad, changes frequently and bathes twice daily. Client's last menstrual period is 17th November, 2022 per calculation her estimated date of delivery was 24th August, 2023 and per scan 24th August, 2023.

1.7 HOBBIES AND LIFESTYLE

Madam Rashida sleeps at 10:30 pm and wakes up at 6:00am. She said that when she wakes up in the morning, she does her morning devotion with the family. After that, she brushes her teeth, sweeps her room and compound but not always because she does it with one neighbor in turns then throws her rubbish away at the dumpsite, which is two minutes' walk away from her house. She washes her dishes and also prepare her kid for school. Client expressed that she normally prepares breakfast for the family before the child goes to school. Her husband now sends the kid to school and also brings her back when she closes since she is pregnant. After preparing breakfast, she takes her bath and watches television and sometimes rest. She mentioned that, she has a great interest in listening to music. She said she prefers fufu with light soup and meat to other foods. Madam Rashida said ever since she became pregnant, she eats on demand. She also said that she prepares supper at 4:00pm and it becomes ready for the family to enjoy around 5:30pm. She said they all sit together and take their supper around 5:40pm. She normally baths her child and does same after supper. Thereafter she supervises the kid to do his homework. At 8:30pm, she supervises her child to go to bed. Client mentioned that she empties her bowel twice (2) and empties her bladder when she feels the urge to and frequently takes in enough fluid in the day.

1.8 PAST OBSTETRIC HISTORY

PREGNANCY

Madam Rashida has had one previous pregnancy (Gravida 2 Para1 A) which she went through successfully without any complication. She had her first pregnancy in the year 2021 and carried it to term. According to client giving birth with a three (3) year interval is something being planned by the couple. She said during all her pregnancy, she experienced some minor disorders such as nausea and vomiting, frequency of micturition, lower abdominal pain, constipation, backache of which she reported to the clinic and were explained to her as a normal physiological change in pregnancy which would resolve as pregnancy progresses. She has never suffered any pregnancy induced condition like gestational diabetes and pregnancy induce hypertension (pre-eclampsia) and has never had any spontaneous or induced abortions in her life. She also visited antenatal clinic for seven (7) times during her pregnancy and received all doses of sulphadoxine pyrimethamine as well as received two (2) doses of tetanus diphtheria injection in her previous pregnancy.

LABOUR

Madam Rashida delivered her child spontaneously through the vagina at Amantin Health Center. She further stated that the duration of her labor lasted for about five (5) hours after which she delivered an alive male baby. He was healthy and weighed 3.4kg at birth from records. She also said she has never had any perineal tear or been given episiotomy during her previous delivery. She added that she did not experience any post-partum haemorrhage, retained placenta and membranes. Her estimated blood loss for her delivery was never about 100mls. Her child

never had any birth injuries, asphyxia, jaundice, cleft lip, cleft palate, extra digits. She was active at birth and started breastfeeding her baby immediately she was taken to the lying-in-ward.

PUERPERIUM

She said she started breastfeeding the baby within the first hour after birth. She practiced exclusive breastfeeding for 6months and then added complementary feeds during the 6th month and she weaned her at age two. She had a safe breastfeeding with no complication. Madam Rashida said her child was fully immunized against the vaccine preventable diseases according to schedules and never suffered any illness as he was growing. He is alive and healthy. Client said she did not experience any illness such as puerperal psychosis, anemia, malaria, post-partum hemorrhage, puerperal pyrexia, puerperal sepsis, mastitis among others. In relation to family planning, she used the natural family planning method thus the lactational amenorrhea and calendar method. Madam Rashida also stated that her family and husband supported her in caring of her baby and some of the household chores.

1.9 PRESENT OBSTETRIC HISTORY

Madam Rashida, Gravida 2 Para 1A felt slight changes as early morning sickness, nausea and vomiting prior to confirmation of the pregnancy. Her first visit to the hospital was on 17th January, 2023 with gestational age of 12 weeks plus 3days, her last normal menstrual period was 17th November, 2023 and her expected date of delivery was calculated as 24th August, 2023. Scan gave her expected date of delivery as 24th August, 2023. Her vital signs and other assessment on that day are as follows;

Temperature…….36.8 degree Celsius

Pulse…….85 beat per minutes

Respiration…… 22 cycle per minutes

Blood pressure ……...134/72 millimeter of mercury

Weight ……. .67.2kilograms

Height ……1.6meters

Symphysiofundal height.....Non palpable

LAB INVESTIGATIONS

Haemoglobin level …… 11.6grams per deciliter

Sickling ……..… Negative (-)

Blood group …….. O

Rhesus factor …… Positive (+)

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

PMTCT……. …… Negative (-)

HEP-B……..... Negative (–)

VDRL…… Non-reactive

Glucose in urine…… Negative (-)

G6PD…… No Defect

Protein in urine ……. Negative (–)

Stool for routine examination indicated no abnormality.

On examination (head to toe), no abnormality was detected. Madam Rashida had no complaints so was educated on the need to attend antenatal clinic regularly. She was put on the following drugs and was scheduled for the next visit.

1. Tab iron III daily x 30 days
2. Tab multivitamins 200mg daily x 30 days
3. Tab folic acid 5mg daily x 30 days 7 days

CHAPTER TWO

ANTENATAL CARE

2.0 INTRODUCTION

This chapter is about the antenatal care given to client and the family at large throughout the period of pregnancy. This includes first contact with the client, antenatal home visits, subsequent visit to the clinic and care plans drawn to manage the problems encountered by the client during the antenatal period.

2.1 FIRST CONTACT WITH CLIENT

Madam Rashida G2P1A was met on Monday 14th August, 2023 at Amantin Health Center at 11:30am when she came for her usual antenatal visit. She was 37 weeks plus 3 days of gestation and it was her fifth (5) time of attending antenatal clinic. On her arrival at the clinic, client seemed to be friendly with the staff and someone who would be ready to share information. Madam Rashida happened to be the first woman met who fell within the eligibility criteria for writing the client/ family centered maternity care study after thorough glance through client's antenatal book thus she was chosen. Rapport and introduction were established as a student midwife from Holy Family Nursing and Midwifery Training College, Berekum and stationed for four (4) weeks for Community Midwifery. Permission was asked to use her as client for the care study since she met the criteria after glancing through her antenatal card. The criteria used for selection was explained to her and she wholeheartedly agreed. She asked if it will cost her money but it was explained to her that no, but only need her cooperation. She was thanked for her understanding. The midwife incharge was informed about the selection of Madam Rashida for the study which she agreed. Client had a normal gait with no deformity observed.

Her vital signs were checked and recorded and investigations carried out were;

Temperature……36.5 degree Celsius

Pulse……91beats per minute

Respiration……..21cycle per minute

Blood pressure…….107/79 millimeter of mercury

Weight…….75 kilograms

Hemoglobin level……12.5 grams per deciliter

Urine testing

Client was given a specimen bottle to provide midstream urine, with the aim of testing for protein and glucose by the use of a urine reagent strip. Protective clothing like apron and gloves were worn. The quantity, colour, odour, smell and sediment were noted. Urine strip was picked and dipped into the urine sample. The strip was immediately removed and edge of the strip was tapped against the side of the urine container to prevent spilling of urine onto `the clothes. After one (1) minute, the strip was compared with colours on the container. There was no change in colour of the strip indicating negative results for both protein and glucose. This procedure was aimed at detecting and ruling out abnormalities and to provide sharp interventions when necessary. All findings were recorded and communicated to her to allay anxiety. Hands were washed with soap under running water and dried. Results were recorded in the antenatal book.

PHYSICAL EXAMINATION (HEAD TO TOE EXAMINATION)

Physical examination (head to toe) procedure was explained to client and consent was sought. Client was assisted onto a couch for the examination. Privacy was provided, hands were washed with soap under running water and dried. Permission was sought to examine Madam Rashida under the supervision of the midwife in-charge and she agreed. Client's permission was sought to wash hand with soap and water and dried with clean towel, rubbed together to keep them warm to prevent premature contraction.

All necessary equipment needed for the examination was gathered on a tray comprising of the following items;

- Gallipot with sterile cotton wool swabs
- A fetal stethoscope
- Examination gloves
- A pen and client's folder
- A receiver for used swabs
- A tape measures
- A watch with a second hand

Privacy was provided and client was assisted to undress and wrapped in her cloth after she had emptied her bladder. She was helped to lie on the examination bed and assisted to assume a left lateral position while hands were washed with soap under running water and dried with a clean towel. Palms were warmed. The general health status of the client was assessed, standing on the right hand of the client and maintaining eye contact, examination was done starting from head to toe

Head and neck

On inspection, her scalp was neatly done with no dandruff, lice, skin infection present. Client was congratulated to keep it up. There was no edema, chloasma and rashes on the face or the eyelids. On examining the eye, the conjunctiva was pink and sclera white, no discharges as well as her nose. The ears were also inspected for discharges and alignment. Client had a healthy tooth with pink tongue and no halitosis as she was engaged in conversation but with slight dry lips, hence encouraged to apply Vaseline or lip gloss on her lips. Client's neck had no enlarged thyroid gland or distended neck vein. Each step was explained to client as examination went on.

Breast examination

Both breasts were exposed to check for size, shape, nipple's position and condition of the skin but nothing abnormal was noticed. One breast was covered and she was asked to put the hand of the part to be examined under her head. The breast was palpated thoroughly in a circular manner using the inner aspect of the fingers and there were no masses, lumps. The nipple was squeezed gently with cotton wool for any discharges (colostrum), the colour of discharge. Same procedure was performed on the other breast and no abnormality was detected. Client was educated and taught how to perform self-breast examination periodically.

Extremities (upper extremities)

The hands and fingers were inspected for equal symmetry, oedema, pallor of palms and capillary refill at the nail bed but nothing abnormal was detected. The lower extremities were of the same size and were of equal symmetry. It was also palpated for oedema, tenderness in the calf muscles, varicose veins, but nothing abnormal was detected.

Back

No deformity of the spine, oedema of the sacral region and costovertebral angle for tenderness was absent.

ABDOMINAL EXAMINATION

This procedure and reason for it was explained to the clients understanding. The purpose for this examination is to observe the signs of pregnancy, assess fetal size and growth, auscultate the fetal heart if present, locate fetal parts, and detect any deviation from normal. She was assisted to lie in dorsal position with arms by her side to relax the abdominal muscles. Hands were washed with soap and water and dried.

Abdominal inspection:

Client had no scars; foetal movement was seen and linear nigra and striae gravidarum were present. The shape and size of the abdomen were globular and medium respectively. Hands were warmed by rubbing them together to avoid inducing contractions. The abdomen was palpated for masses, tenderness as well as enlarged spleen and liver but no abnormalities were detected.

Symphysio-fundal height

Palms were rubbed together to generate warmth in other to prevent stimulation of contraction. The fundus and upper boarder of the symphysis pubis were located. The zero mark of the measuring tape was placed on the fundus and extended along the contour of the abdomen along the midline to the upper boarder of the symphysis pubis and it measured 35cm and her gestational age was 37 + 3 days.

Fundal palpation on the abdomen:

Palms were rubbed together to generate warmth in other to avoid inducing contraction. The palms were placed on either side of the fundus for fundal palpation. Still facing the head of the client, fingers were curved around the fundus to determine what lies in the upper pole. A soft mass was palpated indicating the buttocks. The fundus has grown to the level of the xiphisternum. Lateral palpation on the abdomen: On lateral palpation, the palms were placed on each side of the abdomen, with one hand stabilizing side of the maternal uterus the other hand was moved gently in a circular manner the fetal limbs were palpated at the right side. Same was done at the other side of the abdomen, fetal back was felt a smooth surface at the left side indicating the back.

Pelvic palpation on the abdomen:

On pelvic palpation position was changed to face the feet of the client as pelvic palpation was done. Madam Anima was asked to bend her knees slightly and also to breathe in and out slowly and the palms were placed just below the level of the umbilicus with the fingers directed towards the symphysis pubis and the thumb almost meeting. A hard mass was felt indicating the head of the fetus, the presentation was cephalic, the lie was longitudinal.

Descent:

The anterior shoulder was located during palpation, upon locating the symphysis pubis. The ulna border was placed just above the symphysis. Five fingers occupied the space indicating. Descent of $5/5^{th}$.

Auscultation:

On auscultation, the fetal stethoscope (fetoscope) was warmed by rubbing it on the palms. The fetoscope was placed at the area where the back was located to listen to the fetal heartbeat. With one hand at the maternal radial pulse to ensure that the maternal pulse was not misinterpreted for the fetal heartbeat. The fetal heart rate was counted for 1(one) full minute noting the volume and the rhythm and was it recorded as 140 beats per minute.

Vulva examination:

Permission was sought to inspect the genital area and she agreed. Hands were washed with soap and water and dried with a clean towel also examination gloves were worn. The vulva was inspected for edema, scar, genital warts, rashes, vulva discharges and varicose veins but none was present. The Mons pubis was well shaved. Client was encouraged to continue practicing good vulva hygiene. The clitoris had no scarring or laceration from previous deliveries was absent. She was educated on cleaning the vulva in the anterior-posterior direction anytime she passes faeces. Also, client was advised to wash her panties regularly and dry them in the sun, avoid inserting herbs for douching. Hand washing was done after the procedure and dried. She was thanked for her cooperation and findings were communicated to her. Client was asked to assume lateral position and sit up before getting out of bed, redressed and asked whether she had any complaint but there was none all under the supervision of the midwife in charge. All equipment used was decontaminated appropriately. Hand washing was done and dried with clean dry towel. All findings were communicated to her and client was assisted to raise from the couch to redress. Health education was given on the importance of preventing malaria in pregnancy and encouraged to report any abnormality like headache, excessive vomiting etc. to the clinic. Client

was then reminded on her next visit which was 21st August, 2023. The intention of visiting her in the house was made known to her and she showed the direction to her house and phone numbers were exchanged. A date was scheduled for the home visit which was 16th August, 2023. Hands were washed and dried and medication served as follows:

- Tablet ferrous sulphate - 200mg daily for 7days
- Tablet folic acid – 5mg for 7days
- Tablet paracetamol - 1000mg three times daily for three days

Client was encouraged to take drugs as prescribed, thanked for her cooperation and bid goodbye.

2.2 FIRST ANTENATAL HOME VISITS

The first visit to Madam Rashida house was on Wednesday 16th August, 2023 at 9:30 am. The aim of the visit was to observe the environment where she lives, her source of water and light, the number of people she shares her room with, where she attends natures call (toilet), how she disposes off her refuse and also how she relates with her family members and her neighbors. On arrival, she warmly welcomed and offered a seat in her room and also water to drink which she was thanked for that. She was asked how, herself and the family were faring which she responded that they were doing well. She was asked whether she was busy but the response was no, so we started with our conversation. We had our conversation in her living room. The place was well kept with furniture orderly arranged, it had adequate lightening and proper ventilation, she was asked to keep it up. She was educated on the importance of sleeping under an insecticide treated 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 to sleep under and early in the morning she could remove it which she agreed. Permission

was then asked to enter the inner room where she sleeps. She led me to the room, on entering; the room was not all that neat since there was a cross bar on which some dirty clothes were hanged loosely. Also, their clothes were not well packed into their various bags. 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 hide in them. Madam Rashida had neatly arranged her utensils in her cupboard in her kitchen. There were no dirty dishes found in the kitchen. The common toilet and bathroom she use together with her husband, was well kept because she told me she scrubs every day. A dustbin with a well-fitting lid was seen outside the house which she told me they empty it every morning into the public refuse dump which is some few meres away from their house. They fetch water from the next house. Madam Rashida was educated on the importance of maintaining good personal hygiene and encouraged to continue with her medication and birth preparedness and complication readiness. Client was encouraged to pack her bag with items prepared for delivery and get a companion to help her when her time was due. Also, education was given to client concerning keeping some money on her for the due day in a separate purse. Again, client was encouraged to get a driver who is always available on the due and a blood donor to donate blood in case of any emergency. She is always available on the due and a blood donor to donate blood in case of any emergency. She had a good relation with her co tenants. She was asked whether she had any complaint that day and she complained of constipation and heartburns which was explained to her as the effect of relaxing on the smooth muscles and heart burns due to the relaxation of the cardiac sphincter of the stomach causing reflux of acidic contents of the stomach into the lower esophagus and was educated to minimize the intake of spicy food, stay away from nauseated things and eat in bit. She was made aware that it was a normal physiology which will resolve after delivery. She was thanked and

permission to leave was sought. She was informed about the next visit to the clinic on 21st of August, 2023.

2.3 SECOND ANTENATAL HOME VISIT

The second home visit to Madam Rashida's house was on Friday 18th August, 2023 a t 11:30am. She was met in the house charting with some of her friends. They were greeted and a warm welcome was given and a seat was offered. The wellbeing of the family was enquired and she said they were all doing well by God's grace and that the child had gone to school. The aim of the visit was to inquire about her health whether some changes have been made on what we discussed the other time about the fixing of insecticide treated net, also keeping and arranging their bedroom well and neat. Client was asked about her previous complains and she said it was better now. On inspection, all these things were corrected as taught, her husband and neighbor were her birth companion and she had packed her delivery items with a purse of money and her insurance card as well as antenatal book. Also, a blood donor and taxi driver was confirmed. Education on rest and sleep and true labor signs as appearance of blood-stained mucus discharge (show), regular rhythmic uterine contractions anytime she experiences that she should not hesitate to come to the health facility. She was allowed to ask questions and appropriate answers were given. She complained of swollen feet. The physiology was explained to her as, growing of the gravid uterus and pressure exerted on the legs and then she was educated on true signs of labor which she should report to the facility immediately. Permission was sought to leave, she was thanked and reminded of her next visit to the clinic on the 21st of August, 2023.

2.4 SUBSEQUENT VISIT TO THE CLINIC BY CLIENT

Madam Rashida visited the clinic on Monday 21st August, 2023 at 9:00am. She was welcomed and given a chair to sit. An enquiry was made about her health and that of the family and she

said they are all doing well. Madam Rashida was asked about her swollen feets which she complained about the previous visit and confirmed a reduction in the swelling. She answered she is complying with it and she said she had contacted a driver and gotten a blood donor. Madam Rashida's health was enquired and she complained of leg cramps and backache. It was explained to her that leg cramps are due to the pressure exerted by the growing fetus on the sacral nerves. Client was educated to apply warm compresses and also perform dorsiflexion her legs and massaging the painful area. Also, with the backache was explained to client as due to softening and relaxation of the pelvic ligament by relaxin and progesterone. She was encouraged to maintain a good sitting posture, minimize her workload and apply warm compresses to the lower back. Also, Client was examined from head to toe and no abnormality was detected. Vital signs and other observation were checked and recorded are as follows;

Temperature	36.5 degree Celsius
Pulse	96 beats per minute
Respiration	24 cycles per minute
Blood pressure	107/64 millimeters of mercury
Weight	75 kilograms
Symphysiofundal height	36centimeters
Descent	5/5th
Fetal heart rate	138 beats per minute
Hemoglobin	12.7 grams per deciliter

Urine was tested for protein and glucose which was negative.

Client was advised to take in food rich in vitamins, minerals and proteins. She was also advised to take in enough fruits that contains roughages and was encouraged to take in more fluid. She was educated on perineal hygiene and encouraged to take in her routine drugs. Client was again educated to practice exclusive breast feeding after delivery and also counseled on the practice of family planning after delivery. The need to deliver at the health facility was stressed on to prevent any complications like retain placenta, postpartum hemorrhage and importance of deep breathing exercise during labor. Stress was made on not to delay at home when labor sets in but in the absence of any signs she will continue for her usual weekly visit. She was accompanied to the road side and was bid farewell.

2.5 NURSING CARE PLAN

PROBLEMS IDENTIFIED

1. Complained of constipation 16 August,2023
2. Client complained of heart burns 16 August,2023
3. Client complained of swollen feets 18 August,2023
4. Client complained of leg cramps 21 August,2023
5. Client complained of Backache. 21 August,2023

SHORT TERM OBJECTIVES

1. Client will have free bowl movement within 24 hours.
2. Madam Rashida's heartburns will be reduced within 24 hours and cope with it throughout pregnancy.

3. Client swollen feet will be subside within 72 hours and cope with it throughout pregnancy.
4. Client leg cramps will be reduced within 12 hours and cope with it throughout pregnancy.
5. Madam Rashida's backache will be reduced within 72 hours and cope with it throughout pregnancy.

LONG TERM OBJECTIVES

Madam Rashida will carry the pregnancy, labor and puerperium without any complications to both mother and baby.

TABLE 1: NURSING CARE PLAN DURING ANTENATAL CARE FOR MADAM ISSAKA RASHIDA

DATE / TIME	NURSING DIAGNOSIS	OUTCOME CRITERIA/ OBJECTIVES	NURSING ORDERS	NURSING INTERVENTIONS	DATE / TIME	EVALUATION	SIGN
16/08/239:30 am	Constipation related to activity of progesterone causing decreased peristaltic movement and relaxation of the smooth muscles of the large intestine during late pregnancy.	Client will have free bowl movement within 24 hours as evidenced by; 1. Client verbalizing, she has free bowl movement.	1. Reassure client 2. Explain the physiology of constipation in pregnancy to client 3. Educate client to increase the intake of fresh fruits and vegetables 4. Encourage client to take at least 5 glasses of water daily. 5. Encourage client to exercise (walking) regularly	1. Client was reassured 2. The physiology of constipation in pregnancy was duly explained to client 3. Client was served with fruits and vegetables like banana, pineapple, kontomire, among others 4. Client was encouraged to take at least 5 glasses of water daily and was encouraged to empty her bowel when the urge is felt. 5. Client was encouraged to walk around as a way of exercising	17/08/23 9;30am	Goal fully met as client verbalized the ability to pass stools freely.	T.B.S

TABLE 1: NURSING CARE PLAN DURING ANTENATAL CARE FOR MADAM ISSAKA RASHIDA

DATE / TIME	NURSING DIAGNOSIS	OUTCOME CRITERIA/ OBJECTIVES	NURSING ORDERS	NURSING INTERVENTIONS	DATE / TIME	EVALUATION	SIGN
18/08/23 11:30am	Swollen feet related to excess fluid in the body and pressure from the growing uterus and pressure exerted on the legs.	1. Client swollen feet will be subsides within 72 hours and copes with it throughout pregnancy. As evidenced by; 1. Client demonstrating measures to reduce oedema. 2. Midwife recording normal values for blood pressure and pulse values.	1. Reassure client 2. Assess the degree of oedema. 3. Educate client on measures to manage oedema. 4. Restrict client's sodium intake. 5. Elevate client's feets on pillows	1. Client was reassured to allay fear and anxiety. 2. Client's blood pressure, pulse and weight were checked and were in the normal range. 3. Client was educated on dietary management, drug therapy and other interventions to manage oedema 4. Sodium intake was restricted to not more than 200mg per day. 5. Client's feets were elevated on pillows	21/08/23 1:30pm	1. Goals fully met as client demonstrated some measures to resolve oedema. 2. Midwife recorded normal values for blood pressure and pulse values.	T.B.S

TABLE 1: NURSING CARE PLAN DURING ANTENATAL CARE FOR MADAM ISSAKA RASHIDA

DATE / TIME	NURSING DIAGNOSIS	OUTCOME CRITERIA/ OBJECTIVES	NURSING ORDERS	NURSING INTERVENTIONS	DATE / TIME	EVALUATION	SIGN
21/08/23 9:00am	Leg cramps related to insufficient blood supply to the lower limbs.	Client leg cramps will be reduced within 12 hours and cope with it throughout pregnancy. As evidenced by 1. Client verbalizing a reduction in the pain.	1. Reassure client. 2. Explain the physiology of leg cramps to client. 3. Advise client to perform some exercise like walking 4. Advice client to apply warm compress. 5. Encourage client to apply a gentle massage over the painful area	1. Client was reassured to allay her fear and anxiety 2. Client was educated that her condition was due to limited blood supply to the lower limbs. 3. Client performed dorsiflexion of the legs 4. Client applied warm compress to the calf muscle. 5. Client applied a gentle massage over the painful area.	21/08/23 9:00pm	Goal fully met as client verbalized reduced pain.	T.B.S

TABLE 1: NURSING CARE PLAN DURING ANTENATAL CARE FOR MADAM ISSAKA RASHIDA

DATE / TIME	NURSING DIAGNOSIS	OUTCOME CRITERIA/ OBJECTIVES	NURSING ORDERS	NURSING INTERVENTIONS	DATE / TIME	EVALUATION	SIGN
16/08/23 9:30am	Heartburns related to progesterone relaxing the cardiac sphincter	1. Madam Rashida's heartburns will be reduced within 24 hours and cope with it throughout pregnancy. as evidenced by client verbalizing she is relieved of heart burns.	1. Support client emotionally 2. Explain the physiology of heartburns to the client. 3. Educate client to reduced fatty and spicy foods. 4. Educate client to eat in bits but at a frequent interval. 5. Educate client not to go to bed early after eating.	1. Client was supported emotionally that she will be relieved of heartburns. 2. Physiology of heartburns was explained to client that it is due to the reflux of gastric content into the esophagus 3. Client was educated to reduce fatty and spicy foods. 4. Client was educated to eat bit at shorter intervals. 5. Client was educated to sit for sometimes before going to bed after eating.	17/08/23 2:30am	Goal fully met as client verbalize, she has been relieved of heart burns.	T.B.S

TABLE 1: NURSING CARE PLAN DURING ANTENATAL CARE FOR MADAM ISSAKA RASHIDA

DATE / TIME	NURSING DIAGNOSIS	OUTCOME CRITERIA/ OBJECTIVES	NURSING ORDERS	NURSING INTERVENTIONS	DATE / TIME	EVALUATION	SIGN
21/08/23 9:00am	Backache related to softening and relaxation of the pelvic ligament by relaxing and progesterone.	1. Client backache will be reduced within 72 hours and cope with it throughout pregnancy as evidenced by; 1. Client verbalizing that pain has subsided. 2. Midwife observing client ambulate without pain.	1. Reassure client. 2. Explain the physiology of backache to client. 3. Educate client to maintain a good sitting posture. 4. Educate her on minimal work and exercise. 5. Administer prescribed analgesics	1. Client was reassured. 2. Physiology of backache was explained to client. 3. Client was educated on supporting the back when sited. 4. Client was educated on minimal work and exercise 5. Paracetamol 1gram was administered.	24/08/23 9:00am	Goal fully met as 1. client performed some minor tasks 2. Midwife observed client ambulate without pain.	T.B.S

CHAPTER THREE

LABOUR

3.0 INTRODUCTION

This chapter describes the management of labor, the immediate care of the newborn, examination of the newborn and the care plan drawn for the management of the problems encountered during labor and delivery.

3.1 ADMISSION AND MANAGEMENT OF FIRST STAGE OF LABOUR

On Thursday, 24th August, 2023, Madam Rashida reported to the labor ward at Amantin Health Center at 8:30 am with her husband. Rapport was established and they were offered seats. Client was taken to the nurses' station for necessary information to be taken while reading through her antenatal card. Client gave complaints of **severe waist pains and uterine contractions** since dawn she was reassured and was educated to reduce duration of sitting and ambulate to aid descent of the fetal head, she appeared anxious. They were reassured of competent health team and safe delivery to allay anxiety.

She was encouraged to pass urine frequently and was measured as 100mls, the sample was tested for albumin, sugar and acetone which were negative.

Her vital signs checked and recorded as follows:

Temperature - 36.7 degree Celsius

Pulse - 86 beats per minute

Respiration - 22 cycles per minute

Blood pressure -110/80 millimeters of mercury

Madam Rashida was taken to the examination room and was assisted to change into her clothing. Permission was sought to examine her and all procedures were explained to her. Client was assisted to lie on the couch in a supine position and a quick thorough head to toe examination was conducted and revealed no abnormality.

On abdominal examination

Inspection; the shape was ovoid with normal size and there was Linea nigra present. The fetal movement was present and no scar was observed. Symphysio-fundal height was 37 centimeters with gestation of 40 weeks and 3 days. The fundus was palpated and a breech was identified, lateral palpation was done to find the back and limbs were on the right side as it felt rough. The presentation was cephalic and lie was longitudinal, position was right occipto-anterior. Descent was determined by locating the anterior shoulder below the umbilicus and symphysis pubis which admitted three (3) fingers. Descent was three-fifth ($3/5^{th}$) palpated above the pelvic brim was monitored after 4 hours, uterine contraction was timed every thirty (30) minutes and the first contraction was recorded as two (2) contraction in ten (10) minutes lasting thirty-five (35) seconds.

On Auscultation;

The fetoscope was rubbed on the palm to warm it before placing it on the abdomen to listen to the fetal heart beat for a full minute which read as 132 beats per minute with regular rhythm and good volume. Further assessment was done for thirty (30) minutes after which the results were assessed to be normal.

Vaginal examination;

Permission was sought from Madam Rashida for vaginal examination. A tray already set had two sterile gallipots with one containing cotton and a container with savlon lotion, sterile gloves, a receiver for the used swabs and a sanitary pad. Hands were washed with soap under running water and dried with clean dry towel. A pair of sterile gloves was put on and client was asked to assume a dorsal position with the knee flexed for examination. The vulva was inspected for oedema, wart, scars and varicose veins but there was none present. Five (5) cotton wool swabs were used for the examination. The dominant hand was used to pick the cotton wool and dipped into the lotion; swab was dropped from dominant hand into the non-dominant hand and swab per stroke. Labia majora was wiped from anterior to posterior and the used swab was disposed off into a receiver. Labia minora was wiped from anterior to posterior and the used swab was disposed. The vestibule was pated using the non-dominant hand and the dominant hand was used to swab the vestibule from anterior to posterior. The used swab was disposed into the receiver. Client's permission was sought and the right middle and index finger was inserted into the vagina by firmly pressing downwards. This caused relaxation of the vaginal walls and muscles. The condition of the vagina was warm and moist and cervix was soft, thin and effaced with cervical dilation of four (4) at 8:48am and well applied to the presenting part, membranes were intact and there was no moulding. Ischial spines were blunt and pubic arch was wide. A clean perineal pad was applied on the vulva and client was asked to lie on her left side to prevent supine hypotension syndrome. After doing the vaginal examination, gloves hands were checked before being disposed off. All findings and the progress of labor was explained to client and her support person, also the midwife in charge was also informed and confirmed the progress. The dilatation board was used to explain the cervical dilatation and progress of labor to her. Client

was thanked for cooperating and all information gathered was recorded. Client was made comfortable in bed and encouraged to ambulate.

3.2 PREPARATION FOR BIRTH

Identification of helper and review of the emergency plan

Madam Issaka Rashida was brought to the facility by her husband. The staff midwife on duty was the skilled helper who was also supervising the delivery. The unskilled helper was the client's husband and she was also made aware that she would be called to help when needed. The phone number of a hospital (St Luke Hospital, Kasei) was called and made ready in case of any emergency and a pediatrician was informed. Also, a nearby driver was informed that in case of emergency he would be called.

Preparation of area of delivery

The delivery room was prepared for delivery; the room was made clean and warm by drawing the curtains closer, light was switched on, and torchlight was also made ready in an event of light out. Client was told that her hands, chest and abdomen will be washed with clean water and soap prior to delivery 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.

Preparation of resuscitation area and checking of the function of equipment's

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 function.

3.3 MANAGEMENT OF FIRST STAGE

The fetal heart rate, maternal pulse was checked every 30 minutes, duration of contractions in 10 minutes was done every 30-minute, temperature, blood pressure, respiration as well as vaginal examination was done 4 hourly and the results was plotted on the partograph. She complained of being fatigue and frequent micturition. She was reassured she is in the hands of competent midwives.

Madam Rashida was reassured that labor was progressing well and was encouraged to pass urine frequently to prevent full bladder, since this could impede descent of the fetal head and contraction of the uterus.

Madam Rashida was encouraged to ambulate and rest on lie on her left lateral side when tired to prevent supine hypotension syndrome. Client took one third of the porridge served. Madam Rashida **complained of vomiting**. Sacral massage was performed for client.

At exactly 12:48pm, second vaginal examination was done for client with 8cm dilation and membranes raptured with clear liquor and cord prolapse was excluded. Desent was one-fifth $1/5^{th}$.The fetal heart rate recorded was 139 beats per minute with good volume and rhythm. Uterine contractions were 4 in 10-minute lasting 47 seconds.

Her vital signs were checked and recorded as follows.

Temperature	-	36.2 degree Celsius
Pulse	-	85 beats per minute
Respiration	-	21cycle per minute
Blood pressure	-	120/80 millimeters of mercury

All the findings were communicated to her and recorded on the partograph. Madam Rashida was educated on perineal hygiene. She was advised not to touch her pad when in place. She was then given water to wash her hands and cleaned with a wet towel. She was also given sips of water since she was sweating profusely. The anus was gapping and perineum bulging. The trolley containing the following was set;

Top shelf containing sterile items are as follows:

- Two artery forceps
- 4 drapes
- Cord scissors
- 2 gallipots and with cotton swabs and gauze
- Receiver for placenta
- Episiotomy set (scissors, dissecting forceps and suturing and forceps)

Bottom shelf

- Drum containing gauze and cotton wool
- Cheatle forceps in its container
- Jug for measuring the amount of blood loss
- Identification band
- Perineal pads
- Mackintosh
- Cord clamp in his pack
- An injection tray containing 10 units of oxytocin drug, water for injection, vitamin K, chloramphenicol eye drop
- Examination gloves

- Antiseptic lotion
- Fetal fetoscope
- Syringes and needles
- Sterile gloves in its pack
- Two clean cot sheets
- Lidocaine
- Bulb syringe in a receiver containing water

Other instruments include sutures, face mask, goggle, boots, plastic apron baby's dress, bed pan, light source was directed to the bed immediately

3.4 MANAGEMENT OF THE SECOND STAGE OF LABOUR

At 2:48pm, client complained of urge to bear down and vaginal examination confirmed 10cm dilation. She was fully dilated with moulding (++), descent of $0/5^{th,}$ fetal heart rate of 148 beat per minute, contraction was 4:10 lasting for 45 seconds.

Madam Rashida was transferred to the second stage room and was positioned on the delivery bed at 2:50pm. She was told to be cooperative during delivery and educated on the various positions for delivery. Client was assisted into the lithotomy position with knees flexed apart which was her choice. She was reassured and every procedure to be done was explained to her. Client's abdomen was washed and curtains were drawn. Protective clothing such as mackintosh apron, rubber boots and goggles were worn. Hands were washed with soap under running water, dried with sterile towel and sterile gloves were worn on both hands.

She was reminded that her baby would be delivered unto her abdomen to provide warmth and initiate bonding. At this point a clean perineal pad was applied to the anus to keep the delivery

area clean. Madam Rashida was encouraged to push with each contraction and rest in between contractions.

As labor progressed, the head advanced gradually and flexion was aided by gently pressing the advancing head downwards in other to allow the smallest diameter of the fetal head to distend the vulva and the perineum. Descent of the fetal head continued till crowning of the head occurred, Madam Rashida 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 by holding the two parietal bones. The eyes were cleaned with separate sterile swabs from the inner cantus of the eye outwards. The mouth and nose were cleaned with gauze swabs. Baby's neck was checked for cord around neck but there was none felt.

The head was supported and restitution was allowed to take place and internal rotation of the shoulders while the external rotation of the head through 45 degrees took place. This brought the shoulders into anterior-posterior diameter of the pelvic outlet. Madam Rashida was asked to push with the next contractions and reminded baby will deliver onto abdomen. 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 3:00pm and was noted.

An alive female baby was delivered and cried loudly after delivery. The baby was quickly cleaned from head to toe with a clean cot sheet and covered her with another dry clean cot sheet while on her mother's abdomen.

3.5 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 canthus to the outer canthus to prevent infection. Baby was delivered unto mother's abdomen and cried loudly and had 8/10 as her first minute APGAR score. The baby was dried thoroughly to keep the baby warm and stimulate breathing. The cord was clamped two finger breadths away from the baby's abdomen and the second three finger breadths from the first clamp. The cord was then cut between the two clamps with gauze to avoid splashing, the fifth minute APGAR score was done and baby had 10/10. 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 and date of birth and was tied around the baby's wrist. Baby was then placed on the mother's abdomen to initiate skin to skin. The wet sheet was removed, mother and baby were covered with a warm sheet and the head covered with a 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 promote bonding between mother and baby. The baby was then nursed on the mother's chest to continue skin to skin for an hour with head turned to one side, in order to facilitate drainage of secretions to prevent aspirations.

The Apgar score assessment was as follows:

INDICATOR	**FIRST MINUTE**	**FIFTH MINUTE**
Appearance	2	2
Pulse	1	2
Grimace	2	2
Activity	1	2

Respiration	2	2
Total	**8/10**	**10/10**

3.6 ACTIVE MANAGEMENT OF THE THIRD STAGE OF LABOUR

The third stage of labor was managed using active management of third stage of labor. It is applied regardless of the 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 the use of controlled cord traction. 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 unidentified twin in utero before 10 units of oxytocin was given intramuscularly by the midwife-in-charge to aid in contraction and to prevent any bleeding. The client was asked to empty her bladder which she said she had no urge. The non-dominant hand was placed on the fundus to feel for contractions. As soon as contractions were felt, the clamp was held with the dominant hand while the non-dominant hand was placed on the lower abdomen in the suprapubic area to steady the uterus. The uterus was pushed in an upward direction to serve as counter traction to prevent inversion of the uterus. The cord and the forceps were also held firmly at the same time and with downward traction, the process was repeated until the placenta became visible at the vulva. The placenta was cupped by both hands and twisted to remove pressure on the fragile membranes. The placenta and membranes were delivered completely at 3:05pm. The uterus was massaged to maintain the contraction. Client was taught 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 15 minutes for two hours making sure the uterus was firm, while blood loss was checked.

The placenta and membranes were quickly examined, and all the lobes were intact and healthy. The placenta and membranes were placed in a receiver which was placed in between her legs for thorough examination later. 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. Client was taught how to massage her uterus and encouraged to call when the uterus felt soft.

The blood loss was estimated as 100mls.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 hemorrhage and infections. She was also educated on how it would help in the contractions of the uterus. Madam Rashida was congratulated for her cooperation.

3.7 EXAMINATION OF PLACENTA AND MEMBRANES

The working area was cleaned with 0.5% chlorine solution. After client was made comfortable in bed, the placenta was dipped in 0.5% solution and was placed on a flat surface for thorough examination 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 fitting neatly together without any gaps, the edges forming a uniform circle. There were no blood vessels radiating beyond the placental edges.

The placenta was discarded after decontamination. The instruments and equipment used were soaked in 0.5% chlorine solution and were removed after 10 minutes, washed, rinsed and air

dried and made ready for sterilization and storage. Hands were dipped in 0.5% chlorine solution before discarding the gloves. Amount of blood loss was 100mls.Client was congratulated for the effort made.

3.8 MANAGEMENT OF FOURTH STAGE OF LABOUR

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

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

Temperature - 36.5 degree Celsius

Pulse - 96 beat per minute

Respiration - 20 cycle per minute

Blood pressure - 120/70 millimeter of mercury.

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

Madam Rashida 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 sees any profuse bleeding.

She was asked to change her pad when soiled in order to prevent infection. Madam Rashida vital signs and uterus were checked every 15 minutes for 2 hours and 30 minutes for 1 hour and then hourly for three hours and findings recorded on the partograph. The findings were within the normal range. The baby was also monitored at the same interval to ensure that breathing was normal and the colour of its skin was pink.

3.9 CARE OF THE BABY

PREVENTION OF DISEASES

The following procedures were performed to prevent infection to the eye and cord and also prevent hemorrhagic disease of the newborn. Prevention of disease is done within the first 90 minutes. Two (2) drops of Chloramphenicol eye drop was instilled on each eye, the cord was dressed with sterile cotton and methylated spirit and vitamins K 1.0mg intramuscularly was given to the baby to prevent bleeding. Hands were washed with soap under running water and cleaned with dry clean towel. Baby was then wrapped to keep him warm.

3.10 EXAMINATION OF THE NEWBORN

After an hour, baby was taken from the mother

The baby was put on a cleaned covered flat surface. Baby was then exposed systematically as it was examined from head to toe in the presence of the mother. Baby's colour was pink on observation.

Head and neck examination

The head was examined for shape and size, widened sutures, bulging and depressed fontanelles, any edematous swelling, caput succedaneum, anacephaly, microcephaly, among others but none detected. The ears were examined for size, shape, patency, softness of the cartilage and alignment with the eye. The eyes were examined for its presence of colour, redness of the

conjunctiva, jaundice of the sclera and deformities and alignment with the ears no abnormalities were seen. The nose was examined for shape, size, patency, deviated septum and discharges but no abnormalities were detected. The buccal cavity was inspected for false teeth, tongue tie, cleft lip and palate by using the little finger to feel palate, submucous cleft but no abnormality was detected. Also, the rooting and suckling reflexes were present on assessment. The neck was also palpated for rigidity and congenital goiter.

Chest examination

The chest was inspected for shape, size and chest wall movement with respiration rate was 40 cycles per minute and the apex heart beat was also 130 beats per minute. Breasts were palpated for masses and had no none and nipple was checked for position which was normal.

Extremities

The upper extremities were inspected for equality, number of palmer creases, clubbed fingers, extra or missing digits. No abnormalities were detected. Baby's ability to perform Moro and grasp reflexes was also checked. Hands and arms were inspected for symmetry, movement and paralysis. Colours of nail beds were inspected. The lower extremities were inspected for equality, clubbed feet, talipes, extra or loss digits but none was present. Congenital hip dislocation was also checked using the Ortolani's test and there was no dislocation since a 'clunk' was not heard.

Abdominal examination

The abdomen was examined for shape and size, with no bleeding from the umbilical site and abnormalities such as omphalocele, gastroschisis were absent. The spleen and liver were palpated for enlargement and no abnormalities were found.

Back examination

The back was also examined with baby lying laterally. Two fingers were run through the back to check for swelling, missing vertebra also for spinal bifida, meningocele, among others but none was detected.

Genital examination

The genitalia were examined and the majora covering the libia minora. The clitoris was present. The urethra and anus were present since baby passed urine and meconium,

Measurement

Head circumference 32 centimeters, Length of the baby was 48 centimeters. Baby's weight was 2.9 kilograms. Gloves were removed and disposed aseptically before washing and drying hands. Findings were documented and communicated to her. Baby's vital signs and weight were checked and recorded as follows;

Temperature	36.2 degree Celsius
Apex heart beat	130 beats per minute
Respiration	40 cycles per minute
Weight	2.9 kilograms

3.11 MANAGEMENT OF THE MOTHER

Client was reassured and encouraged to have enough rest and sleep. The mother's initial vital signs were checked every 15 minutes for 2 hours and 30 minutes for 1 hour and then hourly for 3 hours and recorded as follows;

Temperature	36.2 degree Celsius
Pulse	89beat per minute
Respiration	21cycle per minute
Blood pressure	100/70millimeter of mercury

The fundus was rubbed to facilitate contraction. Blood clots were expelled, and the Symphysiofundal height was 17 centimeters. Client was transferred to the lying-in-ward and baby put to breast. The total blood loss after the fourth stage was 100 milliliters. At the end of the fourth stage, the amount of urine passed was 100 milliliters. Lochia was red in colour (rubra), small in quantity and had no foul smell. Vitamins 'A' capsule 200,000 I.U was given to mother. Client was educated on frequent micturition and changing of perineal pads when soaked, how to fix baby to breast, the importance of exclusive breastfeeding for the first six months and feeding on demand was stressed on as well. Client's neighbor was allowed to see her and she was served with warm porridge and bread to restore energy. General condition of client was good and all labor notes were recorded on the partograph sheet.

3.12 CONDITION OF MOTHER

Client was made comfortable in bed and was helped to fix baby to breast. Vital signs were rechecked and the following examinations were done and recorded as follows;

Blood pressure	100/70 millimeter of mercury
Temperature	36.3 degree Celsius
Pulse	87 beats per minute
Respiration	23cycles per minute

Fundus	17centimeters
Blood loss	100mls
Bladder	100mls

Condition of mother after delivery was good.

3.14 CONDITION OF BABY AT BIRTH

Examination gloves were worn for the first examination of the baby. General examination of the baby was done and no abnormalities detected. The baby had a pink skin colour, umbilical cord was not bleeding. The baby was classified as normal and routine care given. Baby passed urine and meconium within some few minutes after birth.

The baby's vital signs and observations are as follows;

Temperature	36.5 degree Celsius
Apex heart beat	130 beats per minute
Respiration	40 cycles per minute
APGAR score for first minute	8/10
APGAR score for fifth minute	10/10
Sex	Female
Weight	2.9 kilograms
Abnormalities	None
Condition of baby	Very good.

3.11 LABOUR CARE PLAN

PROBLEMS IDENTIFIED DURING LABOUR;

On 24th August 2023 client complained of;

1. Anxiety
2. Fatigue
3. Waist pains
4. Frequent micturition.
5. Vomiting.

LONG TERM OBJECTIVES

Madam Rashida will go through labor successfully and deliver a healthy baby without any abnormality or complications

SHORT TERM OBJECTIVES

1. Client will be relieved of anxiety within 30minutes
2. Client's fatigue will resolve within 24 hours.
3. Madam Rashida will be relieved of waist pains within 6 hours after birth.
4. Client will understand and cope with the physiology of increased frequency of micturition within 2 hours
5. Client's vomiting will subside within 24 to 48 hours

TABLE 2: NURSING CARE PLAN FOR MADAM ALIMA DURING LABOUR

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
24/08/23 12:45 pm	Anxiety related to unknown outcome of labor	Client's anxiety will be allayed throughout the period of labor evidenced by; 1. Client seeking clarification on procedures. 2. Midwife observing that client has relaxed in bed.	1. Reassure client to subside her level anxious. 2. Explain every procedure to be carried to her to allay fear. 3. Educate her on possible outcome of labor. 4. Encourage deep breathing exercise. 5. Encourage client to ask questions and answer them tactfully. 6. Introduce client to other staffs who will attend to her and other patients who has had labor successfully.	1. Client was reassured to allay her anxiety. 2. Client cooperating with every procedure carried. 3. Client was educated on possible outcome of labor. 4. Client was encouraged to do deep breathing exercise. 5. Client was encouraged to ask questions and answers were given tactfully. 6. Client was introduced to other staffs.	24/08/23 4:45 pm	Goal fully met as client sought clarification procedures.	T.B.S

TABLE 2: NURSING CARE PLAN FOR MADAM ALIMA DURING LABOUR CONTINUES

DATE /TIME	NURSING DIAGNOSIS	OBJECTIVES /OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTIONS	DATE/ TIME	EVALUATION	SIGN
24/08/23 12:45 pm	Physical exhaustion (fatigue) related to physiological activities that occurred in labour.	Client will be relieved of fatigue within 2 hours evidence by; 1. Client verbalising she is no more tired. 2. Midwife observing client feels comfortable in bed.	1. Reassure client to relieve her of fatigue. 2. Encourage client to rest when contractions wear off. 3. Give client a sacral massage. 4. Stay by client throughout labour. 5. Serve client with soft drinks.	1. Client was reassured to relieve her of fatigue. 2. Client was encouraged to have enough rest when contractions wear off. 3. Client was given sacral massage by rubbing the palm at the sacral region. 4. Client was not left alone relative was always around client throughout labour. 5. Client was served with soft drinks, such as malt.	24/08/23 2:45 pm	Goal fully met as client verbalised, she is no more tired. Midwife observed that client feels comfortable in bed.	T.B.S

TABLE 2: NURSING CARE PLAN FOR MADAM AMINA DURING LABOUR CONTINUES

Date /Time	Nursing Diagnosis	Nursing Objectives	Nursing Orders	Nursing Intervention	Date/ Time	Evaluation	Sign
24/08/23 12:45pm	Altered body comfort (waist pains) related to the effects of contractions and descent of fetal head	Madam Rashida would cope with the waist pains within 6 hours after birth as evidenced by; 1. Client verbalizing those two (2) managements of waist pains. 2.The midwife observing that client is relaxed and tolerating pains	1. Reassure client to cope with the waist pains. 2.Give client sacral massage 3. Explain the physiology of waist pains to client. 4.Teach client deep breathing exercise 5.Encourage client sit for shorter duration	1.Client was reassured to cope with the waist pains 2.Sacral massage was given 3.Physiology of waist pains was explained to client 4.Client was taught deep breathing exercise 5. Client was encouraged to reduce frequent sitting.	25/08/23 6:45pm	Goals fully met as client verbalized two (2) management procedures of waist pain. The midwife observed client tolerated pain	T.B.S

TABLE 2: NURSING CARE PLAN FOR MADAM ALIMA DURING LABOUR CONTINUES

DATE/ TIME	NURSING DIAGNOSIS	OBJECTIVES/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE / TIME	EVALUATION	SIGN
24/08/23 12:45pm	Impaired urinary elimination (frequency of micturition) related to pressure on the bladder by the presenting part	Client will understand and cope with frequency of micturition within the duration of labor evidenced by; 1. Client coping with frequency of micturition. 2. The midwife observing client cope with increased frequency of micturition.	1.Reassure client 2. Explain the physiology of micturition and that it is temporal. 2. Serve bed pan when she wants to urinate. 3. Encourage frequent urination to aid in descent of fetal head. 4. Encourage client on good vulva hygiene to prevent infection. 5Encourage client to use panty linear.	1.Client was reassured be able to cope with the frequency of micturition 2. The physiology of micturition was explained to client as the pressure on the bladder from the growing uterus which results in frequency 2. Bed pan was served when client want to urinate. 3. Client was encouraged to urinate when she has the urge to. 4. Client changes her panties when necessary and bathed at least twice in a day to prevent infection. 5. Client used panty linear to prevent any odour.	24/08/23 5:45pm	Goal fully met as client said she is able to cope with frequent urination and the midwife observed that client coped with increased frequency of micturition.	T.B.S

TABLE 2: NURSING CARE PLAN FOR MADAM ALIMA DURING LABOUR CONTINUES

Date/ Time	**Nursing diagnosis**	**Nursing objective**	**Nursing orders**	**Nursing intervention**	**Date/ Time**	**Evaluation**	**Sign**
24/08/23 12:45pm	Risk for fluid volume deficit (vomiting) related to slow absorption and excessive contraction during labour.	Client's vomiting will reduce within the duration of labor as evidenced by; 1. Client having good skin turgor. 2. Midwife witnessing a reduction in vomiting	1. Reassure client to allay fear and anxiety by explain the physiology associated with vomiting. 2. Move away all nauseating objects from client. 3. Hydrate client to prevent dehydration. 4. Assess client's fluid volume. 5. Serve client a vomitus bowl and measure the amount of vomitus.	1.Client was reassured by explaining the physiology of vomiting to her 2. Nauseating objects was moved away from client. 3. Client was given oral fluids to replace fluid loss. 4. Client was checked for eye sunking, blood pressure and skin turgor. 5. She was served with a vomitus bowel and the amount of vomitus was measured.	24/08/23 4:45pm	Goal fully met as client had a good skin turgor and midwife observed a reduction in vomiting	**T.B.S**

CHAPTER FOUR

PUERPERIUM

4.0 INTRODUCTION

This chapter entails the management of both mother and baby from the delivery day to six weeks post-partum. Care plans drawn for the management of problems encountered during puerperium. Also, health education, counseling, assessment, support for infant feeding and immunization service for baby was done.

This chapter entails seven days postnatal home visit, first week and sixth week's postnatal visit to the facility.

4.1 Day of Delivery

On Thursday, 24th August 2023, Madam Rashida and her baby were transferred to the lying-in room at 3:50pm after the one-hour continuous skin to skin contact. They were closely observed for six hours postpartum. She was made comfortable in bed and baby was then put to breast. Client was educated on the need to ensure that baby was kept warm to prevent hypothermia and also ensure proper personal hygiene and empty her bladder frequently so that the uterus could contract and prevent bleeding. The need to change perineal pad when soiled and applying of new pad to make client comfortable and also to prevent long term genital tract infection was also emphasized. Client was educated to breastfeed baby on demand, practice exclusive breastfeeding and also fixing of the baby well to breast. Client was helped to fix baby to breast and problems associated with breastfeeding such as mastitis, engorgement, cracked nipples and their management were explained to client. Emphasis was also made on hand washing after visiting

the toilet, removing baby's soiled napkins, before handling and breastfeeding the baby to help prevent infection. Client vital signs were checked every 15mins for 2 hours, 30 minutes for 1 hour and hourly for the last 3 hours. Her vital signs and other assessment were recorded as follows:

Temperature	----------	36.2 degree Celsius
Pulse	----------	89 beats per minute
Respiration	----------	21 cycles per minute
Blood pressure	----------	100/70 millimeter of mercury
Lochia	----------	small and rubra
Fundal height	----------	17 centimeters
Condition of uterus	----------	contracted
Breast	----------	lactating

Vital Signs for baby and weight was checked and recorded as follows:

Temperature ---------- 36.7 degree Celsius

Respiration ---------- 40 cycles per minute

Apex heart beat ---------- 130 beats per minute

Weight ---------- 2.9 kilograms

Client complained of afterpains, she was reassured and education was given on the physiology of afterpains. Client was encouraging to continue breastfeeding baby and she was given

paracetamol tablet 1g start also. She was told that the pain was as a result of involution of the uterus so that it returns to normal. Madam Rashida ate fufu and groundnut soup which was brought by her husband and her neighbor. She was also educated to breastfeed exclusively on demand and wash hands before breastfeeding. She breastfed her baby afterwards, took her bath and went to bed.

4.2 SUBSEQUENT CARE OF THE BABY

Continuous monitoring was given to baby and the condition of baby was healthy. Baby was bathed six (6) hours after delivery. Immediately after the baby bath, cord was dressed and was also checked for bleeding. Baby was dressed and wrapped in a warm cot sheet to keep it warm to prevent hypothermia. The breathing rate was also checked and was within the normal range.

Madam Rashida was educated on exclusive and frequent breastfeeding at least 8 to 12 times a day or on demand, proper hand washing before and after handling the baby was encouraged. Client was educated on the newborn care such as cord care and also for any danger sign such as irregular breathing, jaundice, fever and report immediately to the nearest health facility.

BABY BATHING AND CORD DRESSING

REQUIREMENTS

Top shelf

Sterile gloves

Sterile cotton wool swab

Sterile water in a gallipot

Sterile gallipot

A clean baby dress, cap and socks (if available)

Gallipot containing cotton wool swab

Sterile tray for cord dressing cord dressing

Down shelf

Diapers

Dress

Baby's oil or Vaseline

Baby's powder

Basin

Bath thermometer

Mackintosh

Disposable gloves

2 Jugs containing hot and cold water each

Two receptacles for used water and dirty linen

A receiver receptacle for used swab

Methylated spirit

BABY BATH AND CORD DRESSING

PROCEDURE FOR BABY BATH

Bathing of the baby was done six hours following delivery. Madam Rashida's consent was sort to bath the baby which she accepted. She was asked to watch closely in order to enable her learn how to bath baby at home. Requirements needed for the procedure were gathered.

Procedure was explained to the mother on how to bath the baby and all items to be used were assembled. Plastic apron was worn, cold and hot water were mixed and temperature tested with elbow with confirmation by mother. Hands were washed with soap and water and dried and examination gloves worn. Baby was placed on a protected flat surface and undress after which she was wrapped with a cot sheet. Baby was not over exposed to prevent hypothermia. A thorough examination was done. Eyes were cleaned with damp towel from inner cantus out followed by baby's face and dried. The nape of baby's neck was supported with one hand protecting the ears with the middle finger and the thumb. Baby's head was washed with soapy sponge still supporting the nape and the body resting on the elbow with head lifted to the edge of the basin. Soap was rinsed off the head and dried. Baby was placed back on protected flat surface and exposed. Arms and front of the trunk were washed paying attention to skin folds. Baby's back was turned with one arm supporting the chest with the hand holding the distal arm of the baby. The back was washed down to the feet paying attention to the skin folds. Baby was firmly supported and rinsed thoroughly in a quick manner from the trunk to the limbs. Baby was placed on flat surface and covered with a clean big towel. He was dried with a small towel, paying

attention to skin folds. Baby was smeared with pomade and dressed with socks and cap put on. She was then wrapped in a cot sheet and given to mother to be breastfed.

CORD DRESSING

The baby was wrapped in a towel to keep her warm. A tray containing five dry cotton wool balls in a gallipot with antiseptic solution which was methylated spirit and a receiver for the used swabs was already set for cord dressing. Hands were thoroughly washed with soap and under running water and air dried as well. Sterile gloves were worn and the cord was exposed. It was then inspected for bleeding but there was none detected. The base of the cord was cleaned with another cotton wool swab and was discarded. The cord was cleaned the using five of the cotton wool swabs.

The tip of the cord was held with cotton wool swab, up to 5cm away from the base was swabbed and after that the base of the cord was cleaned with separate cotton wool swabs. The tip of the cord was dried with the swab that was used to hold it. The cord was left exposed for some few minutes to allow it to dry and the baby was dressed, wrapped and given to mother to breastfeed. The waste materials were discarded according to infection prevention protocol. Gloves were removed and disposed off. Hands were washed with soap and water. Mother was also advised not to apply anything on it or touch it. Findings were reported and documented.

4.3 FIRST DAY AFTER DELIVERY

Friday 25th August, 2023 was the first day after delivery and baby looked healthy with no abnormality detected after head-to-toe examination done. Client was asked about her complains, afterpains which she said was coping. Client was visited during the evening after she was discharged. Vital signs were checked and recorded as follows;

Observation	**Morning**
Temperature	36.5 degree Celsius
Blood pressure	100/60 millimeter of mercury
Respiration	24 cycles per minute
Pulse	70 beats per minute

The uterus was well contracted, Symphysio- fundal height 16cm. The lochia was red (rubra) and the amount was moderate and not offensive. She was encouraged to empty her bladder frequently whenever she had the urge. She was encouraged to practice exclusive breastfeeding and feeding baby on demand the need to pat baby's back to break wind. educated on the importance of breastfeeding to the mother, baby and the family as a whole. Also, frequent breastfeeding of the baby and also, client was encouraged to change her perineal pad (four (4) hourly and when soaked), proper disposal of the used perineal pad when soiled to prevent ascending infections to the uterus. Baby passed meconium, dark green in colour. Madam Rashida was encouraged not to apply hot compress on the baby's head with the aim of aiding fast closure of the fontanelles, the effect of such practices was given to her. She was informed of her discharge and encouraged to register the baby at birth and death registry.

Baby vital signs are as follows:

Observation	**Morning**
Temperature	36.3 degree Celsius
Apex beat	136 beats per minute

Respiration	43cycles per minute
Weight	2.7 kilograms

The baby was then wrapped in a clean and warm cot sheet and handed over to the mother for breastfeeding. The position and attachment to the breast was done well under supervision and client demonstrated same. Client was reminded on the intake of nutritious diet and taking of fruits. Client was also educated on postnatal exercises such as Kegel and early ambulation. She was also educated changing of diapers frequently, and keeping baby warm always. The baby was given oral polio vaccine and Bacillus Chalmette Guerin (BCG) vaccine intradermal at the right upper arm as a protection against Tuberculosis. Madam Rashida was educated not to massage or apply anything to the injection site. Client was encouraged to visit the Baby Clinic for growth monitoring and to continue with baby's immunization. She was made aware that there will be a tissue reaction over the area and a scar formation will take place which indicates that the baby has effectively been immunised. She was also asked to register the baby at the birth and death registry. Mother and baby was reassessed before leaving the facility and no abnormalities were noticed. Madam Rashida was informed of the first postnatal visit to the clinic to be 2nd December, 2021 was she confirmed they are ready for discharge.

She was given the following drugs;

Tablet folic acid	5mg daily for 15 days
Tablet ferrous Sulphate	200mg bd for 15 days
Tablet multivitamins	200mg daily for 15 days
Tablet paracetamol	1g tid for 5 days
Tab Metronidazole	400mg tid for 14days

At 11 am, client was helped to pack her things and was informed on intended postnatal visits for a period of one week which was explained to her that she will be visited at home for seven days, morning and evening for the first three days then once daily from the fourth day which she agreed.

At 4:00 pm, client was visited at home, the family was glad to be visited. Mother and baby were healthy. Permission was sought to inspect client's perineal pad and it was serosa, moderate in flow without any offensive smell. Her breasts were lactating well. Uterus well contracted on palpation, head to toe examination was done on both mother with no abnormality found. Madam Rashida was encouraged to breastfeed baby on demand. Vital signs were checked and recorded as follows for mother;

Observation	**Evening**
Temperature	37.1 degree Celsius
Pulse	79 beats per minute
Respiration	25 cycles per minute
Blood pressure	110/60 millimeter per mercury

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

Observation	**Evening**
Temperature	36.8 degrees Celsius
Pulse	136 beats per minute

Respiration 48 cycles per minute

Permission was sought to top and tail the baby in front of mother to observe and it was granted. Baby was examined thoroughly from head to toe to examine for abnormality but none was found. Baby's cord was dressed under client's observation. Madam Rashida was informed about the next postnatal home visit. Permission was sought to leave.

4.4 SECOND DAY POST DELIVERY (FIRST DAY POSTNATAL HOME VISIT)

On 26th August 2023, at 8:00am and 5:30pm Madam Rashida was visited in her house. Both mother and baby looked healthy on arrival. The family was much pleased to be visited. Client was asked about her previous complain which she said was better. Explanation was given to Madam Rashida that she and the baby would be examined from head to toe to detect any abnormality for early treatment, she was asked to empty her bladder. Client conjunctiva was examined and it was not pale, the uterus was well contracted and breast was lactating, Symphysiofundal height measured 15 centimeters. The perineum was clean when inspected, Lochia was red with moderate flow and there was no bad odour. Madam Rashida was taught to express breast milk to reduce congestion of breast milk and breastfeed baby on demand also she was taught how to attach baby to the breast. The condition of both mother and baby was good, but she complained of headache and sleeplessness. Client was educated to take more water, reduce her workload and get assistance from relatives. Also, she should rest when baby sleeps. She was educated on the importance to relax when less busy. She was asked to demonstrate how she breastfed her baby which performed well. Her vital signs were taken and recorded as;

Observation	**Morning**	**Evening**
Temperature	36.3 degree Celsius	36.5 degree Celsius

Pulse	76 beats per minute	79 beats per minute
Respiration	22 cycles per minute	24 cycle per minute
Blood pressure	120/70 millimeter of mercury	110/70 millimeter of mercury

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

Observation	Morning	Evening
Temperature	37.0 degree Celsius	36.6 degree Celsius
Pulse	132 beats per minute	136 beats per minute
Respiration	45cycles per minute	42 cycles per minute
Weight	2.6 kilograms	2.6 kilograms

Permission was sought to top and tail the baby in front of mother to observe and it was granted. Baby was examined thoroughly from head to toe to examine for abnormality but none was found. Madam Rashida was encouraged to completely empty one breast before she breastfeeds baby with the other breast. The baby had passed meconium and urine when the diaper was removed and it was inspected before topped and tailed. The cord was also dressed with cotton wool soaked in methylated spirit; it was cleaned and kept dry. Permission was sought to leave and she was reminded that she will be visited the next day.

4.5 THIRD DAY POSTPARTUM (SECOND DAY POST NATAL HOME VISIT)

On 26th August, 2023, the second visit was made to Madam Rashida's house around 8: 00am in the morning and 6:00pm in the evening. Permission was sought to examine both mother and baby. The head-to-toe examination was also done on her and no abnormalities were detected.

Her perineum was clean, the lochia was found to flow moderately the colour was red (rubra) and without bad odour. The Symphysio fundal height was 14 centimeters. Her vital signs were checked and recorded as follows;

Observation	**Morning**	**Evening**
Temperature	36.7^{o}C	36.3^{o}C
Pulse	79bpm	82bpm
Respiration	21cpm	23cpm
Blood pressure	100/60mmHg	110/70mmHg

Baby's vital signs and weight were taken and recorded as follows;

Observation	**Morning**	**Evening**
Temperature	37.2^{o}C	36.9^{o}C
Apex heart beat	127bpm	127 bpm
Respiration	42cpm	42cpm
Weight	2.5kg	2.5kg

The baby was topped and tailed, general examination was carried out and no abnormality was present. The cord was neatly dressed and seen shrinking. It was clean and dry. The baby has passed stools and the colour was brownish yellow and urine according to Madam Rashida. Client was asked about the sleeplessness and headache, and client said she was able to sleep better than the other days.

Permission was sought to leave and Client said she was very grateful and appreciated the care that was given to them.

4.6 FOURTH DAY POSTPARTUM (THIRD DAY POSTNATAL HOME VISIT)

On 28th August, 2023 the third home visit was made to Madam Rashida house at 7:00am in the morning she was greeted. Mother and baby were doing well. Permission was sought to inspect client's perineal pad and it was serosa, moderate in flow without any offensive smell. Her breasts were lactating well. Symphysiofundal height 13 centimeters. Her vital signs were checked and recorded as follows;

Observation	**Morning**
Temperature	37.2^{o}C
Pulse	82bpm
Respiration	23cpm
Blood pressure	120/70 mmHg

The baby was topped and tailed. General examination was carried out and no abnormality was present. The baby also passed stool and urine. The stump was neatly dressed. Baby's vital signs and weight were taken and recorded as follows;

Observation	**Morning**
Temperature	37.1^{o}C
Apex heart beat	124bpm

Respiration	46cpm
Weight	2.5kg

4.7 FIFTH DAY POST PARTUM (FOURTH DAY POSTNATAL HOME VISIT)

The fourth home visit was made to Madam Rashida's house at 7:00am on 29th August, 2023. The health status of mother was enquired, both mother and baby were doing well, but client complained of Fatigue and breast engorgement. She was educated to empty one breast before the other and feed baby on demand. Also, mother was encouraged to feed baby on demand. Also, client's knowledge on the cause and management of sexual dysfunction was assessed. Lochia was pink (serosa) with scanty flow without odour on inspection. Head to toe examination was done and everything was normal. Symphysiofundal height was 12 centimeters. Her vital signs were checked and recorded as follows;

Temperature	36.4^{o}C
Pulse	82bpm
Respiration	23cpm
Blood pressure	110/70mmHg

Baby's vital signs and weight were taken and recorded as follows;

Temperature	37.2^{o}C
Apex heart beat	134bpm
Respiration	46cpm

Weight 2.6kg

Top and tail was done, general examination was done, no abnormality was found. The cord was then dressed and the area was dried and shrieked. The baby passed stools and was yellow in colour and urine.

4.8 SIXTH DAY POSTPARTUM (FIFTH DAY POSTNATAL HOME VISIT)

The fifth postnatal home visit was on 30th August, 2023 at 8:00am. Greetings were exchanged with client and her family after which a seat was offered in client's room. Mother and baby were both in a healthy condition when it was enquired. Madam Rashida said the baby cries a lot, she was reassured that the crying of the baby will reduce when she feeds the baby on demand and changes her diaper frequently because babies have lusty cry to evoke attention. After the head-to-toe examination, no abnormality was detected. Inspection of the lochia was done and the colour was pink (serosa) without any bad odour and flow was scanty. She was educated on the need to take adequate diet. Symphysiofundal height of madam Rashida was 11centimeters. Client's vital signs were checked and recorded as follows:

Temperature 36.7 ^{o}C

Pulse 85bpm

Respiration 21cpm

Blood pressure 110/70mmHg

Baby's vital signs and weight were taken and recorded as follows:

Temperature 37.0^{o}C

Apex heart beat	136bpm
Respiration	45cpm
Weight	2.7kg

Cord was off and mother confirmed it fell off the night before that morning. Baby was bathed, head to toe examination was done and no abnormalities were seen. Stump was then dressed and the area was cleaned and dried. Madam Rashida was reminded of the next visit and she said she was very grateful. Permission was sought to leave.

4.9 SEVENTH DAY POSTPARTUM (SIXTH DAY POSTNATAL HOME VISIT)

The sixth day postnatal home visit was done on 31st August 2023 at 8:00am. Greetings were exchanged with client and her family and a seat was offered in client's room. Mother and baby were both in a healthy condition and mother said the baby's crying had minimized and now sleeps a lot. On head-to-toe examination, no abnormalities were detected. Her breast was lactating well. Inspection of the lochia was done and the colour was pink (serosa) flow scanty without any bad odour. Madam Rashida said the baby pass stool in the morning before arrival. Symphysio fundal height was 10centimeters.

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

Temperature	37.2 ^{o}C
Pulse	79 bpm
Respiration	24 cpm
Blood pressure	100/70mmHg

Baby's vital signs and weight were taken and recorded as follows:

Temperature	36.8^{o}C
Apex heart beat	132bpm
Respiration	42cpm
Weight	2.8kg

Baby was bathed under observation, head to toe examination was done and no abnormality was found on the baby. The stump was then dressed and the area was cleaned and dried. Education was given to her on the importance of ensuring good personal hygiene and the need to feed the baby on demand. Client was educated on some signs of baby that needs early attention and care. She said she appreciated that a lot, and she was thanked for her co-operation, permission was sought to leave. She was remembered of her visit to the clinic on the 1st September, 2023.

4.10 FIRST POSTNATAL VISIT TO THE CLINIC

On 1st September, 2023 at 10:00am, Madam Rashida and her baby came to the facility. A seat was offered to client, she looked healthy. Procedure to be carried out was explained to her and she consented. Midstream urine was taken and checked for protein and sugar and all tested negative. Lochia was checked and it was flowing, the colour was pink (serosa). Hemoglobin level was 12.1g/dl. Her vital signs were checked and recorded as;

Temperature	-	36.2^{o}C
Pulse	-	78bpm
Respiration	-	22cpm

Blood pressure - 110/70mmHg

Madam Rashida was asked to empty her bladder before the head-to-toe examination. Procedure to be carried out on Madam Rashida was explained to her. Privacy was provided and she was assisted to lie on the couch for the head-to-toe examination. Hands were washed with soap and water and dried with a clean towel.

Head to toe examination was done on her. On the head, hair was neat and tied with a ribbon, the conjunctiva was not pale, no discharges from the eyes, nose and ears. There was no abnormality detected in the mouth, and there was absence of enlarged nodes on the neck. Breast was lactating well, no engorgement, sore or cracked nipples were detected. The abdomen was palpated and there was no tenderness, no scars, enlarged liver or spleen on examination and the uterus was well contracted and measured 7cm. There was no oedema, varicosities and tenderness in calf. The perineum was intact and there was no offensive vaginal discharge and the lochia was not offensive with slight flow. Client was thanked for the cooperation and encouraged to assess a family planning method in addition to lactational amenorrhea method. Madam Rashida was then helped to dress up.

Head to toe examination was done on baby and no abnormalities were found. Umbilical stumped had healed. Baby's weight was 2.9kg. She was also educated on the importance of the child welfare clinic. Both mother and baby were handed over to the midwife in-charge for continuity of care and were educated to consult them in case of any problem. She was informed about the six weeks post-natal visit.

Client was congratulated for support; explanation was given to Madam Rashida on the need to be handed over to the midwife in-charge for continuity of care and was informed of frequent calling for checkup.

Baby's vital signs was checked and recorded;

Temperature - 36.8^{o}C

Apex heart beat - 129bpm

Respiration - 46cpm

Weight - 2.9kg

4.11 TERMINATION OF CARE.

Explanation was given to Madam Rashida on the need to be handed over to the midwife in charge for the continuity of care on 1st September, 2023 at 11:00am. Explanation was made to her that the program was ending that day but client was reassured of midwife in charge competency. Client was accompanied to her house and a seat was offered. Client, husband and neighbor were thanked for their corporation, information was provided and permission was sought to leave. According to the midwife in charge client was handed over to the public health nurse of the clinic. They went to the facility to meet the community health nurse and were offered a seat on arrival.

She asked of their mission and explanation was made to her that Madam Rashida was cared for through antenatal, delivery to six weeks postpartum. And it was time to officially hand her over to them for continuity of care. She was reassured that she was in safe hands and their readiness to continue caring for her and her baby. The schedule for child welfare clinic and immunization

were explained to her and client had no questions when asked. They were thanked and permission was sought to leave.

4.12 SECOND POSTNATAL VISIT TO THE CLINIC

Madam Rashida visited the clinic with the baby on 7th October, 2023 according to the midwife in-charge she was welcomed to the clinic by the midwife in charge. Both mother and baby were in good condition and had no complain. Her hemoglobin level was 14.2 gram per deciliter as checked and urine test for protein and sugar were negative. Her recordings were as follows

Temperature	36.2°C
Pulse	82bpm
Respiration	23cpm
Blood pressure	110/60mmHg
Weight	73kg

Baby's Vital signs and weight were checked and recorded as fellows;

Temperature	36.4°C
Respiration	35cpm
Apex beat	136bpm
Weight	4.3kg

Physical examination was done and no abnormality was detected, breast was lactating well, uterus was well involuted, lochia was absent and menstruation has not commenced.

Baby general condition was good, head to toe examination was done and baby's posterior fontanelles were closed. Client was handed over to the midwife in charge at the health center for baby immunization for polio, diphtheria, pertussis, tetanus, haemophilus influenza type B, hepatitis B immunization given to children at six weeks. The extra vaccines namely pneumococcal and rotavirus for protection against pneumonia and diarrhea respectively was also reminded to be given, they were handed over to the child welfare clinic, family planning unit where she was educated on methods available and she chose the calendar-based method. Client was helped through and continuity of care was ensured. Client was educated to consult them in case of any problem. Client was congratulated.

4.11 CARE PLAN DURING POST PARTUM PERIOD

PROBLEM IDENTIFIED

1. Afterpains 24th August, 2023
2. Insomnia 26th August, 2023
3. Headache 26th August, 2023
4. Breast engorgement 29th August, 2023
5. Fatigue 29th August, 2023

SHORT TERM OBJECTIVES

1. Client's afterbirth pains would subdue within 12 hours.
2. Client would sleep at least 6 hours within 24 hours.
3. Client's headache would reduce within 24 hours.
4. Madam Rashida would be relieved of breast engorgement within 48 hours
5. Client would have an increase in libido within a week.

LONG TERM OBJECTIVE

Client will go through puerperium successfully without any complication to both mother and baby.

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
24/08/2023 8:30 am	Acute pain (afterpains) related to physiological changes in puerperium	After birth pains will be reduced within 24 hours as evidenced by 1. client verbalizing two (2) management of afterpains 2. Midwife visualizing that client had a cheerful facial expression during breastfeeding.	1. Reassure client that the pain will reduce. 2. Explain the physiological changes that take place in the uterus during puerperium. 3.Client was encouraged to continue breastfeeding 4. Encourage client to void frequently 5.Give analgesics to reduced pain	1. Client was reassured measures will be put in place to make her feel comfortable. 2. It was explained that the after pains are as a result of contraction and breastfeeding causing involution of the uterus simultaneously. 3. Client breastfed baby on demand. 4. Client was advised to void frequently to relieve pressure on the uterus. 5. Paracetamol 1g was given to reduced pain.	25/08/2023 8:30am	Goal fully met as client verbalized two (2) management for afterpains and midwife visualized that client had a cheerful facial expression during breastfeeding.	T.B.S

DATE/ TIME	NURSNING DIAGNOSES	NURSING OBJECTIVES/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
26/08/2023 8:30am	Altered sleep pattern (reduced sleep) related to breastfeeding and crying of the baby during the night.	Client will be able to cope with the activities of the baby within 48 hours evidenced by; 1. Client verbalizing she is able to sleep for at least two (2) hours in the day and 3 hours apart during the night.	1. Reassure client that she will sleep. 2. Encourage client to sleep when baby was asleep. 3. Encourage client to change baby's diaper when soaked frequently before bed time. 4. Educate client to on the appropriate method in feeding baby. 5. Encouraged client to practice demand feeding.	1. Client was reassured that measures will be put in place to make her sleep well. 2. Client was encouraged to take opportunity of relaxing while baby is asleep if possible. 3. Client was encouraged to change baby's soiled napkin or diaper before bed time to prevent baby from crying overnight. 4. Kangaroo method was adopted in feeding the baby. 5. Client was encouraged to practice demand feeding to enhance proper development of the baby.	28/08/2023 8:30am	Goal fully met as client verbalized, she was able to sleep for at least two (2) hours in the day and 3 hours apart during the night.	T.B.S

DATE/ TIME	NURSNING DIAGNOSES	NURSING OBJECTIVES/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
26/08/2023 8:30am	Headache related to stress from puerperium.	Client will be relieved of headache within 24 hours evidenced by; 1. Client verbalizing she relived of the pain. 2. Midwife observing client had a cheerful facial expression	1. Reassure client. 2. Encourage client to take some rest in the day 3. Encourage client's relatives to support client. 4. Encourage client to reduce workload. 5. Encourage support person to restrict distractions preventing rest and sleep.	1. Client was reassured of competent nursing care. 2. Client was encouraged to have at least 2 hours rest in the day and sleep 8 hours at night. 3. Client's relative assisted with some household chores. 4. Client was encouraged to work within her strength. 5. Client support person was encouraged to restrict visitors so that she can rest and sleep.	27/08/2023 8:30am	Goal fully met as client verbalized a reduction in pain.	T.B.S

DATE/ TIME	NURSING DIAGNOSIS	OBJECTIVE/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
29/08/23 7:00am	Ineffective breastfeeding of baby (breast engorgement) related to poor feeding approach.	Madam Rashida will be relieved of breast engorgement within 48 to 72 hours evidence by; 1.Client demonstrating proper positioning and good attachment of baby to breast 2.Midwife observing frequent feeding of baby	1. Reassure client to allay anxiety 2. Teach client to position and fix baby well to breast. 3. Ask client to apply warm and cold alternatively compress on the breast. 4. Encourage client to continue breastfeeding. 5. Tell her to ensure baby empties one breast before giving her the other.	1. Client was reassured by explaining the cause of engorgement to her that, failure to allow the baby to empty one breast before giving the other caused the engorgement. 2. The various breastfeeding positions thus sitting and side lying were demonstrated to client. 3. Client applied a warm and cold compress alternatively on her breast. 4. Client was encouraged to continue breastfeeding baby on demand. 5. Client was told to ensure that baby empties on breast completely before giving her the other breast.	2/09/23 7:00am	Goal fully met as client demonstrated proper positioning and good attachment of baby to breast	**T.B.S**

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTIONS	DATE/ TIME	EVALUATIONS	SIGN
29/08/23 9:00am.	Fatigue related to stresses of labour	Client will be relieved of fatigue within 48 hours as evidenced by; 1. Client verbalize she is relieved of fatigue	. Reassure client that her condition is temporal and can be managed. 2. Encourage client to rest 3. Advise client to ensure noise free environment. 4. Advise client to have a warm bath before resting. 5. Encourage client support person to help with the house	. Client was reassured that the fatigue is temporal and would be managed. 2. Client took rest when baby was asleep. 3.Client slept in a noise-free environment 4. Client took warm bath before resting. 5. Support person helped client	31/08/23 9:00am.	Goal met as client reported that, she was relieved of body discomfort	T.B.S

SUMMARY AND CONCLUSION

Client G2P1A was met at Amantin Health Center, Amantin when she reported for review on the 14th August, 2023. She was managed from the 37 +3 days of pregnancy through labour and puerperium. During pregnancy, she experienced some minor disorders like lower abdominal pains, waist pains, sleeplessness, loss of appetite and others as stated of which the necessary management and education were given to her. She was also educated on environmental hygiene, birth preparedness and complication readiness. She adhered to all educations given to her and went through pregnancy successfully. During labour, she encountered challenges like painful uterine contractions and anxiety of which her pain and anxiety were allayed by encouraging her as well as some nursing interventions as stated. Client had positive labour outcome to a healthy live female child on 24/08/23 without any complications to mother and baby. After -delivery, client experienced fatigue, headache and sleeplessness among others as some disorders associated with puerperium. Client was managed accordingly and they resolved within the shortest possible time. Her entire family was not left out, they were also involved in rendering care to the client and her baby. All postnatal visits to the house and subsequent visit to the clinic by the client were done and all examinations were conducted on both mother and baby. Client, her baby and the entire family were handed over to the public health nurse in her community for continuity of care. In conclusion, this care study was of great benefit because it helped in acquiring new knowledge and put into practice what has been thought in the classroom. It has also given me much knowledge on how to render care to a woman during pregnancy, labour and puerperium in the society and the nation as a whole.

To the country, this will help reduce maternal and neonatal mortality as well as morbidity rate among expectant mothers and babies. To the clinic it will help increase the number of

attendances to the clinic during antenatal care, labour and puerperium. Client and her baby were healthy at the end of the whole interaction

BIBLIOGRAPHY

1. Ghana Health Service: *National Safe Motherhood Protocol*. (1st edition) Ghana, Accra, Yamens Press Ltd.

2. King L.T., Brucker, M. C., Fahey, J., Kriebs, J. M., Gegor, C. L., & Varney, H. (2014)

3. Konar, H (2011, 2013): *Textbook of Obstertrics* (7th edition) London, New Central Book Agency (P) Ltd.

4. Davis, C. P. (2022, March 29). *Definition of pregnancy*. Retrieved October 3, 2022, from RxList: https://www.rxlist.com/pregnancy/definition.htm

5. Marshall, J. E., & Raynor, M. D. (2014). *Myles textbook for midwives* (17th ed.). Oxford: Churchill Livingstone.

6. D.C. *Dutta's Textbook of Obstetrics* (2008, 2013). Kolkata: New Central Book Agency (P) Ltd.

7. Myles. M. (2014) . *Myles Texkbook for Midwives (16th ed).* London: Church hill Livingstone, Elsevier Limited.

8. The World Health Organization (WHO) envisions a world where "every pregnant woman

And newborns receives quality care throughout the pregnancy, childbirth and the

Postnatal Period'' (TunÇalp, et.,2019).

9. King L.T, M. C. (2014). *Varney's Midwifery (fifth ed.)*. New Delhi: Jones and Bartlett India Pvt. Ltd.

10. Konar, H. (2011). *Textbook of Obstetrics*. Kolkata: New Central Book Agency (P) Ltd.

APPENDIX

COMPLETE DIAGNOSTIC INVESTIGATIONS

DATE	SPECIMEN	INVESTIGATION	NORMAL RANGE	FINDINGS	REMARKS
17/01/2023	Blood	Hemoglobin level	11.4- 16.0g/dl	116g/dl	Normal
		Sickling status	Negative	Negative	Normal
		HIV/PMTCTVDRL	Negative	Negative	Normal
		G6PD	No defect	Negative	Normal
		HBsAg	Negative	Negative	Normal
		Blood Group	A, B, O, AB	0+	Normal
		URINE (Protein)	Trace	Negative	Normal
		URINE (Sugar)	Negative	Negative	Normal
10/03/2023	Urine	Protein	Trace	Negative	Normal
		Sugar	Negative	Negative	Normal

05/04/2023	Urine	Protein Sugar	Negative Negative	Negative Negative	Normal Normal
05/05/2023	Urine	Protein Sugar	Negative Negative	Negative Negative	Normal Normal
10/06/2023	Urine	Protein Sugar	Negative Negative	Negative Negative	Normal Normal
31/06/2023	Urine	Protein Sugar	Negative Negative	Negative Negative	Normal Normal
21/07/2023	Urine	Protein Sugar	Negative Negative	Negative Negative	Normal Normal
14/08/2023	Urine	Protein Sugar	Negative Negative	Negative Negative	Normal Normal

COMPLETE DIAGNOSTIC INVESTIGATIONS

APPENDIX 11

PHARMACOLOGY OF DRUGS FOR MOTHER

NAME OF DRUG	CLASSIFICATION	DOSAGE	ROUTE	ACTION AND USES	ACTUAL EFFECT	SIDE EFFECTS	SIDE EFFECT EXPERIENCED
Tetanus diphtheria	Anti-tetanus vaccine	0.5milligram	Subcutaneous	Protect against tetanus	Client was protected against tetanus infection	Slight fever and chills	None observed
Tablet Multi vitamin	Vitamin Preparation	200 milligrams twice daily	Oral	Increase Appetite, helps in the formation of red blood cells	Increased appetite.	Gastrointestinal disturbance	None observed
Tablet Ferrous Sulphate	Haematinics	200 milligrams daily	Oral	Helps in red blood cell formation.	Increase in hemoglobin level.	Gastrointestinal disturbance and blood stool	None observed
Tablet Folic Acid	Vitamin Preparation	5 milligrams Once daily	Oral	Proper formation and function of red blood cell	Hemoglobin level increased	Nausea and vomiting	None observed
Tablet Paracetamol	Analgesics	1 gram 3 times daily for 3 days	Oral	Helps to relieve pain	Pain was relieved	Prolong use causes damage to the liver.	None observed

PHARMACOLOGY OF DRUGS FOR MOTHER CONT'D

NAME OF DRUG	CLASSIFIC-ATION	DOSAGE	ROUTE	ACTION AND USES	ACTUAL EFFECT	SIDE EFFECTS	SIDE EFFECT EXPERIENCED
Injection oxytocin	Oxytocic drug	10 units	Intramuscular	Stimulation of uterine contractions	Good uterine contractions and control of bleeding	Vomiting, rise in blood pressure and uterine spasm	None observed
Tablet Sulphadoxine Pyrimethamine	Anti-malaria and prophylaxis	3 doses stat from 16weeks or after quickening and the remaining doses within 4weeks interval until she delivers.	Oral	Prevention of malaria	Malaria was prevented	Nausea, vomiting, itching, dizziness and headache	None observed

PHARMACOLOGY OF DRUGS FOR BABY

NAME OF DRUG	CLASSIFIC-ATION	DOSAGE	ROUTE	ACTION AND USES	ACTUAL EFFECT	SIDE EFFECT	SIDE EFFECT EXPERIENCED
Vitamin K	Coagulant	1milligram	Intramuscular	Production of prothrombin	No bleeding	None	None observed
Chloramphenicol eye drop	Prophylaxis antibiotic	2 drops	Instillation	To prevent eye infections	Infection of the eye prevented	Nephroxicity	None observed
Oral Polio Vaccine	Antigen	2 drops	Oral	Production of antibodies against poliomyelitis	Diarrhea may occur	There may be diarrhea	None observed
Bacillus Calmette Guerin injection	Antigen	0.05mg	Intradermal	Immunity against Tuberculosis	Prevention of Tuberculosis	Mild fever, swelling at injected site and blister formation	Blister noticed
Pneumococcal 1	Antigen	0.5 ml	Intramuscular (right thigh)	Immunity against pneumonia	Baby is under observation	Fever and redness at the site of injection	None observed

Pentavalent 1	Antigen	0.5 ml	Intramuscular (left thigh)	Immunity against Dipthteria,Pertussis, Tetanus,Haemophilus influenza B and Hepatitis B	Baby is under observation	Low grade Fever	None observed
Rotavirus 1	Antigen	1.5ml (2 drops)	Oral	Immunity against rotavirus(diarrhea)	Baby is under observation	Vomiting	None observed

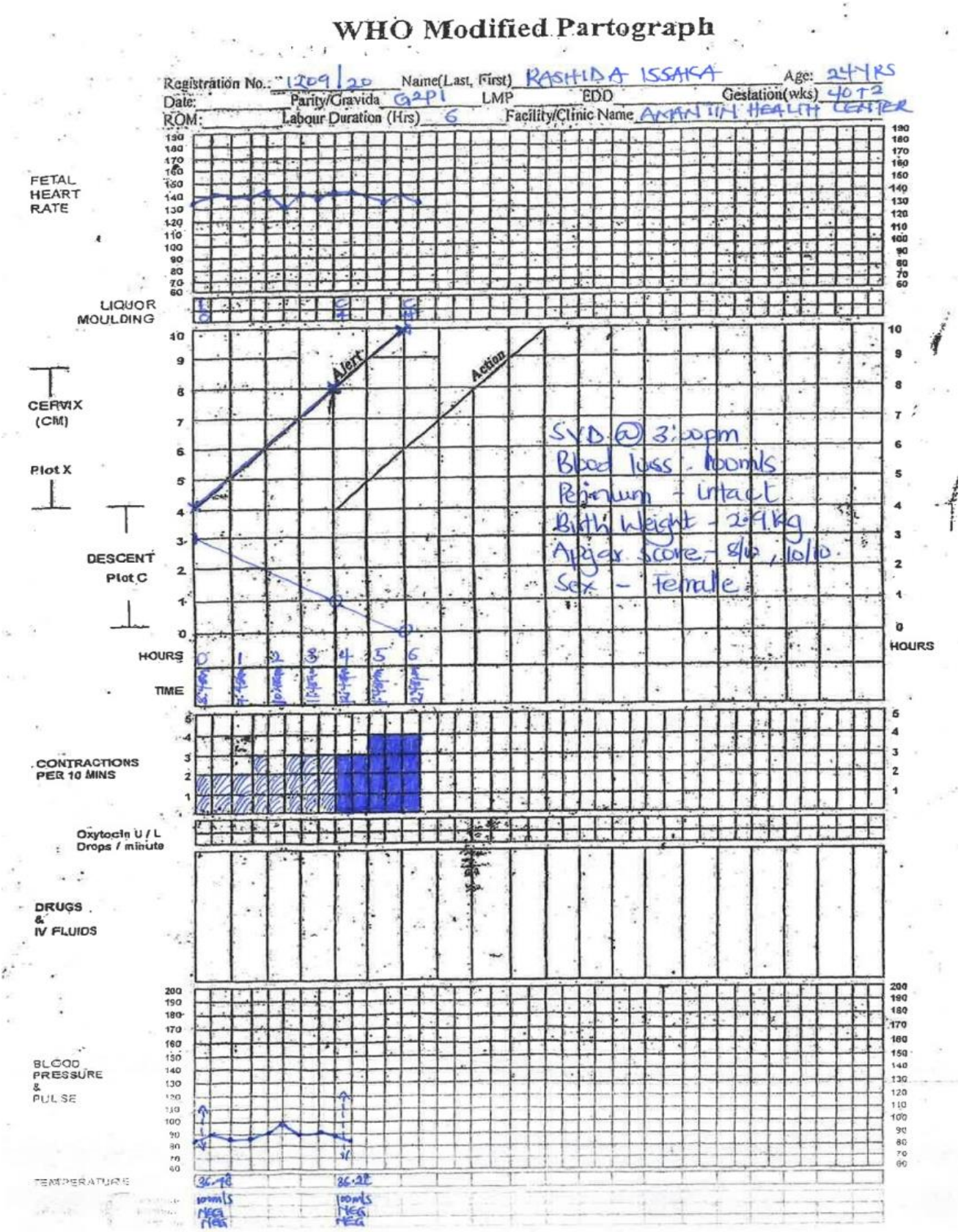
APPENDIX 111

ANTENATAL CHART RECORD

Date	BP (mmHg)	Weight (kg)	Urine Protein/ Sugar	Gestation (weeks)	Fundal Height (cm)	Presentation	Descent	Fetal Heart Rate(FH)	Complains	Treatment	Name and sign
17/01/2023	110/60	63.7	Negative/ Negative	12+3	12	_	_	-	Feels well	Tablet(multivite,folic acid,ferrous sulphate)	T.B.S
10/03/23	100/60	66	Trace/ Negative	16+3	16	_	_	-	Feels well	Tablet(multivite,folic acid,ferrous sulphate)	T.B.S
05/04/23	100/50	67.4	Negative/ Negative	19+3	20	_	_	-	Feels well	Tablet(multivite,folic acid,ferrous sulphate)	T.B.S
05/05/23	100/60	68	Negative/ Negative	23+3	26	Cephalic	$5/5^{th}$	138	Headache	Treatment(multivite,folic acid,ferrous sulphate)	T.B.S
10/06/23	110/70	69	Negative/ Negative	29+3	28	Cephalic	$5/5^{th}$	139	Feels well	Treatment(multivite,folic acid,ferrous	T.B.S

										sulphate)	
31/06/2023	100/60	69	Negative/ Negative	33+3	31	Cephalic	5/5th	139	Waist pains	Tablet(multivite,folic acid,ferrous sulphate)	T.B.S
21/07/2023	100/60	64	Negative/ Negative	36+3	35	Cephalic	5/5th	140	Abdominal pains	Tablet Folic acid Tablet Ferrous sulphate Tablet multivite	T.B.S

14/08/23	110/60	72	Negative/ Negative	37+3	37	cephalic	5/5th	136	Abdominal pains	Tablet folic acid Tablet Ferrous sulphate	T.B.S


WHO Modified Partograph
Registration No.: 1209/20
Name(Last, First) RASHIDA ISSAKA
Age: 24YRS
Date:
Parity/Gravida G2P1
LMP
EDD
Gestation(wks) 40+2
ROM:
Labour Duration (Hrs) 6
Facility/Clinic Name AMANTIN HEALTH CENTER
FETAL HEART RATE
LIQUOR MOULDING
CERVIX (CM)
Plot X
DESCENT
Plot C
Alert
Action
SVD @ 3:00pm
Blood loss - 100mls
Perineum - intact
Birth Weight - 2.9kg
Apgar score - 8/10, 10/10
Sex - female
HOURS
TIME
CONTRACTIONS PER 10 MINS
Oxytocin U / L
Drops / minute
DRUGS & IV FLUIDS
BLOOD PRESSURE & PULSE
TEMPERATURE

LABOR NOTES Client G2P1 with gestation of 40 weeks + 2 days had an SVD @ 3:00pm to an active female infant. IM. Oxytocin was given to a mother after which a second twin was not diagnosed on palpation. Skin to skin contact ensured. Active third stage of labour was completed successfully through CC. @ 3:05pm. Essential care done to the baby and mother is cleaned nicely. Client sustained no tear. Baby and mother are in a good condition and was made comfortable in bed.

Please circle or write responses.

DELIVERY

DATE: 24/08/23 TIME: 3:00pm METHOD: (Spontaneous) / Vacuum Extraction / C/S / Other

PERINEUM: (Intact) / Episiotomy / Laceration

ANESTHESIA: (None) / Local / General

THIRD STAGE

Active Management: (Yes) / No Medication: Time 3:05pm Type/Dose Oxytocin 10units.

PLACENTA: TIME: 3:05pm (Complete) / Incomplete

BLOOD LOSS AMOUNT: (Small (Less than 250 cc)) 100ml's / 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	1	2	1	2	8/10
5min	2	2	2	2	2	10/10

COMPLICATIONS OF MOTHER / BABY: (None) / Other: N/A

FOURTH STAGE MONITORING

Frequency	Time	B/P.	Pulse	Fundus	Bleeding	Bladder
Every 15 minutes first 2 hours	3:30pm	120/70	96	Contracted	Small	Emptied
	3:45pm	100/70	89	Contracted	Small	
	4:00pm	110/70	87	Contracted	Small	
	4:15pm	100/75	89	Contracted	Small	
	4:30pm	105/80	88	Contracted	Small	Emptied
	4:45pm	115/72	92	Contracted	Small	
	5:00pm	120/80	96	Contracted	Small	
	5:15pm	122/84	87	Contracted	Small	
Every 30 minutes For 1 hour	5:30pm	112/79	82	Contracted	Small	
	5:45pm	108/70	84	Contracted	Small	Emptied

Birth Attendant Tang Bayele Sandra (Student Midwife) Date 24/08/2024

Assisted by Kate Authur.

NEW BORN EXAMINATION FORM

Name: BABY ISSAKA RASHIDA Date of Assessment: 24/08/23 Time: 8:59pm

Date of Birth: 24/08/23 Time of Birth: 3:00pm Sex: ☐ M ☑ F Age at time of Assessment (days/hrs) 1DAY

Astational Age ☐ 40 ☐ Mode of Delivery: ☑ Vaginal Assisted Vaginal C-Section

APGAR: 1min ☒ 5min ☐ Birth Weight: ☐ 2.9kg ☐ Length: 48 cm Head Circumference: 36 cm

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

Name of Assessor (Midwife/Doctor): _____

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

2. Activity/Movement
- ☑ 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*
- ☐ Scaphoid*
- ☐ Abdominal defect*
- ☐ Masses: _____
- ☐ Other _____

21. Back (spine)
- ☑ Normal
- ☐ Abnormal Swelling *
- ☐ Hairy 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 clitoris *
- ☐ Other: _____

24. Anus
- ☑ Patent
- ☐ Imperforate*

25. Resuscitation provided
- ☑ None
- ☐ Suction/stimulation
- ☐ Bag and mask
- ☐ Endotracheal Tube
- ☐ Ventilator/CPAP

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

*May indicate severe disease that requires urgent referral

Diagnoses (if known) _____

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

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

NEW BORN EXAMINATION FORM

Name: BABY ISSAKA KASHIDA Date of Assessment: 25/08/23 Time: 10.30am

Date of Birth: 24/08/23 Time of Birth: 3:00pm Sex: ☐ M ☑ F Age at time of Assessment (days/hrs) 1 DAY

Astational Age ☐ 40+2 ☐ Mode of Delivery: ☑ Vaginal Assisted Vaginal C-Section

APGAR: 1min 8 5min 10 Birth Weight: ☐ 2.9 kg ☐ Length 48 cm Head Circumference: 36 cm

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

Name of Assessor (Midwife/Doctor): MIDWIFE MMG SANDRA BAYELE (STUDENT)

1. Respiration

Rate _____

- ☐ Rate <30 b/m *
- ☐ Rate <60 b/m *
- ☑ 30-60 b/m
- ☐ Retractions *
- ☐ Grunting *
- ☐ Stridor *

2. Activity/Movement

- ☑ Spontaneous symmetric movements
- ☐ Reduced/Absent Movement in ≥1 limb *
- ☐ No Movement

3. Tone

- ☑ Normal
- ☐ Flappy *
- ☐ 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 haemorrhage
- ☑ 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*
- ☐ Spaphoid*
- ☐ Abdominal defect*
- ☐ Masses: _____
- ☐ Other _____

21. Back (spine)

- ☑ Normal
- ☐ Abnormal Swelling *
- ☐ Hairy 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 clitoris *
- ☐ Other: _____

24. Anus

- ☑ Patent
- ☐ Imperforate*

25. Resuscitation provided

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

26. Services provided

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

*May indicate severe disease that requires urgent referral

Diagnoses (if known) _____

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

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

NEW BORN CHART

Name: BABY ISSAKA RASHIDA ..... No: 1 ..... Birth Weight: 2.9kg

Sex: FEMALE ..... Mother's No: 1269/20 ..... Length: 48cm

Nature of Delivery: SPONTANEOUS VAGINAL DELIVERY ..... Diagnosis: TERM BABY

Date of Birth: 24/08/2023 ..... Time: 3:00PM ..... Date of Discharge: 24/08/24

Date	24/8/23		25/8/23		26/8/23		27/8/23		28/8/23		29/8/23		30/8/23		31/8/23							
No. of Days	DOD		D1		D2		D3		D4		D5		D6		D7							
Weight	2.9kg		2.8kg		2.7kg		2.6kg		2.5kg		2.5kg		2.6kg		2.7kg.							
Temperature	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM
		36.7°C	36.3°C	36.8°C	37.0°C	36.6°C	37.2°C	36.9°C	37.1°C		37.2°C		37.0°C		36.8°C							
Stools		Passed	Passed	Passed	Passed	Passed	Passed	Passed	Passed		Passed		Passed		Passed							
Urine		Passed	Passed	Passed	Passed	Passed	Passed	Passed	Passed		Passed		Passed		Passed							
Remarks	HEAD NECK TRUNK LIMBS GENITALIA — NO ABNORMALITIES DETECTED.																					

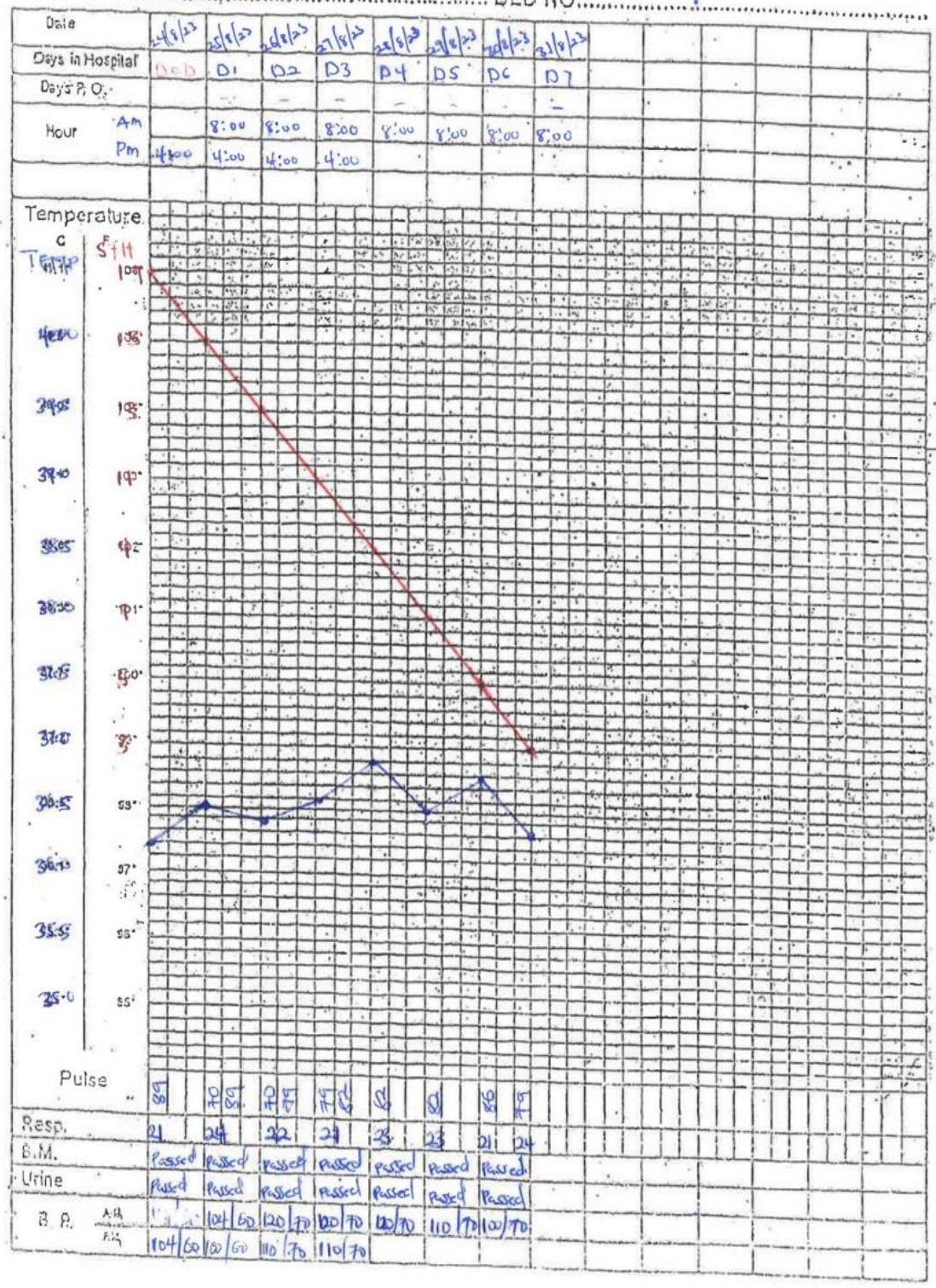
MATERNITY CHART

KEY;
-> TEMPERATURE
-> SYMPHYSIO FUNDAL HEIGHT

NAME: MAD RASHIDA ISSAKA

AGE: 24 YEARS WARD: LYING - IN

IP NO.: 1269/20 BED NO.: 1



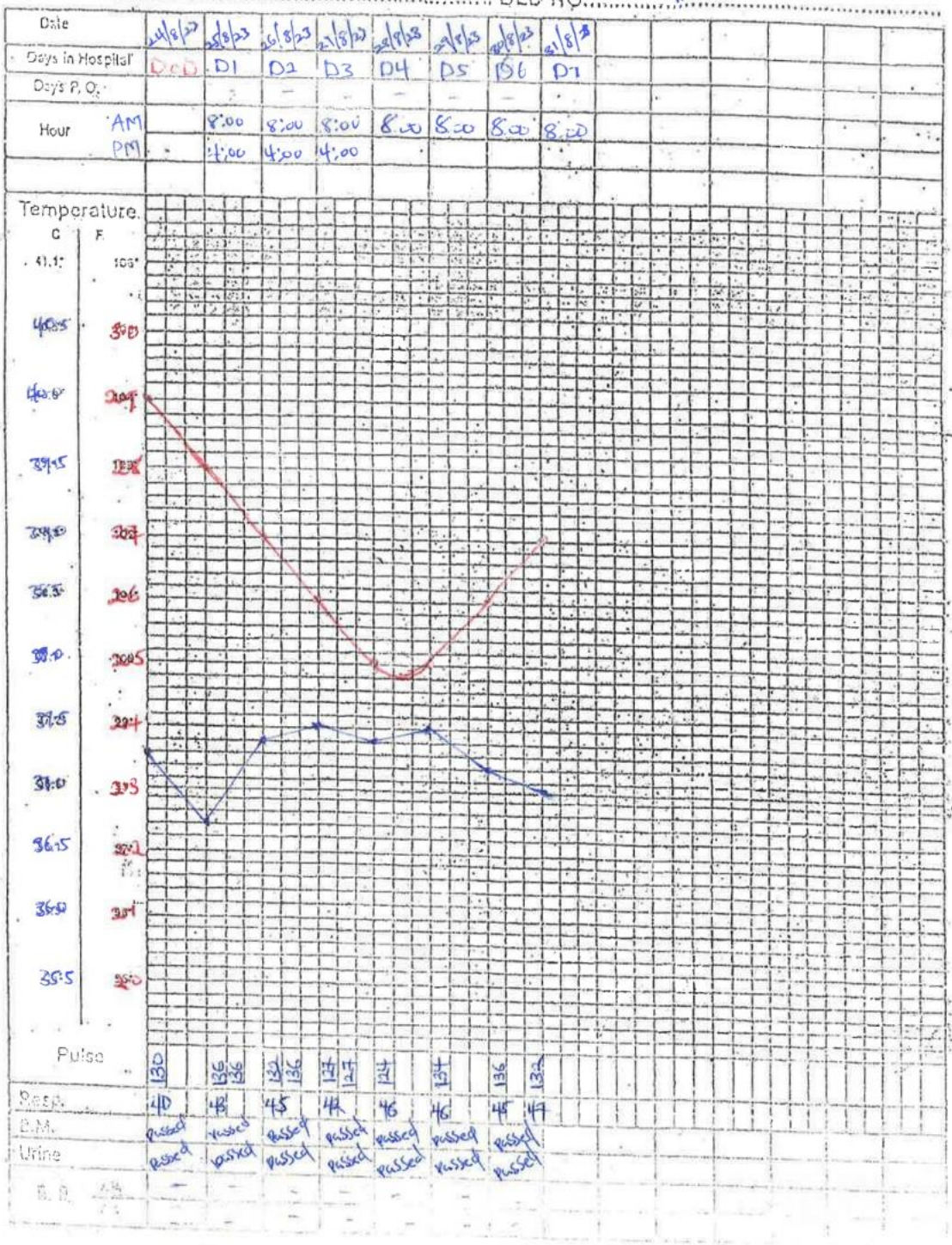
TEMPERATURE CHART

KEY :
→ TEMPERA
→ WEIGHT

NAME: BABY ISHKA RASHIDA

AGE: NEW BORN WARD: LYING IN

IP NO.: - BED NO.: 1



SIGNATORIES

NAME: TANG BAYELE SANDRA

SIGNATURE: .....

DATE 7/06/24

THE MIDWIFE- IN-CHARGE (AMANTIN HEALTH CENTER)

NAME: MS KATE AUTHUR

SIGNATURE..... (for)

DATE 7/06/24

THE SUPERVISOR

NAME: MRS. MONICA BOAKYE

SIGNATURE.....

DATE 7/06/24

THE PRINCIPAL

NAME: MONICA NKRUMAH

PRINCIPAL
HOLY FAMILY NURSING AND
MIDWIFERY TRAINING COLLEGE
BEREKUM

SIGNATURE.....

DATE 10/06/24