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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A CLIENT/FAMILY CENTERED MATERNITY CARE STUDY SUBMITTED TO THE NURSING AND MIDWIFERY COUNCIL OF GHANA IN PARTIAL FULFILMET TOWARDS THE AWARD OF LICENCE TO PRACTICE AS A PROFESSIONAL MIDWIFE (DIPLOMA).

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PREFACE

Midwifery is a very vital aspect of health care given to the pregnant women and their families'. Client and Family centered maternity care study is a systematic, comprehensive and holistic approach used in rendering obstetric care to the expectant mother and her family as a whole throughout pregnancy, labor and puerperium. The case involves data collection, nursing diagnosis, assessment, identification of problems, planning; implementation and evaluation of the data that would help solve the individual's problems. The care also focuses on the mother's physical, emotional, spiritual, psychological and social needs to help attain maximum standard of care. The family centered maternity care study also gives the student midwife an opportunity to use her knowledge and skills acquired both practically and theoretically during her period of training to care for a pregnant woman throughout pregnancy, labour and puerperium.

Moreover, the family centered care study helps the student midwife to use the new trend in midwifery like the partograph and nursing process in management of first stage of labour and to diagnose any complication during pregnancy. The nursing process provide framework for solving problems and making decisions in the management of the client and family in a systematic manner. The study also enables student midwife to educate the client and family and also promote cordial relationship between the student midwife, the mother and her family.

Furthermore, the study helps the student midwife to put into practice the concept of safe motherhood initiative which has being adapted to render quality maternity care through antenatal, labour and puerperium which will eventually reduce maternal and neonatal mortality.

It also equips the student midwife with the holistic and individualized care to all clients. The family centered maternity care study is an academic exercise required by the Nursing and Midwifery Council of Ghana so as to enable the student midwife to practice after completion of her training.

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I would also like to express my sincere gratitude to my supervisor Ms. Monica Boakye for the editing, construction, critics and contributions towards the success of this care study.

I am also very grateful to my client Madam Mavis and her family. For offering me the necessary information to recounting and understanding this script.

My sincere appreciation goes to the midwife in –charge, Mrs. Ernestina Appiah at St. Edward hospital at Adugyama in the Ashanti Region and other supportive staff members who co-operated with me so much in the course of this exercise.

I am particularly indebted to my dear lovely Parent Mrs. Philomina Owusu and Mr. Aboagye Donkor and my siblings and my guardian Mr. Elvis Frimpong for their support and love for me, who offered me a peace of mind in this my care study by providing me with both financial and spiritually support and helped me in one way or the other to finish this script. May God richly bless them and give them long life to reap what they had sown.

Finally, the authors and publishers of the various books used as references cannot be left out.

INTRODUCTION

The family centered maternity care is a systematic approach used in the care of an expectant mother involving her family during which the care is extended to the community the client lives. It is based on consideration of the client as a unique individual with specific problems and needs to assist her in solving them.

This care study was written on Madam Pokuaa Mavis a 30-year-old Gravida three Para two all alive (G3P2AA). Who was met on the 28th October, 2021 at the antenatal clinic at St Edward hospital during clinical attachment. She was 37 weeks plus 2 days pregnant and that was her 5th visit to the antenatal clinic. She caught attention as a result of the fact that she had previously complained of vaginal discharge, for which she was reassured of appropriate management plan and selected for the care study. She was managed from 37 weeks plus 2 days of pregnancy through labour and early puerperium.

Thorough assessment and physical examination were done on her with vivid and clear explanation of all procedures to her. She had normal pregnancy. Home visits were also carried out to assess her environment and community in which she lived. The family was also involved in the nursing care plan during antenatal. This study is made up of four chapters namely, chapter one, chapter two, chapter three and chapter four.

Chapter one deals with the particulars of client that is her personal and social history, family history, medical history, surgical history, menstrual history, lifestyle and hobbies as well as her past and present obstetric histories.

The second chapter deals with the antenatal care of the client, a description of the first encounter with the client and the home visits made to her. The nursing care plan used in providing care for the client, where problems were identified, objectives set, then an implementation plan used in rendering services.

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

Chapter four consist of management of puerperium, first day post-delivery and discharge, postnatal home visits and tenth day postnatal visit to the hospital.

The problems both actual and potential disorders identified were managed using the nursing process and care plan was drawn at the end of each chapter except chapter one.

This report includes termination of care, summary and conclusion, bibliography, appendices and signatories. The source of information was from the client records, textbooks and her family. The client will be called Madam Mavis throughout this project.

LITERATURE REVIEW

PREGNANCY

Myles (2009) pregnancy is confirmed when many physiological changes take place in the body and return to its pre-pregnant state during puerperium due to the effect of certain hormones namely oestrogen and progesterone. These hormones are responsible for the major changes that take place during pregnancy. Even though these hormones have their own effects by causing the minor disorders that occur during pregnancy, they are one way or the other an advantage for the mother and the growing fetus since the fetus depends solely on the mother for survival when in utero. There are varieties of care that are rendered to the expectant mothers and their entire families include history taking, physical examination (head to toe examination and abdominal examination. inspection, palpation and auscultation), laboratory investigation (urine, blood and stool), administration of routine drugs (folic acid, ferrous sulphate and multivitamins), and tetanus toxoid, education on minor disorders, danger signs of pregnancy, diet and rest and sleep, exercise, personal hygiene and environment hygiene, birth preparedness and complication readiness. The anatomical and physiological change in the uterus plays an essential role in pregnancy by protecting and supporting the fetus, placenta and amniotic fluid. At the time of labour, it is able to contract regularly and forcibly to expel the fetus due to its unique properties of contractility and elasticity.

Tiran (2008) Pregnancy is the condition of having a developing embryo or fetus within the body. It is a state from conception to the delivery of the fetus. The normal duration of 280 days (40 weeks) counted from the first day of the last normal menstrual periods to delivery. During this period, physiological and psychological changes such as relaxation of the cardiac sphincter, relaxation of the smooth muscles of the intestines occur due to the effect of oestrogen and progesterone. These hormones provide nutritive and protective environment for the developing embryo and also prepare the breast for lactation.

Fraser and Cooper (2008) pregnancy is the fusion of the woman's egg and a man sperm cell unite to form a zygote. All changes in the mother's body during pregnancy are due to the effects of specific hormones. These changes enable her to nurture the fetus, prepare her body for labour and develop her breast and lay down stores of fats to provide calories for production of breast milk during puerperium. The woman's psychological state is also affected by hormonal changes. The gestational period is divided into three trimesters. The first trimester is from the time of conception to the 12th week. The second trimester is from the 13th week to the 24th week whilst the third trimester is from is from the 25th week to the 38th. During pregnancy, antenatal care is given to the woman throughout the period and should commence from the time pregnancy is diagnosed and continue until the safe delivery of the baby. This is why it is so important that the midwife has knowledge and understanding of the common disorders of pregnancy which include, constipation, fatigue, lower abdominal pain, waist pain, leg cramp, backache insomnia, increase vaginal discharge among others in order to advise the woman on strategies that will help her cope with the condition and minimize the effects she experiences.

Weller B.F (2009) Pregnancy is a state of being with a fetus from the time of conception to the expulsion of the fetus. The normal period is 280 days or 40 weeks counted from the first day of the last menstruation period. It is divided into three trimesters. The first trimester is from the day of conception to the 12th week. The second trimester starts from the 13th week to the 28th week and the third trimester is from the 29th week to delivery. During this period many physiological changes occur in all the system of the woman's body due to hormonal changes and these changes may lead to minor disorders like, nausea constipation, backache, heartburn and vomiting and if not managed may deteriorate the woman's health and the fetus. Disorders can be very distressing and life threatening if not managed appropriately. These changes and many other problems (example, personal and environmental) are identified during antenatal care and the expectant mother is assisted and managed as to how to cope and adjust to the

situation. This is normally done through health education, counselling and interaction with the client and family.

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

Marshall & Raynor (2014) pregnancy starts from the time conception is confirmed until the beginning of labour and also the midwife facilitates woman-centered care by providing her with accessible and relevant information to help her make an informed choice throughout pregnancy. The aim of antenatal care is to monitor the progress of pregnancy optimize maternal and fetal health. To achieve this, the midwife critically evaluates the physical, psychological and sociological effects of pregnancy on the woman and her family. The key principles of antenatal care by the midwife are, providing a holistic approach to the woman's care that meets her individual needs, recognizing complications of pregnancy and appropriately referring women to the obstetric team or relevant health professionals or other organizations, facilitating the woman and her family in preparing to meet the demands of birth, and making a birth plan, offering parenthood education within a planned programme or on an individual basis.

Konar (2013) pregnancy is the progressive anatomical, physiological and biochemical change not only confined to genital organs but also to all systems of the body. This is principally a phenomenon of maternal adaption to the increasing demand of the growing fetus. Unless understood, this physiological adaptation to normal pregnancy can be misinterpreted as pathological there is enormous growth of the fetus during pregnancy. In late pregnancy, frequency of micturition once more reappears due to pressure on the bladder as the presenting part descends down the pelvis. Stress incontinence may be observed in late pregnancy due to urethral sphincter weakness. The gums become congested and spongy and may bleed to touch. Muscle tone and motility of the entire gastrointestinal tract are diminished due to high progesterone level. Cardiac sphincter is relaxed and regurgitation of acid gastric content into oesophagus may produce chemical esophagitis and heart burn. There is diminished gastric secretion and delay emptying time of stomach. Risk of peptic ulcer disease is reduced. A tonicity of the gut leads to constipation while diminished peristalsis facilitates more absorption of food materials.

Marie Elizabeth (2013) defines pregnancy as when the woman's egg and a man's sperm cell unit to form zygote. The duration of pregnancy has traditionally been calculated by the clinicians in terms of 10 lunar months or 9 months and 7 days or 280 days or 40 weeks, calculated from the first day of the last menstrual period. This is called menstrual or gestational age. It is divided into 3 trimesters. First trimester is from conception to 12^{th} weeks, the second trimester is from the 13^{th} weeks to the 28^{th} weeks and the third trimester is from 29^{th} week to the time of delivery. General check-up is done at interval of 4 weeks up to 28 weeks; at interval of two weeks up to 36 weeks and thereafter weekly till the expected date of delivery. Ideally this should be more flexible depending on the need, and the convenience of the patient.

LABOUR

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

Fraser and Cooper (2008) Labour is described as the process by which the products of conception are expelled through the birth canal. Labour was classified under four stages. The first, second, third and fourth stage. The first stage of labour begins with the dilatation of the cervix up to ten centimeters (10cm) dilation or full dilation of the cervix. This is a result of the regular rhythmic and painful uterine contractions. The second stage of labour also starts when the cervix is fully dilated and it continuous till the expulsion of the fetus. The third stage of labour is the complete expulsion of the placenta and its membranes and the control of bleeding. The fourth stage also is the six hourly close observations of the mother and the baby after the third stage. It involves the checking of the vital signs of both the mother and the baby every 15 minutes within the first hour after the delivery of the placenta and membranes. It deals with the establishment of lactation and detection of abnormalities and any complications in both mother and baby. During this stage, the mother is also given health education on personal

hygiene, care of the cord, frequent change of perineal pad, frequent ambulation to prevent postpartum haemorrhage and exclusive breastfeeding.

Ojo and Briggs (2006) labour is the process by which the uterus empties its content after the 38th weeks of pregnancy. It entails contraction and retraction of the uterine muscle fibres, the dilatation of the cervical os and the expulsion of the baby, liquor amni, placenta and membrane. The causes of onset of labour are unknown but many theories have offered few of these and are stated as, overstretching and over distention of the uterus at term, placental efficiency is diminished toward term, resulting in reduction in the level of estrogen and progesterone. The uterus becomes sensitive to the effect of oxytocin produced by the posterior pituitary gland there is an increase contractibility of the uterus towards term. Braxton Hicks' contractions increase in amplitude and may bring about the onset of labour. The onset has been associated with hyperpyrexia, cyanosis and emotional upset. First stage of labour starts from the onset of regular uterine contractions to full dilation of the cervical os. It lasts 12-14 hours in primigravida and 6-12 hours in multigravida. The first stage of labour comprises; painful uterine contractions, waist pain, lower abdominal pain, progressive dilatation of the cervix, formation of the forewaters and rupture of membranes. Second stage of labour; starts from full dilatation of the cervical os to the complete expulsion of the baby. It usually last up to 1 hour in primigravida and 5-30 minutes in multigravida. Third stage of labour entails complete expulsion of the placenta and membranes, usually within 5-15 minutes of birth of the infant.

Tiran (2008) Labour is defined as the process by which product of conception are expelled from the uterus through the birth canal. Labour normally occurs spontaneously at term that is between 38 and 42 weeks of pregnancy. The fetus should present with vertex and once started, the contractions should increase in strength and frequency without interruption and artificial stimulation until foetus, membranes and placenta are expelled by the maternal effort through the vagina. Partograph is the graphical recording of labour progress obtained by assessment of

visual patterns of cervical dilatation and descent of the presenting part in conjunction with records of maternal and foetal wellbeing.

Marshall & Raynor (2014) Labour, purely in the physical sense, may be described as the process by which the fetus, placenta and membranes are expelled through the birth canal; however, labour is much more than a purely physical event. What happens during labour can affect the relationship between the mother and baby and can influence the likelihood and or experience of future pregnancies. Pregnancy is considered to last approximately 40 weeks, with labour usually occurring between 17 and 42 weeks gestation. Complex physiological and psychological changes occur during the last few weeks of pregnancy and also during the onset of labour that prepare the woman for the process of labour and birth. Four stages of labour are described, the first, second, third stage and fourth but this is a rather pedantic view, as labour is obviously a continuous process. It has also been acknowledged that there are more than four phases of labour, namely, the latent, active and transitional phases, and these not only encompass specific physical changes but should also account for the emotional effect observe in women during this time.

Konar (2013) defined labour 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 into the outer world. The onset of labour is determined by a complex interaction of maternal and foetal hormones and is not fully understood. It would appear to be multifactorial in origin, being a combination of hormonal and mechanical factors.

Marie Elizabeth (2013) defines labour as a series of events that takes place in the genital organs in effort to expel the viable products of conception out of the womb through the vagina into the outer world. Labour is called normal if it fulfills the following criteria; spontaneous in onset, with vertex presentation, without undue prolongation, natural termination with minimal aids,

without having any complication affecting the health of the mother and or the baby. The features of true labour signs are: painful uterine contraction at regular intervals, 'Show', Progressive effacement and dilatation of the cervix, formation of the 'bags of waters. The events of labour are divided into four stages; first, second, third and fourth stage. First stage starts from the onset of true labour pain and ends with full dilatation of the cervix. Its average duration is six hours in multipara. Second stage starts from full dilatation of the cervix and ends with expulsion of the foetus from the birth canal. Third stage begins after the expulsion of foetus and ends with the expulsion of the placenta and membranes (afterbirth). Average duration is about 15 minutes in both multi and primigravida. Fourth stage is the stage of observation after expulsion of the afterbirth. Four factors are significant in the process of labour; that is the pelvis, passenger, powers and psyche. These are known as the four P's.

Fraser and Cooper, (2008) Puerperium starts immediately after the delivery of the placenta and its membranes and continuous for six weeks. It is within this period that all systems of the woman's body recover from the effects of pregnancy and return to their non-pregnant state. Lactation is well established and baby accepted into the family. During this period also, there is the drainage of lochia (the discharges from the uterus). It is normally red in colour during the first 3-4 days described as lochia rubra, from 5-9 days, it is pink in colour and is called lochia serosa; and from next 2-3 weeks it is paler, creamy-brown in colour and this is called lochia alba. Further states that it has been traditional to associate after pains with multiparity and breastfeeding. However, women experience after pains regardless of whether they have had previous pregnancies and when they are not breastfeeding. Management of after pains is by an appropriate analgesic.

PUERPERIUM

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

Henderson (2009) puerperium is traditionally defined as the time from immediately after the end of labour until the reproductive organs have returned as nearly as possible to their pregravid condition, a period estimated to be around 6-8 weeks. Puerperium is a time of major physiological change and a time of major emotional and personal upheaval. Early postnatal check includes: maternal haemoglobin and assessment of the baby and the mother looking particularly for tiredness and depression. The falling progesterone levels affect the alimentary tract. The smooth muscle tone gradually improves throughout the body, and symptoms of heartburn the woman may have experienced should resolve. Constipation may however remain a common problem during the postnatal period.

Konar (2013), puerperium is the period following child birth in which the bodies tissues, especially the pelvic organs revert back approximately to the pre-pregnant state both anatomically and physiologically. During puerperium the following physiological changes take place in all women as the body returns to its pre-pregnant state; Involution of the uterus and other soft parts of the genital tract, commencement of lactation. Physiological changes in other systems of the body. It is important that the midwife is familiar with these to ensure that

appropriate care and advice are given. Involution is the process whereby the genital organs revert back approximately to the state as they were before pregnancy. The woman is termed as puerperal. Puerperium begins as soon as the placenta is expelled and lasts for approximately 6 weeks when the uterus becomes regressed almost to the non-pregnant size. The period is arbitrarily divided into; immediate – within 24 hours; early – up to 7 days and remote – up to 6 weeks. Lochia is the vaginal discharge during puerperium. The discharge originates from the uterine body, cervix and vagina. Depending upon the variation of the colour of the discharge, it is named as;

1. Lochia rubra: red, 1-4 days
2. Lochia serosa: 5-9 days the colour is yellowish or pink or pale brownish
3. Lochia alba: 10-15 days, pale white

Ojo and Briggs (2006) at the end of labour the uterus is still very large and mobile; the genital tract is greatly bruised, distended and perhaps lacerated. The abdominal muscles are flaccid. Within the period of six to eight weeks postpartum are called puerperium, and where the bruises heal and genital organs and any other which underwent changes during pregnancy return to their pregravid states. This process of readjustment is called involution and lactation is established during this period. Involution is brought about by a shrivelling up of the muscle fibers and the absorption of their substance, partly into the bloodstream and partly into the lochia. The lochia is made up of blood from the site where the placenta was attached and the crumbling of the uterus which had developed so greatly in pregnancy. In the first five days after childbirth, the lochia mostly consists of blood and is consequently red in colour and is called lochia rubra. For the next 5 to 10 days, it is reddish brown as the blood loss lessens and more of the uterine lining in expelled and is called lochia serosa. By the 12 day, it has become pale either yellowish or white and the discharge may persist varying in amount for up to six weeks. Minor disorders that may occur after delivery as the body begins to change to it

non-pregnant state. After pains; after delivery, the uterus does not stop contracting. The contraction continues painlessly for the most part, but in some woman, particularly multigravida, painful contractions persist in the few days of the puerperium and may require analgesics. Backache; It mostly affect one woman in five in the weeks for occasionally month after childbirth. Backache appears to be more common if the woman has had an epidural anesthetic or a long second stage of labour. There is no specific treatment and backache gets better by itself. Urination; In the first 24 hours after delivery, the mother sometimes finds it difficult to pass urine because of the stretching during delivery of the vaginal tissues and the tissues around the bladder and with early ambulation help.

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

1. Immediate –within 24 hours
2. Early- up to 7 days
3. Remote –up to 6 weeks
4. Immediately following delivery, the uterus becomes firmer and retracted with alternating

hardening and softening. At the end of 6 weeks, its measurement is almost similar to that of the non-pregnant state and it weighs 60gram. The lower uterine segment becomes thin, flabby and collapsed structure. The cervix contracts slowly; the external os admits to fingers for the few days but by the end of the first week, narrows down to admit the tip of a finger only. The external os never revert back to the nulliparous state. During puerperium the number of muscle fibres is not decreased but there is substantial reduction in the myometrial cell size. The arteries are constricted by contraction of its wall and thickening of the intima followed by thrombosis. New blood cells grow in the thrombi. Soon after

birth it takes a long time (4 to 8 days) for the vagina to involute. The vaginal discharge for the first fortnight during puerperium is the lochia. The lochia originates from the uterine body, cervix and vagina. Depending upon the variation of the colour of the discharge it is named as:

1. Lochia rubra (red) 1 -4 days.
2. Lochia serosa (yellowish or pink or pale brownish) 5- 9 days.
3. Lochia alba (pale white) 10 -15 days.
4. The average amount of discharge, for the first 5-6 days is estimated to be 250 ml.

Marshall & Raynor (2014) puerperium starts immediately after the delivery of the placenta membrane and continues for six (6) weeks. In many cultures around the world, 40 days for recuperation is a time honored practice. The general expectation is that by six weeks after birth all the systems in a woman's body will have recovered sufficiently from the effects of the pregnancy and recovered to their non-pregnancy state. The general expectation is that by 6 weeks after the birth, a woman's body will have recovered sufficiently from the effects of pregnancy and the process of parturition.

WHY CLIENT WAS CHOSEN

Madam Pokuaa Mavis, 30 years old, Gravida 3 Para 2 all alive visited the antenatal clinic at the St Edward hospital, on the 28th October, 2021, with gestational age of 37 +2 weeks. It was her 5th visit to the clinic. She was warmly welcomed and offered a seat. After a short education on minor disorder during pregnancy. I took my time to answer all client's questions. Subsequently, I asked for client's health records to glance through and realized that client had frequency of micturition and heart burns. I asked client about it and she told me that the heartburns have subsided but she still urinates frequently. The physiology was explained as the pressure of the fetal head on the bladder. I realized that during her first born she did not practice exclusive breastfeeding for six months. She did it for three months so education on exclusive breastfeeding and its importance of it was made known to her. I expressed interest in using client for my maternity care study to the midwife in charge of the unit and she agreed. Introduction was done as a student midwife from Holy Family Nursing and Midwifery Training College, Berekum on practical session. The concept of the family centered maternity care study was explained to her and the intension to use her as a client for the care study and to give individualized care to her and her family for the rest of the period of her pregnancy, labour and puerperium. She accepted and promised to co-operate with me. She gave direction to her house and we exchanged phone numbers. Appointment was booked for home visit.

CHAPTER ONE

CLIENT'S PARTICULAR

1.0 INTRODUCTION

This chapter gives the overview of the client's social, family, medical, surgical, menstrual and obstetrical history. It also captures her lifestyle and her hobbies

1.1 SOCIAL HISTORY

Madam Pokuaa Mavis, Gravida 3 para2 age 30years, is a native of the Wasa - Mampong in the Ashanti region but lives in Kwame Kyei kurom in the Ashanti Region. She is dark brown in complexion, 1.63 meters tall and weighed 65kg when she first attended antenatal clinic. She is the only wife of Mr. Samuel Owusu and she said that they have been married for 5years. They have two children named Rosemond Owusu who is the first born. She is six years old. She lives with Madam Mavis's elder sister at Offinso in Ashanti region. Judith Owusu who is the second child lives with her at Kwame Kyei kurom. She is 2years old. She named her next of kin as Mr. Samuel Owusu, her husband. Madame Pokuaa Mavis is a Farmer. She is being supported by her husband in her pregnancy and said that, she intends to deliver at St Edward Hospital when she was asked. She attained her education up to secondary level.

Madam Pokuaa Mavis said that, her husband Mr. Owusu married her at Wasa- Mampong and brought her to Kwame Kyei kurom for them to stay there. Madam Pokuaa together with the husband are both Christians who attend Methodist Church. According to her, she and the husband earn their living through their work as farmers. She and the husband both speaks Twi, and English.

1.2 FAMILY HISTORY

Madam Mavis is the seventh child of eight children by Mr. James Opoku and Mrs. Grace Opoku. Her parents live in Wasa-Mampong.

She said that, there is no known history of inherited conditions like heart disease, sickle cell disease, diabetes, jaundice, respiratory disease, mental illness, birth defects, club foot, epilepsy spinal bifida, reduction of limbs and extra digit in her family. She mentioned that all the members of the family report to the hospital whenever they are sick and at other times, they use over the counter drugs and drug peddlers for minor illness. Lastly, she said that, all of her family members as far as she could remember died a natural death and there was no history of mysterious death in their family.

1.3 MEDICAL HISTORY

According to Madam Mavis, she has never been admitted nor detained at the hospital for any medical condition and to add to that, has no chronic disease like; diabetes, epilepsy, hypertension, respiratory diseases, mental illness, sickle cell and has no allergies. She only stayed in the hospital when she was going to deliver. She treats her minor ailments with the drugs from one peddler in the village and also uses herbs but reports to the hospital when it becomes severe. She was counselled to always report to the hospital whenever she fell sick of which the family is inclusive.

Education was given to Madam Mavis to report to the hospital anytime she falls sick and the dangers associated with traditional Medicine, over the counter drugs as well as those drug from the drug peddler.

She belongs to blood group B Positive. She was not on any medication aside her routine drugs when I met her and has no allergies to any food and drug.

1.4 SURGICAL HISTORY

Madam Mavis has never had any surgical procedure performed on her, neither has she been involved in any form of road traffic accident which might have affected the pelvis or hip bone. She had never donated blood throughout her lifetime nor transfused. Upon physical examination, there were no scars from any form of surgery, road traffic accident or episiotomy.

1.5 MENSTRUAL HISTORY

Madam Mavis had her menarche at the age of 15. She has 28days menstrual cycle with a moderate blood flow with slight dysmenorrhea which she takes a lot of water and paracetamol to relieve pain. Her menstruation lasts for 5days. She uses clean sanitary pad to absorb the blood. She changes her pad twice daily during her menses. According to Madame Mavis, she cannot recall her last menstrual period

1.6 CLIENT'S LIFESTYLE AND HOBBIES

Madame Mavis usually goes to bed at 7:00pm in the evening and usually wakes up at 6 :00 am in the morning. Right from bed, she cleans her teeth with toothbrush and toothpaste, and cleans her youngest child. She cleans the teeth twice daily and bath twice in a day.

She then sweeps the compound goes to fetch water and prepares breakfast for her family. She prepares supper at 4:00pm, She also said that, she prefers heavy food for breakfast to light ones. Normally, she takes "TuoZafi" with "Ayoyo" soup for breakfast and leaves some to be taken as lunch. She usually takes ampesi and garden eggs stew with fish for supper.

After breakfast, she bathes her child and she prepares to go to farm. Mostly she goes to farm with the husband when he is around and returns home at around 3:00pm in the evening. She prepares supper at 4:00pm, after which she feeds her child, help her to do revision not to forget what she was taught.

She visits the toilet in the morning and voids when necessary. She prefers chatting with the neighbours rather than sleeping in the afternoon. She was counselled to at least rest and sleep for two hours in the afternoon to reduce the stress and strains of pregnancy as well as having a sound mind.

After supper, she chats with the family before going to bed. According to the client she does not take alcoholic drinks.

1.7 PAST OBSTETRICAL HISTORY

Madam Mavis is gravida three para Two (G3P2AA). She said she carried her previous pregnancy till full time. She also added that she has never had an abortion whether spontaneous or induced pre-eclampsia and anaemia among others. She attended Antenatal for six (6) times and received one dose of Sulphadoxine Pyrimethamine (SP) and had her 3rd dose of tetanus injection

Madam Mavis was asked about the mode of delivery in her first child, she said she had spontaneous vaginal delivery. She said her child weighed 2.5kg. She also added that, she labour at home and was later sent to the hospital. She did not labor for more than 24 hours and she was able to deliver through fully dilated cervix without perineal tear. There was nothing like retained placenta during the third stage and she said that her blood loss was not very much although she could not give an approximate amount and there was no post-partum haemorrhage. The second child was delivered at St Edward Hospital. She had spontaneous vaginal delivery. She weighed 2.8kg

The client said that her first and second child has never contracted any severe illness since birth and she experienced after pains few days after delivery. She also practiced exclusive breastfeeding for two months for her first child and three months for the second child. She

added porridge to the breast-milk during weaning of her children. She breastfed her with a total duration of two years' extra-uterine life.

She added that during pueperium, she had no illness and she was always in a good condition except she added that, she had no house help and so try as much as she could to manage herself together with sometimes the little support from her mother in -law when she was around. Her children also received the required immunizations

1.8 PRESENT OBSTETRICAL HISTORY

Madam Mavis made her first visit to St Edward antenatal clinic on 15th July, 2021. Where she was at 22weeks plus 2 days of gestation and symphysio-fundal height of 19cm. The scan gave last menstrual period as 7th February 2021 and her expected date of delivery was calculated as 14th November 2021.

She was asked of the date of which she thinks she would deliver and the answer was November 2021 but could not tell the actual date.

Her vital signs were as follows;

Temperature	-	36.3°C
Pulse	-	85bpm
Respiration	-	19cpm
Blood pressure	-	94/65 mmHg
Weight	-	65kg
Height	-	1.63m

Her laboratory investigations were recorded as;

Hb level	-	11.5g/dl

Blood group	-	B
Rhesus factor	-	Positive
Urine, Protein	-	Negative
Sugar	-	Negative
HIV Antibody	-	Negative
Hepatitis B	-	Negative
Sickling	-	Negative

Blood film for malaria parasite – No malaria parasite detected

She made complains of whitish discharges from vagina and loss of appetite

She was served

Tab R/D daily for 30 days

TD3 given

Clotrimazole Vaginal pessaries to apply.

The head-to-toe examination was done and nothing abnormal was detected. On abdominal palpation symphysio-fundal height was 19cm and education on the minor disorders of pregnancy and personal hygiene was done. She was asked to come back to the clinic in a month time but should report when sick.

CHAPTER TWO

ANTENATAL CARE

2.0 INTRODUCTION

Antenatal care refers to the care given to a pregnant woman from the time conception is confirmed until the beginning of labour. The aim of antenatal care is to monitor the progress of pregnancy to optimize maternal and fetal health. It is essential that the midwife critically evaluates the physical, psychological and sociological effects of pregnancy on the woman and her family.

2.1 FIRST CONTACT WITH THE CLIENT

The first contact with Madam Pokuaa Mavis took place at St Edward health centre antenatal clinic. It all happened on Thursday 28th October, 2021, at around 10:00 am in the morning, when she visited the clinic for her usual antenatal care.

We met at the desk and she greeted in a nice way; she was responded and offered a seat, asked how she was faring and her mission at the clinic. She explained that, she had come to the antenatal unit as booked by the midwife, introduction of myself was made as a student midwife from Holy Family Nursing and Midwifery Training College, Berekum, who is on a clinical practice and the interest to select her for the care study was explained to her.

She agreed and said she was glad. All procedures to be carried out on her was explained to her understanding and she agreed for them to be done. She was encouraged to ask questions when necessary and was also thanked for her co-operation. The in charge was also informed and she agreed.

Her antenatal booklet was taken and glanced through. She was commended for her regular attendance. Explanation of every procedure that would be carried on her was given and her consent sort.

A baseline vital signs was done which yielded the following results:

Temperature	-	36.3°C
Pulse	-	80beat per minute
Respiration	-	22cycle per minute
Weight	-	66kilogram
Blood pressure	-	106/70milligram per mercury
Height	-	1.63metres
Haemoglobin	-	10.2gram per decilitre

She was asked to empty her bladder and a urine container was given to her to collect midstream urine to check for protein and glucose using a reagent strip. The result was negative for both tests. The procedure was again explained and consent sort. She was helped to lie on the bed and privacy provided. A thorough hand washing with soap and water was done and hands dried with a clean towel. After that client was examined from head to toe.

General head to toe examination.

Her hair was neatly braided and held backwards with a ribbon. The hair was clean with no sign of dandruff.

Her eyes were clear especially the sclera and the conjunctiva were pink indicating that the client was not anaemic. The nose and the ears were clean and free from discharges. Client was engaged in a conversation and funny comment was then passed for the client to laugh just to see her mouth, tongue and gums for any inflammation or halitosis but none was noticed. Her teeth were clean with no dental carries. The lips were not cracked as well. The neck was then inspected for nodules and distended neck veins but none was present.

On breast inspection, the breast appears to be a bit larger and one looks little larger than the other with no scars or cracks. The breast was also examined for inverted nipples but no abnormalities were found. In the axilla too, no axillary nodules were noticed. Her upper extremities were inspected for equality and no abnormality was detected, the finger nails were cut short. On inspection of the abdomen, the abdomen was ovoid in shape with a normal size compared to gestation age. Linea nigra and striae gravidarum were present, foetal movement could be observed on the abdomen, scars of previous operation as well as rashes were all absent. There was no sacral oedema or abnormalities at her back.

At the lower extremities, she was inspected for varicose veins, size, length and equality of the extremities, no abnormality was detected. On the ankle, there was the presence of slight oedema of which she complained she experiences it when she sits or stand for a long time but becomes normal when she sleeps and wake up. She was then advised to place her legs on a stool or anything she will feel comfortable with when sitting and avoid prolong standing as well as elevate the foot during sleep.

Permission was sort and granted to inspect the vulva. It was nicely shaved there was no oedema, varicose veins, genital warts or bleeding, but there was discharge at the vulva.

Abdominal examination

Inspection: On abdominal inspection there was no scar except for some few trace marks of striae gravidarum and linea nigra. The shape and size of the abdomen was oval and medium respectively. Fetal movement was also found.

Measurement of the symphysio fundal height: The upper border of the fundus was located and the zero end of the measuring tape was placed on the fundus of the uterus and extended to the Symphysis pubis. The fundal height measured 36 centimetres and gestational age was 37+2 weeks.

.**Fundal palpation:** The palm was rubbed to make it warm. On fundal palpation, upon facing the woman, whiles standing at the client's right side, each palm was placed on either side of the fundus. The fingers were curved around the top of the fundus and palpated to determine what was in the fundus. A soft mass was felt which indicated the buttocks.

Lateral palpation: During lateral palpation, each palm was placed on each side of the uterus at the level of the umbilicus. One hand was used to stabilize the uterus. Using a rotary movement of the other hand to map out the back which was smooth at the mother's right side to the neck, on the left side, the same movement was done to reveal the limbs which was rough.

Pelvic palpation: On pelvic palpation, upon facing the woman's feet, she was asked to bend her knees slightly and also to breathe out slowly to help her relax the abdominal muscles. Each palm was placed on either side of the uterus, just below the umbilicus, hands directing towards the symphysis pubis as the thumbs were almost meeting, a hard mass was felt indicating the head of the fetus.

Descent: Location of the anterior shoulders was done using two fingers. The symphysis pubis was also located and with the ulna border just above the symphysis pubis and the anterior shoulder, five fingers occupied the space between the symphysis pubis and the anterior shoulder indicating descent of 5/5. Therefor from the above, it was deduced that, lie was longitudinal, presentation was cephalic, descent was 5/5 above pelvic brim and the position was right occipito anterior.

Auscultation: On auscultation, fetoscope was rubbed in the palm to make it warm. It was placed at the area where fetal back was located. The ear was placed against the fetoscope to listen for fetal heart beat for a minute as it was being compared with maternal pulse. The fetal heart rate was138 beats per minute.

Vulva

Permission was sought to inspect the genital area and she agreed. Hand washing was done with soap under running water and cleaned with a clean towel. She was then asked to bend her knee and open the thighs. The mons pubis was well shaved; there were no scars, oedema, genital warts, clitorectomy and no abnormal discharges from the vagina. All findings were communicated to her and she was thanked for her cooperation. Client was encouraged to continue keeping the vulva clean and dry, change panties when wet, avoid wearing nylon panties and avoid douching but rather wear cotton panties. Madam Mavis was helped to get off the examination bed, as she turned to her left side, sat up before getting out of the bed. She was encouraged to ask any questions bothering her mind and she asked whether the vaginal discharge was going to have any effect on her baby after birth. She was reassured and educated that it is due to proliferation of vaginal epithelium and for that reason vulval hygiene should be re-enforced.

She complained of lower backache, waist pains and constipation. Client was reassured and educated that they were all due to the pregnancy. She was advised to break in between works to prevent circulatory stasis in the lower extremities as well as strengthen the muscles during pregnancy and delivery. She was also educated to lie on her left side when sleeping to prevent supine hypotensive syndrome and also encouraged to wear low heels to reduce the waist pains:

Prescribed medications given to client are as follows:

- Tablets multivitamins 200mg daily for 14 days
- Tablet folic acid 5mg daily for 14 days
- Tablet ferrous Sulphate200mg daily for 14 days
- Tablet paracetamol 1000mg 3 times daily for 3 days.

The next visit on 4th November, 2021 was made known to her and also to report to the clinic when there was any problem even if her next visit was not due. Appointment for home visit on 29th October 2021 was also booked and she gave the direction to her house.

2.2 FIRST ANTENATAL HOME VISIT.

On 29th October 2021 around 10:30am, a visit was made to Madam Mavis's house. The aim of the visit was to know her family, her environment and how she was faring. On arrival, she was found cooking just in front of her house. There were two people who were also around. They welcomed me and asked me of my mission, and I introduced myself as a student midwife from Holy Family Nursing and Midwifery Training College, Berekum who has been brought to St Edward hospital for a client/family centred maternity care study of which Madam Mavis and family are the people chosen for the care study. They were pleased and then my client introduced the middle aged man to me as Mr Samuel Owusu her husband and the other man Ebenezer, as her brother in-law, who had come to paint their house for them.

PHYSICAL ENVIRONMENT

A quick assessment of the environment was done after which a seat was offered. Client lives in their own house with her family thus her husband and children. The house was built with cement, roofed with iron sheet and has three bedrooms. Client prepares her food in front of her house. She also uses the public toilet whenever she feels like defecating. She has her own bathroom at the back of her building. The floor of the room was covered with carpet and the windows with louver blades but have no net. Madam Mavis was educated to place mosquito net in the window to prevent entry of mosquito into the room from the windows.

Madam Mavis and her family occupies one room and sleeps under intermittent treated mosquito net in which confirmation was made after being ushered into her room. They normally fetch water from a pipe, located few distance away from the house which was being used for bathing and cooking and they usually store the water in a barrel covered with lid. The

family had a medium size basket covered with a sheet of plywood into which they put their waste and later emptied in the pit for burning. The environment around the house was spacious enough. Madam Mavis's house has access to electricity. The room had two windows which could be opened for ventilation. She was asked, whether she has informed her first child of her pregnancy and for that matter expecting to deliver in a matter of time. The answer was no, much stress was given as to her introducing the pregnancy to her daughter, telling her that, the big abdomen she is now having contains her sibling who will be out in no time. In so doing it prevent sibling rivalry. When labour is due, she should tell her she is going to bring her sibling. In doing this, it will break any enmity chain between her and the baby. She was pleased with my advice and in my presence she started with the process. After assessing the environment, the place was observed to be well kept but there were unwashed utensils around the place. The opportunity was then taken to educate her on environmental hygiene and how unhygienic environment affect our health. Afterwards Madam Mavis was asked to bring her things she had packed for her delivery, of which she said she had not prepared yet. The stages of labour were therefore explained to her and stress was made on birth preparedness and complication readiness plan as well as the merits of hospital delivery with reference to the demerits of home delivery. Further explanation was given to her on the layette which was supposed to contain items belonging to the baby and sanitary pad to be applied to the perineum to prevent infection and during the second stage of labour.

She was told to have in a bag her antenatal card, insurance identity, and the reports of any scan that she has for observation and references. She was encouraged to put them all in a bag so that, when labour begins, she would not leave any of them behind.

They were finally thanked for the time and an ear given to me. Permission was sought and request granted to leave the house. Madam Mavis was asked if there was any pregnant woman

around that a visit could be paid to but she said, there was none known. She accompanied me to her door steps and I left for my house.

PSHYCOSOCIAL ASSESSMENT.

Madam Mavis 30 years old G3P2 all alive, who comes from Wasa Mampong in Ashanti Region Ghana, now stays at Kwame kyei kurom with her mother in –law and her daughter. The house is a three-bedroom house roofed with iron sheet. People who live in the house happened to be her mother in-law. She lives very well with her family and has a warm relationship with all the people living around her. Her friends mostly visit her and she also visits them with her leisure time. She behaves nice and cracks jokes. She has respect for human. She also attends social gathering like wedding, naming ceremonies and communal labour. Madam Mavis and family were thanked and appreciated for their warm respect and permission sought to leave.

2.3 SECOND ANTENATAL HOME VISIT

Madam Mavis's second visit was on 2nd November 2021 at 2:15pm in the evening. The aim of the visit was to keep a check on the improvement that has taken place based on the previous antenatal and home visit as well as the family at large and also was to know how she was preparing towards the impending labour.

On arrival, Madam Mavis was seen cooking and her daughter was playing. Their general condition was asked and was replied as they are fine but made a complain of fatigue and sleeplessness.

At a glance, my heart was filled with happiness because the environment was clean and tidy and also there were no dirty utensils around in fact, I was really pleased with myself because madam Mavis and her family were coping with me. They were then congratulated for the advances they were making She was asked to bring the things she has bought and packed for her delivery and surprisingly it was already kept in a different bag for the unborn baby alone

and all that she will also need. The things were inspected and it was realized that everything was in intact. She was advised to keep a purse of money in the layette and to arrange with a driver who will take her to the hospital as well as the one who will escort her to the hospital when the need arises. She was finally advised on the true labour signs; example was the painful rhythmic regular uterine contraction accompanied by a blood stained mucus known as show.

Once again she was congratulated and thanked for her cooperation and they were left to continue with their activities.

2.4 SUBSEQUENT VISIT TO THE HOSPITAL

Madam Mavis came to the hospital the second time on 4th November,2021 around 10:30am. She was well. Every procedure to be carried out on her was explained to her and she consented. Her vital signs and weight were checked with following results.

Temperature	-	36.5C
Pulse	-	75bpm
Respiration	-	21cpm
Blood pressure	-	99/63mmhg
Weight	-	66kg

A specimen urine container was given to her for midstream urine for protein and glucose test. They all tested negative. She was then asked to go and empty her bladder and provided privacy. A thorough hand washing with soap and water was done and dried with a clean towel. The hair, eyes, nose and neck had no observed abnormalities detected as well as the sacral region. On abdominal examination, the abdomen was ovoid with linea nigra and striae gravidarum, foetal movement was visible on the abdomen with no rashes or scars. After rubbing my palms together, the symphysio fundal height measured 34centimetres with 38+2weeks gestation. The

lie was longitudinal, cephalic presentation and foetal back palpated on the right side of the mother. On auscultation, the foetal heart rate was 144bpm with a good volume and rhythm.

She was asked of her complains for the day and she complained of frequent urination in the night and lower abdominal pains. Together with her a recap of the previous education was made and then advanced to education on rest and sleep. Once more, explanation was given to her that, she is gradually approaching labour, therefore, if she experiences any sign of true labour; regular painful rhythmic uterine contraction, the presence of show, even rupture of membranes, she should report to the hospital though her next visit is 11th of November, 2021.

She was still having some of the routine antenatal drugs she took on the previous visit, so she was encouraged to continue taking them. She was thanked and seen off the clinic since she had no questions and concerns.

2.5 NURSING CARE PLAN DURING ANTENATAL CARE

PROBLEMS IDENTIFIED

On the 4th of November,2021 Madam Mavis complained of

1.Waist pain (28th October)

2. Constipation (28th October)

3.Backache (28th October)

4.Fatigue (2nd Nov)

5. Sleeplessness (2th Nov)

6. Lower abdominal pain (4nd Nov)

SHORT TERM OBJECTIVES

1. Client fatigue will be reduced within 48hours

2. Client waist pains will be reduced within 48hours and copes with it till the end of pregnancy.

3. Client will have her bowel movement at least once in 24 hours.

4.Client backache will be reduced within 48hours and cope with it throughout pregnancy

5.Client will be able to sleep for at least 3 hours within 24 hours.

6. Client lower abdominal pain will be reduced within 48 hours and cope with it throughout pregnancy.

LONG TERM OBJECTIVES

Madam Mavis will be able to carry her pregnancy to term, with all the education, encouragement and support needed to avoid complications

DATE/TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES	NURSING ORDERS	NURSING INTERVENTION	DATE/TIME	EVALUATION	SIGN
2/11/21 At 10:30am	Fatigue related to inadequate rest	Client lower abdominal pain will be reduced within 48 hours and cope with it throughout pregnancy. evidenced by client verbalizing that her tiredness has reduced	1.Reassure client 2.Encourage family members to help in household chores 3.Advice client to take up little work 4.Teach client energy conservation techniques such as sitting rather than squatting or standing whiles washing 5.Encourage client to rest during the day	1.Client has been reassured that she will be relieved of the fatigue 2.Family members were encouraged to help in the household chores 3.Client was encouraged to take up little work 4.She was taught energy conservation techniques such as sitting rather than squatting or standing.	4/11/21 At 10:30am	Goals fully achieved as client understood what was taught and could give feedback	MAG

DATE/TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES	NURSING ORDERS	NURSING INTERVENTION	DATE/TIME	EVALUATION	SIGN
28 /10/ 21 AT 10:50am	Constipation related to relaxation of smooth muscles and bowel.	Client will regain bowel movement once every 24 hours as evidence by 1. Client verbalizing.	1. Reassure client. 2. Explain the physiology of constipation to client. 3.Encourage client to take fruits and vegetables at least three times daily. 4.Encourage client to take at least 2 litres of water per day. 5.Encourage client to eat roughages and fiber diet.	1. Client was reassured. 2. The physiology of constipation was explained to client. 3. Client increased intake of fruits and vegetables at least three times daily. 4. Client was encouraged to take at least 2 litres of water per day. 5 .Client increased intake of fiber and roughages like oranges and pineapple.	29/10/21 At 10:50am	Goal fully met as client verbalizing that she has regained her bowel movement once every 24 hours.	MAG

DATE/TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES	NURSING ORDERS	NURSING INTERVENTIONS	DATE/TIME	EVALUATION	SIGN
28/10/21 At 8:35am	Waist pain related to descent of the fetal head putting pressure on the sacral nerves.	Client waist pains will be reduced within 48hours and copes with it till the end of pregnancy. as evidenced by client behavior.	1. Reassure client. 2. Encourage client to have 2hours rest during the day. 3. Educate client to sit in between activities. 4. Educate client to engage in exercises but harmless. 5.Administer prescribed analgesics.	1. Client was reassured that she will be relieved of waist pain. 2. She was encouraged to have 2hours rest during the day. 3. Client was educated to sit in between activities. 4. Client was educated to engage in exercises. 5. Tab. paracetamol1g was served as prescribed.	30/10/21 At 8:35am	Goal fully met as client said that she was able to cope with the pains.	MAG

NURSING CARE PLAN FOR PREGNANCY

DATE / TIME	**NURSING** DIAGNOSIS	**NURSING OBJECTIVES/ OUTCOME CRITERIA**	**NURSING ORDERS**	**NURSING INTERVENTIONS**	**DATE / TIME**	**EVALUATION**	**SIGN**
2/11/21 at 9:00am	Sleeplessness related to difficulty in adopting comfortable position at night.	Client will be able to sleep for at least 3 hours within 24 hours as evidence by client stating that she was able to sleep for at least 6 hours during the night.	1. Reassure client to allay her fears and anxiety. 2. Encourage client to take warm bath before going to bed at night 3. Encourage client to take warm milo drink to induce sleep. 4. Encourage client to allow fresh air into her room. 5. Teach client to sleep on her left lateral.	1. Client was reassured to allay her fears and anxiety. 2.Client was encouraged to take warm bath before going to bed. 3.Client was encouraged to take warm milo drink to induce sleep. 4. Client was encouraged to allow fresh air in her room. 5. Client was taught to sleep on her left lateral.	3/11/21 at 9:00 am.	Goal fully met as client verbalized that she was able to sleep for 6 hours during the night.	MAG

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES	NURSING ORDERS	NURSING INTERVENTIONS	DATE/ TIME	EVALUATION	SIGN
4/11/21 at 8:00 am	Lower abdominal pain related to descent of the fetal head.	Client lower abdominal pain will be reduced within 48 hours and cope with it throughout pregnancy As evidenced by client posture.	1. Reassure client. 2. Explain the physiology of lower abdominal pains to client. 3. Advice client to reduce household activities. 4. Encourage client to wear low heel shoes. 5. Encourage client's husband to help client with household chores. 6. Serve prescribed analgesics.	1. Client was reassured that her pain would be subsided. 2. The cause of lower abdominal pains was explained to client. 3. Client was advised to reduce household activities. 4. Client was encouraged to wear low heeled shoes. 5. Client's husband was encouraged to help client with household chores. 6. Clients were served with prescribed analgesics.	6/11/21 at 8:00am.	Goal fully met as evidence by client's posture.	MAG

DATE/ TIME	NURSING DIAGNOSIS	OBJECTIVES\ OUTCOME CRIITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN.
28/10/21 At 8:45am	Backache related to weight of pregnant uterus, relaxation of muscles and ligaments by progesterone and relaxin.	Client backache will be reduced within 48hours and cope with it throughout pregnancy evidence by; 1.Client verbalizing that the pain has reduced. 2. Client scoring zero on pain assessment scale. 3. Client looking cheerful on assessment.	1. Reassure client possible care to relieve backache. 2.. Educate client on the physiology of backache 3. Encourage client to have rest. 4. Encourage client to apply warm compress to the back. 5. Encourage client to support her back with pillows while lying down. 6. Encourage client to wear low heel shoe and lift light objects. 7. Encourage client to do position and support when sitting.	1. Client was reassured on the possible care to relieve backache. 2. Client was educated on the physiology of backache 3. Client had enough rest. 4. Client was applying warm compress to the lower back. 5. Client was supporting her back with pillows while lying down. 6. Client was wearing low heel shoe and lifting light objects. 7. Client was performing and support when sitting.	30/10/21 At 8:45am	Goal fully met as evidence by: 1.Client verbalizing that pain has reduced. 2. Client scoring zero on comparative pain assessment scale. 3. Client looking more cheerful on assessment.	**MAG**

CHAPTER THREE

LABOUR

3.0 INTRODUCTION

This chapter describes the management of labour, immediate care of the newborn, subsequent care, examination of the newborn and care plan drawn for the management of the problems encountered during the period.

3.1 ADMISSION AND MANAGEMENT OF FIRST STAGE OF LABOR

Client reported to the hospital at 12:56pm on 9th November, 2021 accompanied by her mother in-law. They were welcomed and offered a seat. She complained of lower abdominal pains, painful uterine contractions, nausea and vomiting. Enquiries made indicated that client had seen blood stained mucus (show). Client's appearance indicated that she was in pain. Client was asked about her last meal and she said she ate rice and stew. According to Madam Mavis labour started around 8:00 am. Client antenatal book was glanced through for previous histories and also to confirm clients expected date of delivery. Client was taken to the delivery room, was offered a well laid bed and reassured of a successful birth outcome. Procedures to be done were explained to her and consent was gained. Client vital signs were checked and recorded as follows;

Temperature	36.6 degree Celsius
Pulse	85 beats per minute
Respiration	20 cycles per minute
Blood pressure	110/70 millimeters of mercury.

Client was served with a bed pan to empty her bladder and midstream urine specimen was taken and tested negative for protein and glucose. The amount of urine emptied was 150mls.

Client was helped unto the couch; hands were washed and dried with clean towel. Client was examined from head to toe and no abnormalities were detected.

Abdominal examination

On inspection, the shape was ovoid with normal size and there was linea nigra present**.** The symphysio fundal height was 36 centimeters while the gestation was 39 weeks. Fundus was palpated and the foetal buttock was felt occupying the upper pole of the uterus. On lateral palpation, fetal limbs were palpated at the right side and the foetal back was felt at the left side of the mother's abdomen. The lie was longitudinal and the presentation cephalic, the anterior shoulder was located using two fingers. Three fingers were admitted between the shoulder and the symphysis pubis indicating a descent of 3/5th above the pelvic brim. On auscultation, the foetal heart beat was 138 beats per minute. After the palpation, hands were warmed by rubbing them together in order to check for contractions. There were three contractions in ten (10) minutes lasting thirty seconds. Permission was sought from Madam Mavis for vaginal examination. A tray already set had two sterile gallipots with one containing cotton, Savlon lotion, sterile gloves, a receiver for the used swabs and a sanitary pad. Hands were washed with soap under running water and dried with clean dry towel. A pair of sterile gloves was put on and client was asked to assume a dorsal position with the knee flexed for examination. The vulva was inspected for edema, wart, scars and varicose veins but there was none present. Five cotton wool swabs were used for the examination. The dominant hand was used to pick the cotton wool and dipped into the lotion; swab was dropped from right hand into the left hand and swab per stroke. Labia majora was wiped from anterior to posterior and the used swab was disposed of into a receiver. Labia minora was wiped from anterior to posterior and the used swab was disposed.

The vestibule was patted using the non-dominant hand; a swab was used to wipe the vestibule from anterior to posterior. The used swab was disposed into the receiver. Client's permission was sought and the right middle finger was inserted into the vagina by firmly pressing downwards. The index finger was also inserted. This caused relaxation of the vaginal walls and muscles. The condition of the vagina was warm and moist and cervix was soft, thin and well applied to the presenting part. The cervix was effaced and dilatation was (5) centimeters. Ischial spines were blunt and pubic arch was wide. Membranes were intact and there was no moulding (0). A clean perineal pad was applied on the vulva and client was asked to lie on her left side to prevent supine hypotension syndrome. Gloved hands were dipped into 0.5% chlorine solution before discarding. All findings and the progress of labour was explained to client. The dilatation board was used to explain the cervical dilatation and progress of labour to her. Client was thanked for cooperating and all information gathered was recorded on a partograph sheet. Client was made comfortable in bed and encouraged to ambulate.

PREPARATION FOR BIRTH.

In preparing for birth, two skilled and unskilled helpers were identified. The first skilled helper was the Midwife-in-charge who was consulted in case of anything and the second skilled helper was a staff nurse who always helps the Midwife-in-charge whenever there was a labour case. The unskilled helper was the client's mother in-law. The Doctor was informed that there was a client in labour so in case of any emergency, he will be consulted. Client's in-law was also asked to contact the taxi driver to be alert in case there is the need for a referral (advanced care), he would be called. The area for delivery was prepared. Madam Mavis was assisted to wash her hands and abdomen to prepare for skin-to-skin care prior to the second stage of labour. Windows and doors would be closed and a curtain drawn when labour was near to provide privacy and also to provide warmth. A portable lamp was made available to assess the baby in case of light off. Hands were washed thoroughly with soap and clean water to prevent the

spread of infection. The area for ventilation was also prepared and the equipment was checked. A dry, flat and safe space was prepared to receive ventilation if needed. The equipment to help baby breath was assembled at the area for ventilation. The functions of the equipment were tested especially the ventilation bag and mask. Delivery set, drugs and protective clothing [boots, goggle, face mask, cap and apron] were made available for use. Head covering, scissors, cord clamp and sterile glove were also made available.

Having finished with birth preparation, Madam Mavis was seen anxious that she did not know the outcome of the labour and was seen pushing each time there was contractions. Client was reassured of normal labour with a healthy baby without any complications after delivery. Client was encouraged to breathe through her mouth when there was contraction and also avoid pushing during contractions since the cervix was not fully dilated and to prevent the cervix from becoming edematous and possible tearing of the perineum. Client was also encouraged to empty her bladder frequently to enhance effective contraction and descent of the foetal head since full bladder could slow down progress of labour.

Client was educated not to use her perineal pad when it falls and the importance of changing the pad when soiled and not to be touching the perineal area. The foetal heart rate, contractions and maternal pulse were monitored every thirty (30) minutes but temperature, blood pressure, dilation of the cervix and descent of the fetal head were checked every four (4) hours.

At 4:00pm vaginal examination was done to rule out cord prolapse and she was eight (8) centimeters dilated. On vaginal examination the vagina was warm and moist, and well applied to the presenting part, fetal heart rate was 142 beats per minutes, moulding was (+) which indicated that the bones are in apposition with each other, and liquor was clear with descent of $1/5^{th}$. Contractions were three (3) in ten (10) minutes lasting for forty (40) seconds. Client was assisted to wash her hands and abdomen.

Vital signs were checked and recorded as below;

Temperature	36.7 degree Celsius
Pulse	80beats per minute
Respiration	20 cycles per minute
Blood Pressure	100/60 millimeters of mercury

The amount of urine emptied was hundred (100) milliliters. Urine was tested for protein and glucose but was negative. Client was made comfortable in bed by cleaning all discharges and a new perineal pad applied. All findings were documented on a partograph sheet and communicated to the client as well. At exactly 5:59pm, membranes ruptured spontaneously. Vagina examination was done at 6:00pm and the cervix was fully dilated (10cm). Descent was 0/5th, moulding was two plus (++) which indicated that the bones were overlapping each other but could slip off, contractions were four(4) in ten (10) minutes lasting forty five(45) seconds. Fetal heart rate was 140 beats per minute. Client complained of having the urge to bear down. The Midwife-In-Charge was called to confirm full dilatation. Findings were recorded on the partograph sheet and client was informed of the full dilatation of the cervix. Client was informed that the baby would be delivered onto the abdomen to establish bonding. Client was encouraged to push with contractions and rest in between contractions.

Trolley was set with the following items on the top and down shelf as;

TOP SHELF

- ✓ Sterile cord scissors sterile artery forceps
- ✓ Sterile sheets Membrane pierce
- ✓ Sterile gauze/cotton Sterile receiver for placenta

- ✓ Sterile gloves
- ✓ Bulb syringe
- ✓ Suture
- ✓ Anaesthesia such xylocaine
- ✓ Syringe
- ✓ Oxytocin

Cord clamps

Episiotomy tray containing;

Episiotomy scissors

Dissecting forceps

Suturing forceps

BOTTOM SHELVE

- ✓ Cot sheet
- ✓ Measuring jug
- ✓ Identification band
- ✓ Savlon
- ✓ Resuscitation tray

Catheter

Perineal pad

Bed pan

Examination gloves

3.2 MANAGEMENT OF SECOND STAGE OF LABOUR

The second stage of labour starts from full dilatation of the cervix that is 10cm to the birth of the baby. She was also told that the baby would be delivered onto her abdomen. The labour process was explained to her and she was reassured of positive prognosis since she was anxious about the outcome of the delivery. She was asked to assume any position which would be comfortable and she chose the lithotomy position because it was comfortable to her during her previous delivery. Protective clothing such as rubber apron, boots, mask and goggles were put on. The already prepared trolley was sent to the bed side. Hand washing was done with soap under running water and dried with a clean towel. The delivery pack was opened while the sterile gloves were being downed. Madam Mavis was draped with a clean towel, her vulva and upper thigh were swabbed with sterile cotton wool soaked in savlon solution. She was then encouraged to bear down with each contractions and rest in between them.

Again, full dilatation of the cervix was confirmed, and perineal pad was applied at the anus to prevent fecal matter from contaminating the delivery field. My index and middle fingers were then placed on the fetal head when it was visible to aid flexion and allow the smallest diameter to present to avoid expulsive delivery, cerebral hemorrhage and maternal trauma. Client vagina was roomy and so there was no need for episiotomy. When crowning of the head took place, she was told to push slowly until the head fully appears in the vagina. The head was delivered by extension when the sinciput, the face and the chin sweep the perineum. The baby's face and eyes were wiped immediately with sterile gauze from inside out of the eyes. I checked for cord around neck, but there was none. Restitution was allowed to take place and external rotation of the head indicating internal rotation of the shoulder. After, the baby's head was held in between my palms on each side of the temporal bones and with downwards traction, the anterior shoulder was delivered and with an upward movement, the posterior shoulder was also delivered and the rest of the body was finally delivered by lateral flexion, and a male baby was born onto the mother's abdomen at exactly 6:20pm. The baby was dried and placed on the mothers' abdomen to facilitate bond between the mother and the baby and also provide the baby with warmth.

The baby cried soon after birth. The cord was then clamped with two artery forceps, one was clamped 2cm from the baby's abdomen and the other was 3cm away from the first clamp. The cord was cut in between the clamp with sterile scissors covered with sterile gauze swab to prevent the blood from splashing. The baby was shown to the mother in other to identify the sex which she mentioned as a male. The baby was covered to prevent heat loss. The mother was congratulated for her effort and co-operation. Breast feeding was initiated.

3.3 IMMEDIATE CARE OF THE BABY

As soon as the head was born, sterile gauze was used to clean the baby's eyes starting from the inner contour outward and as well as the face. The airway was cleared and the cord clamped

and out. The baby was made warmly by wiping off liquor amnii with sterile gauze and covered with a warm cot sheet whiles on mother's abdomen. An identification band which bared the baby's name, sex, date and time of delivery as well as the mother's name was placed on the baby's wrist.

First and five minute APGAR score:

APGAR	1 minute	5 minutes
• **Appearance**	**2**	**2**
• **Pulse**	**2**	**2**
• **Grimace**	**1**	**2**
• **Activity**	**2**	**1**
• **Respiration**	**1**	**2**

3.4 MANAGEMENT OF THIRD STAGE OF LABOUR

The management of the third stage of labour is the complete delivery of the placenta, membranes and control of hemorrhage. This stage begins immediately after the expulsion of the baby. Client was still in the lithotomy position and after checking for undiagnosed twin, 10 units of oxytocin was given intra muscularly on the thigh to aid in the contractions of the uterus which would also lead to the separation of the placenta. The procedure was then explained to the client. The cord was reclamped closer to the perineum and cord placed in receiver which was placed in between her thigh. After that, non-dominate hand was placed on the fundus to feel for contractions and when the uterus contracted, my hand was removed and placed on the lower abdomen in the supra pubic area in order to stabilize the uterus. With control cord traction, using counter pressure the clamp was firmly held in my right hands and gentle downward traction was applied until placenta became visible at the vulva. Both of my hands were used to cup the placenta by twisting the placenta until the whole placenta and its'

membranes were completely delivered at 6:27pm after which the placenta was placed into receiver. Quick examination of the placenta to rule out missing lobes was done. The fundus was gently massaged to expel blood clot. The client was taught on how to massage the uterus. Madame Mavis was then cleaned up and the cervix was examined, vagina and perineum was also examined for lacerations and tears but they were intact. The total blood loss was 150 milliliters. Client was cleaned and a new perineal pad was applied to the vulva to absorb any lochia and client was made comfortable in bed. She was then asked to urinate when she had the urge to prevent bleeding and also help the uterus to contract. Continuous breastfeeding was also ensured. She was again congratulated for her effort and co-operation and also for a successful nine months' journey.

3.5 EXAMINATION OF THE PLACENTA AND MEMBRANES

Inspection of the placenta and membranes was done in order to ensure that all lobes are intact. There was one big vein and two arteries in the cord. The cord was centrally situated. The placenta was held by the cord, allowing the membranes to hang. A thorough examination was done. The placenta was placed on a flat surface, on inspection; sterile gauze was used to wipe the tip of the cord and checked. A hand was inserted into the hole which the fetus was delivered. The amnion was peeled from the chorion. The fetal surface was intact with no abnormality. On the maternal surface, the lobes were intact and the edges forming a uniform circle which meant there was no missing lobe. The placenta was discarded into a receptacle provided. The instruments and equipment's used were soaked in 0.5% chlorine solution. Gloved hands were also dipped in 0.5% chlorine solution before discarding the glove. After 10 minutes, instruments were removed with utility gloves, washed in soapy water and rinsed in clean water then, air dried and packed for sterilization. The client was informed about the findings and necessary documentations were made.

3.6 MANAGEMENT OF FOURTH STAGE

The fourth stage of labour is a period of six hours of vigilant observation of mother and her baby following the third stage. During this period client and her baby were monitored and was encouraged to void, the fundus was rubbed for contraction and blood clot was expelled out. There was no active bleeding.

BABY

Prevention of diseases

Chloramphenicol eye drops was instilled on the baby's eye as prophylaxis for any eye infection. The baby was covered to provide warmth to prevent heat loss, vitamin K 1.0milligram was given intramuscularly on the thigh to prevent bleeding. Hands were washed and cord was dressed with methylated spirit and cotton. The baby was put to breast. She was further asked to report when she observes any bleeding, discharge and redness of the cord. Hands were washed with soap and water and dried with a clean towel.

Her immediate post-delivery vital signs and symphysio fundal height was measured as;

Examination of the new born

The procedure (examination of the newborn) was explained to client. Baby's weight was 2.9 kilograms. Measurements of the baby were done and the head circumference 34 centimeters, chest circumference 31centimeters, length of the baby was 48centimeters. Baby's vital signs were checked and recorded as follows;

Temperature	36.6 degree Celsius,
Apex heartbeat	142 beats per minute
Respiration	40 cycles per minute

Examination gloves were worn and the baby was examined in the presence of the mother in a clean, warm environment, where nearby windows were closed. Baby was put on a covered flat surface and only the part to be examined was exposed. The general condition of baby was checked to be normal. The colour was pink, chest was moving normally and the baby was active. A detailed head to toe examination was carried out to detect any abnormality.

The head/face: The head and scalp were normal with no caput succedaneum, bulging or sunken fontanels. The eyes were examined for the presence of eye balls, for jaundice, discharge and redness but no abnormality was found.

Nose: The nose was inspected for size and shape and examined for deviated septum but the septum was normal. The nostrils were inspected for patency and discharges and the mucosa for color and polyps. No abnormality was detected.

Mouth: The mouth was examined by pressing the angle of the jaw which opened the mouth and the tongue, gum and palate were inspected and there was also no false tooth noticed. There was no cleft palate or cleft lip, or tongue thigh.

Ears: The ears were inspected, the upper notch of the pinnae was at the same level with the canthus of the eye. External auditory meatus was patent and the cartilage in the pinnae was checked for it softness. The shape and size was also noted and no abnormality was detected.

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

Chest and abdomen: The chest was examined, the respiratory movement was regular and the respiratory rate was 40cpm. The space between the nipples was noted and the nipples were in alignment. The abdomen was round with no bleeding from the umbilical cord. The cord was examined and there was one vein and two arteries.

Upper extremity: Hands and arms were inspected for symmetry, movement and paralysis, and the palm for the number of palmer creases. Shape and color of nail beds were inspected for reflexes (grasping, Moro) and they were normal. Hands were again examined for clubbing, extra or missing digits nail growth and webbing and no abnormality was detected.

Genitalia and anus: The genital area was examined. The scrotum was palpated to notice decent of the testes and the penis inspected for the urethra meatus were without any abnormality and the anus was patent.

Lower extremity: The length and movement of the limbs were also noted. The digits

Were counted to be normal and separate to exclude webbing. The feet were examined for any

disability such as talipes equinovarus. The lower limbs were also examined for congenital dislocation of the hip but no abnormality was detected.

Spine: The spine was also examined with baby lying in prone position. The back was palpated for swelling, dimpling, hairy patches to exclude spinal bifida.

The baby was weighed and the weight was 2.9kg, head circumference was 34centimeters, length 48centimeters.Vitamin K 1milligram was given to baby intramuscularly to prevent bleeding. In all, there was no abnormality detected. The baby was classified as normal and routine care of the baby initiated. Gloves were removed and disposed aseptically before washing hands with soap under running water and dried with clean dry towel. The baby's skin was smeared with baby oil and wrapped. All findings were reported and recorded.

MOTHER

Her vital signs were checked every 15 minutes for the first two hours, then 30 minutes for the third hour and hourly for the fourth, fifth and sixth hour's post-delivery. Madam Mavis's vital signs were checked and recorded as follows;

Her vital signs were checked as follows

Temperature	-	36.3°C
Pulse	-	84beats per minute
Respiration	-	18 cycles per minute
Blood pressure	-	100/60 ml of mercury

The soiled linen and pad were changed and new ones were applied. She was taught how to massage her own fundus.

Warm milo with bread was served to restore her energy. Fixing of baby to breast was demonstrated to her and she perfectly fixed the baby to breast. Madam Mavis was encouraged to have a bath in order to make her comfortable, she was also encouraged to pass urine frequently and also take plenty of fluid. A fresh clean pad was kept at the perineum after bathing.

All the labour notes were recorded onto the partograph.

3.7 SUMMARY OF LABOUR

Date of delivery	9th November 2021
Time of delivery	6:20pm
Type of delivery	Spontaneous Vaginal Delivery
Estimated blood loss	150mls

DURATION OF LABOUR

1st stage	7 hours
2nd stage	20 minutes
3rd stage	7 minutes
Total	7 hours 27 minutes

DURATION OF LABOUR

CONDITION OF MOTHER AND BABY

MOTHER

Temperature	36.4 degree Celsius
Pulse	85 beats per minute
Respiration	20 cycles per minute
Blood pressure	100/67 millimeters of mercury
Symphysio fundal height	17 centimeters
Odour of lochia	Non- offensive
Lochia	Red in color
Perineum	Intact

BABY

Sex	Male
Birth weight	2.9kg
Apgar score at 1st minute	8/10
Apgar score at 5th minute	9/10
Full length	48cm
Head circumference	34cm
Meconium	passed
Urine	passed

Abnormality	None detected
General condition	Satisfactory

Uterus well contracted and mother's condition was satisfactory.

CONDITION OF PLACENTA AND MEMBRANES

Lobes and membrane	Complete and healthy
Maternal surface	Normal
Fetal surface	Normal
Blood vessels	2 Arteries, 1 vein
Cord situation	Central

3.8 CARE PLAN DURING LABOUR

PROBLEMS IDENTIFIED

On the 9th November, Client complained of:

1. fatigue
2. anxiousness
3. backache.
4. lower abdominal pain
5. nausea and vomiting

SHORT TERM OBJECTIVES

1. Madam Mavis will be relieved of fatigue within 6 hours
2. Client will be relieved of anxiety within 3hours.
3. Client will be relieved of backache within five hours.
4. Client will be relieved of lower abdominal pains within 5 hours
5. Client will be relieved from nausea and vomiting within 2 hours

LONG TERM OBJECTIVES

Madam Mavis will go through all the stages of labour successfully without complications.

TABLE 1: CARE PLAN DURING LABOUR

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES/ OUTCOME CRITERIA	NURSING ODERS	NURSING INTERVENTION	EVALUATION	DATE/TIME	SIGN
10/12/21 At 10:00am	Fatigue related to advance state of pregnancy	Madame Mavis will be relieved of fatigue within 6hours as evidence by client verbalizing that she was relieved of fatigue.	1.Reassure client of available management to relieve the fatigue. 2. Encourage client not to scream during contraction. 3. Support client to perform deep breathing exercise during contraction. 4. Educate her on all the four stages of labour. 5. Advise client to relax in between contractions. 6. Advise her to take enough fluids such as malt.	1. Client was reassured of wellbeing. 2. She was informed about the progress of labour. 3. Emotional and physical support was given throughout labour. 4. She was educated on all the four stages of labour. 5. She was advice to relax in between contractions. 6. She was advised to take in enough fluids such as malt	Goal achieved as midwife reported that client said she was relieved of tiredness	10/12/21 At 4:00pm	MAG

TABLE 2: CARE PLAN DURING LABOUR

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES/ OTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTIONS	DATE/ TIME	EVALUATION	SIGN
09/11/21 At 3:05pm	Alteration in body comfort(backache) related to relaxation of the pelvic ligament and pressure on the sacral nerves	Client relieved of backache within 24 hours as evidenced by the client verbalizing pain relieved.	1.Reassure client that she will be relieved from back pains in no time. 2. Provide a quiet environment. 3.Support clients back with pillows. 4. Provide diversional therapy. 5 Asked client to assume a comfortable position. 6 Perform a sacral massage.	1 Client was reassured of being relieved from back pains 2 A quiet environment was provided. 2 Client back was supported with pillows 3 Diversional therapy was provided. 4 Client was asked to assume a comfortable position 5 A sacral massage was performed	10/11/21 At 3:05pm	Goal fully met as evidence by client verbalization	MAG

TABLE 2: CARE PLAN DURING LABOUR

DATE/ TIME	NURSING DIGNOSIS	OBJECTIVES/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
09/11/21 At 12:05am	Emotional disturbance (anxiety) related to unknown outcome of labour	Client will be relieved of anxiety within 3 hours as evidenced by client verbalizing that, she is no more anxious and the midwife visualizing	1.Reassure Madam Comfort 2.Explain all the procedures to be carried out. 3.Counsel her on the possible outcome of labour. 4.Encourage client to ask question and answer her tactfully in simple term. 5.. Introduce other clients who have gone through labour and delivery successfully to her 6.Encourage her to have some rest	1.MadamComfortwas reassured. 2.Every procedure was explained to her. 3.Madam Mavis was counselled on the possible outcome of labour. 4.Client was encouraged to ask questions and was answered simply. 5.Client was introduced to other women who had gone through labour and delivery. 6. Client was encouraged to have some rest	09/11/21 At 3:05am	Goal fully met Madam Mavis no more fears the outcome of labour.	MAG

TABLE 4: CARE PLAN DURING LABOUR

DATE/ TIME	NURSING DIAGNOSES	NURSING OBJECTIVES/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTIONS	DATE/ TIME	EVALUATIONON	SIGN
09/11/21 At 3:05pm	Lower abdominal pain related to physiology of labour	Client will be relieved of lower abdominal pains within 5 hours as evidenced by the client verbalizing that she is coping with the pains and the midwife visualizing it.	1. Reassure client and explain the physiology behind her condition. 2. Give sacral massage to help relieve client pains. 3 Assist client to assume comfortable position 4. Engage client in a diversion therapy 5. Educate her on deep breathing exercise.	1. Madam Mavis was reassured and physiology behind her condition was explained to her. 2. Sacral massage was done by the midwife to relieve pains. 3. Client adopted the left lateral position. 4. Client was asked to watch television and her attention was diverted from the labour. 5. Client was educated on deep breathing exercise.	09/11/21 At 8:05pm	Madam Mavis was able cope with after pain. Goal met.	MAG

TABLE 3: LABOUR CARE PLAN

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE / TIME	EVALUATION	SIGN
09/11/21 At 4:50pm	Vomiting related to hormonal fluctuations in labour	Client's vomiting will be relieved from nausea and vomiting within two hours and cope with it throughout labour as evidence by 1. Client verbalizing.	1. Reassure client 2. Remove away all nauseated items from client. 3. Assess the hydration level of the client. 4. Assist client to rinse her mouth after vomiting. 5. Encourage client to eat light and dry foods	1. Client was reassured that vomiting will stop after labour. 2. Nauseated items were moved away from client 3. Client hydrated level was assessed throughout labour. 4. Client rinsed her mouth after vomiting. 5. Client ate light and dry food like porridge and biscuit.	09/11/21 At 6:50pm	Goal fully met as evidenced by client verbalizing that she is no more vomiting.	MAG

CHAPTER FOUR

PUEPERIUM

4.0 INTRODUCTION

Pueperium is a period of six weeks which begins as soon as the placenta and its membranes are expelled from the uterus and control of bleeding. During this period, a number of physiological and psychological changes occur. This chapter entails the day of delivery, subsequent care of mother and baby during puerperium at the health facility and in the house after discharge, till the six weeks' postnatal visit as well as care plan for problem identified and intervention.

4.1 DAY OF DELIVERY

On 9th November, 2021 Madam Mavis and her baby were observed closely for 30 minutes before they were transferred into a warm and comfortable bed in the lying-in with baby still on skin to skin with mother. All observations and examinations done were recorded in the fourth stage notes. Both mother and baby were kept warm. She was encouraged to put the baby to the breast to promote bonding between them and also stimulate uterine contractions to aid involution of the uterus. She was also advised to empty her bladder frequently to help in fast involution of the uterus.

An opportunity was taken to educate her on exclusive breastfeeding for the first six months, emptying of one breast before the other and the need to feed the baby frequently at least 8 to 12 times a day, as well as how to fix the baby to breast. She was also educated to keep the baby warm to prevent hypothermia, and advised to change the baby's soiled napkins and diapers frequently to prevent nappy rash and to make the baby comfortable. She was encouraged to wash her hands under running water with soap after visiting the lavatory, changing her perineal pad, removing the baby's soiled napkins and also before and after touching the baby. It was explained to her the need to change her perineal pad frequently.

Her vital signs were recorded as follows:

Temperature - 36.4 degree Celsius

Pulse - 85 beat per minute

Respiration - 22 cycle per minute

Blood pressure - 100/65 millimeter of mercury

The vital signs were checked every 15 minutes for two hours and thirty minutes for one hour,1 hour for 3 hours and was then checked for every 4 hours. The Symphysio fundal height was measured to be 17centimeters. Lochia was also inspected and it was red (rubra) in colour and small in amount with no bad odour. The baby was examined from head to toe and no abnormality was detected. The client's relatives were asked to excuse mother and baby so that they could have some rest. Client complained of lower abdominal pains. Physiology of after pain was explained to her, tablet paracetamol was served with good effect. Warm compresses were applied to the lower abdomen. Client was advised to urinate frequently since full bladder could alter uterine contractions and bring about postpartum hemorrhage. She was also encouraged to try and walk about in order to aid in drainage of lochia. Again, she was advised to change her sanitary pad frequently since she was at risk of infection. She was educated on the importance of hand washing before and after changing of her sanitary pad.

Madam Mavis was encouraged to eat good nourishing and balanced diet, adequate intake of fluids, more fruits and roughages to enhance bowel movement and to help repair all worn out tissues. She was again encouraged to rest and sleep and exercise especially the abdominal and pelvic floor exercises. Madam Mavis's mother in-law was advised to assist her in the care of the baby and also the household chores. She was then informed of possible discharge the following day.

SUBSEQUENT CARE OF THE BABY

After 6 hours Madam Mavis was informed about the need for baby bath and general examination of the baby and she responded positively. The baby was bathed with warm water. Head to toe examination was done. Cord was dressed with methylated spirit and cotton technique and the cord was checked for bleeding and no abnormality was detected. The baby passed meconium and urine which indicated that urethra and anus were patent. The baby was dressed nicely, wrapped in a warm dry cot sheet to maintain body temperature, and was placed beside her mother to breastfeed. The mother was advised not to place cow dung and other items on the cord with the exception of methylated spirit that will be given to her. She was encouraged to practice exclusive breastfeeding.

BABY'S FIRST BATH

REQUIREMENT

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

All windows and doors were closed, fans switched off and the lights switched on to make the room warm. Procedure was explained to Madam Mavis and was thanked for accepting. After gathering all items, the hot and cold water were mixed and temperature was tested with the elbow. Plastic apron was then worn, hands were washed with soap and under running water and dried with a clean towel. Sterile gloves were worn and the baby was positioned on a

protected flat surface, he was undressed and covered with the towel leaving the face. The general condition was observed and baby had a pink skin colour covered with vernix caseosa. Baby's eyes were cleaned with cotton wool swab soaked in clean water from the inner canthus out and then the face was cleaned with damp face towel and dried. The baby's neck was supported with the hand, the ears were plugged with the thumb and middle finger to prevent water from entering the ears. The hair was washed with soap and sponge in a circular manner, rinsed, dried and covered with a clean cap.

The baby was placed back on the working surface and exposed arms and front of the trunk was washed to the feet paying attention to the skin folds then turned to the back and with one arm supported the chest and the back, it was washed down to the feet paying attention to the skin folds. Baby's body was immersed in a bath of warmed water, with the head supported above the water and the body rinsed thoroughly. The baby was then placed on a cleaned cot sheet and a small cleaned dried towel was used to dry the body paying attention to the skin folds. Baby oil was applied on the skin and baby was dressed leaving the umbilical cord exposed for dressing and the hair combed neatly. Gloved hands were dipped into 0.5 percent chlorine solution and was removed and discarded, hands were washed and dried with clean towel. Mother was encouraged to observe bathing and the dressing of the cord so that, she could do same when they are being discharged home.

Cord dressing

The cord was dressed by wrapping the baby in a towel to keep him warm. Mother was asked to protect him on the table. The tray containing six dry cotton wool swabs in a gallipot containing antiseptic solution which was methylated spirit and a receiver for the used swabs was already set. Hands were thoroughly washed again with soap and under running water and dried in a clean towel. Sterile gloves were worn and the cord was exposed. The cord was inspected for bleeding but there was none. The tip of the cord was held with one swab in the

non-dominant hand. The base of the cord was cleaned with another cotton wool swab and was discarded. The whole cord was cleaned using five of the cotton wool swabs from the base upwards. One cotton wool swap was used to clean the anterior part, two (one each) for the lateral sides and another one was also used to clean the posterior part of the cord. The tip of the cord was dried with the swab that was used to hold it. The cord was left expose to air dry.

Baby was dressed nicely, wrapped and given to mother to breastfeed. The waste materials were discarded according to infection prevention protocol. Gloves were removed and discarded. Hands were washed with soap and water before handling the baby. Observation was made and the findings were communicated to the mother.

At 7:00am mother and baby were seen to find out how they were faring, they were in a good condition. They were both examined and their vitals were checked since they were not going to be discharged.

MOTHER

Temperature	36.2 degree Celsius,
Pulse	80 beats per minute,
Respiration	22 cycles per minute,
Blood pressure	110/67 millimeters of mercury.

Observations were made on the baby and findings communicated to mother as;

Temperature	36.5 degree Celsius,
Pulse	40 cycles per minute,
Respiration	134 beats per minute,
Weight	2.9 kilogram.

4.3 FIRST DAY POST DELIVERY (DAY OF DISCHARGE)

The first day post-delivery for Madam Mavis was on the 10th November, 2021. Mother and baby were seen in the lying-in ward at 7:00am and 4:30pm to find out how they were faring. Greetings were exchange and Madam Mavis was asked about how she and the baby were doing and she said they are both doing well, except that she had after pain while breastfeeding the baby. She was reassured and educated on the physiology of after pain that, it is a normal physiology that is the suckling triggers the release of oxytocin which causes uterine contraction and therefore causes after pain. She was given paracetamol 1gram to reduce the pain. She also complained of sleeplessness and she was reassured and encouraged to attend to the baby wherever needed in the night and have enough sleep when the baby is asleep. She was educated to change baby's diapers when wet.

Her vital signs were checked and recorded as follows;

Temperature	-	36.5°C
Pulse	-	78beats per minute
Respiration	-	20 cycles per minute
Blood pressure	-	100/68 ml of mercury

Permission was sought for head to toe examination to be performed on her and was granted, and there was no abnormality detected. The breast was lactating well and the uterus was well contracted when palpated and measured with symphysio fundal height of 16cm. On inspection, perinea pad, the lochia flow was small and the colour was red (rubra) with no odour. She was encouraged to ambulate to promote effective circulation and drainage of lochia. She was served with tom brown and a loaf of bread as breakfast. Baby was also examined with permission from the mother after hand washing was done with soap under running water and dried with clean towel. A thorough head to toe examination was performed on the baby again but no abnormality was detected. Mother was educated not to apply hot compress on baby's head with

the intention of closing the fontanels but the fontanels closes naturally. The cord was inspected for bleeding, odour and discharge but there was none. The baby was top and tailed with the cord dressed with methylated spirit. The baby was dressed nicely and wrapped in clean warm sheet. The baby's weight was 2.8kilogram. The baby's vital signs were checked and recorded as follows and finding communicated to mother.

Temperature	36.3 degree Celsius
Pulse	130 beats per minute
Respiration	42 cycles per minute
Weight -	2.8kg

Education on how to position herself when breastfeeding and how to put the baby to breast was demonstrated to Madam Mavis. She was asked to give return demonstration and she did that perfectly. She was educated on the intake of nutritious diet which would help boost her immunity and repair worn out tissues. She was educated to maintain good personal hygiene and also advised and encouraged to sleep whenever the baby is sleeping so that she can also have rest. She was educated on the minor disorder in puerperium such as breast engorgement and skin rashes on the baby and told to report to the clinic whenever she sees them. The baby was given polio vaccine of 2 drops at the back of the tongue orally to protect the baby against polio myelitis and Bacilli Calmette Guerine (BCG) immunization 0.05 millimeters intra dermal on the right upper arm for protection against tuberculosis. She was educated not to apply anything at the site of injection or massage it. She was told that there could be a tissue reaction over the area, a scar formation later indicating that the child had been immunized against tuberculosis effectively. Before discharge, client was told to continue with the baby's immunization schedule at the clinic and to register the baby at the birth and death unit. Prescribed drugs were served as follows; Tablet folic acid 5mg once daily for 7days.

Tablet multivitamin 200mg once daily for 7 days

Table ferrous sulphate200mg once times daily for 7 days.

Table paracetamol 1g tds for 7days

The dosage and the time for taking the drugs were explained to her. Madam Mavis was also advised on the importance of keeping the baby's cord clean and dry and to avoid the application of unprescribed medications on it. Madam Mavis was also educated on the importance of reporting to hospital anytime she notices danger signs like bleeding from the cord, offensive odour from the cord or high temperature of the baby. Madam Mavis was encouraged to sleep under treated mosquito net together with the baby to prevent malaria. She was also educated to breastfeed the baby on demand and also encouraged her husband and mother in-law to help her take care of the baby. Client was encouraged to have adequate rest and sleep. She was encouraged to sleep under treated mosquito net together with the baby to prevent malaria. Her belongings were packed, and her health insurance card was used to settle her bills. She was escorted to the road side to pick a taxi with her items. The information about visits to her house to continue the care up to the seventh day as well as the date for the one week visit (17th November, 2021) was reinforced and at 9:30am client was bind welfare.

4.4 FIRST POSTNATAL HOME VISIT (1ST DAY POST DELIVERY)

On 10th November 2021, a visit was paid to Madam Mavis at 4:30pm. She welcomed me and offered me a seat and water after exchanging greetings. She was asked about their health and she responded that they were doing well.

On arrival, Madam Mavis had already gathered her requirements needed to bath the baby; the baby was bathed by me in the presence of the mother and cord dressed and while bathing the baby, she passed meconium and urine. Permission was sought to examine the mother and the baby from head to toe. There were no observed abnormalities, the breast was lactating well. On inspection of the perineal pad, the flow of lochia was rubra . Upon palpation, the uterus was

well contracted; the symphysio-fundal height measured 16cm. She was asked of her elimination pattern and there was no problem but complained of inadequate sleep during the night as a result of night breast feeding. She was reassured and encouraged to sleep during the day when the baby sleeps. Client was also encouraged to do passive exercise to help effective drainage of the lochia.

Her vital signs were checked and recorded as follows;

Temperature	-	36.5°C
Pulse	-	78beats per minute
Respiration	-	20 cycles per minute
Blood pressure	-	100/68 ml of mercury

Permission was again sought to inspect the perineal pad. Lochia was moderate and the colour was red with no odour. Her general condition was good and gave no complains. She was educated on how to care for the perineum and to change perineal pad to prevent ascending infection to the uterus. Client was encouraged to urinate frequently to prevent post-partum haemorrhage and urinary tract infections. The baby was also examined and no abnormalities were detected. Baby had passed meconium once and urinated twice as reported by the mother. The baby was bathed with warm water and cord dressed with cotton soaked with methylated which was given to them at the hospital and no bleeding was noticed. Baby was nicely dressed, wrapped and put to breast.

The baby's vital signs were checked and recorded as

Temperature	-	36.3°C
Apex beat	-	138 beat per minute
Respiration	-	40cycle per minute
Weight	-	2.8kg

The baby was wrapped nicely and given to the mother to breastfeed. She was educated on keeping the cord clean and dry. Permission was granted to my request of leaving the house.

4.5 SECOND DAY HOME VISIT

On the 11th November, 2021 the second visit was made to Madam Mavis's house at 7:00am and 4:30pm and Madam Mavis said her condition had improved. Baby was also doing well. Permission was sought from Madam Mavis to inspect her perineal pad and perineal area was clean and the Lochia was red, not offensive and the flow was small. Head to toe examination was also done and everything was normal. The breast was heavy and colostrum was flowing freely.

Client's assessment was done and recorded as follows;

Observation	Morning	Evening
Temperature	36.3	36.4
Pulse	72bpm	82bpm
Respiration	18cpm	20cm
Blood pressure	100/60mmHg	100/70mmHg
Lochia	Rubra	Rubra
Fundal height	15cm	15cm
Condition of the uterus	Contracted	Contracted
Breast	Lactating	Lactating

The baby was topped and tailed paying attention to the skin folds and general examination was carried out on the baby from head to toe and no abnormality was revealed. The cord was neatly dressed and it was dry with no sign of infection. The baby passed stools and urine according to Madam Mavis. Baby was assessed and recorded as follows;

BABY

Observation	Morning	Evening
Temperature	36.5	36.2
Heart rate	137bpm	138bpm

Respiration	40cpm	41cpm
Skin colour	Pink	Pink
Cord	Clean and dry	Clean and dry
Suckling	Yes	Yes
Weight	2.7kg	
Stool colour	Yellowish	Yellowish

Nothing abnormal was detected during the examination. Madam Mavis complained of interrupted sleeping pattern because baby normally cries at night. She was reassured and encouraged to breastfeed baby well before bed time and to change her napkin when soiled. She was reminded on exclusive breastfeeding and on demand, maintenance of personal hygiene, eating of fruits and highly nutritious diet and warm saline sitz bath on each visit. Family members were encouraged to help in activities so that mother could have adequate sleep. Permission was sought to leave and Madam Mavis said she was very grateful and appreciated the care that was given to them.

4.6 THIRD DAY POSTNATAL HOME

On the 12th November, 2021, the third home visit was made to Madam Mavis's house at 7:30am and 4:45pm. Mother and baby were doing well. Permission was sought to inspect Madam Mavis's perineal pad and the lochia was rubra (red) without offensive odour. Head to toe examination was also done and everything was normal. She was assessed and recorded as follows;

MOTHER 3^{rd} day (12^{th} November, 2021)

Observation	Morning	Evening
Temperature	37.0 degrees celsius	36.3 degrees celsius
Pulse	78bpm	72bpm
Respiration	18cpm	19cpm

Blood pressure	99/70mmHg	100/70mmHg
Lochia	rubra	Serosa
Fundal height	14cm	14cm
Condition of uterus	Contracted	Contracted
Breast	Lactating	Lactating

Nothing abnormal was detected during the examination. Baby was topped and tailed paying attention to the skin folds and general examination was carried out and no abnormality was present. The cord was neatly dressed and was dry without bad odour. The baby also passed stools and urine. Baby's vital signs and other observations were taken and recorded as follows;

BABY

Observation	Morning	Evening
Temperature	36.3	36.4
Apex heart beat	120bpm	130bpm
Respiration	44cpm	40cpm
Skin colour	pink	Pink
Condition of cord	Clean and dry	Clean and dry
Suckling	Yes	Yes
Weight	2.7 kg	
Stool colour	Dark yellow	Dark yellow

Observation was made that baby had skin and Madame Mavis also made a complained of fatigue. Education was given to her to dress baby according to the weather. She was also

encouraged to visit the toilet immediately when she had the urge. On the fatigue, she was encouraged to have enough rest and sleep and not stress herself. She was advised to breastfeed the baby frequently and on demand, dress the baby with light clothing and change napkins frequently when they are soiled to prevent the risk of developing sore buttocks, tepid sponge the baby to reduce fever. She was also advised to bring the baby outside the room for fresh air. Findings were communicated to her and was thanked for her cooperation and also reminded of my next visit. My request to leave the house was granted and we exchanged good bye.

4.7 FOURTH DAY POSTNATAL HOME VISIT

Madam Mavis and her baby were visited again on 13th November, 2021 at 7:00am to continue with the postnatal care. Madame Mavis and her baby were physically examined and nothing abnormal was detected. Lochia was serosa (pink) on inspection. Head to toe examination was done and everything was normal. Her vital signs and other assessments were check and recorded as follows;

MOTHER

Observation	4th day (13th November, 2021)
Temperature	36.2 degree celsius
Pulse	80bpm
Respiration	20cpm
Blood pressure	100/60mmHg
Lochia	Serosa
Fundal height	13cm
Condition of the uterus	Contracted
Breast	Lactating

Baby had been topped and tailed by client's mother in my presence so the general examination

was carried out. No abnormality was found. The cord was neatly dressed and no abnormality was detected. The baby passed stools and urine. Baby's vital signs and other observations were recorded as follows;

BABY

Observation	4th day (13th November, 2021)	EVENING
Temperature	37.0	36.8
Heart rate	122bpm	130bpm
Respiration	44cpm	42cpm
Skin Colour	Pink	pink
Cord bleeding	No	No
Cord condition	Shrinking and almost off	
Weight	2.8kg	
Suckling	Yes	Yes

client was also educated on environmental hygiene, by draining gutters and also weed around their houses to prevent mosquitoes. Client was educated on care of baby including hand washing before and after attending to the baby to prevent infections to the baby. Permission was sought to leave, I thanked her and she was informed about my next visit to the house.

4.8 FIFTH DAY POSTNATAL HOME VISIT

Madam Mavis and her family were visited on 14th November 2021 and their general conditions were fair. These had been a bit improvement in the hygiene of their environment. They were congratulated and greased their elbow to make more advances. Client had already bathed and the baby was bathed and dressed by the client under my supervision. Baby was examined from head to toe with no abnormality detected and cord had fallen off, but the stump not completely

healed. On the 5th day, the baby passed brownish yellow stools. Mother was examined from head to toe with no abnormality detected. Her perineal pad was inspected and the lochia was serosa (pinkish) in colour. The symphysio fundal height measured 12cm. Their baseline assessment were recorded as

MOTHER

Observation	5th day (14th November, 2021)
Temperature	36.0
Pulse	80bpm
Respiration	20cpm
Blood pressure	110/60mmHg
Lochia	Serosa
Fundal height	12cm
Condition of the uterus	Contracted
Breast	Lactating

BABY

Observation	5th day (14th November, 2021)
Temperature	36.2
Heart rate	136bpm
Respiration	41cpm
Skin colour	Pink
Cord bleeding	No
Cord condition	off
Weight	2.9kg
Suckling	Yes

Stool colour	Yellow

She was congratulated on the weight improvement of the baby and she was encouraged to frequently breastfeed the baby and continue taking the drugs given to her on discharge alongside nutritious foods. My profound gratitude was expressed and also reminded them of my next visit.

4.9 SIXTH DAY POSNATAL HOME VISIT

The sixth postnatal home visit was made on 15th November, 2021 at 7:00 am. Greetings were exchanged with client and her family and a seat was offered in Client's room. Mother and baby were both in a healthy condition and client said the baby's crying had minimized. She complained of backache. She was reassured and advised to adopt a good posture when breastfeeding the baby. Inspection of the lochia was done and the colour was serosa without any bad odour. After the head to toe examination, no abnormality was detected. Client was assessed and recorded as follows;

MOTHER

Observation	6th day (15th November, 2021)
Temperature	36.6 degree celsius
Pulse	78bpm
Respiration	21cpm
Blood pressure	100/60mmHg
Lochia	Serosa
Fundal height	11cm
Condition of the uterus	Contracted
Breast	Lactating

Baby was given a warm bath paying attention to the skin folds, head to toe examination was done and no abnormality was found on the baby. During the examination, it was realized that the cord stump was clean. The stump was then dressed and the area was cleaned and kept dry.

Baby's assessments were recorded as follows:

BABY

Observations	6th day (15th November, 2021)
Temperature	36.8
Apex heart rate	134bpm
Respiration	40cpm
Skin colour	Pink
Cord bleeding	No
Cord condition	Healing
Weight	3.0kg
Suckling	Yes
Stool colour	Light brown

Education was given to her on the importance of ensuring good personal hygiene and the need to feed the baby continuously on demand. Madame Mavis was thanked for her co-operation. She was reminded and told that the next day was going to be the last home visit.

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

At 7:00am in the morning of 16th November, 2021, client and family were visited again. A warmly greetings were exchanged and the health of client and her family was inquired and positive response was given. Permission was then sought and routine examination was carried out on both mother and baby from head to toe and no abnormality was detected in any of them. Mother was examined from head to toe and no abnormality was detected and was lactating well. Her perinea pad was inspected and lochia was serosa (pinkish) in colour. The symphysio fundal height was 10cm. The vital signs were checked and recorded as;

BABY

Observations	7th day (16th November, 2021)
Temperature	36.6degree celsius

Apex heart rate	136bpm
Respiration	46cpm
Skin colour	Pink
Cord condition	Healing
Cord bleeding	No
Weight	3.1kg
Suckling	Yes
Stool colour	Light brown

MOTHER

Observations	7th day (16th November, 2021)
Temperature	36.7 degree Celsius
Pulse	80bpm
Respiration	20cpm
Blood pressure	99/60mmHg
Lochia	Serosa
Fundal height	10cm
Condition of the uterus	Contracted
Breast	Lactating

Client alleged that she has been relieved of all the complaints that she made earlier. She was encouraged to continue adhering to all the advices and encouragement given to her especially on nutrition, exercise, rest and sleep and maintaining good personal and environmental health. Madam Mavis was also advised to take good care of the baby and breastfeed exclusively. Client was also reminded to register the baby at the birth and death unit and complete all the

immunization schedules. Madam Mavis was informed about my departure, which made her sad. Last greetings and farewell messages were exchanged.

4.11 FIRST POSTNATAL VISIT TO THE CLINIC

At 8:00am Madam Mavis and her baby reported at the hospital on 17th November, 2021. She was accompanied by her sister. Mother and baby looked healthy and cheerful. They were welcomed to the postnatal unit and a seat was offered to them to listen to a health talk on immunization against the preventable childhood disease, exclusive breastfeeding and family planning. After the talk, client and baby were taken to the examination room to be examined. With permission from mother, baby was undressed and wrapped in a clean cot sheet and was put on a flat surface in the presence of the mother. Procedure was explained to Madam Mavis and hands were washed and dried. The fontanelles and sutures were examined for any bulging fontanelles or widening sutures but there were none. The eyes, nose and ears were examined and no abnormality was detected. Baby had no rushes or bruises on the skin. The abdomen was soft, not distended, and the umbilical cord was completely healed. The extremities and the back were also examined and there was no abnormality. Baby's weight was 3.2kg and her vital signs checked and recorded were as follows:

Temperature - 36.5°C

Pulse rate - 142bpm

Respiratory rate - 40cpm

Symphysio-Fundal height was palpable.

All findings were communicated to mother and recorded. Mother claimed the baby has good bowel movement and breastfeeds well. Midstream urine was taken to check for protein and sugar in urine but they were both negative. Hemoglobin level was 11.9g/dl when the Hb was checked. Madam Mavis was also examined and before that, she was asked to empty her bladder after the procedure has been explained to her. She was assisted onto the examination couch and

privacy was provided. Hands were washed and dried. On inspection, client's hair was clean and nicely plaited. Madam Mavis's conjunctiva and sclera were pink without any pallor. The nose, mouth and ears were clean without any discharges. The breast was heavy, soft and lactating well with healthy nipples. The upper and lower extremities were without edema and her back was normal. On abdominal palpation, the uterus was palpable. The lochia was serosa. She was helped out of the examination couch after the examination. Findings were communicated to her and documented.

Client was advised to maintain good personal and environmental hygiene in the care of herself and the baby. Madam Mavis was again educated on her nutrition and was asked to eat foods that are rich in proteins and vitamins, she was encouraged to continue with exercise and have adequate rest and sleep. Client said the backache has subsided. The baby was taken to the birth registry where she was registered and certificate was given to the mother. Client was reminded of the six weeks' postnatal visits to the clinic. Gratitude was expressed to Madam Mavis and the entire family for their support and co-operation throughout the writing of the care study. Madam Mavis was handed over to the midwife in charge for the continuity of care. Madam Mavis vital signs were checked and recorded as follows:

Temperature	36.6^{o}C
Pulse	86bpm
Respiration	20cpm
Blood Pressure	108/68mmHg
Symphysio-Fundal height	was palpable.

4.12 SECOND POSTNATAL VISIT

According to the midwife in-charge client reported on 21th December, 2021, a general head to toe examination was carried out on her which revealed that the uterus was not palpable. All reproductive organs had returned to their non-pregnant state and the breast was soft and lactating well. A speculum examination revealed no bruises on the cervix but showed a slit like appearance of the cervical os. She had not resumed menstruation when asked. Madam Mavis was educated on the need to start a family planning method to prevent unplanned pregnancy.

On examination of the baby, the posterior fontanelle was closed and the cord was completely healed. Her vital signs and weight was checked and recorded as follows;

Temperature	-	36.5 degree Celsius
Pulse	-	80 beats per minute
Respiration	-	20cycle per minute
Blood pressure	-	100/60 millimeters of mercury
Weight		65 kilogram

Madam Mavis urine was checked for protein and sugar and it was negative for both, and the haemoglobin was 12.8g/dl. The baby was examined from head to toe and no abnormality was found. The following immunizations were given to the baby;

Vaccine	Dosage	Route of Administration
Polio 1	2 drops	Oral
Rotavirus	2 drops	Oral
Penta	0.5 millimeters	intramuscularly on right thigh

Baby's vital signs and other observations were checked and recorded as:

Temperature - 36.2degree Celsius

Respiration - 24 cycle per minute

Pulse - 142beats per minute

Weight - 5.6 kilogram

Mother was encouraged to practice exclusive breastfeeding for 6 months to inhibit ovulation and prevent infection or any disease to the baby. Client was congratulated for taking good care of the baby as seen in the baby's weight gain. She also expressed her gratitude for all the support offered to them. She was also taken to the family planning unit and the child welfare clinic for immunization and continuity of care.

TERMINATION OF CARE

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

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

4.13 CARE PLAN DURING PUERPERIUM

PROBLEM IDENTIFIED

1. After pain on 10th november,2021
2. Insomnia on 17th November,2021
3. Fatigue 17th November, 2021
4. Backache on 17th November,2021
5. Skin rashes 12th November,2021

SHORT TERM OBJECTIVES

1. Client will be relieved of after pain within 48 hours.
2. Client will be able to sleep at least 6 hours within 24 hours.
3. Client will be relieved of fatigue within 24 hours.
4. Client will be relieved of backache within 48 hours
5. Baby's skin rashes will subside within 48 hours.

LONG TERM OBJECTIVES

Client and baby will go through puerperium successfully without any complication

TABLE 1: PUERPERIUM CARE PLAN

DATE/ TIME	NURSING DIAGNOSIS	OBJECTIVES/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTIONS	DATE/ TIME	EVALUATION	SIGN
17/11/21 At 8:00am	After pain related to involution of the uterus.	Client will be relieved of after pain within 48 hours as evidenced by 1.Client verbalizing that the pain has resolve.	1 Reassure client that pain is temporal. 2. Explain the physiology of after pain to client. 3. Encourage client to assume any comfortable position. 4. Encourage client to empty her bladder frequently. 5. Serve her with prescribed analgesics	1. Client was reassured that pain is temporal. 2. The physiology of pain was explained to client. 3. Client assumed a prone position with pillow under her lower abdomen 4. Client emptied her bladder frequently 5. Client was served with analgesic (paracetamol 1g)	19/11/21 At 8:00am.	Goal fully met as client verbalized that she has been relieved of after pain.	MAG

TABLE 2: PUEPERIUM CARE PLAN

DATE/ TIME	NURSING DIAGNOSIS	OBJECTIVES/ OUTCOME CRITIREA	NURSING ORDERS	NURSING INTERVENTIONS	DATE/ TIME	EVALUATION	SIGN
17/11/21 At 8:00am	Insomnia related to baby crying and feeding at night.	Client will be able to sleep at least 6 hours within 24 hours as evidenced by 1. Client verbalizing that she can sleep.	1. Reassure client 2. Encourage client to feed baby on demand. 3. Encourage client to change baby's soiled napkins. 4. Encourage client to practice kangaroo mother care. 5. Encourage client relative to help her in taking care of the baby.	1. Client was reassured. 2. Client feed baby on demand. 3. Client changed baby's soiled napkins. 4. Client was encouraged to practice kangaroo mother care. 5. Client relatives helped in taking care of the baby.	20/11/21 At 8: 00am	Goal fully met as client verbalized that she's able to sleep.	MAG

TABLE 3: PUEPERIUM CARE PLAN

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
17/11/21 At 8:00am	Fatigue related to stress from labour.	Client will be relieved of fatigue within 24 hours as evidence by 1. Client verbalizing that she is relieved of fatigue.	1. Reassure mother that fatigue will subside 2. Encourage client to sleep in the day when the baby is asleep. 3. Encourage client's support person to assist in the caring of the baby. 4. Encourage client to have rest. 5. Encourage client to assume a comfortable position.	1. Mother was reassured that she will regain her energy. 2. Client slept in the day when the baby was asleep. 3. Client's support person assisted in the caring of the baby. 4. Client was encouraged to have rest. 5. Client assumed a left lateral position.	18/11/21 At 8:00am	Goal fully met as evidenced by client verbalized that she has been relieved from fatigue.	MAG

TABLE 4: PUEPERIUM CARE PLAN

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES/ OUTCOME CRITIREA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
17/11/21 At 8:00am	Backache related to physiological changes during pregnancy	Client will be relieved of backache within 48 hours as evidenced by 1. Client verbalizing she is relieved of backache	1. Reassure client that backache will be relieved 2.Explain the physiology of backache to the client. 3. Encourage client to sleep on a firm mattress and to assume proper positioning 4. Give body massage 5. Educate client against lifting of heavy loads	1. Client was reassured that backache will be relieved 2. Physiology of backache was explained to client. 3. Client was encouraged to sleep on a firm mattress. 4. Body massage was given. 5. Client was educated on the need to avoid lifting of heavy loads.	19/11/21 At 8:00am	Goal fully met as evidence by client verbalized that she has been relieved of backache.	MAG

TABLE 5: PUEPERIUM CARE PALN

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES	NURSING ORDERS	NURSING INTERVENTIONS	DATE/ TIME	EVALUATION	SIGN
17/11/21 At 8:00am	Skin rashes on baby related to skin reaction to soap	Baby's skin rashes will subside within 48 hours as evidenced by 1. Mother verbalizing that rash has reduced. 2. Midwife observing that baby skin rashes has reduced	1. Reassure mother that rashes will resolved 2. Educate mother to dress baby with cotton cloths. 3. Educate client not to scratch the rashes. 4. Educate mother to use antiseptic solution (salvon) when bathing baby	1. Client was reassured 2. Mother dressed baby with cotton cloths. 3. Client was educated not to scratch the rashes as it would cause more pain and infection. 4. Mother was educated to use antiseptic solution when bathing baby.	19/11/21 At 8:00am	Goal fully met as evidenced by 1.Mother verbalized that rashes has resolved. 2.Midwife observing that baby has no skin rashes.	MAG

SUMMARY AND CONCLUSION

Madam Mavis, aged 30 years Gravida 3 Para2 all alive and a native of Kwame kyem kurom in the Ashanti Region was met when she was 37+2 weeks pregnant on 28th of October, 2021 during Seven weeks' practical experience at the St Edward Hospital Adugyama. She was chosen as a client to help her go through pregnancy, labour and puerperium successfully without any complications after she consented. She was chosen for the care study so that she could be helped to manage her problem. She has a successful pregnancy and went into labour and had spontaneous vaginal delivery to a live male infant on 09th November, 2021 with no complications like postpartum hemorrhage. She was visited at home during puerperium and cared for in her own environment. Client was managed throughout pregnancy, labour and puerperium. Undertaking this family centered maternity care study, since what was being taught both knowledge and skills was put into practice. Scientific approach was used in the nursing care to collect data from her. Identification of her needs was rendered by providing a comprehensive care. Hope to apply this knowledge in caring for all expectant mothers and their families. This has also help in recognizing the importance of family support, participation and choice in rendering total care to the client.

APPENDIX 1

PHAMACOLOGY OF DRUGS

NAME OF DRUG	CLASSIFICATION	DOSAGE	ROUTE	USE AND ACTION	ACTUAL EFFECT	SIDE EFFECT	SIDE EFFECT EXPERIENCED
Table multivitamin	Vitamin preparation	200milligrams 3 times daily	Orally	Increased appetite Helps in formation of red blood cells	Increased appetite	Gastrointestinal disturbance	None
Tablet fersolate	Iron supplement	200milligrams once daily	Orally	Helps in the formation of red blood cells	Increased haemoglobin level	Gastrointestinal disturbance Dark stools	Dark stool
Tablet folic acid	Vitamin preparation	5milligrams once daily	Orally	Formation and functioning of red blood cells	Increased haemoglobin level	Nausea and vomiting	None
Tablet paracetamol	Analgesic and antipyretic	1gram 3 times daily	Orally	Relieve pain Reduce body temperature	Pain relieved	Prolong use may cause liver damage	None
Tablet sulfadoxinepyrimethamine	Antimalaria and prophylaxis	3 tablet start in 16-20 weeks 3 tablet in 22-24 weeks 3 tablet in 26-36weeks	Or ally	Treatment and prevention of malaria	Malaria prevented	Itching Nausea Dizziness Headache	None

Injection oxytocin	Oxytocic drug	10 units	Intra-muscular	Stimulate uterine contraction	Stimulated uterine contraction	Vomiting Increase blood pressure	None
Injection vitamin k	Group K vitamin	1 unit	Intra-muscular	Production of prothrombin Aids in clotting	No bleeding	Risk of haemolysis in people with G6PD deficiency	None
Capsule vitamin A	Group A vitamin supplement	200,000 units for 2 days	Orally	Growth, development and proper sight	Normal vision and healthy skin	Vomiting	None
Polio vaccine	Antigen	2 drops	Orally	Production of antibodies	Poliomylitis was prevented	Diarrhoea and fever may occur	None

APPENDIX 2

COMPLETE DIAGNOSTIC INVESTIGATION

DATE	SPECIMEN	INVESTIGATION	NORMAL VALUES	FINDINGS	REMARKS
15/7/2021	Blood	Haemoglobin level	11.0-16g/dl	17.5 gms	
			Negative		
	Urine	Protein	Negative	Negative	Normal
	Urine	Sugar		Negative	Normal
16/8/2021	Blood	Voluntary counselling and testing on PMTCT	None reactive	None reactive	Normal
16/9/2021	Blood	Haemoglobin level	11.5g/dl – 16g/dl	11.8g/dl	Abnormal
	Blood	Sickling	Negative	Negative	Normal
	Blood	Grouping	A, B, AB and O	A	Normal
	Blood	Rhesus	Positive, negative	Positive	Normal
	Urine	Protien	Negative	Negative	Normal
	Urine	Sugar	Negative	Negative	Normal

21/10/2021	Urine Urine	Protein Sugar	Negative Negative	Negative Negative	Normal Normal
	Urine Urine	Protein Sugar	Negative Negative	Negative Negative	Normal
28/10/2021	Blood Urine Urine Urine Urine	Haemoglobin level Colour Odour Protein Sugar	 Amber Slight aromatic Negative Negative	12.1 g/dl Amber Slight aromatic Negative Negative	Normal Normal Normal Normal Normal
4/11/2021	Urine Urine	Protein Sugar	Negative Negative	Negative Negative	Normal Normal
14/7/2014	Urine Urine	Protein Sugar	Negative Negative	Negative Negative	Normal Normal
4/8/2014	Blood Urine Urine	Haemoglobin level Protein Suger	 Negative Negative	11.7 g/dl Negative negative	 Normal Normal

APPENDIX 3

ANTENATAL RECORD

DATE	TEMPERATURE	BLOOD PRESSURE	URINE FOR PROTEIN AND SUGAR	PRESENTATION	FOETAL HEART RATE	GESTATIONAL AGE	FUND-AL HEIGHT	DESCENT	WEIGHT	HAEMOGLOBIN LEVEL	COMPLAINS	TREATMENTAND ADVICE
15/7/2021	36.3◦C	94/65	Negative	Cephalic	Positive	22+2	19	5/5	62	17.5g/dl	Whitish discharge from the vagina and loss of appetite	Tablet mltivitamin, folic acid, fersolate, ,TD3 Clotrimazole vaginal passareis to apply Education was given on perineal hygiene
16/8 /2021	36.1◦C	90/53	Negative	-	Positive	26+6	24	5/5	62	-	Loss of appetite	Tablet multivitamin, folic acid, fersolate, tablet mebendazole 500mg start
16/09/2021	36.5◦C	97/64	Negative	Cephalic	Positive	31+2	30	5/5	63	11.8 g/dl	Well	Tablet multivitamin, folic acid, fersolate.

21/10/2021	37.3◦C	96/60	Negative	Cephalic	Positive	36+2	33	5/5	64	-	Well	Tablet multivitamin, folic acid, fersolate,
28/10/2021	36.4◦C	106/71	Negative	Cephalic	Positive	3+2	34	5/5	65	-	Well	Tablet multivitamin, folic acid, Fersolate 1st SP given
4/11/2021	36.4◦C	99/63	Negative	Cephalic	Positive	38+2	34	5/5	66	12.1 g/dl	Well	Tablet multivitamin, folic acid, fersolate advised on perineal care

TT – tetanol toxoid

SP – sulfadoxinepyrimethamin

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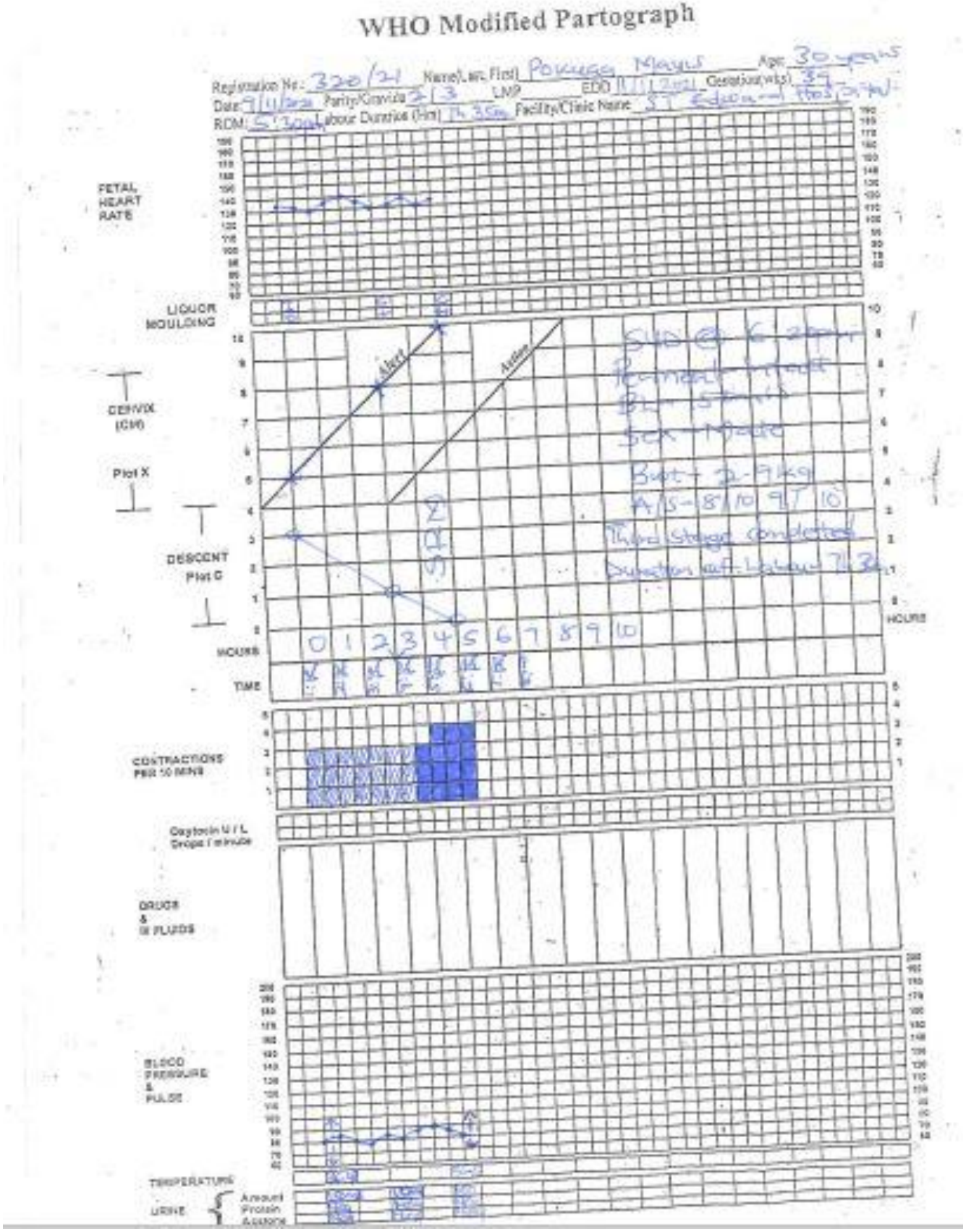

WHO Modified Partograph
FETAL HEART RATE
LIQUOR MOULDING
CERVIX (CM)
Plot X
DESCENT
Plot O
HOURS
TIME
Alert
Action
CONTRACTIONS PER 10 MINS
Oxytocin U / L
Drops / minute
DRUGS & IV FLUIDS
BLOOD PRESSURE & PULSE
TEMPERATURE
URINE
Amount
Protein
Acetone

LABOR NOTES

Client G3P2 with 39weeks Gestation reported to the unit with complains of LAP. O/E SFH-36cm, FHR-144bpm, Descent 3/5th, contraction 3:10: 20 seconds, Lie - longitudinal, Presentation cephalic. V/E done cx @5cm dilated. @ 6:20pm client delivered a live male child at said time. Baby cleaned and BWT-2.9kg, AIS-8/10, 9/10, HC-34cm, FL-48cm. Essential baby care done. 10unit Oxytocin given Im. third stage completed. uterus massage to expell blood clots.

Please circle or write responses.

DELIVERY

DATE: 9/11/2021 TIME: 6:20pm METHOD: (Spontaneous) / Vacuum Extraction / C/S / Other

PERINEUM: (Intact) / Episiotomy / Laceration

ANESTHESIA: (None) / Local / General

THIRD STAGE: Delivered by Control Cord traction

Active Management: (Yes) / No Medication: Time 6:21pm Type/Dose 10 unit

PLACENTA: TIME: 6:22pm Complete / Incomplete

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

BABY

Weight: 2.9kg

Sex: (Male) / Female

Baby Position: (Vertex) / Breech / Other

APGAR

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

COMPLICATIONS OF MOTHER / BABY: None / Other: None.

FOURTH STAGE MONITORING

Frequency	Time	B/P.	Pulse	Fundus	Bleeding	Bladder
Every 15 minutes first 2 hours	6:20pm	100/61mmHg	85 bpm	17cm	[illegible] amount	100mls
	6:35pm	101/67mmHg	84 bpm	17cm.	Small amount	–
	6:45	104/71mmHg	86 bpm	Contracted	Small amount	–
	7:05pm	98/69mmHg	90 bpm	Contracted	Small amount	Emptied
	7:15pm	[illegible]	91 bpm	Contracted	Small amount	–
	7:45pm	100/[illegible]mmHg	89 bpm	Contracted	Small amount	–
	8:15pm	101/69mmHg	92 bpm	Contracted	Small amount	Emptied
	8:45pm	[illegible]	90 bpm	Contracted	Small amount	–
Every 30 minutes For 1 hour	9:15pm	[illegible]	86 bpm	Contracted	Small amount	–
	9:45pm	96/[illegible]mmHg	86 bpm	Contracted	Small amount	Emptied

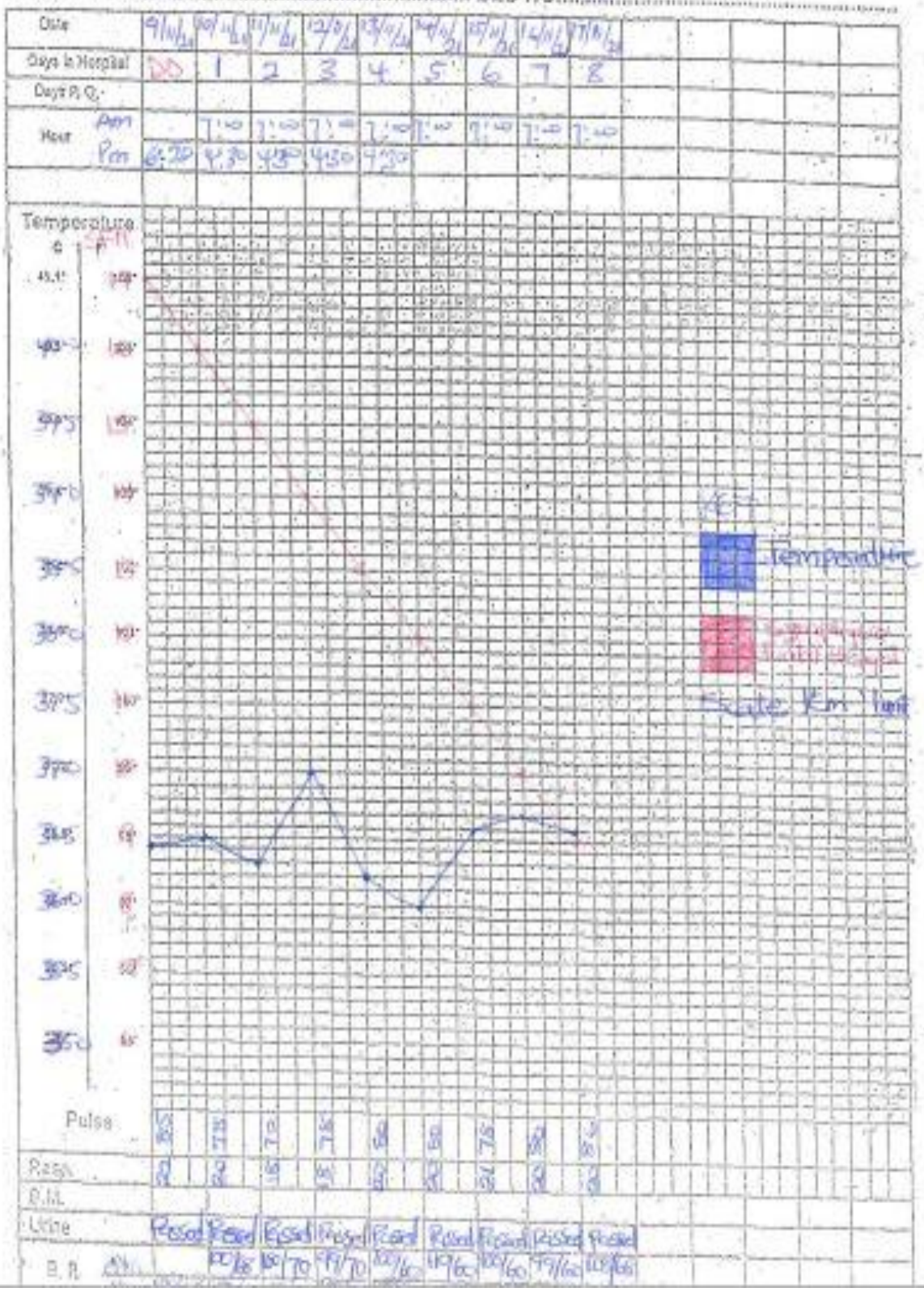
Birth Attendant: Mavis Adu Gyamfi (student) Love (SRI) Date 9/11/21

MATERNITY CHART

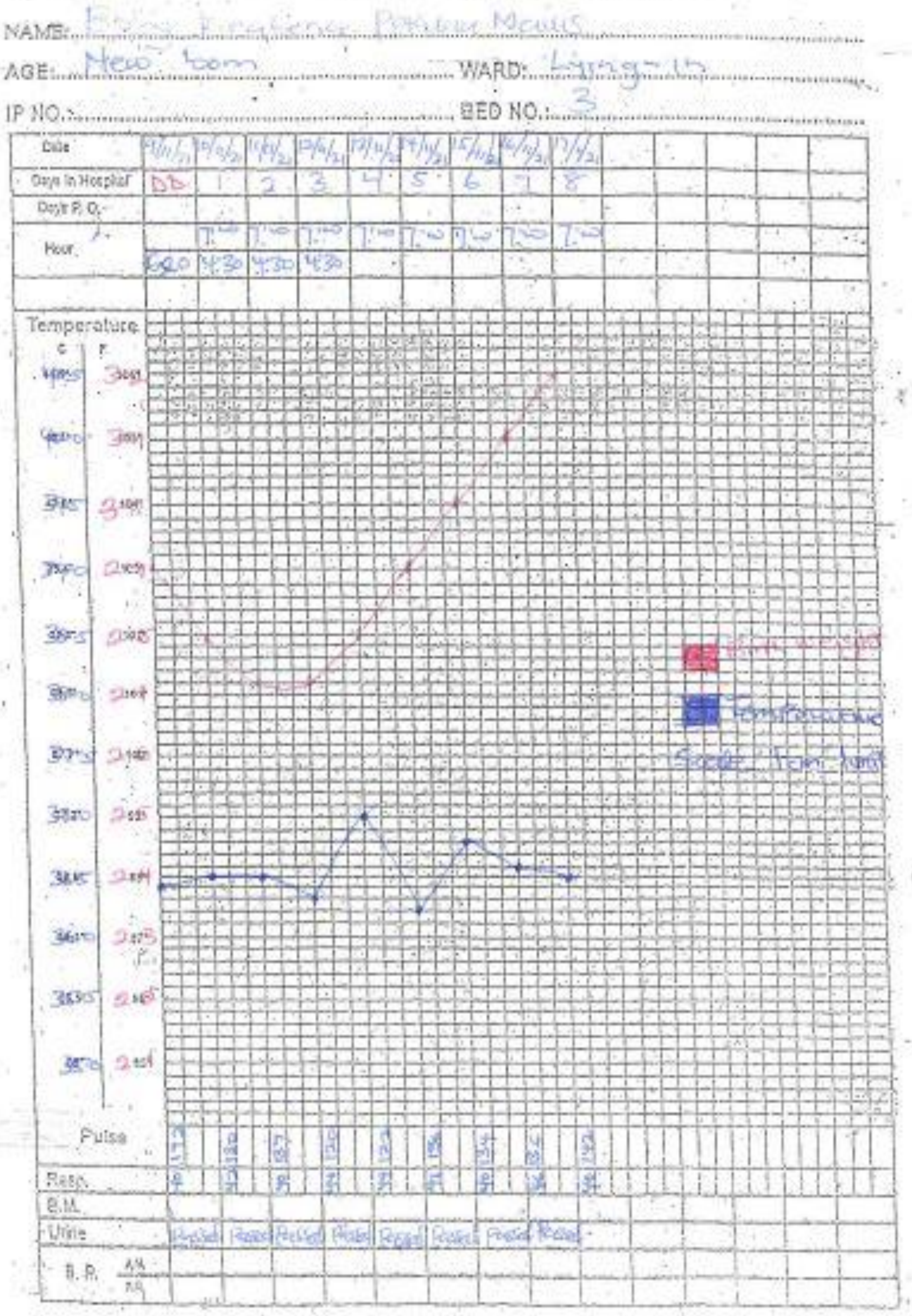
NAME: Madam Pokuaa Moses

AGE: 30 years WARD: Lying - in

IP NO.: BED NO.: 3



TEMPERATURE CHART



NEWBORN EXAMINATION FORM

Name: Baby Kwalena Pokuaa Mfuls Date of Assessment: 10/11/21 Time: ....
Date of Birth: 9/11/21 Time of Birth: 6:20 Sex: ☑M ☐F Age at time of Assessment(days/hrs): 1 day
Gestational Age: 39 wks Mode of Delivery: ☑Vaginal ☐Assisted Vaginal ☐C-Section
APGAR: 1 min 8/10 5min 9/10 Birth Weight: ☐2.9 Kg☐ Length 48 Cm Head Circumference 34 Cm
Temperature at time of Assessment: ...... °C Urine passed: Yes No Meconium passed: Yes No
Name of Assessor (Midwife/Doctor): ....

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

2. Activity Movement
☑ Spontaneous symmetric movement
☐ Reduce d/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*
☐ Jaundice*

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. Fontanelle
☑ 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 ....

14. Neck
☑ Normal
☐ Swelling
☐ Webbed
☐ Other ....

15. Clavicle
☑ Normal
☐ Swelling/Fracture

16. Chest
☑ Normal (shape/movement)
☐ Abnormal ....

17. Heart rate
Rate ....
☑ Normal (100-160)
☐ <100*
☐ >160*

18. Femoral pulse
☐ Present
☐ Not palpable*

19. Abdomen
☑ Normal
☐ Distended*
☐ Scaphoid*
☐ Abdominal defect*
☐ Masses ....
☐ Other ....

20. Black (spine)
☑ Normal
☐ Abnormal Swelling
☐ Hairy patch over spine
☐ Abnormal dimple
☐ Abnormal curvature

21. Limbs
☑ Normal
☐ Abnormal ....

22. Genitalia Male Genitalia
☑ Normal
☐ Undescended tests
☐ Abnormal meatus
☐ Hernia
☐ Other ....

23. Female Genitalia
☐ Normal
☐ Fistula (meconium/urine through abnormal opening in vagina)*
☐ Large clitoris
☐ Other ....

24. Anus
☑ Patent
☐ Imperforate*

25. Resuscitation provided
☐ None
☐ Suction/Stimulation
☐ Bag and mask
☐ Endotracheal Tube
☐ Ventilator/CPAP

26. Service provided
☑ Vitamin K given
☑ Eye care provided
☑ Cord care provided
☑ Breastfeeding initiated
☑ Breastfeeding established
☑ BCG ☑ Polio Immunization
☑ Antibiotics in mother
☐ Antenatal corticosteroids

*May indicate severe disease that requires urgent referral
Diagnoses (if known): Spontaneous vaginal delivery
Classification: (Overall assessment) [ ] Normal [ ] Baby with a Problem [ ] Danger Sign/<1800g [ ] severe Jaundice
Plan: [ ] Routine Care [ ] Problem Continue supportive in-patient care [ ] Urgent Referral Advanced

NEWBORN EXAMINATION FORM

Name: Baby Rebecca Mantis Date of Assessment: ____ Time: ____

Date of Birth: 31/8/21 Time of Birth: 6:30 Sex: ☑M ☐F Age at time of Assessment(days/hrs): ____

Gestational Age: 37 wks Mode of Delivery: ☑Vaginal ☐Assisted Vaginal ☐C-Section

APGAR: 1 min 8/10 ☐ 5min 9/10 ☐ Birth Weight: ☐2.9 Kg ☐ Length: 48 Cm Head Circumference: 34 Cm

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

Name of Assessor (Midwife/Doctor): ____

1.Respiration

Rate: ____
- ☐ Rate < 30 b/m*
- ☐ Rate > 60 b/m*
- ☐ 30-60 b/m
- ☐ Retractions*
- ☐ Grunting*
- ☐ Stridor*

2.Activity Movement
- ☑ Spontaneous symmetric movement
- ☐ Reduce d/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*
- ☐ Jaundice*

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

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

7. Suck
- ☑ Good
- ☐ Weak
- ☐ Absent*

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

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

10. Fontanelle
- ☑ 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 ____

14. Neck
- ☑ Normal
- ☐ Swelling
- ☐ Webbed
- ☐ Other: ____

15. Clavicle
- ☑ Normal
- ☐ Swelling/Fracture

16. Chest
- ☑ Normal (shape/movement)
- ☐ Abnormal ____

17. Heart rate

Rate: ____
- ☑ Normal (100-160)
- ☐ <100*
- ☐ >160*

18. Femoral pulse
- ☐ Present
- ☐ Not palpable*

19. Abdomen
- ☑ Normal
- ☐ Distended*
- ☐ Scaphoid*
- ☐ Abdominal defect*
- ☐ Masses: ____
- ☐ Other: ____

20. Back (spine)
- ☑ Normal
- ☐ Abnormal Swelling*
- ☐ Hairy patch over spine
- ☐ Abnormal dimple
- ☐ Abnormal curvature

21. Limbs
- ☑ Normal
- ☐ Abnormal ____

22. Genitalia Male Genitalia
- ☑ Normal
- ☐ Undescended testis
- ☐ Abnormal meatus
- ☐ Hernia
- ☐ Other: ____

23. Female Genitalia
- ☐ Normal
- ☐ Fistula (meconium/urine through abnormal opening in vagina)*
- ☐ Large clitoris
- ☐ Other: ____

24. Anus
- ☑ Patent
- ☐ Imperforate*

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

26. Service provided
- ☑ Vitamin K given
- ☑ Eye care provided
- ☑ Cord care provided
- ☑ Breastfeeding initiated
- ☐ Breastfeeding established
- ☐ BCG ☐ Polio Immunization
- ☐ Antibiotics in mother
- ☐ Antenatal corticosteroids

*May indicate severe disease that requires urgent referral

Diagnoses (if known): Spontaneous Vaginal delivery

Classification: (Overall assessment) [ ] Normal [ ] Baby with a Problem [ ] Danger Sign/<1800g [ ] severe Jaundice

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

NEW BORN CHART

me: Baby Kwabena [redacted] No: — Birth Weight: 2.9kg

x: Male Mother's No: 220/21 Length: 45cm

ture of Delivery: Spontaneous Vagina Delivery Diagnosis: Term baby

te of Birth: 09/11/2021 Time: 6:20pm Date of Discharge: 10/11/2021

Date	9/11/21		10/11/21		11/11/21		12/11/21		13/11/21		14/11/21		15/11/21		16/11/21		17/11/21					
o. of Days	DO		1		2		3		4		5		6		7		8					
Weight Kg	2.9		2.8		2.7		2.7		2.8		2.9		3.0		3.1		3.2					
	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM
emperature		36.4	36.5	36.3	36.5	36.2	36.3	36.4	37.0	36.8	36.2		36.8		36.6		36.5					
Stools		Passed	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		Passed					
Remarks	Head NECK Trunk Limbs Genitalus — No Abnormality detected																					

SIGNATORIES

CANDIDATE NAME

NAME: MAVIS GYAMFI ADU

SIGNATURE: .....

DATE: 10/10/2022

THE MIDWIFE IN- CHARGE

NAME: MRS. ENERSTINA APPIAH

SIGNATURE: .....

DATE: 11/10/2022

SUPERVISOR

NAME: MS. MONICA BOAKYE

SIGNATURE: .....

DATE: 11/10/2022

THE PRINCIPAL

NAME: MONICA NKRUMAH

SIGNATURE: .....

DATE: 11/10/2022

STAMP: .....