HOLY FAMILY NURSING AND MIDWIFERY TRAINING COLLEGE

BEREKUM

A CLIENT/FAMILY CENTERED MATERNITY CARE STUDY

ON

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BY

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PREFACE

The Client/Family Centered Maternity Care Study which is a systematic and thoughtful approach is designed to provide accurate and quality care based on the understanding of the knowledge acquired in midwifery.

The focus of this booklet is therefore on a selected client who is appreciated as a unique individual with special needs peculiar to herself and the family. It is well known that most pregnant women in some years back refused to see trained midwives in the society for midwifery care perhaps due to cultural and ethical values, ignorance and bad attitude of some midwives towards them. Many of such instances ended up in complications as they sought the care of untrained birth attendants in the communities.

As a qualified midwife and student render quality care through establishment of rapport, health education, counselling and notifying any deviation from normal during the pregnancy till the end of puerperium, maternal and infant mortality is reduced.

This however serves to equip the student with basic and necessary skills required to be exhibited in the midwifery profession since it offers her the opportunity to learn and acquire the knowledge and skills needed for holistic care for the woman and her family in pregnancy, labor and puerperium.

For quality care and prevention of complications, problems need to be identified and managed early enough in pregnancy for safe labor and puerperium.

As part of the Nursing and Midwifery Counsel's requirement for awarding midwifery students a certificate, every student Midwife is required to undertake this care study to be qualified for the award.

ACKNOWLEDGEMENT

I wish to express my heartfelt gratitude to the Almighty God who gave me wisdom, knowledge and guidance to write this script.

My sincere appreciation also goes to the Principal, Monica Nkrumah and the entire staff of Holy Family Nursing and Midwifery Training College - Berekum for their tutorials, support and encouragement through my three year stay at the school not forgetting Holy Family Hospital-Berekum.

My sincere thanks go my supervisor, Miss Diana Owusu Serwaa for the time spent in reading through the manuscript and making of corrections.

I wish to express my gratitude to Madam Brago Elizabeth (client) and her family, it would be impossible not to acknowledge their contribution in helping with this project. Without her cooperation this project would not have been reality.

The next on my list goes to Mrs. Patience Adika and the entire staff of Patience's Angel Maternity home for their guidance, encouragement and good inter-personal relationship with me throughout my stay with them.

Also, a very big thanks goes to my Parents Mrs. Helen Adongo and Mr. David Adongo. And my siblings Miss Lawrencia Adongo and Miss Lucy Adongo and my entire family for their support, prayers and encouragement. Another sincere thanks go to my spiritual leader Rev. Father Nicholas Larsey for his prayers and spiritual guidance. May the Almighty God bless each and every one abundantly.

Thanks to the Authors of books used, may God grant them wisdom and to all those who in diverse ways contributed to making the writing of this care study a success.

INTRODUCTION

The family centered maternity care study is a systematic approach of nursing care given to an expectant mother and family throughout pregnancy, labor and puerperium. This study also gives the opportunity to adopt approach to collect relevant data, analyze the data, plan nursing care and intervention to resolve the identified problems after which would be evaluated to see if any objectives were achieved.

The study was carried out on Madam Brago Elizabeth a 23year old pregnant woman, gravida 2 para 1 alive, during her pregnancy, labor and puerperium.

The interaction started when she visited the clinic 15th August, 2023. By this time, she was 38weeks pregnant when we met at the ANC. After getting some personal information about her, her permission was sought to take her as a client so she could be nursed through pregnancy, labor and puerperium. She was introduced to the in-charge as a client to be used for the care study and permission was granted.

Madam Elizabeth was cared for during antenatal period. Her home was visited to know her family, her surroundings and community in which she resided. She was then given the required education, support and management throughout the four stages of labor. The management included support and encouragement during the periods of pregnancy, labor and puerperium.

Madam Elizabeth's health condition from the beginning till the end of the interactions was good and satisfactory.

The study was grouped into four chapters.

Chapter one is about client's particulars which includes her personal and social histories, family, surgical, menstrual, activities of daily living, past and present obstetrical histories.

Chapter two is about antenatal care, the care rendered when she was met during her ANC period, the visits made to her home, her physical psychosocial histories and the nursing care plan used in rendering care to her.

Chapter three also talks about her admission during labor and delivery including the immediate care of the new born.

Chapter four is about the care giving during puerperium which involves the care given to both the mother and her baby from the first day of delivery to the seventh day after delivery.

Also find in this write up is summary, conclusion, bibliography, appendix and signatories.

LITERATURE REVIEW

PREGNANCY

According to Tiran (2008) Pregnancy is the condition of having a developing embryo or fetus within the body. The state from conception to delivery of the fetus.

However, King et al (2014) states that, the prenatal period covers the time from the first day of the last menstrual period to the start of true labor, which marks the beginning of the intrapartum period.

Henderson & Macdonald (2009) states that, pregnancy may be suspected by the woman based on her knowledge of her menstrual cycle, sexual activity and the signs and symptoms of pregnancy. Women may confirm their pregnancy using a home pregnancy test.

Henderson & Macdonald (2009) further states that, confirmation of pregnancy may also be sought from a midwife or doctor. This is established by a detailed history and relevant clinical examination based on the signs and symptoms of pregnancy. The signs and symptoms of pregnancy are; amenorrhea, breast changes, nausea and vomiting, increased frequency of micturition, enlargement of the uterus, skin changes and quickening. The signs will become obvious to the woman in sequential stages. The signs and symptoms of pregnancy may be considered as presumptive, probable and positive.

Tiran (2008) states that, the normal duration of pregnancy is 280days (40wks or 9months and 7days) counted from the first day of the last menstrual period.

Konar (2013) indicated that, the duration of pregnancy has traditionally been calculated by the clinician in terms of 10 lunar months or 9 calendar months and 7days or 280 days or 40wks calculated from first day of the last menstrual period. This is called menstrual or gestational age. He further explains that the period of pregnancy is divided into 3 sets of months. The first 3months is known as first trimester (first 12wks)

The next 3 months following the first is the second trimester (13- 28wks) while the last 3 months is known as the 3rd trimester (29-40).

Konar (2013) further explains that anatomical, physiological and biochemical changes are not only confined to the genital organs but also to all systems of the body. This is principally a phenomenon of maternal adaptation to the increasing demands of the growing fetus. The vulva becomes edematous and more vascular superficial varicosities may appear especially in multiparous. Labia minora becomes pigmented and hypertrophied. The vagina walls become hypertrophy, edematous and more vascular. Increased blood supply of the venous plexus surrounding the walls gives the bluish coloration of the mucosa (Jacquemiers sign) the length of the anterior vagina walls is increased. The secretion becomes copious, tend and curdy white due to marked exfoliated cells and bacteria, the PH becomes acidic (3.5- 6) due to more conversion of glycogen to lactic acid by the lactobacillus acidophiles. Consequent on high estrogen level. There is increase secretion which is white due to high level estrogen known as **leucorrhea**.

However according to Marshall & Raynor (2014) the uterus plays a remarkable role in pregnancy by stretching and expanding to accommodate and nature the growing fetus.

This expansion and activation takes place in the middle muscle layer of the uterine wall **the myometrium**, which is partly covered and protected by the outer layer, the **perimetrium**. An internal layer, the endometrium lines the uterine wall during pregnancy, the peritoneal sac is greatly distorted as the uterus enlarges and rises out of the pelvis, growing up the two folds of the broad ligaments on either side. By the 3rd trimester the ligaments and uterine tubes appear lower on the side of the uterus

The author further explains that the myometrium undergoes dramatic moulding during pregnancy to provide support for the growing fetus and ultimately to expel it during labor. The endometrial cells also undergo a transformation known as decidual relation which extend into then junctional zone and forms the decidua of pregnancy. The primary function of decidualization is to provide nutrition and immunological adequacy for the early embryo. At 5wks gestation the uterus feels like a small unripe pear. By 8 weeks it is like a large navel orange by 10wks it is about a size of a grape fruit and by 12wks it is a size of a cantaloupe melon.

The cervix has been described as the gate keeper of pregnancy. The cervix becomes thin more elastic and flexible, there is increase blood flow to the cervix which results in the bluish-purple coloration known as Goodell's sign.

Verral's (2014) said that, the cervix undergoes a slight growth during pregnancy. It becomes softer as the pregnancy advances.

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

These complex adaptations are necessary to

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

The heart is enlarged by chamber dilatation and a degree of myocardial hypertrophy in early pregnancy leading to a 10 -15% increase in ventricular wall muscles. The enlarging uterus raises the diaphragm upward and to the left to produce a slight anterior rotation of the heart on its long axis. It also increases in blood volume known as hemodilution, further explains that to accommodate increase oxygen requirement and physical impact of enlarging uterus intricate changes occurring in respiratory physiology. The driving force for change in the respiratory stimulation effect of progesterone initiating hyperventilation by increasing sensitivity to carbon dioxide. Through lowering threshold at which the respiratory counter is stimulated. The lower ribs flare outwards prior to any mechanical pressure from the growing uterus. Changes are mediated by progesterone and relaxin which increase rib cage and elasticity by relaxing ligaments in a similar mechanism to that occurring in the pelvis.

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

The striking anatomical and physiological changes occurring in the urinary system are critical for optimal pregnancy outcome. In a healthy pregnancy the kidneys lengthen

by up to 1.5cm and kidney volume increase by as much as 30%. The ureters become longer and are thrown in the single or double curves of various sizes. Dilated ureters with reduced peristalsis and mechanical obstruction by the enlarged uterus all contribute to urinary stasis leading to the increase risk of urinary tract infection in pregnancy. The trogon becomes deeper and wider as pregnancy progresses leading to reduced bladder capacity. To compensate for this the urethra lengthens by about o.5cm and the bladder tone increase to help maintain continence in spite of the urinary incontinence can be troublesome in pregnancy. As the uterus enlarges the bladder becomes distorted and it is drawn upwards interiorly becoming an abdominal organ by the third trimester.

Marshall & Raynor (2014) also says anatomical and physiological changes takes placed in each organ of the gastrointestinal system. The increased abdominal pressure due to the enlarging uterus causes a shift in pressure gradient between the abdomen and the thorax. The angle of the gastro esophageal sphincter is displaced into the negative pressure of the intrathoracic cavity these mechanical changes, along with the relaxing effect of progesterone which reduces gastrointestinal transit, all contribute to reflux of gastric contents leading to heart burn

Progesterone combines the pressure of the gravid uterus on the recto sigmoid colon decreasing motility of the small intestine of the colon and increase transit time in the 2nd and 3rd trimester. Identifying the position of the appendix in the later stages of pregnancy can be challenging due to anatomical alteration. The enlarging uterus displaces the appendix and caecum superiorly to the level of the liver and laterally to the right upper quadrant of the abdomen.

The gallbladder enlarges in pregnancy and emptying it slower due to reduced motility. However, a well-integrated metabolic shift is required by the woman to provide for the increased physiological demands of pregnancy labor, lactation, increased cost of physical activity to ensure provision of adequate nutrients critical for maintaining a healthy viable and optimally growing fetus. These adaptations are orchestrated within a few weeks of conception by estrogen and progesterone originating from fetal placenta unit and by prolactin and human lactogen from the maternal pituitary gland.

The changes in carbohydrate metabolism are the most dramatic of all the production of glucose from carbohydrate in the maternal diet increases its uptake to guarantee sufficient availability of glucose for the fetus as its primary source of energy for cellular metabolism. Relaxation of pelvic joints commence at 10-12 weeks' gestation. The increase in weight and the anterior shift into center of gravity leads to biochemical changes and the characteristics waddling gate of pregnancy. There is decreased neuromuscular control and coordination, decreased abdominal strength. Increase spinal lordosis and changes in mechanical loading and joints kinetics, all of these influences postural control and may be related to the increased risk of falling. There is a significant increase in angles of thoracic kyphosis lumber lordosis and pelvic inclination.

Pregnancy also causes a variety of common changes in skin hair, and nails which in the majority of cases is a normal physiological response modulated by hormonal and metabolic factors. Certain changes have been showed to have a genetic predisposition, particularly strae gravidarium and pigmentation changes. Almost all women note some degree of skin darkening as are of the earliest sign of pregnancy resulting from the increase in melanocyte stimulating hormone, progesterone and estrogen serum

level. Hyper pigmentation is more marked in dark skinned areas that are normally pigmented example areola, genitalia and umbilicus. The line alba is a line that lies over the midline of the rectus muscle from the umbilicus to the symphysis pubis. Hyperpigmentation causes it to darken resulting in **Linea nigra**. Pigmentation of the face affects up to 50-70% of pregnant women and known **as chloasma or melosna** or mask of pregnancy. Marshall & Raynor further explains that the change in all compartments of the endocrine system and their timing are critical for initiating and maintenance of pregnancy, fetal growth and development and for parturition. Hormone levels are influenced by and vary according to parity, body mass index, age, gestation ethnicity and smoking.

However, she said the physiological changes throughout pregnancy within the woman's body. Example varicosities sleep disturbance breathlessness, urinary incontinence, ptyalism, nausea and vomiting, heartburn, abdominal distension, constipation, hemorrhoid and back ache.

Furthermore, some signs and symptoms of early pregnancy may include amenorrhea, nausea and vomiting, breast discomfort or changes, fatigue.

According to Ghana Health Service (2008), ANC is the care given to pregnant woman from the time conception is confirmed until the beginning of labor. The number of times a client needs to be seen during pregnancy may vary for the uncomplicated pregnancy. It is recommended that at least four ANC visits should be made, but the client can be seen more than four depending on the client's condition. There are two types of antenatal care that is focused antenatal care and traditional care.

According to Ghana Health Service (2008) the traditional antenatal care assumes that more frequent ANC is better and thus quantity of care is emphasized rather than the essential elements of care. However, Ghana Health Service (2008) further defines focused antenatal care as an individualized client centered comprehensive ANC and emphasize on quality of care rather than quantity and the goals of focused antenatal care are as follows.

1. Identification of pre-existing health condition and issues
2. Early detection of complication arising during the pregnancy.
3. Birth preparedness and complication plan.

According to Marshall & Raynor (2014). The assessment components of Antenatal care are history taking, social, menstrual, obstetric, medical and surgical history, family history and lifestyle, risk assessment.

Physical examination example weight, blood pressure, urinalysis, blood test, head to toe examination, and record keeping.

LABOUR

According to Marshall & Raynor (2014) labor purely in the physical sense, may be described as the process by which the fetus, placenta and membranes are expelled through the birth canal. Also, Tiran (2008) defined labor as occurs spontaneously at term with vertex presentation of a singleton fetus and is completed with 24 hours without trauma to mother or fetus. However, WHO as cited by Marshall & Raynor (2014) defines normal labor as one that is low risk throughout spontaneous in onset

with the fetus presenting by vertex, culminating in the mother and infant being in good condition following birth.

Konar (2013) defined labor as series of events that takes place in the genital organs in an effort to expel the viable products of conception out of the womb through the vagina in the outer world.

The onset of labor is determined by a complex interaction of maternal and fetal hormones and is not fully understood. It would appear to be multifactorial in origin, being a combination of hormonal and mechanical factors. Levels of maternal estrogen rise sharply during the last weeks of pregnancy, resulting in changes that overcome the inhibiting effects of progesterone. High levels of estrogens causes uterine muscle fibers to display oxytocic receptors and form gap junctions with each other. Estrogen also stimulates the placenta to release prostaglandins that induce a production of enzymes that will digest collagen in the cervix, helping it to soften.

Also, Verrals (2014) describes the onset of labor 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 labor.

There are three stages of labor that has being established; the first, second third and fourth stages.

The first stage of labor 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 labor 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 labor and partograph recording.

The second stage of labor begins with the expulsion of the fetus from the birth canal, it starts when the cervix is fully dilated and the woman has the urge to expel the foetus.it ends when the fetus is born.

The third stage of labor is the complete expulsion of the placenta and its membranes as well as the arrest of hemorrhage.

The fourth stage of labor is 6 hours after the delivery of the placenta and membranes and the arrest of hemorrhage.

PUERPERIUM

Konar (2013) puerperium as the period following childbirth during which the body tissues, specially the pelvic organs revert back approximately to the pre-pregnant state both anatomically and physiologically.

Marshall &Raynor (2014) says puerperium starts immediately after birth of the placenta and membranes and continues for 6weeks.

Verrals (2014) defines puerperium as when there is a delivery of the placenta and membranes, and when the woman begins the physiologic transition to the non-pregnant state lasting for 6 weeks.

By the 6 weeks most women have completed the last of the physiologic transitions; uterine involution is complete, lochia has ceased and laceration is well established.

Konar (2013) defines involution as the process whereby the genital organs revert back approximately to the state as they were before pregnancy. The woman is termed as puerperal.

During this stage there are many physiological changes that takes place. In the postnatal period all the mother's body systems have to adjust from the pregnant state back to the pre pregnant state. Mothers go through a transitional period and the period of physiological adjustment and recovery following birth is closely related to the overall health status of the mother.

Among the physiological changes Konar (2013) says the uterus becomes firm erect with alternate hardening softening. The uterus measures about 20×12×7.5 centimeters (length, breadth, and thickness) and weighs about 1000grams. At the end of six weeks, its measurement is almost similar to that of the non-pregnant state and weighs 60 grams.

The cervix contracts slowly, the external Os admits two fingers for a few days but by the end of the first week, narrows down to admit the tip of finger only. The contour of the cervix takes a longer time to regain (6 weeks) and the external os never reverts back to the nulliparous state.

In the muscles there is marked hypertrophy and hyperplasia of muscle fibers during pregnancy, during puerperium, the number of muscle fibers is not decreased but there is substantial reduction of the myometrial cell size. Withdrawal of the steroid hormones, estrogen and progesterone, may lead to increase in the activity of the

uterine collagenase and the release of proteolytic enzyme autolysis of the protoplasm occurs by the proteolytic enzyme with liberation of peptones which enter the blood stream.

The changes of the blood vessels are pronounced at the placental site. The arteries are constricted by contraction of its wall and thickening of the intima followed by thrombosis. During the first week the arteries undergo thrombosis, hyalinization and fibroid arteries and the veins are obliterated by thrombosis. New blood vessels grow inside the thrombi.

Konar (2013) further explains that the distensible vagina, noticed soon after birth takes a long time (4-8 weeks) to involute. It regains its tone but never to the vaginal state. The mucosa remains delicate for the first few weeks and sub mucous venous congestion persists even longer. The rugae partially reappear at the third week but never the same degree as in the pre-pregnant state. The intriotus remains permanently larger than the vaginal state. Hymen is lacerated and is represented by nodular tags-carunculae myrtiformes.

Broad ligaments and round ligaments require considerable time to recover from stretching and relaxation.

Pelvic floor and pelvic fascia take a long time to involute from the stretching effect during parturition.

The lochia that is the vaginal discharge for the first fortnight during puerperium originates from the uterine body, cervix and vagina. It has got a particular fishy smell.

Its reaction is alkaline tending to become acid towards the end, the color depends upon the variation.

Lochia rubra (red) 1-4 days.

Lochia serosa (yellowish pink or pale brownish) 5-9 days.

Lochia alba (pale white) 10-15 days.

The amount whether scanty or absent signifies infection. Also, the persistence of red blood color beyond the normal limit signifies sub involution.

The urinary tract that is the bladder mucosa becomes edematous and hyperemic and often shows evidence of sub mucous extravasations of blood. The bladder capacity is increased. The bladder may be over distended without the desire to pass urine. The common urinary problems are

1. Over distension
2. Incomplete emptying
3. Presence of residual urine.

With all definitions and changes it can be deduced that puerperium is the period from birth to 6 weeks of delivery.

WHY CLIENT WAS CHOSEN

Madam Elizabeth was chosen as a client for the client / family centered maternity care study on

15th August, 2023, which happened to be her sixth visit to the antenatal clinic at Patience Angel's maternity home at Atuna at exactly 9:45am.

During examination, client’s facial expression on observation was not cheerful. Client was asked and she said she is having lower abdominal pain and the physiology behind was explained to client and client was further reassured. Client was then educated on rest and various forms of exercises that help reduce body pains like “pelvic rock” that help relieve backache and pressure in the abdomen and strengthens muscles in the abdomen. “Head and shoulder lift” that strengthens muscles in the abdomen. “squatting” which also strengthens leg muscles and ¨rib cage lift¨ which strengthens leg muscles and makes it easier to breath. Madam Elizabeth was much grateful for the services rendered to her and was cooperative.

At the glance through her ANC card, she was 36 weeks and 4days, she had no bad obstetrical history, and was a regular ANC attendant and very cooperative at the antenatal clinic. She was Gravid 2 Para 1 being spontaneous vaginal delivery. client had a normal gait and no deformity was detected. An introduction as a student midwife from Holy Family Nursing and Midwifery Training College, Berekum on practical’s was made. She was informed that she will be taken as a client for the study. She will be monitored during pregnancy, labor and puerperium and she agreed. She was thanked for her understanding and cooperation. The in-charge was informed about the selection of Madam Elizabeth for the study of which she agreed.

CHAPTER ONE

CLIENT/FAMILY PARTICULARS

1.0 INTRODUCTION

This chapter analyses critically on the client health status. It gives information about her family and her community which includes social, family, medical, surgical, present obstetrical history and habit of daily living.

1.1 PERSONAL AND SOCIAL HISTORY

Madam Elizabeth is a twenty-three (23) year old gravida 2 para 1, a native of and resides in Atuna, sub district Abakasu, in the Bono region. She is dark in complexion, one hundred and fifty-five (155) cm tall and weigh fifty-four (54.0) kilogram (kg) according to her antenatal care record at booking.

According to Madam Elizabeth, she completed Atuna RC primary and junior high school at Atuna in the Bono region of Ghana and she is now a Hair dresser. She is married to Mr. Ibrahim Kwame with one child, a male. He works as a mason at Atuna. They are both Christians precisely Pentecostals. Both couple speak Bono language. According to madam Elizabeth her next of kin is her younger sister, Fokuo Lydia. Madam Elizabeth lives in a compound house and relates well with her neighbors.

1.2 FAMILY HISTORY

Madam Elizabeth said she is the fifth child among four siblings of Mrs. Afia Vida and Mr. Kofi Brago, and they are all alive. Both mother and father come from Atuna the sub district of Abakasu in the Bono region of Ghana. According to her, one of her sibling is deceased four years ago of which the cause of death was natural. She also added that, there is no hereditary diseases like diabetes, hypertension, heart disease, sickle cell disease, epilepsy,

mental illness in her family as well as her husband's family. She also mentioned that there is a history of twin pregnancy in her family but not in her husband's family.

1.3 MEDICAL HISTORY

According to madam Elizabeth, she has been admitted to the hospital twice with diagnoses of Malaria of which she was given Malaria drugs and discharged three days later. She said that she has neither received nor donated blood.

She was educated on the importance of sleeping under an insecticide mosquito net and the need to weed around homes and drain all stagnant waters to prevent breeding of mosquitoes which she agreed. She added that she has no chronic medical condition like hypertension, diabetes, sickle cell, epilepsy, and among others and she is not allergic to any drug and food.

According to her, she has not experienced any signs and symptoms of sexually transmitted disease like burning sensation, abnormal vaginal discharge, swelling of the genital and painful urination.

1.4 SURGICAL HISTORY

According to Madam Elizabeth, she has never undergone any surgical operation since childhood and has never been involved in any accident or injury to any part of the pelvic or had head injury. She has never donated blood or been transfused and no episiotomy nor female genital mutilation done on her.

1.5 MENSTRUAL HISTORY

Madam Elizabeth said that she attained menarche at the age of fifteen (15) and since then she has 28 days' menstrual cycle with regular moderate flow for 5 days and experience mild dysmenorrhea but resolved after her previous delivery. She added that she uses two sanitary pads a day and bath twice daily. According to her, her last menstrual period was 18th November

, 2022. Her expected date of delivery (EDD) was calculated to be 25th November 2023. Her first scan taken gave and estimated date of delivery as 20th August ,2023

1.6 ACTIVITIES OF DAILY LIVING

Madam Elizabeth wakes up at 5:30am says her prayers and empties her bladder, brushes her teeth with tooth paste and tooth brush and sweeps her room and environment, she goes to dispose her rubbish at the refuse dump. She then prepares her son for school after serving him his breakfast. She empties her bowel, takes her bath and goes to her shop. She returns home around 4:00 pm to prepare supper for the family. Her favorite food is Rice and stew with meat. She usually washes their clothing and does general cleaning on Saturdays. She does not drink alcohol nor smoke. She's a quiet person and always with her family at home when she's not at her shop. She baths her son and her herself twice daily and watches television for about an hour and thirty-minutes and says her prayers and finally goes to bed around 9:30pm.

On Sundays, Madam Sarah goes to church with her family and closes around 10:00am. She then comes home and prepares food for the family.

1.7 PAST OBSTETRICAL HISTORY

Pregnancy

Madam Elizabeth is Gravida 2 Para 1 (alive). According to her, she has never had an abortion or still birth. She also said she experienced some minor disorders like vomiting, backache and frequency of micturition in her previous pregnancy, but never experienced any conditions as pregnancy induced hypertension, pre-eclampsia or anemia in her previous pregnancy. She received regular antenatal care during her pregnancy. She took four (5) doses of Sulphadoxine Pyrimethamine (SP) during her pregnancy and also received two doses of tetanus diphtheria in her pregnancy. The first child is four (4) years.

Labor

Client said that, her son was delivered spontaneously per vaginum at the hospital. She was not able to recall the weight of the baby but said he was neither small nor large and he cried immediately after birth. Placenta was completely delivered 5 to 10 minutes soon after the baby was born and blood amount loss was also within 150 to 200mls. Also added that the duration of labor for her son did not exceed 10 hours. There were no complications such as postpartum hemorrhage. Client said she was in good health after delivery and she started breastfeeding her baby immediately she was transferred to the lying-in ward.

Madam Elizabeth said that her baby was in good condition at birth thus he cried immediately he was born. She also said her baby had no abnormalities like cleft palate, cleft lip or extra digits nor jaundice and also he had no ill health after delivery

Puerperium

He was fully immunized against the childhood preventable diseases. According to her she breastfed her baby exclusively for six months and weaned him at 18 months. According to her the only family planning method she has done was the injectable type specifically Depot Provera (given at the left upper arm which last for three months). She further added that her support person was her husband and sister. Client went through puerperium successfully without any complications.

1.8 PRESENT OBTETRICAL HISTORY

Madam Elizabeth stated that she began her antenatal visit on 10th March, 2023 when she was 20weeks of gestation. She gave her last menstrual period (LMP) as 18th November ,2022. Her expected date of delivery (EDD) was calculated to be 25th November 2023.

Laboratory investigations were done and the results were recorded as the following:

Hemoglobin	11.2g/dl
Hepatitis B	Negative

Rhesus factor	Positive
Blood Group	O+
HIV Status	Negative
Sickle Test	Negative
Urine for Protein and Sugar	Negative /Negative
G6PD	Normal
Syphilis (VDRL)	Non-reactive

Vital signs and other assessments recorded as:

Temperature	37.1 degrees Celsius
Respiration	20 cycles per minute
Blood Pressure	109/60mmHg
Pulse	89 beat per minutes
Weight	54.0 kilograms
Height	155centimeters

According to the midwife in charge she ensured that head to toe examination was done but no abnormality was detected and Madam Elizabeth looked very healthy. Client was educated on danger signs of pregnancy. She was given third dose of Tetanus Diphtheria injection and was given routine drugs as

Tablet Folic acid	5mg daily for 7days
Tablet ferrous sulphate	200mg daily for 7days
Tablet multivitamin	200mg daily for 7days.

Client was routinely cared for and managed on routine drugs during the periods of her antenatal visit. All procedures were carried out on her appropriately with no abnormality

detected. Client complied with all education given and took all her routine drugs until she was met and chosen for the study at 36weeks of gestation which was her 6th antenatal visit.

CHAPTER TWO

ANTENATAL CARE

2.0 INTRODUCTION

The care given to Madam Elizabeth from the time of her first contact till labor. This includes the first contact with the client, subsequent visits to the clinic, home visits during antenatal period and care plans drawn to solve any problem faced by the client.

2.1 FIRST CONTACT WITH CLIENT

Madam Elizabeth was a regular attendant to the antenatal clinic for her visits and it was through one of these visits that she was met on 15th August 2023, of which she was 38weeks which was her 7th visit to the clinic. She was warmly welcomed and offered a seat. During examination, client's facial expression was not cheerful and client was assured of competent care and confidentiality and hence was asked to share whatever was bothering her especially if it had to do with her health, Client complained of lower abdominal pain and the physiology behind was explained to her, that it is due to the growing uterus causes compression on the nerves can cause lower abdominal pain radiating to the back and legs. Education on rest and exercise was done and client participated well during the discussion. She was also educated on the importance of attending antenatal clinic on time and also educated her to reduce her work load in this state of pregnancy. After education was done based on complains of lower abdominal pain, her antenatal was collected and glanced through to note previous history, client met student midwife's criteria, an introduction was made by the student midwife from Berekum Nursing and Midwifery Training College who came to have clinical experience, showed interest in handling madam Elizabeth as a client and most importantly to involve her in a study named as Family centered maternity care study. The midwife in charge was already informed about a quest to find a client who met the criteria to be used for the client

and family centered maternity care study and the midwife in charge explained and sought consent from the client, the client was found to have met the criteria. Detailed information and procedures involved in the study were explained to her and she gladly agreed and promised to give all the information needed and her maximum cooperation. She was introduced to the ward in charge as the client selected for the care study, which she also gave her consent to.

All procedures to be done on her was explained to her and she gave her consent. Vital signs and weight were taken and the findings recorded in her antenatal book as follows;

Temperature	36.7degree Celsius
Pulse	89bpm
Respiration	20cpm
Blood Pressure	120/60mmhg
Weight	62kg
Height	155 centimeters

The results of the various laboratory investigations done were as follows

Hemoglobin	12.0g/dl
Hepatitis B	Negative
Rhesus factor	Positive
Blood Group	O
HIV Status	Negative
Sickle Test	Negative
G6PD	Normal
Syphilis (VDRL)	Non-reactive

Urine testing

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

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

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

The procedure involved in physical examination was explained to her and she consented. Privacy was provided by closing doors, nearby windows and curtains drawn and hand washing was done.

HEAD TO TOE EXAMINATION

Madam Elizabeth was assisted to sit on the bed, lie on her right side and then assume a supine position after client has been assisted to undressed, examination was started.

Head and Neck**;** on examination from the head, there were no scars on the scalp. The hair was check for brittleness, dandruffs, lice, infection and also distribution of hair but that moment her hair was combed and styled nicely and neatly. Few educations were done and she was congratulated. The face was also examined for the presence of edema, chloasma and rashes but no abnormalities were detected and the skin looked smoothed and facial color was well distributed. Her eyes were examined and there was no pallor, jaundice and discharges from it. The nose was examined with no discharges, the mouth was examined with no dental carries,

and tooth decay, halitosis during conversation, no cracks or sores were found on the lips, the gum and tongue were inspected for pallor and they were normal. Her ears were examined with no pain and discharges from it. Her neck had no enlarged thyroid gland, palpable lymph nodes or distended veins.

BREAST EXAMINATION

Client was informed on examining the breast and she consented. On breast examination both breasts were present, the shape and size were normal, the areolar was very dark in color, and the skin of the breast were smooth with the nipple well projected. The breast nearer was covered and the other one farther was exposed to be examined. The client was asked to put the hand of the part to be examined under her head and with the left hand supporting the breast, the right hand was used to palpate the breast systematically in a circular manner using the inner aspect of the fingers for masses, enlarged axillary lymph nodes but no abnormality was detected. The nipple was also squeezed gently with cotton wool and expressed fluid was examined for it color and it was clear with no foul smell and same procedure was performed on the other breast. While doing the breast examination she was told to be observant, since she would have to repeat what was done at home to detect abnormalities of the breast after every menstruation. She was made comfortable and covered up. Findings were explained to client.

EXTREMITIES

Upper Extremities; after client was informed about the continuation of examination, Client was asked if she had tingling and tightness in an attempt to make a fist, and she answered negative. Her upper extremities were examined for equality, extra digit, presence of edema, nail beds for pallor and there were no abnormalities. Her nails had also been cut and kept clean.

The Client was informed about the next step and client was assisted into a left lateral position.

Lower Extremities; Madam Elizabeth was asked to lie on her back again for examination of the lower extremities. There was no pain found in the calf, her toe nails were short and clean, there was no varicose vein, extra digit or edema on the lower extremities. The legs were checked for equalities and nail bed for pallor. She was congratulated for a neat and healthy body.

Back; her back was examined for any abnormalities of the spine and sacral region for edema and for varicose veins of which no abnormality was detected. The skin was in good condition and costovertebral angle tenderness was absent.

ABDOMINAL EXAMINATION

Before abdominal examination, palms were rubbed together to provide warmth to prevent inducing contractions.

Inspection; There were no scars on the abdomen. The abdomen had an ovoid shape with the signs of pregnancy like strae gravidarium running through the midline of the abdomen. There were fetal movements.

Measuring of Symphysio-Fundal Height**;** the zero end of the measuring tape was placed on the fundus of the uterus and the tape extended to the upper boarder of the symphysis pubis and the symphysio-fundal height measured 36cm and gestational age of 36weeks.

Fundal Palpation; hands were warmed by rubbing them together to avoid inducing contractions. Standing on the right side of the client, both hands were placed just below the xiphisternum and down the abdomen until the upper part of the fundus were felt. The fundus was occupied by a soft round mass indicating the buttocks.

Lateral Palpation; with one hand stabilizing the right side of the uterus, the other hand was moved gently on the left side where rough parts were felt indicating the fetal limbs palpated. This was repeated at the right side and a smooth round part was palpated indicating the fetal back.

Pelvic Palpation; Upon facing the client's lower limbs and placing the palms of both hands on either side of the lower abdomen below the umbilicus pointing downwards and inwards, the head was palpated in the lower pole of the uterus. On palpation the lie was longitudinal, presentation was cephalic and the position was right occipito-anterior.

Descent**;** the anterior shoulder was located 2.5cm below the umbilicus and with the ulna border just above the symphysis pubis, five fingers occupied the space indicating descent of $5/5^{th}$ above pelvic brim.

Auscultation; The fetal heart was auscultated by warming and placing fetal stethoscope (fetoscope) on the area where the back was located; the ear was placed against the fetoscope, making sure hands were not touching the fetoscope and the fetal heart beat was counted. Comparing the rate with the maternal pulse and counting how many beats were heard for one minute, it was 134bpm with regular rhythm.

VULVA EXAMINATION

Permission was sought to inspect her vulva after hand washing was done. Client's vulva was inspected after the examination light was turned towards the genital area for clear view. The vulva was well shaved and clean. The perineum, labia and clitoris were inspected and it was clean, they had no abnormalities such as swollen tissue, rashes, warts or blisters and there was no indication of female genital mutilation, and no abnormal discharges found. Hands were washed and dried. Findings were communicated to her and she was congratulated for her cooperation. She was thanked and was helped to turn to her left side before getting off

the bed and to do so any time she rises from bed. She was assisted to dress up. Madam Elizabeth was offered a seat and she was asked if she had any other complains, of which she gave the discomfort of urinating frequently especially at night. Explanation was made to her that it was one of the physiological changes that occur in later part of pregnancy as a result of the descending fetal head exerting pressure on the bladder, she was told to drink more water during the day but less during the night as this might help reduce the frequency of urination at night. She was encouraged to continue maintaining personal hygiene and also to have enough rest and sleep. She was told to get all her items needed for delivery ready and well packed this was done after being educated on the signs of labor. Finally, education on the need to attend antenatal on time was reinforced. Signs of labor was explained to her as she was in her late weeks. She was also reminded about her next visit to the clinic which was on 4th September,

2023. Phone numbers were exchanged and the direction to the client's house was taken. Agreement was made on the date for a visit to her house which was on, 18th August,2023.

Client left the hospital happily afterwards. The routine drugs served were as follows;

1. Tablet folic acid 5mg daily for 7 days
2. Tablet ferrous sulphate 200mg daily for 7 days
3. Tablet multivitamin 200mg daily for 7 days

2.2 FIRST ANTENATAL HOME VISIT

On 19th August at 4:30pm, a visit was made to Madam Elizabeth house as arranged. The main purpose was to check on her physical wellbeing as well as her family's welfare. The journey was made by foot to client's house using the direction given on the day she came for antenatal care. On arrival, a boy in about his sixteen's was met and pleasantries exchanged as well as establishment of rapport. When enquiries about Madam Elizabeth was made, he

mentioned that she has gone to a provision shop in the next house to buy something. Her husband too was not in as he had gone to work. A seat was offered and opportunity was taken to move around the house and observe the surroundings as well.

CLIENTS PHYSICAL ENCIRONMENT

The house was located behind the chief's palace with house number of AT-234-13 at Atuna. It was built with cement bricks, which is plastered and painted and was roofed with aluminum roofing sheets. It contained three rooms and a corridor with a kitchen beside the house. There was a bathroom and a toilet which was built with cement bricks and was semi-detached from the house. The floor of the bathroom was cemented. It was observed that the surroundings were neat. Their water source was from a standpipe in the house stored in a barrel and covered neatly. Madam Elizabeth mentioned that, she and her family were occupying one room. The other rooms were occupied by other tenants. The room had windows which she said she opens it always to allow fresh air to enter the room. She mentioned that they use water from the standpipe for domestic purposes and also as a drinking water. She again added that refuse was dumped in the bush, few meters away from the house, room was very spacious and well ventilated. It was observed that, she and her family sleeps under a treated mosquito net. A chance was given to educate her on how and the need to keep a good personal and environmental hygiene.

An opportunity was then given to inspect her layette for labor. She said she has gotten all the needed items for labor and were well packed so permission was sought to inspect the items and they were accurate as she had said, she was also educated on true labor signs such as "the appearance of show" and painful rhythmic regular uterine contractions. Madam Elizabeth returned with some few items she has bought from the shop and she was glad about the visit.

PSYCHOSOCIAL ENVIRONMENT

Madam Elizabeth lives with her family and colleague tenants. She relates well with her tenants and neighbors, Client said whenever there is a problem concerning the house, a sitting is orga nized for them to bring in their views on how to solve the issue. Disputes are being settled between tenants to ensure there is peace and harmony. Madam Elizabeth attend funerals, weddings and other ceremonies when the need arises with her husband. An introduction was made to the tenants and neighbors as a student midwife who will be taking care of her through pregnancy, labor and puerperium.

Madam Elizabeth and her family were then appreciated for their warm reception and provision of adequate information which was useful. She was asked if she had any complains and she responded that she had no complains. Permission was sought to leave and she accepted. She was pre informed of a second home visit which was on 19th August, 2023.

2.4 SECOND ANTENATAL HOME VISIT

The second home visit to Madam Elizabeth's house was made on the 20th August,2023 around 4:00pm as scheduled. On reaching her house, client gave a smiling welcome and greetings were exchanged. A seat was offered afterwards. At this time the whole family were at home. The aim of the visit was to check up on her wellbeing and the family members, also to ascertain whether the education given was taken and to assess her preparation towards delivery. Client was asked how she was faring as well as the whole family, she said they were all doing well accept that she is having constipation and cannot also sleep well.

Client was educated to take more fluid and roughage diet. She was asked of her previous complains and she confessed that she is coping with them. She was asked to mention the true signs of labor and she was able to recall all of them. She was then reminded to report immediately to the clinic if she experiences any of them. She was asked of the one who will

accompany her to the clinic and she said her husband. She was also reminded to arrange with a taxi driver who will pick her to the hospital when the need arise. The opportunity was used to inspect her packed items in a suitcase and the items were complete. The compound was checked and everything was well kept.

Client was thanked for her cooperation and was reminded of her next antenatal care visit which was on 24th August, 2023 ..

2.5 SUBSEQUENT VISIT TO THE CLINIC

On the 18th August, 2023 Madam reported at the facility. She was warmly welcomed, offered a seat and congratulated for her regular attendance. Her antenatal book was collected and glanced through. All the routine procedures to be carried out were explained to her and her consent was sought. Her vital signs and weight were checked and recorded as follows:

Temperature	36.4 degrees Celsius
Pulse	79beats per minute
Respiration	19cycles per minute
Blood pressure	110/ 70millimetres of mercury
Weight	62 kilograms

She was asked to empty her bladder and urine was tested for the presence of protein and glucose which were both negative. She was then sent to the palpation room. She was assisted to position herself on the examination bed. After hand washing with antiseptic soap under running water and well dried with a clean dry towel, head to toe examination was done and no abnormality was detected. Abdominal inspection was done and there was no abnormality detected. On palpation, the gestation was 38weeks; Symphysio-fundal height 36cm, lie longitudinal, and position was left occipito-anterior, presentation cephalic, descent 4/5th, fetal

heart rate was 140bpm on auscultation. She was then congratulated, asked to lie on her left side, sit and then get up from the examination bed. A seat was offered to her and findings were communicated to her. Client complained of fatigue and was then encouraged to have enough bed rest and sleep and was asked to come to the facility in a week's time if she had not delivered. She was not served with any of her routine drugs because the previous ones had not yet finished. She was then thanked and seen off.

2.6 NURSING CARE PLAN DURING ANTENATAL PERIOD

PROBLEMS IDENTIFIED

- Lower abdominal pains 19/08/23
- Frequency of micturition 19/08/23
- Constipation 20 /08/23
- Insomnia 20/08/23
- Fatigue 20/08/23

SHORT TERM OBJECTIVES

- Client will be able to cope with the lower abdominal pains throughout pregnancy.
- Client will regain her normal bowel movement within 24 hours.
- Client will be able to cope with frequency of micturition within 4 hours.
- Client will be able to sleep for at least 2 hours continuously during the day and 6 hours continuously at night within 48 hours.
- Client's fatigue will resolve within 72hours.

LONG TERM OBJECTIVE

Madam Elizabeth will go through pregnancy successfully without any complications to both mother and fetus.

TABLE 1: NURSING CARE PLAN DURING ANTENATAL

DATE/ TIME	NURSING DIAGNOSIS	OBJECTIVE/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTIONS	DATE/ TIME	EVALUATION	SIGN
1/08/23 At 10am	lower abdominal pain related to descent of fetal head.	Client will cope with lower abdominal pain within 24hours and throughout pregnancy as evidenced by 1, Client verbalizing that lower abdominal pain has subsided. 2.Midwife observing client being able to cope with pain after minimizing strenuous activities	1. Reassure client. 2. Explain the physiology of lower abdominal pain to the client. 3.Encourage client to adopt a comfortable position. 4.Encourage client to rest between activities. 5.Serve prescribed analgesics.	1. Client was reassured of good pain management 2. The condition was explained to that due to the descent of the fetal head which is having a straining effect on the pelvic ligament. 3. Client was encouraged to adopt a comfortable position like side lying. 4.Client was encouraged to rest between activities. 5.Client was served with 1 gram of paracetamol.	19/08/23 At 10:00am	Goal met as client verbalized that abdominal pains had reduced. 2. midwife observed that client is looking cheerful.	A.J

TABLE 1: NURSING CARE PLAN DURING ANTENATAL CONTINUED

DATE/ TIME	NURSING DIAGNOSIS	OBJECTIVE/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTIONS	DATE/ TIME	EVALUATION	SIGN
18/08/2023 At 10am	Frequency of micturition related to descent of the presenting part.	Client will have knowledge on the physiology of frequent micturition within 24hours as evidence by client verbalizing that she understood the physiology behind the frequency of micturition and she is coping with it. 2.Client mother verbalizing that she is coping with frequency of micturition.	1. Reassure client. 2. Explain the physiology to client. 3.Encourage client on the need to keep vulva clean 4.Encourage client to void every 1 to 2 hours. 5Encourage her to have pail close to her bedside when sleeping and encourage drinking more water during the day and less at night.	1. Client was reassured on competent care. 2. The physiology of frequency of micturition was explained to her as reduced bladder capacity. 3. Client was encouraged on the need to keep vulva clean and wearing of cotton under wears. 4. Client was encouraged to void whenever she feels the urge to. 5. Client was encouraged to use a pail at night rather than walking a distance to urinate and client was encouraged to drink more during the day and less at night	19/08/2023 At 10am	Goals met as 1 client understood the physiology of frequency of micturition 2 And clients mother says client empties her bladder anytime she has the urge to urinate.	A.J

TABLE 1: NURSING CARE PLAN DURING ANTENATAL CONTINUED

DATE/ TIME	NURSING DIAGNOSIS	OBJECTIVE/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTIONS	DATE/ TIME	EVALUATION	SIGN
19/08/23 At 4:00pm	Constipation related to inadequate fiber intake and activity of progesterone causing decrease peristalsis and relaxation of smooth muscles of the large intestines.	Client will regain her normal bowel movement within 24 hours as evidenced by client verbalizing she has regained her normal bowel movement And clients mother client does not complain of constipation again.	1.Reassure client of competent nursing care. 2.Explain physiology of constipation to client. 3.Encourage client to take in fiber diets and roughages at least three times daily.	1. Client was reassured on free bowel movement. 2. The physiology of constipation was explained to her as, due to activity of progesterone causing decrease peristalsis and relaxation of smooth muscles in the large intestines causing the content to stay in the intestines for long hence causing absorption of fluid from the faeces leading to constipation. 3.Client was encouraged to eat fiber diets at least three times daily such as oranges and garden eggs stew.	20/08/23 At 4:00pm	Goal partially met as Madam Elizabeth said that she emptied her bowel 2, And client mother verbalizing that client has not complained of constipation for a while.	A.J

TABLE 1: NURSING CARE PLAN DURING ANTENATAL CONTINUED

			4. Educate client to take in more fluids at least 8-10cups a day 5.Advice client on exercise	4.client was educated on the need to take more fluids as this helps increase peristalsis and relieves her of constipation. 5.Client walked around as an exercise.			

TABLE 1: NURSING CARE PLAN DURING ANTENATAL CONTINUED

DATE/ TIME	NURSING DIAGNOSIS	OBJECTIVE/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTIONS	DATE/ TIME	EVALUATION	SIGN
19/08/23 At 4:00p m	Sleep pattern disturbance (Insomnia) related to frequent micturition.	Patient will be able to sleep at least 3hours continuously at night as evidenced by 1. Client verbalizing, she is able to sleep at night. 2. Client's mother verbalizing that client sleeps well.	1. Reassure client. 2. Educate client to take in less fluid at night. 3. Educate client to empty her bladder whenever she has the urge to. 4. Encourage client to eat early before going to bed. 5. Encourage client to reduce intake of caffeinated beverages.	1. Client was reassured. 2. Client was educated to take in less fluid before going to bed. 3. Client was educated to empty her bladder whenever she has the urge. 4. Client ate two hours before going to bed. 5. Client reduced the intake of caffeinated beverages.	20/08/23 At 7:00pm	Goal fully met as 1, client verbalized that she slept well throughout the night. 2 midwife being informed by client's mother that she sleeps well at night.	A. J

TABLE 1: NURSING CARE PLAN DURING ANTENATAL CONTINUED

DATE/ TIME	NURSING DIAGNOSIS	OBJECTIVE/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTIONS	DATE/ TIME	EVALUATION	SIGN
19/08/23 At 10am	Activity intolerance (Fatigue) related to weight of product of conception and inadequate rest.	Client's fatigue will reduce and body comfort will be restored within 48 hours as evidenced by Client verbalizing reduction in fatigue and improvement in body comfort. And midwife observes client no longer complains	1. Reassure client that fatigue will reduce. 2. Encourage family members to help with household chores. 3. Encourage client to take up little work 4. Teach client energy conservation techniques such as sitting rather than squatting or standing while washing. 5. Encourage client to have enough sleep and rest.	1. Client was reassured of adequate support to reduce fatigue. 2. Family members were encouraged to help with the household chores. 3. Client was encouraged to take up little work that she can tolerate. 4.Client was taught energy conservation techniques such as sitting rather 5. Client was encouraged to have enough sleep and rest especially during the night.	20/08/23 At 10am	Goal fully met as 1 1, Client verbalized reduction in fatigue and improvement in body comfort. 2, midwife observed that client has not made any complains.	A. J

CHAPTER THREE

LABOUR

3.0 INTRODUCTION

This chapter describes the admission and management of all the stages of labor, immediate care of the new born, examination of the new born and the care plans drawn for the management of the problems encountered during this period.

3.1 ADMISSION AND MANAGEMENT OF FIRST STAGE OF LABOUR

During afternoon shift on the 24th August, 2023, Madam Elizabeth arrived at the labor ward at 03;10pm accompanied by her husband. After her husband called on phone to give information about her wife experiencing lower abdominal pain, waist pain, excessive sweating and was asked to come to the hospital. Assessment was done to assess the progress of labor before client was taken through the admission process. History of labor was taken from client and she said labor started around 10am and she was experiencing mild waist pain and contractions, show was noticed at home and the contractions became frequent. Madam Elizabeth said she had not seen any trickling of water or blood but could feel increased fetal movements. Enquires were made to know if she took any medications or herbs since the pain started but she answered no and also said she ate before coming and had a normal bowel movement when asked. Client was reassured of competent care to be rendered after which she was made comfortable in bed and privacy maintained. Client layette was arranged by her bedside and she was encouraged to empty her bowel and bladder when she had the urge into a bed pan provided. Client was asking questions about the duration and outcome of labor and client was seen to be anxious.

Madam Elizabeth was reassured of competent care, as well as education on procedures to be performed and the stages of labor. She was also reassured that she will not be left alone but

the husband will be readily available for her as well as the midwives ensuring that they do their best to render their best care.

Her vital signs were checked and recorded as follows;

Temperature	-	36.6 ^{0}C
Pulse	-	82bpm
Respiration	-	21cpm
Blood Pressure	-	120/75 mmHg

Privacy was provided and explanation was given on procedure for physical examination from head to toe. Consent was sought from client and she agreed. Madam Elizabeth was asked to empty her bladder and take a midstream urine to test for protein and acetone which when tested was negative for protein and glucose. Client passed 150mls of straw-colored urine. Client was assisted to undress and cover herself with a piece of cloth and assisted onto the examination bed. Hands were washed under running water with soap and dried with clean dry towel. The head-to-toe examination was done under the supervision of the midwife in-charge. The hair, sclera, conjunctiva, nose, mouth, ears, neck were examined without any abnormality seen. The face was a bit tensed because of the painful contractions. The breasts were firm on the chest with no engorgement or inversion of the nipples. The arms were proportionate in length, the nails were also short and clean. On her lower extremities, there was no varicose vein found on the legs. There was no pallor, edema nor jaundice. The hands were warmed again by rubbing them together.

Inspection; on abdominal inspection, the abdomen was globular in shape, there was Linea nigra on the abdomen and no strae gravidarium or previous scar was observed.

Measuring of the symphysio-fundal height; Symphysio - fundal height was 37 centimeters with gestation of 38 weeks.

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

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

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

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

On auscultation; the fetoscope was rubbed on the palm to warm it before placing it on the abdomen to listen to the fetal heart beat for a full minute which read as 130 beats per minute with regular rhythm and good volume.

The uterine contraction was timed for 10minutes and it recorded 3 in 10 minutes lasting 35 seconds approximately.

Vaginal Examination

Permission was asked to perform vaginal examination of which she agreed. Procedure for vagina examination was explained to her in order to promote comfort and seek her cooperation. A sterile tray was set containing two gallipots, one containing savlon antiseptic solution, the other gallipot with sterile cotton wool swabs, a pair of surgical gloves and a receiver for used swabs and all was covered with a sterile towel. Privacy was ensured. Hands were washed with soap under running and dried with a clean dry towel. Client was then helped into a lithotomy position with her knees flexed and thighs apart. Examination gloves were worn and soiled pad removed, examined and discarded with the left hand. A pair of surgical gloves were worn. The vulva was well shaved though soiled with the blood-stained mucous (show), it had no abnormalities. A sterile cotton wool swab was picked with the right

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

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

PREPARATION FOR BIRTH

In preparing for birth, helpers were identified including the skilled and unskilled personnel.

The midwife in-charge was identified as the skilled personnel and the client's husband was identified as the unskilled personnel. The doctor on call was notified about the client's admission. Emergency boxes (like PPH and Eclampsia) with their appropriate items were available. The delivery room had been already cleaned. Client was encouraged to wash hands

with soap under running water and dried with clean dry towel and she was informed that the windows will be shut and fans will also be put off to provide a warm environment for the baby when it is time for delivery of which she agreed. Room was well lighted and ventilated. Madam Elizabeth was also educated that the baby would be delivered onto her abdomen on a sterile towel and she will have to support the baby. She was also informed that her abdomen will be cleaned for skin-to-skin care with the baby. The resuscitation box had all the items needed such as a stethoscope, scissors, cord clamp, sucker, self -inflating bag and mask of different sizes. The self-inflating bag was tested to see whether it was functioning, also the radiant bulb was switched on to provide warmth to the cot. Other items like cot sheets were also made available. Referral centers and their numbers as well as ambulance and its driver were all checked to be available. Delivery items were also made available.

Madam Elizabeth was encouraged to assume any position favorable to her. She was encouraged to assume a left lateral position to increase placental perfusion and prevent supine hypotension. She was encouraged to ambulate to aid in the descent of the fetal head. A bed pan was provided for her and was encouraged to urinate when she feels the urge to further aid in descent of the fetal head. Client was encouraged to take in water or any sweetened fluid to prevent dehydration. Client was served with mashed kenkey and bread which was brought by the husband.

Madam Elizabeth was reminded of the deep breathing exercises so as to conserve energy for the second stage. Sacral region was massaged during contractions to relieve her from pain. Client was continuously and closely monitored on the partograph throughout the first stage of labor, maternal and fetal conditions were recorded and labor progressed well. Client was monitored on the partograph as follows; fetal heart rate, uterine contractions and maternal pulse were checked every thirty (30) minutes. The cervical dilation, descent, membranes, moulding, blood pressure and temperature were checked every four (4) hours. Urine test for

protein and acetone was done every four (4) hours. Client was reassured again of competent care to be rendered and all procedures were explained before their performance. All findings were communicated to her.

At 4:10pm fetal heart rate was 133bpm, contractions were 3 in 10 lasting for 36 seconds and maternal pulse was 85bpm. At 5:10pm fetal heart rate was 132bpm, contractions were 4 in 10 lasting 36 seconds and maternal pulse was 75bpm. She was assisted to lie on her left and breathe through her mouth since she was complaining of severe waist pain. She was reassured that she will soon have her baby and all discomforts will be resolved and a sacral massage was given to reduce the pain. She was encouraged to assume a favorable position and the physiology of uterine contraction was explained to her. At 6:10p m fetal heart rate was 134bpm contractions were 4 in 10 lasting 38 seconds, maternal pulse was 76bpm.The progress of labor was documented and then communicated to client. Client was sweating a lot and was cleaned with a wet towel. She was also given iced water to calm herself. At 7;10pmTemperature was checked and recorded as 36.7˚C and blood pressure was 115/70mmHg, urine was taken to test for protein and acetone and they all showed negative and the amount of urine as 110mls and head descent was 2/5th. fetal heart rate was 137bpm, contractions were 4 in 10 lasting 42 seconds, maternal pulse was 87bpm. Client was due for vaginal examination. It was observed that client had removed pad onto bed. She was quickly made aware not to do that since she could be infected. She was encouraged to wash her hands with soap under running water and dried with clean dry towel and discard pad if fallen.

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

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

Delivery trolley was set paying attention to sterility. It contained the following items;

Top shelf

- A sterile bowl for Savon solution

- A HLD delivery pack containing;

  Two sterile towels

  Two artery forceps

  Two dissecting forceps

- A HLD episiotomy pack containing;

  Episiotomy scissors

  Needle holder

  Dissecting forceps

- Receiver for placenta
- Sterile gauze swabs and cotton wool swabs in a gallipot
- Clean sucker.

Bottom shelf

- Pre-packed sterile gloves
- Warm towels and blanket
- Jug to measure blood loss
- Perineal pads,
- Syringes and needles
- Cord clamp
- Baby identification band
- Antiseptic lotion
- Fetoscope
- Drainage bag and catheter
- A drug tray containing injection Oxytocin, Lidocaine, water for injection, injection vitamin K, and Chloramphenicol eye drop
- Two clean cot sheets.

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

At 8:10pm fetal heart rate was 133bpm, contractions were 4 in 10 lasting 45sec and maternal pulse was 90bpm. At 8:20pm membranes ruptured spontaneously with clear liquor. Vaginal examination was done to exclude cord prolapse and there was none, cervix was 10cm dilated with molding (++), descent was 0/5th, fetal heart rate was 139bpm, contractions were 4 in 10 lasting 48 seconds and maternal pulse was 85bpm. Client complained of bearing down and was encouraged to breathe through her mouth. The perineum was quickly examined, the vulva and anus were gaping, perineum was bulging and a trickle of blood was evident. Progress of labor was communicated to the midwife in-charge and the client that the cervix was fully dilated. All findings were explained to her and recorded on the partograph sheet.

The midwife in charge confirmed full dilation of the cervix.

3.2 MANAGEMENT OF THE SECOND STAGE OF LABOUR

Client was positioned in the second stage room at 8:25pm. She was asked which position she preferred and she responded that she wanted to lie in a dorsal position. She was helped on to the delivery bed and asked to lie on her side.

A sterile trolley was pushed near the delivery bed at the right side of her. Client was reassured to allay her anxiety. Protective clothing was worn (mackintosh apron, safety boots, goggles, and nose mask). Hands were washed under running water with soap and dried with clean dry towel and a pair of sterile gloves were put on. Client's abdomen was cleaned. A perineal pad was applied to the anus to prevent fecal matter from contaminating the delivery field hence infecting the baby. Client was encouraged to bear down with contractions and rest in between. The fingers of the left hand were placed on the advancing head to aid the smallest diameter of the head distends the perineum. When the head crowned, she was asked to stop pushing and pant and the fingers were spread equally over the vertex to restrain any sudden expulsive effect. She was asked to take a deliberate breath to aid pushing. The head was

delivered by extension, by allowing the sinciput, the face and chin to glide slowly over the perineum to be delivered. The baby's eyes were cleaned with sterile cotton wool swabs from the inner canthus to the outer canthus to prevent infection using one swab for each eye. The mouth and nose were also wiped gently with sterile gauze. Neck was felt for cord but there was none. Restitution took place followed by external rotation of head allowing the shoulders to lie in the anterior-posterior diameter of the pelvic outlet, the hands were placed on the sides of the baby's head over the ears and with gentle downward traction the anterior shoulder was delivered towards the mother's anus followed by upward traction toward the mother's abdomen to deliver the posterior shoulder. The rest of the body was delivered through lateral flexion along the curve of carus onto the mother's abdomen. At exactly 8:45pm a live female infant was delivered and she cried loudly. The client was congratulated for her effort and cooperation. Baby was shown to the mother and mother identified the sex.

Baby was wiped, placed on mother's abdomen for skin-to-skin contact and covered. Her husband and mother were informed of her successful delivery.

3.3 IMMEDIATE CARE OF THE BABY

Immediately the head was delivered, sterile gauze was used to clean the baby's face, mouth and nose. The eyes were cleaned with sterile cotton wool from inside out. The baby was delivered onto the mother's abdomen. The baby cried immediately after delivery and client was congratulated. The baby was wiped with a clean cloth paying attention to the skin folds. Wet linen was changed. The baby was shown to the mother for confirmation of sex which she identified as male and the baby was put to breast to initiate breastfeeding whiles on the mother's abdomen for skin-to-skin care.

A cap and baby's socks was put on as well as cloth for warmth. The cord was clamped 3cm from the baby's abdomen, and 2cm from the first clamp with artery forceps and was cut in between the two forceps with a sterile scissors covered with sterile gauze to prevent splash of

blood. This was done to separate the baby from the mother. The first minute Apgar score was 8/10 and the fifth minute Apgar score was 9/10. An identification band with the name of the mother, sex, date and time was placed at the baby's wrist. Client was congratulated.

APGAR SCORE		**FIRST MINUTE**
Appearance	-	1
Pulse/heart rate	-	2
Grimace/reflex	-	1
Activity/muscle tone	-	2
Respiration	-	2
Total	-	8/10

APGAR SCORE		**FIVE MINUTE**
Appearance	-	2
Pulse/heart rate	-	2
Grimace/reflex	-	1
Activity/muscle tone	-	2
Respiration	-	2
Total	-	9/10

3.4 MANAGEMENT OF THE THIRD STAGE OF LABOUR

The third stage of labor starts after delivery of the baby and ends with complete expulsion of the placenta and its membranes and control of bleeding and was actively managed. The procedure was explained to her. The presence of undiagnosed second twin was checked and there was none. Ten (10) unit of oxytocin was injected intramuscularly at the thigh to aid contraction of the uterus and separation of the placenta by the midwife in-charge. Controlled cord traction was the method used in delivering of the placenta in order to prevent having

retained placenta or products of conception. The cord was reclamped with an artery forceps closer to the perineum and the tip end placed in a receiver in between the thighs. The left hand was placed on the fundus and as soon as there was contraction, the left palm was placed just above the symphysis pubis to support the uterus, with the palm facing the fundus of the uterus. This was done to prevent inversion of the uterus. With the right hand, the clamped cord was held. When the uterus was contracted, a very gentle pull was applied on the cord in a downward motion. The downward and outward pulling was continued until the placenta was visible in the vulva. The two hands were used to receive the placenta and it was gently twisted to tease out the membranes completely at 8:50pm (5minutes). The placenta was placed in the receiver and inspection was quickly made to be sure that the membranes and lobes were intact. The uterus was massaged to stimulate contraction and expel clots. Gauze was wrapped around the first and second fingers of both hands to inspect the vulva, vaginal walls and the cervix as well as the perineum which were all intact. Blood loss per vaginum was about 150mls. Client was cleaned nicely and perineal pad was applied over the vulva and she was made comfortable in bed to rest at the labor ward, the uterus was massaged and client was taught how to massage her own uterus to aid more contraction. She was encouraged to urinate frequently whenever she had the urge so that the uterus could contract well and help in involution of the uterus and to prevent postpartum hemorrhage. All items used was decontaminated in 0.5% chlorine solution for 10 minutes. Items were then washed, rinsed, dried and packed for sterilization. Hands were then washed with antiseptic soap under running water and dried with clean dry towel.

EXAMINATION OF PLACENTA AND MEMBRANES

Protective clothing was worn and a thorough inspection of the placenta and membranes was done in order to ensure no part of it has been retained during its delivery after it had been sent to the sluice room. The placenta was put in 0.5% chlorine solution to make it less infectious and it was held by the cord allowing the membranes to hang loosely downwards. The cord

was of normal size and the cut edge was cleaned with cotton wool which revealed two arteries and one vein. It was surrounded by Wharton's jelly. The cord insertion was central, it had no false or true knots. The fetal surface was shinny and smooth with its color being bluish grey. The branches of the cord vessels were seen radiating on its surface. The placenta was placed on a flat surface with the maternal surface facing upward. On inspection, the color was dark red and the cotyledons were intact. There were no infarcts or extra lobes on the maternal surface and neither was it edematous. It was then disposed of appropriately. The working surface was wiped with 0.5% chorine solution and decontaminated the delivery instruments in 0.5% chlorine solution for 10minutes, washed with soap and water, rinsed, allowed to air dry and packed to the central sterilization supply department for sterilization. Findings were recorded on the labour sheet, delivery book and summary of delivery in the antenatal book. The partograph was also completed

3.5 MANAGEMENT OF THE FOURTH STAGE OF LABOUR

The fourth stage of labor refers to the first six (6) hours after the delivery of all products of conception. During this period, the baby and mother were closely monitored to detect any complication that may arise and be managed accordingly.

MANAGEMENT OF MOTHER

At 9:50pm Madam Elizabeth was assisted to the lying-in-ward to an already prepared warm bed after one-hour uninterrupted skin to skin care at the labor ward. Her vital signs and condition of the uterus were checked every 15 minutes. Client's immediate post - delivery vital signs were checked and recorded as follows;

Temperature	-	36.3^0c
Pulse	-	80bpm
Respiration	-	20cpm
Blood Pressure	-	110/70 mmHg

The uterus was palpated and it was well contracted and symphysio-fundal height was 18 centimeters. She was encouraged to urinate frequently as this will aid contraction of the

uterus and involution. Her perineum was observed and the pad for amount of lochia which was bright red, moderate and not offensive. Madam Elizabeth was encouraged to change her pad frequently when soaked and to wash her hands before and after changing pad and before handling baby. For the first six hours she was given porridge with bread after which she continued breastfeeding. She was also encouraged to massage her uterus, change pad and to void if she has the urge.

MANAGEMENT OF BABY

PREVENTION OF DISEASES OF THE NEW BORN

This was done after one (1) hour uninterrupted skin to skin care. The procedure to be carried out on the baby was explained to the mother. Hands were washed under running water with soap and dried with a clean dry towel. The baby was put on a clean, warm and flat surface in the presence of mother. Two drops of chloramphenicol eye drop were instilled on the inner canthus of the eye with the hand pressing on the cheek. Cord was inspected for bleeding but it was in good condition without any bleeding. The umbilical cord was cleaned with sterile cotton wool swabs soak in methylated spirit and kept dry. One milligram of vitamin K injection was given as a prophylaxis for prevention of hemorrhagic disease of the newborn after examination of the newborn due to the pain it causes.

EXAMINATION OF THE NEWBORN

At 10:00pm, baby was put on a clean warm and flat surface. Baby was then exposed systematically as it was examined from head to toe in the presence of the mother. Its color was pink on observation and she appeared active.

HEAD - The head was examined for shape and size, widened sutures, bulging or depressed fontanelle, any edematous swelling

(Caput succedaneum) no abnormalities were found. A tape measure was used to encircle its head starting from the occipital protuberance to the supraorbital ridges to

measure the head circumference and it was 36centimeters. The ears were examined for size, shape, and patency, softness of the cartilage, alignment and discharges. The eyeballs were examined for its presence and color, pallor, jaundice and deformities. The nose was examined for shape, size, patency, deviated septum and discharges. The buccal cavity was inspected for false teeth, tongue tie, color of tongue and gum, cleft lip palate using the little finger to feel for palate for any sub mucous cleft, the neck for nodules, rigidity and congenital goiter but no abnormality was detected. On the chest, respiratory movement was normal, nipples were in alignment without discharges, and breast had no mass.

THE UPPER EXTREMITIES- were inspected for equality, number of palmer creases clubbed fingers, extra or loss digits. Baby's ability to perform Moro and grasp reflexes was

also checked and was present. The abdomen was examined for shape, size, with no bleeding from the umbilical site and abnormalities such as omphalocele, gastroschisis were absent.

THE LOWER EXTREMITIES - were inspected for equality, clubbed feet, extra/loss digits, none was detected. Congenital hip dislocation was also checked using the Ortolani's test and there was no dislocation since a clunk sound was not heard.

BACK; With baby lying on one side, the back was examined for abnormalities like spinal bifida, meningocele, edema which were absent.

GENITALS AND ANUS; The genitalia were inspected. The clitoris was of normal size , the labia majora covers the minora , the urethra was patent The anus was also examined and it was patent as baby passed meconium. Baby was weighed and it was 3.5 kilograms and full length was 51 centimeters. Vitamin K (1mg) was injected intramuscularly at the right thigh of the baby to prevent hemorrhagic diseases of the new born. The baby was monitored for cord bleeding and there was none. Gloves were removed and disposed aseptically before washing

and drying hands. All the findings were communicated to the parents and recorded afterwards. The baby was then dressed nicely in a warm sheet and given to the mother for breastfeeding while observing suckling reflex. Client was educated on the importance of exclusive breast feeding for the first six months of birth.

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

Temperature	36.6 degrees Celsius
Apex beat	127bpm
Respiration	45cpm

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

3.6 SUMMARY OF LABOUR

Date and time of delivery	-	24th August ,2023 at 8:45pm
Type of Delivery	-	Spontaneous Vaginal Delivery
Time injection oxytocin was given	-	8:46pm
Time of Expulsion of Placenta and membranes	-	8:50pm
Drugs given	-	Injection Oxytocin 10 units

DURATION OF LABOUR

1st Stage	-	6 hours, 5minutes
2nd Stage	-	20minutes
3rd Stage	-	5 minutes
Total time	-	6 hours, 30 minutes

CONDITION OF MOTHER

Condition of mother	-	Stable
Perineum	-	Intact
Fundal Height	-	18cm

Blood Pressure	-	115/80mmHg
Pulse Rate	-	84bpm
Respiration rate	-	19cpm
Temperature	-	36.6ºC

CONDITION OF BABY

Apex beat	-	127bpm
Respiration	-	47cpm
General condition of baby	-	Satisfactory
Sex of Baby	-	female
Baby's Weight	-	3.5kg
Congenital Abnormalities	-	None detected.
Baby's Full Length	-	51cm
Head circumference	-	36cm
Meconium	-	Passed
Urine	-	Passed

3.7 NURSING CARE PLAN DURING LABOUR

PROBLEMS IDENTIFIED

- Anxiety 24/08/23
- Lower abdominal pain 24/08/23
- Waist pain 24/08/23
- Excessive sweating 24/08/23
- Risk of infection 24/08/23

SHORT TERM OBJECTIVES

- Client will be allayed of anxiety within 30 minutes Client will cope with lower abdominal pain within 24 hours.
- Client will cope with waist pain within 2 hours.

LONG TERM OBJECTIVE

Client will go through labor successfully with healthy baby without complication to both mother and baby.

TABLE 2: NURSING CARE PLAN DURING LABOUR

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES /OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTIONS	DATE /TIME	EVALUATION	SIGN
24/08/23 at 2:50pm	Anxiety related to unknown outcome of labor.	Client will be allayed from anxiety within 30 minutes as evidenced by 1. Client verbalizing, she is no longer anxious and having a cheerful facial expression. 2. Midwife observing that client was no longer asking questions and facial expressions had changed.	1. Reassure client. 2 Encourage her to voice all her needs and fears. 3.Encourage client to ask questions. 4.Involve client in her care 5.Keep client informed of the progress of labor.	1. Client was reassured of competent care to be rendered. 2.Client voiced out all her needs and fears and was reassured 3.Answers to client's questions were provided appropriately 4.Client was involved in her care as she was involved in all processes done on her 5.Progress of labor was communicated to client the dilation board.	24/08/23 at 3:20pm	Goal met as client's anxiety was allayed and she had a relaxed facial expression 2. midwife observed that client is looking cheerful.	AJ

URSING CARE PLAN ON LABOUR

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES /OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTIONS	DATE/ TIME	EVALUATION	SIGN
24/08/23 at 2:50pm	Lower abdominal pain related to painful uterine action	Client will have reduced lower abdominal pain within 2 hours as evidenced by client verbalizing that she can cope with pain and cooperating during labor 2. Midwife observing client coping with the pain.	1.Reassure client of competent care. 2.Explain physiology to client as due to uterine contractions to push the baby down the birth canal, causing in the lower abdominal pain 3.Encourage client to adopt comfortable position. 4.Encourage client to do deep breathing exercise. 5.Provide diversional therapy.	1. Client was reassured of effective pain management. 2.Physiology of lower abdominal pain was explained as due to painful uterine contractions due to oxytocin 3.Client adopted left lateral position. 4.Client did deep breathing exercise during contractions. 5.Diversional therapy was provided to client by conversing with her to divert her from the pain.	24/08/23 at 4:50pm	Goal met as client coped with the lower abdominal pain and cooperated during labor 2. midwife observed client performing deep breathing exercises when contractions began.	AJ

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES /OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTIONS	DATE /TIME	EVALUATION	SIGN
24/08/23 at 2:50pm	Potential risk for infection related to mishandling of perineal pad	Client will be free from infection within 24hours as evidenced by 1.Client verbalizing, she does not see any sign or symptom of infection 2. midwife observing that client shows no signs of infection and recording normal vital signs	1. Reassure client. 2 Educate client to was hands with soap under running water. 3.Educate client on the need to change perineal pad 4.Educate client to discard pad if fallen 5.Administer prescribed prophylactic antibiotics.	2. Client was reassured of competent care to be rendered. 2.Client was educated to was hands with soap under running water. 3.client changed soaked perineal pad to prevent infections. 4 clients discarded fallen perineal pad. 5.prescribed prophylactic antimicrobials such as intravenous ciprofloxacin and metronidazole was administered.	25/0/823 at 2;50pm	Goal met as 1.client verbalized that she does not feel signs and symptoms. 2. midwife observed that client no longer complains.	AJ

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES /OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTIONS	DATE /TIME	EVALUATION	SIGN
24/08/23 at 2:50pm	Excessive sweating related to increase in glucose level and hormonal changes affecting body's temperature regulation leading to increase sweating.	Client will remain comfortable within 24hours as evidence by 1.client feeling relaxed and comfortable 2.midwife observing that client feels comfortable and not sweating excessively and there is a reduction in glucose level.	1. Reassure client 2.explain the cause of the perspiration 3.encourage hydration, help her drink plenty of water to stay hydrated which will help regulate her glucose level. 4. support her in using breathing exercises to manage stress and promote relaxation, which can help regulate	1.Client was reassured of competent care to be rendered. 2.The cause of the perspiration was explained her that it is due to hormonal changes affecting body's temperature regulation leading to increase sweating. 3.Client was encouraged to drink enough water to keep her hydrated. 4client was supported in how to adapt the deep breathing exercises in order to manage stress.	25/08/23 at 3:50pm	Goal met as 1.client verbalized that she does not feel signs and symptoms. 2. midwife observed that client is comfortable and relaxed and glucose level has reduced from 8.9-7.6mmol/L.	AJ

			glucose levels.				
			5.mop the face and body of client with wet towel	5 client face and body was mopped with wet towel			
			6.improve ventilation.	6.windows were opened and fan put on.			
			7.frequently check clients vital signs including blood glucose level in order to quickly identify any potential complications	7.client’s glucose level was checked and recorded			

CHAPTER FOUR

PUERPERIUM

4.0 INTRODUCTION

This chapter gives detailed information on the care rendered to the client, the baby and family from the day of delivery till six weeks postnatal.

4.1 DAY OF DELIVERY

Madam Elizabeth delivered on 24 August,2023 at 8:45pm to an alive female baby. Client and her baby were transferred to the lying-in ward after one-hour uninterrupted skin to skin contact with the baby and for close observation when their conditions were satisfactory. Her immediate post-delivery vital signs were checked and recorded as follows;

Mother's Vital Signs

Temperature	-	36.3^0C
Pulse	-	80bpm
Respiration	-	20cpm
Blood Pressure	-	110/70 mmHg
Fundal height	-	18cm

On palpation the uterus was well contracted and the symphysio-fundal height measured 18cm just below the umbilicus. The lochia was red in color and flow was moderate. On examination, no abnormality was detected. She was encouraged to change her sanitary pad when wet to avoid the risk of infection and for comfort. She was encouraged to report any excessive bleeding and also, urinate frequently to enable the uterus to contract firmly. Emphasis was placed on fluid and adequate diet to help replace worn out tissues and promote growth of the baby, and encouraging husband and other family members to provide adequate water and protein food like (meat, egg, beans, milk etc.), fruit (orange, apple, banana etc.) and vegetable (kontomire etc.). At 1:00am, client complained that when her baby suckles, she

experiences pain. Client was reassured and it was explained to her that suckling will help in the involution of the uterus so she should continuously breastfeed the baby. Madam Elizabeth was served with 1g of paracetamol and baby was put to breast and he suckled effectively. Client was educated to breastfeed baby exclusively and on demand and wash hands with soap under running water and clean with dried towel before breastfeeding baby. Her husband brought her porridge and bread.

SUBSEQUENT CARE OF THE BAB Y

Baby bath and cord dressing

After 6hours of delivery, permission was sought from mother to bath the baby of which she consented. Hand was wash with soap under running water and dried with clean towel. Brief examination was done and no abnormality was detected. The baby passed meconium and urine which was normal. The cord was inspected for bleeding and discharge but there was none. Baby's vital signs was checked and recorded as,

Baby's Vital Signs

Temperature - 36.7 ℃

Apex beat - 125bpm

Respiration - 43cpm

Weight - 3.5kg.

REQUIREMENT NEEDED FOR BABY BATH

1. Soap
2. Sponge
3. Cream / powder / oil
4. Basin

5. Towels: 1 big towel and 3 small ones
6. Cot sheet 2
7. Apron
8. Gloves
9. A clean baby dress, cap and socks
10. Mackintosh
11. 2 jugs containing hot and cold water each
12. Two receptacles for used water and dirty linen
13. A receiver for used swab
14. Methylated spirit
15. Sterile cotton in a gallipot or wrapped.

A plastic apron was put on. Hands were washed with soap under running water and dried with clean towel. Both cold water and hot water were mixed together and the temperature of the water was checked using the elbow. Gloves were worn and the baby was put on a protected flat surface and was undressed. Baby was then wrapped with a cot sheet with the head exposed for it to be bathed. The eyes were cleaned with clean cotton wool swabs soaked in clean water from inner canthus to outer canthus and the face cleaned with damp face towel and dried. The nape of the baby's neck was supported with one hand. The head was supported and the baby's ears plugged with two fingers. The head was then washed with soapy sponge. Baby was then lifted off flat surface, supporting the nape of the neck and the body resting in the elbow, to the edge of the basin and soap rinsed off baby's hair and dry. Baby was then put on protected flat surface and exposed. The arms and front of trunk were

washed paying attention to the skin folds. The back of the baby was turned with one arm supporting the chest and with a hand holding the distal arm of the baby. The back was washed down to the feet, paying attention to the skin folds. Baby was supported firmly and immersed in warm water, with head above water and rinsed thoroughly. She was then placed on the flat surface covered by a big bath towel. A small towel was used to dry the baby, paying attention to skin folds. Baby oil, as well as, powder was applied on the baby. The baby was wrapped with clean dry cot sheet after which the cord was exposed. The gloves were removed, hands were washed with soap under running water and dried with clean towel and a sterile gloves worn. The cord was inspected for bleeding but there was none. Six sterile cotton wool swabs were used to dress the cord. The tip of the cord was held with sterile cotton wool swab soaked in methylated spirit, then swabbed 5cm away from the base and after that the base of the cord was cleaned with separate cotton wool swabs soaked in methylated spirit. The whole cord was cleaned from the base upwards and lastly the tip was also cleaned with separate cotton wool swab soaked in methylated spirit. The cord was left exposed to air dry. Baby was dressed after diaper was put on. The baby was wrapped with clean dry cot sheet to maintain her temperature and given to her mother. Findings were communicated to the mother and she was thanked for her co-operation and she was accompanied to the bedside. The working surface and the instruments were decontaminated with 0.5% chlorine solution for 10 minutes; it was then washed. The gloves were removed and hands washed with soap under running water and dried with clean towel and the procedure was documented

Mother was informed that the baby will be immunized against tuberculosis and poliomyelitis.

4.2 FIRST DAY POST DELIVERY (DAY OF DISCHARGE)

On Thursday, 25th Aigust,2023 was the first day after delivery, Madam Elizabeth and her baby were very healthy with cheerful looking face when they woke up around 6:30am. All

procedures to be carried out on both mother and baby were explained. Perineal pad was inspected and blood flow was small and red in color (rubra) without odor, and enquiries about her bladder habit was asked, of which she said it was resuming to normal. She brushed her teeth, emptied her bowel and had warm bath. Client was serve with milo drink and bread as her breakfast.

Client complained that she cannot sleep well in the night which she said was due to breastfeeding of the baby at night therefore does not have enough sleep at night. She was encouraged on good and enough breastfeeding during the day and to ensure the atmosphere is calm at night this will enable the baby to sleep at night so that she can also rest. She was also educated to sleep in the afternoon when the baby too is asleep. It was explained to client the importance of feeding baby at regular intervals. She was made comfortable in bed. Her vital signs were checked and recorded as follows;

Client's assessment was recorded as follows;

Temperature	36.5^{o}c
Pulse	84bpm
Respiration	22cpm
Blood Pressure	120/70mmHg
Lochia	Rubra
Fundal Height	17cm
Condition of the uterus	contracted
Breast	Lactating

Madam Elizabeth's symphysio- fundal height was 17 centimeters above the symphysis pubis. Her lochia was red (rubra) in color when checked and amount was minimal and not offensive after permission was sought to inspect it. Client was encouraged and taught to perform Kegel exercise to strengthen the perineal muscles.

The baby was also examined with permission from the mother after hand washing with soap under running water and dried with clean dry towel. On examination, there was no abnormality detected. The baby passed meconium and urine which was normal. The cord was inspected for bleeding and discharge but there was none. Vital signs of the baby were checked and recorded. The baby's cord was dressed with cotton swabs and methylated spirit and given to mother to breastfeed. On observation, mother positioned baby well and baby also had a good suckling and swallowing reflex. The baby's assessment was recorded as follows;

Temperature 36.5^{o}c

Apex beat 128bpm

Respiration 44cpm

Skin color Pink

Cord condition Clean dry

Cord bleeding None

Suckling Good Weight 3.4kg

Stool color Meconium

All findings were communicated to mother. Later in the day around 8:30am, the baby was given the immunization against tuberculosis with Bacilli Calmette Guerin (BCG) by the community health nurse from the Reproductive and Child welfare Clinic but polio ,0 (OPV0) which prevents the baby against poliomyelitis was given since it was a day after delivery. The BCG was given intradermal on the right upper arm of which the mother was informed that it

will form a blister and scar later and she was advised not to apply anything to the site in other to ensure effectiveness of the vaccine and 2 drops of Polio ,0 vaccine (OPV0) was given at the back of the tongue. Client was told to come with the baby to take the rest of the immunization at the time scheduled in order to protect the baby from any of the childhood preventable diseases like measles, tetanus, and diphtheria and among others. She was informed of her discharge which was that same day. She was educated on healthy adequate nutritious diet like fish, ground nut, and green leafy vegetables to help in the production of more breast milk and improve her immunity as well. This could help repair worn out tissues. She was also educated on personal hygiene, the various family planning method available and post-natal exercises. Furthermore, she was educated on demand feeding and exclusive breast feeding.

Madam Elizabeth was educated to breastfeed the baby frequently. She was health insured therefore her medicines were collected for her from the pharmacy and some money paid for other billings. Routine drugs were served as prescribed. Client was educated and was informed of her discharge. Client's drugs were given to her and the dosage and time for taking the drug were explained to her again as follows:

Capsule Amoxicillin - 500 milligram tds for 7 days

Tablet Metronidazole - 400 milligrams tds for 7 days

Tablet Paracetamol - 1gramtds for 5 days

Tablet folic acid - 5 gram dly for 7 days

Tablet multivite and folate - 200milligram for 3 days

She was educated on when the fontanelles will close naturally and therefore no hot water should be applied with the intention of helping it to close earlier.

She was helped to pack her belongings and was educated on intended post-natal visits for a period of one week which was explained to her that she would be visited at home for seven days for continuity of care. Client was educated on and how to manage common breast problems such as cracked nipple and breast engorgement. She was also encouraged not to apply anything on the cord aside the use of cotton and methylated spirit. She was examined, her breast was lactating and uterus well contracted. Perineal pad was expected and lochia was bright red and not offensive. Vital signs were checked and recorded as follows;

Temperature	36.4^{o}c
Pulse	80bpm
Respiration	20cpm
Blood pressure	110/70mmHg
Lochia	Rubra
Condition of the uterus	Contracted
Breast	Lactating

Head to toe examination was done on the baby but there was no abnormality found. The baby was assessed and recorded as follows;

Temperature	36.6^{o}c
Apex beat	128bpm
Respiration	48cpm
Skin color	Pink
Cord bleeding	None
Cord condition	Clean dry
Suckling	Good
Weight	3.4kg
Stool color	Meconium

Client was encouraged to register the baby at the birth registry and informed of continuity of care. She was then discharged at 10:00am and went home with her husband.

4.3 FIRST POSTNATAL HOME VISIT

On 26th August,2023 at 9:00am in the morning and 5;00pm in the evening, client and family were visited as promised. Client was at home with her mother and baby. Greetings were exchanged on arrival. Enquiry about the baby and her health was made of which she responded they were all fine. Client complained of interrupted sleep during first day post-delivery when asked. Client said she was able to sleep better than previous night. Permission was sought to do the examination of which she agreed. After hand washing, symphysio-fundal height was measured. The reading was 16 centimeters above the symphysis pubis. The perineal pad was checked and the color of the lochia was red and not offensive. Client's vital signs checked and recorded as follows; The baby was topped and tailed and the cord was dressed aseptically with methylated spirit and cotton wool swabs making the cord look clean and dry. After that she was dressed up with cap and socks, wrapped in a warm sheet and was given to the mother to breastfeed. Client was also educated to keep the baby warm always and not to expose the baby to cold weather. According to Madam Elizabeth, the baby passed meconium and urine. Client was encouraged to practice demand feeding and exclusive breastfeeding. She was also encouraged to maintain personal and environmental hygiene to prevent infections. After interacting with her for some time, permission was sought to leave.

In the evening client and her family were visited at home again, greetings were exchanged on arrival. Enquiry about baby and her health was made of which she responded that they were all fine. She was examined, her breast was lactating well and uterus well contracted. Perineal pad was expected and lochia was red and not offensive. Vital signs were checked and recorded for both mother and baby. She was asked whether she had any problem or complains and she responded no. Head to toe examination was done on the baby but there was no abnormality found. Vital signs for both mother and baby was checked and recorded as follows:

MOTHER'S VITAL SIGNS AND OTHER OBSERVATIONS

0bservation	Morning	Evening
Temperature	36.4	36.2
Pulse	79	69
Respiration	19	20
Blood pressure	100/70mmHg	110/60mmHg
Lochia	Rubra	Rubra
Fundal height	16cm	16cm
Condition of the uterus	Contracted	Contracted
Breast	Lactating	Lactating

BABY'S VITAL SIGNS AND OTHER OBSERVATIONS

Observation for baby	Morning	Evening
Temperature	36.7	37.0
Apex beat	133bpm	132
Respiration	43cpm	44cpm
Skin color	Pink	Pink
Cord condition	Dry and clean	Dry and clean

Cord bleeding	None	None
Suckling	Yes	Good
Weight	3.3kg	3.3kg
Stool color	Meconium	Meconium

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4.4 SECOND POSTNATAL HOME VISIT

On the 27th August ,2023 at 8:30am in the morning and 5:00pm in the evening, another visit was made to client's house. The main aim of the visit was to know if the mother and baby were in good health. Madam Elizabeth was examined, her breast was lactating well and her uterus was well contracted, her symphysiofundal height was 15cm. Perineal pad was inspected and lochia was red in color (rubra), the flow was moderate and not offensive. She was congratulated after the examination. The baby was topped and tailed in the present of the mother while singing a lullaby to her and cord dressed for the second time and it looked dry. Baby passed greenish brown stool and urine. The baby was then dressed nicely with cap and socks and wrapped loosely in a warm sheet and made comfortable in bed. Client was asked if she has any complains and she said everything is good.

. Client was educated and assisted to position and fix baby well to the breast while breastfeeding. Client was again educated to breastfeed baby frequently and also make sure one breast is completely empty before giving the other one to the baby. Client was educated to continue to express as often as necessary milk to make her comfortable. Vital signs were checked and findings were recorded. The baby's vital sign was checked and recorded after which cord was dressed. Client was asked if she had any complains and she responded she

had no complains. Permission was then sought to leave and she was informed of the next visit.

Client's assessment was recorded as follows;

MOTHER'S VITAL SIGNS AND OTHER OBSERVATIONS

0bservation	Morning	Evening
Temperature	36.3	36.6
Pulse	77bpm	77bpm
Respiration	21cpm	19cpm
Blood pressure	110/60mmHg	100/70mmHg
Lochia	Rubra	Rubra
Fundal height	15cm	15cm
Condition of the uterus	Contracted	Contracted
Breast	Lactating	Lactating

BABY'S VITAL SIGNS AND OTHER OBSERVATIONS

Observation for baby	Morning	Evening
Temperature	36.6	36.7
Apex beat	129bpm	131bpm
Respiration	46cpm	35cpm

Skin color	Pink	Pink
Cord condition	Clean and dry	Clean and dry
Cord bleeding	None	None
Suckling	Present	Present
Stool color	Greenish brown	Greenish brown

4.5 THIRD POSTNATAL HOME VISIT

On the 28th August,2023 at 8:00am in the morning and 5:00pm in the evening, a visit was paid to madam Elizabeth and her family, they were all in good health but client looked moody. She was encouraged to share her problems and to be happy for what God has done for her and her family. Client was examined from head to toe and the uterus was well contracted. The symphysio-fundal height was 14cm. The perineal pad was inspected for lochia and the color was red (rubra), the flow was moderate with no odor. The breast was also lactating well. Client said the baby can now hold the breast and breastfeeding well. Client complained of perineal pain and backache, she was educated on the cause of the pain and was reassured. Client's mother was assisted to top and tail the baby and after that she was taught how to use methylated spirit in dressing the cord. The baby passed yellowish stool and urinated during the procedure. She wrapped the baby loosely in a sheet and made her comfortable in bed. Baby's vital signs and other observations were recorded. In the evening, mother and baby were visited again. Client was assessed and recorded and baby's cord was assessed and dressed. Vital signs of baby were checked and recorded. She was also informed about the change of visit to daily bases. Baby and mother's vital signs and other

investigations were recorded. Client was asked if she had any complains and she replied she had no complains. Permission was then sought to leave and it was granted.

MOTHER'S VITAL SIGNS AND OTHER OBSERVATIONS

0bservation	Morning	Evening
Temperature	36.5	36.9
Pulse	69bpm	63bpm
Respiration	19cpm	21cpm
Blood pressure	110/60mmHg	100/70mmHg
Lochia	Rubra	Rubra
Fundal height	14cm	14cm
Condition of the uterus	Contracted	Contracted
Breast	Lactating	Lactating

BABY'S VITAL SIGNS AND OTHER OBSREVATIONS

Observation for baby	Morning	Evening
Temperature	36.7	36.7
Apex beat	131bpm	132bpm
Respiration	40cpm	38cpm

Skin color	Pink	Pink
Cord condition	Shrinking	Shrinking
Cord bleeding	None	None
Suckling	Present	Present
Weight	3.2kg	3.2kg
Stool color	Yellowish	Yellowish

4 .6 FOURTH POSTNATAL HOME VISIT

On 29th August,2023 madam Elizabeth and family were visited at 8:00am. The aim of the visit was to know how they were fairing. All the family members were around on arrival, they were all in good health when asked and their environment was clean. Client verbalized that the pains she felt in her breast had subsided greatly and they also felt lighter when asked. Head to toe examination was done and was detected that the engorged breast has resolved and there was no abnormality detected on the client. Her perineal pad was inspected for lochia and the flow was moderate, pink in color (serosa) and not offensive. Symphysiofundal height was measured and it was 13cm and recorded as follows;

Temperature	36.4^{o}c
Pulse	72bpm
Respiration	20cpm
Blood pressure	110/60mmHg
Lochia	Serosa
Fundal height	13cm
Condition of the uterus	Contracted

Breast	Lactating

Madam Elizabeth topped and tailed her baby under supervision. Baby’s cord was dressed with methylated spirit and it looked dried and about to slough off. Baby was dressed nicely and wrapped in white cloth and made comfortable in bed. Client said the baby has already passed yellowish brown stool and urinated. Baby was assessed and the observations were recorded as follows;

Temperature	37.0^{o}c
Apex beat	134bpm
Respiration	48cpm
Skin color	Pink
Cord	Dried and about to slough off
Cord Bleeding	None
Suckling	Present
Weight	3.3kg
Stool color	yellowish brown

She was informed of the next home visit and permission was asked to leave. Client was asked if she had any complains and said she had none. They expressed their gratitude for the visit and was accompanied outside the house.

4.7 FIFTH POST NATAL HOME VISIT

On the 30th August ,2023 approximately 8:30 am, she was visited once again. On arrival, client was brushing her teeth. The rest of the family members were asked how they were doing and they responded they were fine by God’s grace. Hot water was already available for bathing but she requested that, she would like to perform some pelvic exercises before bathing. The symphysio-fundal height was 12 centimeters. The perineal pad was examined

and the color was pink (serosa) without any offensive odor and no abnormalities detected at the perineum. Client's assessment was recorded as follows;

Temperature	36.5^{o}c
Pulse	70bpm
Respiration	20cpm
Blood pressure	110/60mmHg
Lochia	Serosa
Fundal height	12cm
Condition of the uterus	Contracted
Breast	Lactation

The baby's cord was off, she was bathed and the stump dressed with methylated spirit. Yellowish-brown stool and urine were passed during bathing.

Baby's assessment was recorded as follow;

Temperature	36.8^{o}c
Apex beat	128bpm
Respiration	40cpm
Skin color	pink
Cord	Off
Cord bleeding	Absent
Suckling	Present
Weight	3.4kg
Stool color	yellowish brown

Client's mother was encouraged to assist client in the care of the baby and was educated not to apply anything on the stump to prevent infection but should always leave it clean and dry.

Client was asked if she had any complains and she responded she had no problems. Permission was asked to leave.

4.8 SIXTH POSTNATAL HOME VISIT

Client was visited again on 31st August,2023 at 8:30am. Everybody in the house was in good health. Client was seen happy and was smiling all around as she has adequate support and love from her relatives. Every procedure to be carried on was explain to her. The symphysio-fundal height was 11cm. The perineal pad was examined and the color was pink (serosa) without any offensive odor. Head to toe examination was carried out without any abnormalities detected.

Client's assessment was recorded as follows;

Temperature	36.2°c
Pulse	72bpm
Respiration	20cpm
Blood pressure	110/70mmHg
Lochia	Serosa
Fundal height	11cm
Condition of the uterus	Contracted
Breast	Lactation

Warm water was available for bathing the baby. The baby was bathed and the stump dressed with methylated spirit. Yellowish brown stool and urine had been passed before bathing.

Baby's assessment was recorded as follows;

Temperature	36.7°c
Apex beat	130bpm
Respiration	48cpm
Skin color	Pink

Cord	Healing
Cord bleeding	No
Suckling	Present
Weight	3.5kg
Stool color	yellowish brown

She reported of no complains when she was asked if she had any. They were informed about the next day to be the first postnatal visit to the hospital and the last post-natal home visit to them. They were not really happy about the last visit announcement, but they were assured of meeting again at the postnatal clinic. They were bid goodbye.

4.9 SEVENTH POST NATAL HOME VISIT

The last post-natal home visit was on the 1st September,2023 at 5:00pm after the first postnatal visit to the clinic. On arrival, Client had her baby on her laps while singing lullaby. Greetings were then exchanged and routine examinations started after permission was sought. Client's symphysio- fundal height was 10cm. Her perineal pad was inspected and the lochia was pink (serosa) and not offensive with the flow reduced in amount. On examination, there was no abnormality detected on her. Client's assessment was recorded as follows:

Temperature	36.3^{o}c
Pulse	79bpm
Respiration	19cpm
Blood pressure	110/80mmHg
Lochia	Serosa
Fundal height	10cm
Condition of the uterus	Contracted
Breast	Lactating

The baby's vital signs were checked with temperature 36.8 degrees Celsius and weight was 3.5kg, respiration 38 cycles per minute and apex beat 130 beats per minute. The baby was dressed nicely and wrapped in a loose warm sheet. There was no abnormality detected on her.

Baby's assessment was recorded as follows;

Temperature	36.8^{o}c
Apex beat	130bpm
Respiration	44cpm
Skin color	Pink
Cord	Off
Suckling	Yes
Weight	3.6kg
Stool color	Dark yellow

Client was encouraged to continue feeding the baby on demand and also to fix baby properly onto the breast when feeding her. Interaction went on for a while in which she was asked of any complains and she said she had no complains. Client's husband was encouraged to help her to take warm baths and also on the need to massage the breast. They were then discharged from home visits. The family was thanked for their understanding and cooperation. Emphasis of that visit being the last was made again. They also expressed their gratitude.

4.10 FIRST POST-NATAL VISIT TO THE CLINIC

On 4th September,2023, Madam Elizabeth and her baby visited to the clinic around 8:30am. Madam Elizabeth and husband were warmly welcomed and a seat was offered to them. Client was looking cheerful and neatly dressed. The baby was also looking very active, nice and healthy. Every procedure to be done was explained to her to gain her consent and her vital signs were checked and recorded as follows;

Mother's Vital Signs

Temperature	-	36.6 degrees Celsius
Pulse	-	74 beats per minute
Respiration	-	21 cycles per minute
Blood pressure	-	100/80 millimeters of mercury
Fundal height	-	8cm
Weight	-	62 kilogram

Baby's Vital Sign

Temperature	-	36.8 degrees Celsius
Pulse	-	132 beat per minutes
Respiration	-	40 cycles per minutes
Weight	-	3.6kilogram

Since it was her first postnatal clinic visit, her blood sample was taken and tested for hemoglobin level. Client was therefore given a specimen bottle to take midstream urine as she went to empty her bladder. Her urine was tested for albumin and glucose level.

She was educated on the need of the procedure done on her. The results were as follow;

Hemoglobin	11.6 g/dl
Urine protein	Negative
Glucose	Negative

The results were explained to her and she expressed signs of joy upon hearing that all results were normal.

Client was then sent to the palpation room where privacy was provided by drawing the curtains and closing doors and windows. She was helped to assume a comfortable position

with which she chose to lie laterally on her left on the examination bed. Hands were washed with soap under running water and dried with a clean dry towel.

Head to toe examination was done on her. On the head, hair was neat and well styled. The conjunctiva was pink and there was no discharged from the eyes, nose and ears. No abnormality was found in the mouth and neck as the mouth buccal cavity looked pink without any odor and neck was free from any palpable masses and free from distensions of blood vessels as well. On the breast, it was lactating well but engorgement was detected. On examining the abdomen, no abnormality such as sub involution, tenderness, enlargement of liver and spleen was detected. The symphysio-fundal height was 8cm.

With the lower extremities, certain condition such as edema was looked out for. She showed no abnormality.

The perineum was intact and there was no offensive vaginal discharge and the lochia was white in color. All findings were communicated to her after the procedure. She was then thanked for her co-operation and helped to dress up.

Head to toe examination was also performed on the baby to look out for abnormalities. On the head, the anterior and posterior fontanelles was palpated for pulsation and it was present and normal. A few skin rashes on the baby's forehead which looks like heat rash. Client was reassured that its normal for babies to develop skin rashes as their skin is sensitive to a different environment and encouraged to dress the baby according to the weather, she should ensure baby wears clean and dry cotton clothing, wash her hands before and after handling the baby and ensure diapers are changed frequently when soiled. There were no discharges from the eye and nose. The skin was nice, very pink and with no rashes. The chest movement was normal as well as the extremities. The umbilical cord was healed. Findings were communicated to the mother and she was congratulated for taking good care of the child and

herself. She was educated on various family planning methods, when to resume sex, which can be after 6 weeks, the need to feed the baby exclusively for 6 months especially in the night. She was also encouraged to register the baby at the birth registry. She was again educated on the need to attend child welfare clinic in order to monitor the growth of her baby, early detection of infection or disease and the need to complete all the immunization. She was encouraged to continue practicing of exclusive breastfeeding and the pelvic floor muscle exercise. Both mother and baby were in good health and documentation was done on all findings. She was reminded of the six weeks' post-natal visit to the clinic.

Explanation was given to Client and family on the need to be handed over to the midwife in-charge for continuity of care. Client was reassured of the midwife in-charge's competency. Client and family were then handed over to the midwife in charge at the clinic for continuity of care. Client was promised to be checked on from time to time through phone calls and was seen off. She was thanked for her cooperation.

4.12 SECOND POST-NATAL VISIT TO THE CLINIC

According to the midwife in charge, on the 3rd October,2023. Madam Elizabeth came to the clinic for six weeks visit. They were warmly welcomed and they all looked very healthy. General examination was conducted from head to toe as well as vital signs, after which permission was sought.

Her vital signs and weight were checked and recorded as follows:

Temperature	36.7ºc
Pulse	74bpm
Respiration	21cpm
Blood Pressure	110/60mmHg

Weight	66kg

Client was given a urine sample container to provide some urine to be sent to the laboratory for urine analysis to be performed. She was educated on the need and procedure to provide midstream urine for the examination. A sample of blood was also taken from client with her consent to be sent to the laboratory to be tested for hemoglobin level. The samples were then sent to the laboratory. The results from the Laboratory were as follows;

Hemoglobin-	12.2 g/dl
Urine protein	Negative
Glucose	Negative

The results were explained to her and she was satisfied. Client was sent to the palpation room where privacy was provided by drawing the curtains and closing doors and windows. She was helped to assume a comfortable position on the examination bed. Hands were washed with soap under running water and dried with a clean dry towel.

Head to toe examination was done on her. On the head, hair was neat and well styled. The conjunctiva was pink and there was no discharge from the eyes, nose and ear. No abnormality was found on the mouth and neck. On the breast, no abnormalities such as sore nipple, engorgement, cracked nipple and mastitis were detected and the breasts were lactating well. On examining the abdomen, no abnormality such as sub involution, tenderness, enlargement of liver and spleen was detected. No scars were found and uterus was not palpable.

With the lower extremities, certain condition such as edema was looked out for. It was detected that she showed no abnormality.

She was asked if she has resumed menstruation but she said no. She was educated on the need to start a family planning method to prevent unwanted pregnancy.

Her baby was also examined from the head to toe to look out for abnormalities. On the head, the anterior fontanelle was palpated for pulsation and it was pulsating. The posterior fontanelle had closed. There were no discharges from the eyes and nose. The skin was smooth with no rashes. The chest and upper extremities were normal. The umbilical stump was inspected and it had healed and cord was off. The lower extremities were normal. Weight of baby was 4.2kg

The baby`s vital signs and weight were as follows:

Temperature	36.7ºC
Respiration	38cpm
Apex heart beat	132bpm

Mrs. Elizabeth Brago and her baby were handed over to the child welfare clinic and family planning unit for the six weeks' immunization against diphtheria pertussis, tetanus, haemophilus influenza type B and hepatitis B. (pentavalent).

She was encouraged to ask questions but she asked none and made no complaints either. She was reminded on exclusive breastfeeding, rest and sleep, exercise and nutritious diet, which would help in lactation. Client and her children were able to cope with their new sibling. She was finally handed over to the public health nurse for continuity of care but she was encouraged to report to the facility any time she encountered any health-related problem.

She was thanked for her cooperation and understanding during the interaction and was bid farewell.

4.13 NURSING CARE PLAN DURING PUERPERIUM

PROBLEMS IDENTIFIED

- Insufficient sleep 3/10/23

- Backache 3/10/23
- Perineal pain 3/10/23
- Skin rashes 3/10/23

SHORT TERM OBJECTIVES.

- Client will be able to sleep at least 6 hours during the night continuously.
- Client will be relieved of backache within 48hours
- Client's perineal pain will reduce within 48hours

LONG TERM OBJECTIVE

Madam Elizabeth will go through puerperium successfully without any complications to both mother and baby.

TABLE 3: NURSING CARE PLAN DURING PUERPERUIM CONTINUED

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
3/10/23 at 6:30am	Insufficient sleep related to caring for baby at night.	Client will be able to sleep at least 2hours continuously during the day and 6 hours continuously during the night within 24hours as evidence by 1. client verbalizing that she now has adequate sleep. 2.midwife observing client been more relaxed in caring for baby.	1.Reassure client. 2.Encourage client to sleep when baby sleeps. 3.Educate client and family to limit visitors. 4.Teach client how to breastfeed in other position. 5.Educate client to feed baby adequately before going to bed	1.Client was reassured that baby's demand is important so she will be assisted. 2.Client slept whenever baby was sleeping. 3.Client and family reduced the number of visitors in order for client to have enough sleep during the day. 4.Client used other position like lying down position to breastfeed. 5.Client fed baby adequately before going to bed to make sure baby is well fed to sleep long.	3/10/23 at 6:30am	Goal met as 1, client verbalized that she was able to sleep continuously for 2 hours during the day and 6 hours continuously during the night 2, midwife visualized that client was more relaxed in caring for her baby.	A.J

DATE/ TIME	NURSING DIAGNOSIS	OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
3/10/23 At 8:00am	Altered body comfort (backache) related to improper positioning during breastfeeding.	Client will be reduced of the intensity of backache within 48 hours as evidenced by client having an improved mobility and comfort. 2, midwife helping clients with correct in lifting	1.Reassure client. 2.Educate client on good posture, lifting techniques and proper body mechanics. 3.Educate client on correct positioning and fixing of baby to breast. 4.Educate client on comfortable sleeping positions and use of pillows as support.	1.Client was reassured that she would be relieved of backache. 2.Client was educated on good posture and lifting techniques and also proper body mechanics 3.client was educated on correct positioning and fixing of baby to breast 4.Client was educated on comfortable position like lying on the left lateral position.	4/10/23 at 8:00am	Goal met as evidence by client verbalizing that backache has reduced 2. midwife observed that client has adapted the correct techniques in lifting	A.J

			5. educate client on heat or cold therapy. 6.Educate client on rest and sleep.	5.Client was educated on heat or cold therapy such as cold compresses. 6.Client was educated on rest and sleep.			

TABLE 3: NURSING CARE PLAN DURING PUERPERUIM CONTINUED

DATE/ TIME	NURSING DIAGNOSIS	OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
3/10/23 At 8;00am	Perineal pain related to tissue trauma during delivery	Client perineal pain will be relieved within 48hours as evidence by 1.client verbalizing that pain has relieved 2midwife observing client looking cheerful	1, Reassure client 2. encourage client to maintain good perineal hygiene 3, encourage client to practice warm sit bath 4.Encourage client to breastfeed the baby by lying on or sitting on a cushion. 5.Administer prescribed analgesics	1.client was reassured that perineal pain is as a result of minor tissue trauma(lacerations) 2.client was encouraged to maintain good personal hygiene 3.client was encouraged to practice warm sit bath 4.client was encouraged to breastfeed the baby by lying down or sitting on a cushion 5.Paracetamol 1g was served	5/10/23 At 8;00am	Goal met as 1.client verbalizing that pain has resolved 3.Midwife observed that client looking cheerful	AJ

DATE/ TIME	NURSING DIAGNOSIS	OUTCOME CRITERIA0	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
10/10/23 8:00am	After pain related to involution of the uterus	Client after pain will be reduced within 48 hours as evidence by the client verbalizing that the pain has relieved. 2, midwife observing pain has reduced from moderate to mild	1. Reassure client. 2Explain the physiology of after pain to client as due to uterine contractions during involution of the uterus 3.Encourage client to apply warm compress 4.Encourage client to breastfeed the baby by lying down or sitting on a cushion 5. Administer prescribed analgesics	1.Client was reassured that the perineal pain is as a result of tissue trauma during delivery 2.Physiology of afterpain was explained to client. 3. client was encouraged to apply warm compress 4.Client breastfed the baby by lying down or sitting on a cushion 5.Paracetamol 1g was served	12/10/23 8:00am	Goal met as client reported that the pain has reduced and 2, midwife assessed patients pain level and observed pain has reduced from mild to moderate	A.J

TABLE 3: NURSING CARE PLAN DURING PUERPERUIM CONTINUED

3/10/23 At 8;00am	Altered body skin rashes related to warm environment	Client will be Baby will be relieved of skin rashes within 48 hours as evidenced by client verbalizing baby no longer has rashes 2, midwife observing baby's skin free from rashes	1.Reassure client. 2.Educate client on dress baby with cotton cloths 3. Educate client to use mild soap when bathing baby 4. educate client to was hands with soap under running before handling baby. 4.. Encourage mother to apply baby powder to baby's skin	1.Client was reassured that it is a normal physiology and it will subside. 2.Client was educated to dress baby in cotton clothing 3Client was educated to use mild soap when bathing baby 4.Client was educated to wash hands with soap under running water. 4. Client was educated to apply baby powder to baby's skin	4/10/23 at 8:00am	Goal met as goal Goal fully met as evidence by 1. client verbalizing baby no longer has rashes 2. midwife observed baby no more has rashes	A.J

DATE/ TIME	NURSING DIAGNOSIS	OUTCOME CRITERIA0	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
10/10/23 8:00am	After pain related to involution of the uterus	Client after pain will be reduced within 48 hours as evidence by the client verbalizing that the pain has relieved. 2, midwife observing pain has reduced from moderate to mild	1. Reassure client. 2Explain the physiology of after pain to client as due to uterine contractions during involution of the uterus 3.Encourage client to apply warm compress 4.Encourage client to breastfeed the baby by lying down or sitting on a cushion 5. Administer prescribed analgesics	1.Client was reassured that the perineal pain is as a result of tissue trauma during delivery 2.Physiology of afterpain was explained to client. 3. client was encouraged to apply warm compress 4.Client breastfed the baby by lying down or sitting on a cushion 5.Paracetamol 1g was served	12/10/23 8:00am	Goal met as client reported that the pain has reduced and 2, midwife assessed patients pain level and observed pain has reduced from mild to moderate	A.J

TABLE 3: NURSING CARE PLAN DURING PUERPERUIM CONTINUED

SUMMARY AND CONCLUSION

Mrs. Elizabeth a 23-year-old Gravida two Para one (G2P1) was the client used for the

Family Centered Maternity care study conducted at Patience Angel's maternity home in the Bono Region. She made her first antenatal visit on 10th march, 2023 in her early pregnancy. She was met on 15th August,2023, during her usual antenatal clinic visit with gestation of 38 weeks and was given individualized care both at the clinic and home visits. Minor problems identified were managed using the nursing process. Client finally had a spontaneous vaginal birth to a live healthy female child on the 24th August, 2023, at 8:45pm with no complication 8to both mother and baby

Client and baby were cared for during the puerperium through continuous home visits for a week. On 4th September, 2023 thus the first postnatal clinic visit, they were handed over to the community health nurse for continuity of care.

In conclusion, this care study provided an opportunity to practice all the theoretical knowledge acquired in classroom with the help of the clinical in-charge.

It has helped to improve the skills of conducting a very good delivery.

It has also helped to build a trustworthy relationship with the client and the family.

It has helped to know how to care for a client in their own environment.

It has helped to know how to help client make decision on their own and solve problem.

BIBLIOGRAPHY

Ghana Health Service (2008). *National Safe Motherhood Service Protocol* (revised edition). Accra. Yamens Press Limited

Henderson, C, & Macdonald, S., (2009). *Mayes` Midwifery*. (13th edition). London: Bailliere

Tindall, Elsevier Limited.

King, L., T., Brucker M. C., Fahey O.J., Gegor L.C. & Varney H., (2014). *Varney`s Midwifery* (15th edition.). New Delhi: Jones and Bartlett India Pvt. Limited.

Konar, H., (2013). *D. C. Dutta's Textbook of Obstetrics. Kolkata*: New Central Book Press Limited.

Marshall, J, & Raynor, M (2014): *Myles Text Book for Midwives* (16th edition), London, Churchill Livingstone Elsevier Ltd.

Tiran, D. (2008). *Bailliere's Midwives Dictionary* (11th edition), London: Elsevier Limited.

Verrals, S., (2014). *Anatomy and Physiology Applied to Obstetrics,* (3rd edition) Singapore.

APPENDIX I

TABLE 4: COMPLETE DIAGNOSTIC INVESTIGATIONS

Date	Specimen	Investigation	Normal Value	Findings	Remarks
10/03/23	Blood	Hemoglobin	11-16g/dl	11.2g/dl	Normal
		Sickling test	Negative/positive	Negative	Normal
		HIV status	Negative/positive	Negative	Normal
		Grouping and cross matching	AB, AB, O	AB	Normal
		Rhesus factor	Positive / Negative	Positive	Normal
		G6PD	Positive / Negative	Negative	Normal
7/04/23	Urine	Sugar and Protein	Positive /Negative	Negative	Normal
		Urine R/E	Positive/ Negative	Negative	Normal
	Blood	Hemoglobin level	11-16g/dl	11.2g/dl	Normal
		HBsAg	Positive/Negative	Negative	Normal
		Syphilis	Positive/Negative	Negative	Normal
	Stool	Stool R/E	Positive/Negative	Negative	Normal
5/05/23	Urine	Sugar and Protein	Positive/Negative	Negative	Normal
	Blood	Hemoglobin level	11-16g/dl	11.4g/dl	Normal
		Malaria Parasites	Positive/Negative	Negative	Normal
2/06/23	Urine	Protein and sugar	Positive / Negative	Negative	Normal
	Blood	Hemoglobin level	11-16g/dl	12.0g/dl	Normal
7/7/23	Urine	Protein and sugar	Positive/Negative	Negative	Normal
	Blood	Hemoglobin level	12-16g/dl	11.6g/dl	Normal

APPENDIX II

TABLE 5: PHARMACOLOGY OF DRUGS FOR THE MOTHER

NAME OF DRUG	CLASSIFICATION	DOSAGE	ROUTE	ACTION AND USES	ACTUAL EFFECT	SIDE EFFECTS	SIDE EFFECT EXPERIENCED
Tablet Multivite	Vitamin Preparation	200 milligrams Once daily	Oral	Increase Appetite, helps in the formation of red blood cells	Increased appetite	Gastrointestinal disturbance	None observed
Tablet Ferrous Sulphate	Iron supplement	200 milligrams Once daily	Oral	Helps in the formation of hemoglobin and aids in the formation of blood cells.	Increase in hemoglobin level	Black stool, diarrhea and constipation	Non observed
Tablet Folic Acid	Vitamin Preparation	5 milligrams Once daily	Oral	Proper formation and function of red blood cell	Hemoglobin level increased	Nausea, vomiting and constipation	None observed
Tablet Sulphadoxine - Pyrimetha mine.	Anti- malaria and prophylaxis	3 doses stat from 16 weeks or after quickening and the remaining doses within 4 weeks interval until delivery	Oral	Prevention of malaria	Prevention of malaria in pregnancy	Nausea, itching, headache	None observed

TABLE 5: PHARMACOLOGY OF DRUGS FOR THE MOTHER CONTINUED

NAME OF DRUG	CLASSIFICATION	DOSAGE	ROUTE	ACTION AND USES	ACTUAL EFFECT	SIDE EFFECTS	SIDE EFFECT EXPERIENCED
Injection Tetanol	Anti-tetanus	0.5 milligram	Intramuscular	Prevention of tetanus	Protect client against tetanus	Mild fever and chills	None observed
Paracetamol	Analgesic /Antipyretics	1g 3 times daily x 5days	Oral	Help the relieve of pain	Pain was relieved	Prolong use causes damage to the liver.	None observed
Injection oxytocin	Oxytocin drug	10 units	Intramuscular	Stimulation of uterine contraction and controls bleeding.	Uterine contraction was effective	Vomiting, uterine spasm and rise in blood pressure	None observed
Capsule vitamin A	Vitamin A supplement	200,000 units for 2 days	Oral	Growth, development, and proper eyesight	Normal vision and healthy skin.	Diarrhea and vomiting	None observed
Cap Amoxicillin	Penicillin	500mg tds x 7	Oral	Inhibit a process transpeptidation, leading to activation of autolytic enzymes in the bacterial cell.	Stopped the growth of bacteria	Nausea, vomiting, headache and diarrhea	None observed
Tab Metronidazole le	Nitroimidazole	400mg dly x 7	Oral	Inhibit protein synthesis by interacting with DNA structure and strand breakage.	Causes cell death in susceptible organism	Dizziness, headache, constipation and diarrhea	None observed

APPENDIX III

TABLE 6: PHARMACOLOGY OF DRUGS FOR THE BABY

NAME OF DRUG	CLASSIFICATION	DOSS AGE	ROUTE	ACTION AND USES	ACTUAL EFFECT	SIDE EFFECT	SIDE EFFECT EXPECTED
Vitamin K	Coagulant	1. 0mg	Intramuscular	Aids in clotting	No bleeding	None	None observed
Chloramphenicol eye drops	Antibodies	2 drops	Instillation	To prevent eye infection	Infection of the eye was prevented	Nephrotocity	None observed
polio O vaccine	Antigen	2 drops	Orally	Production of antibodies to prevent poliomyelitis	Still under observation	There may be diarrhea	None observed
Injection Bacilli Calmette Guerin (BCG)	Antigen	0.05 ml	Intradermal	Production of antibodies to prevent tuberculosis	Still under observation	Blister formation at the injection site and slight fever	Blister noticed
Pneumococcal 1	Antigen	0.5mls	Intramuscular right thigh	Vaccinates neonate against pneumonia	Pneumonia prevention	Redness at the side of injection and fever	None observed
Pentavalent 1	Antigen	0.5 mls	Intramuscular left thigh	Vaccinate neonate against diphtheria, pertussis (whooping cough), tetanus, hepatitis B, haemophilus influenza type B	Prevention of childhood preventable diseases	Low grade fever	None

Rotavirus vaccine	Antigen	1.5 mls	Orally	Immunity against Rotavirus (diarrhea)	Rotavirus was prevented	Vomiting	None

APPENDIX IV

TABLE 7: ANTENATAL CHART RECORD

DATE	BLOOD PRESSURE (MMHG)	URINE FOR SUGAR AND PROTEIN	PRESEN- ATION AND POSITI ON	FOET AL HEAR T RATE	GESTAT -IONAL AGE	FUNDAL HEIGHT	DESCENT	WT	COMPLAINS	TREATMENT AND ADVICE	REMARK
10/03/23	106/63	Negative	-	-	20weeks	-	-	54kg	No complain	Tab folic acid, tab ferrous tab multivite, Injection tetanus diphtheria and education on immunization	Healthy
7/04/23	111/70	Negative	-	Positive	24weeks	13	-	55kg	Feels well	Tabs folic acid tab multivite, SP and education on sleeping under treated net	Healthy

05/05/23	95/60	Negative	-	Positive	28weeks	15cm	-	57kg	Body pains	Routine drugs, SP and Encouraged to avoid stressful exercise	Healthy

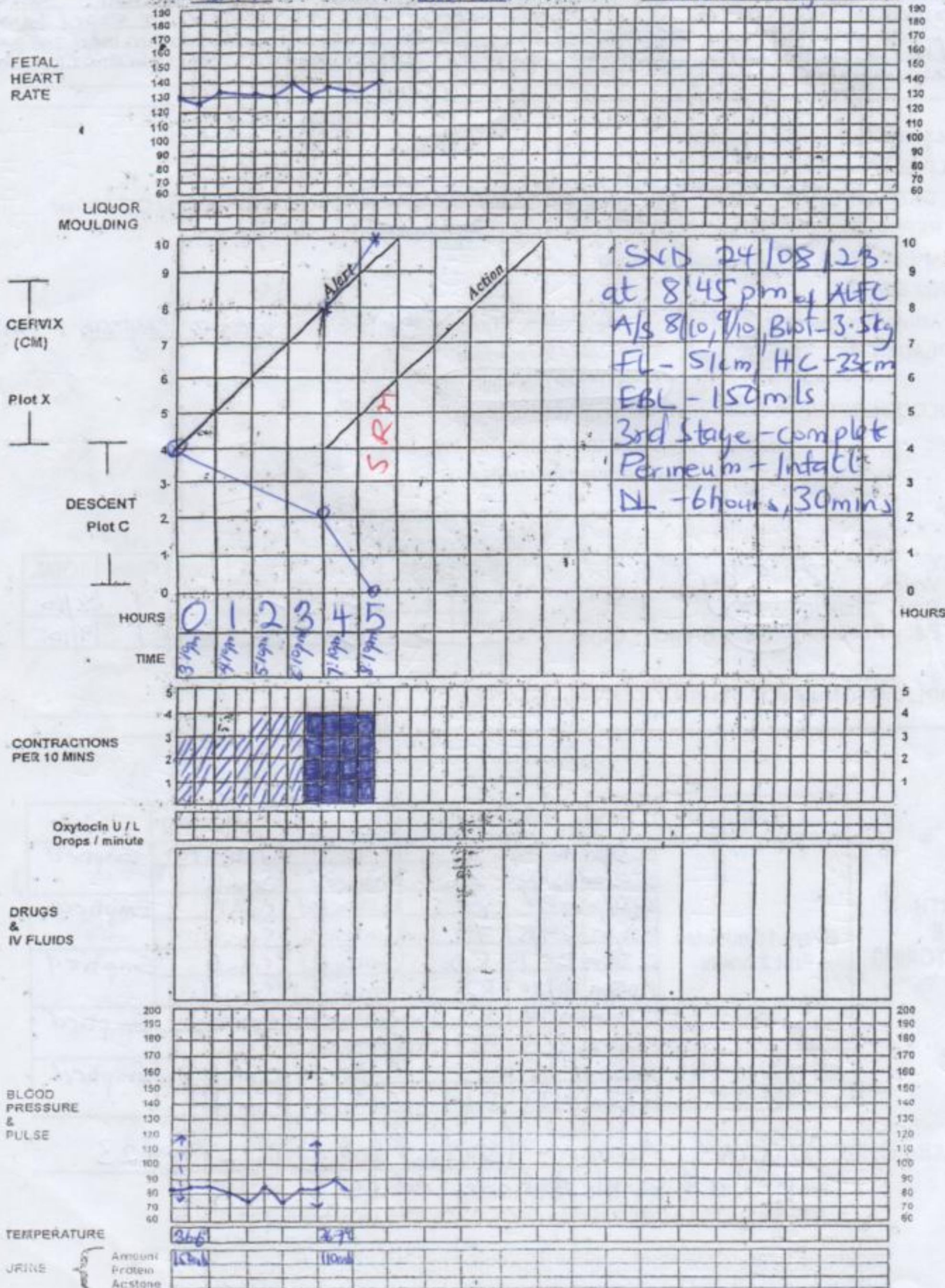
TABLE 7: ANTENATAL CHART RECORD CONTINUED

DATE	BLOOD PRESSURE (MMHG)	URINE FOR SUGAR AND PROTEIN	PRESEN - ATION AND POSITI ON	FOET AL HEAR T RATE	GESTAT -IONAL AGE	FUNDAL HEIGHT	DESCENT	WT	COMPLAINS	TREATMENT AND ADVICE	REMARK
2/6/23	100/60	Negative	Cephalic	138	32weeks	29cm	-	58kg	No complain	Routine drugs, SP and education on danger signs of pregnancy	Healthy
7/723	110/70	Negative	Cephalic	138	36weeks	32cm	5/5	59kg	Feels well	Routine drugs, SP and educated on complication readiness	Healthy
14/7/23	120/60	Negative	Cephalic	132	37weeks	34cm	5/5	62kg	Lower abdominal pain and body pains.	Routine drugs and educated on rest and exercise	Healthy

17/7/23	110/60	Negative	Cephalic	135	37weeks + 2days	35cm	5/5	62	No complains	Routine drugs and education on neonatal care and danger signs in newborn.	
4/8/23	110/70	Negative	Cephalic	128	38weeks	36cm	5/5	62kg	Fatigue.	Routine drugs, SP and educated on birth preparedness and signs of labor	Healthy

WHO Modified Partograph

Registration No.: 1323 Name(Last, First) Brago Elizabeth Age: 23years
Date: 24/8/23 Parity/Gravida G2P1 LMP 18/11/22 EDD 25/08/23 Gestation(wks) 38weeks
ROM: SRM Labour Duration (Hrs) 6hrs: 30mins Facility/Clinic Name Patience Angel maternity Home



LABOR NOTES

Labour progressed and client had spontaneous vaginal delivery to an alive female baby. APGAR score for 1st minute and 5th minute was 8/10 and 9/10 respectively. Placenta and membranes were completely delivered at 8:50pm, uterus was massaged to expel blood clot about 150mls. Perineum was intact. baby was examined thoroughly and no abnormalities detected skin to skin contact and breastfeeding was initiated.

Please circle or write responses.

DELIVERY

DATE: 24/08/23 TIME: 8:45pm METHOD: (Spontaneous) / Vacuum Extraction / C/S / Other

PERINEUM: (Intact) / Episiotomy / Laceration

ANESTHESIA: (None) / Local / General

THIRD STAGE

Active Management: (Yes) / No Medication: Time 8:46pm Type/Dose Injection oxytocin 10units

PLACENTA: TIME: 8:50pm Complete / Incomplete

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

BABY

Weight: 3.5kg

Sex: Male / (Female)

Baby Position: (Vertex) / Breech / Other

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

COMPLICATIONS OF MOTHER / BABY: None / Other: ______

FOURTH STAGE MONITORING	Frequency	Time	B/P.	Pulse	Fundus	Bleeding	Bladder
	Every 15 minutes first 2 hours	9:50pm	110/70	80	18	150mls	Emptied
		10:05pm	115/70	86	Contracted	Small	
		10:20pm	110/70	84	Contracted	Small	Emptied
		10:35pm	120/75	79	Contracted	Small	
		10:50pm	120/70	80	Contracted	Small	Emptied
		11:05pm	110/70	82	Contracted	Small	
		11:20pm	100/70	85	Contracted	Small	Emptied
		11:35pm	115/75	85	Contracted	Small	
	Every 30 minutes For 1 hour	12:05pm	110/75	85	Contracted	Small	Emptied
		12:35pm	110/70	81	Contracted	Small	

Birth Attendant Justina Afongo (student Midwife) Date 24/8/23
Supervised by Ms. Patience Adika

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

NEW BORN EXAMINATION FORM

Name: Baby of Elizabeth Brago Date of Assessment: 24/8/23. Time: 6:30 am
Date of Birth: 24/8/23 Time of Birth: ______ Sex: [ ] M [x] F Age at time of Assessment (days/hrs) 11hrs. 30m
Astational Age 38 [x] weeks [ ] Mode of Delivery: [ ] Vaginal Assisted Vaginal C-Section
APGAR: 1min 8 [ ] 5min 9 10 Birth Weight: 3.5 kg [ ] Length: 51 cm Head Circumference: 33 cm
Temperature at time of Assessment: 36.6 °C Urine passed: Yes No Meconium passed: Yes No
Name of Assessor (Midwife/Doctor): Adongo Justina

1. Respiration
Rate 48cpm
- [ ] Rate < 30 b/m *
- [ ] Rate < 60 b/m *
- [ ] 30-60 b/m
- [ ] Retractions *
- [ ] Grunting *
- [ ] Stridor *

2. Activity/Movemnet
- [x] Spontaneous symmetric movements
- [ ] Reduced/Absent Movement in ≥1 limb *
- [ ] No Movement

3. Tone
- [x] Normal
- [ ] Floppy *
- [ ] Increased *

4. Colour
- [x] Pink all over
- [ ] Pink body but blue hands/feet
- [ ] Blue all over *
- [ ] Pale *
- [ ] Jaundiced *

5. Cord
- [x] Normal
- [ ] Red. draining pus
- [ ] Bleeding

6. Cry
- [x] Normal
- [ ] Shrill *
- [ ] Absent *

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

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

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

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

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

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

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

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

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

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

18. Heart rate
Rate: 128bpm
- [ ] Normal (100-160)
- [ ] <100 *
- [ ] >160*

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

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

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

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

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

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

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

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

26. Services provided
- [x] Vitamin K1 given
- [x] Eye care provided
- [x] Cord care provided
- [x] Breastfeeding initiated
- [x] Breastfeeding established
- [x] Immunization (BCG/Polio)
- [x] BCG [ ] Polio Immunization
- [x] 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 of Elizabeth Brago Date of Assessment: 24/8/23 Time: 9:30am
Date of Birth: 24/8/23 Time of Birth: 8:45pm Sex: [ ] M [✓] F Age at time of Assessment (days/hrs) 90mins
Astational Age 38 weeks [ ] Mode of Delivery: [✓] Vaginal Assisted Vaginal C-Section
APGAR: 1min 8/10 5min 9/10 Birth Weight: 3.5 kg [ ] Length: 51 cm Head Circumference: 33 cm
Temperature at time of Assessment: 36.6 °C Urine passed: Yes ✓ No Meconium passed: Yes ✓ No
Name of Assessor (Midwife/Doctor): ____________

1. Respiration
Rate 45cpm
- [ ] Rate <30 b/m *
- [ ] Rate <60 b/m *
- [ ] 30-60 b/m
- [ ] Retractions *
- [ ] Grunting *
- [ ] Stridor *

2. Activity/Movemnet
- [✓] Spontaneous symmetric movements
- [ ] Reduced/Absent Movement in ≥1 limb *
- [ ] No Movement

3. Tone
- [✓] Normal
- [ ] Floppy *
- [ ] Increased *

4. Colour
- [✓] Pink all over
- [ ] Pink body but blue hands/feet
- [ ] Blue all over *
- [ ] Pale *
- [ ] Jaundiced *

5. Cord
- [✓] Normal
- [ ] Red. draining pus
- [ ] Bleeding

6. Cry
- [✓] Normal
- [ ] Shrill *
- [ ] Absent *

7. Suck
- [✓] Good
- [ ] Weak
- [ ] Absent

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

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

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

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

12. Ears
- [✓] Normal (size / shape/position).
- [ ] Abnormal: ____________

13. Mouth
- [✓] Normal
- [ ] Cleft palate
- [ ] Cleft Lip
- [ ] Other: ____________

15. Neck
- [✓] Normal
- [ ] Swelling
- [ ] Webbed
- [ ] Other: ____________

16. Clavicle
- [✓] Normal
- [ ] Swelling/Fracture

17. Chest
- [✓] Normal (Shape/movement)
- [ ] Abnormal ____________

18. Heart rate
Rate: 127bpm
- [ ] Normal (100-160)
- [ ] <100 *
- [ ] >160*

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

20. Abdomen
- [✓] Normal
- [ ] Distended*
- [ ] Scaphoid*
- [ ] Abdominal defect*
- [ ] Masses: ____________
- [ ] Other ____________

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

22. Limbs
- [✓] Normal
- [ ] Abnormal ____________

23. Genitalia

Male Genitalia
- [ ] Normal
- [ ] Undescended testes
- [ ] Abnormal meatus
- [ ] Hernia
- [✓] Other: ____________

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

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

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

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

*May indicate severe disease that requires urgent referral

Diagnoses (if known)____________

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

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

MATERNITY CHART

NAME: Elizabeth Brago

AGE: 23 years WARD: Labour Ward

IP NO.: 1323 BED NO.: 4

Date	24/8/23	26/8/23	27/8/23	28/8/23	29/8/23	29/8/23	31/8/23	1/9/23	2/9/23
Days in Hospital	DD	D1	D2	D3	D4	D5	D6	D7	D8
Days P. O.									
Hour X49	9:45	6:30	9:00	8:30	8:00	8:00	8:30	8:30	
			5:00	5:00	5:00				5:00
Temperature									
Pulse	80bpm	84bpm	74bpm	71bpm	69bpm	72bpm	72bpm	72bpm	74bpm
Resp.	20cpm	22cpm	18cpm	21cpm	19cpm	20cpm	22cpm	20cpm	19cpm
B.M.	Passed	Passed	Passed	Passed	Passed	Passed	Passed	Passed	Passed
Urine	Passed	Passed	Passed	Passed	Passed	Passed	Passed	Passed	Passed
B. P.									

TEMPERATURE CHART

NAME: Baby of Elizabeth Brago

AGE: New WARD: labour Ward

IP NO.: 1323 BED NO.:

Date	24/8/23	26/8/23	27/8/23	28/8/23	29/8/23	30/8/23	31/8/23	1/9/23	2/9/23
Days in Hospital	DD	D1	D2	D3	D4	D5	D6	D7	D8
Days P. O.									
Hour AM	9:45	6:30	9:00	8:30	8:00	8:00	8:30	8:30	
PM	-		5:00	5:00					5:00

Temperature

C	F
41.1°	106°
40.5° 39.5	105° 37
40.0° 39.0	104° 36
39.4° 38.5	103° 35
38.8° 38.0	102° 34
38.3° 37.5	101° 33
37.7° 37.0	100° 32
37.2° 36.5	99° 31
36.5° 36.0	98° 30
36.1° 35.0	97° 29
35.5	96° 28
35.0	95° 27

Symphysio Fundal height

Temperature

	24/8/23	26/8/23	27/8/23	28/8/23	29/8/23	30/8/23	31/8/23	1/9/23	2/9/23
Pulse	125bpm	128bpm	133bpm	129bpm	131bpm	134bpm	128bpm	132bpm	135bpm
Resp.	43cpm	44cpm	43cpm	46cpm	40cpm	48cpm	40cpm	48cpm	41cpm
B.M.	Passed	Passed	Passed	Passed	Passed	Passed	Passed	Passed	Passed
Urine	Passed	Passed	Passed	Passed	Passed	Passed	Passed	Passed	Passed
B. P.									

NEW BORN CHART

Name: Baby of Elizabeth Brago No: 1323 Birth Weight: 3.5kg

Sex: Female Mother's No: 1323 Length: 51 cm

Nature of Delivery: Spontaneous Vaginal Delivery Diagnosis: Term baby

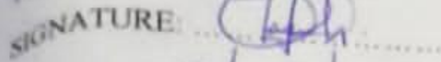
Date of Birth: .... Time: 8:45pm Date of Discharge: 25th August, 2023

Date	24/8/23		26/8/23		27/8/23		28/8/23		29/8/23		30/8/23		31/8/23		1/9/23		2/9/23					
No. of Days	DD		D1		D2		D3		D4		D5		D6		D7		D8					
Weight	3.5kg		3.4kg		3.3kg		3.2kg		3.2kg		3.3kg		3.4kg		3.5kg		3.8kg					
	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM
Temperature		36.7°C	36.5°C		36.7°C	37.0°C	36.6°C	36.7°C	36.7°C	36.7°C	36.7°C		36.8°C		36.8°C		36.8°C					
Stools		Passed	Passed		Passed	Passed	Passed	Passed	Passed	Passed	Passed		Passed		Passed		Passed					
Urine		Passed	Passed		Passed	Passed	Passed	Passed	Passed	Passed	Passed		Passed		Passed		Passed					
Remarks	Head, Neck, Limbs, Genitalia } No Abnormality Detected																					

SIGNATORIES

THE STUDENT MIDWIFE

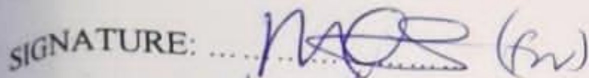
NAME: ADONGO JUSTINA

SIGNATURE: 

DATE: 07/06/24

THE MIDWIFE- IN-CHARGE PATIENCE ANGEL'S MATERNITY HOME

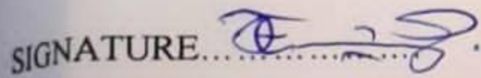
NAME: MS. PATIENCE ADIKA

SIGNATURE: 

DATE: 07/06/24

THE SUPERVISOR

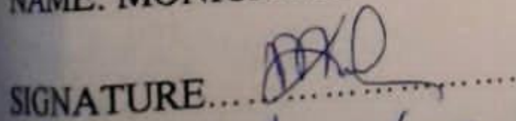
NAME: MS. DIANA OWUSU SERWAA

SIGNATURE 

DATE 07-06-2024

THE PRINCIPAL

NAME: MONICA NKRUMAH

SIGNATURE 

DATE 10/06/24

PRINCIPAL
HOLY FAMILY NURSING AND
MIDWIFERY TRAINING COLLEGE
BEREKUM