HOLY FAMILY NURSING AND MIDWIFERY TRAINING COLLEGE, BEREKUM.

A CLIENT AND FAMILY CENTERED CARE STUDY

ON

MADAM AGYEMANG ATTA YAA JUNIOR

BY

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A CLENT/FAMILY CENTERED MATERNITY CARE STUDY SUBMITTED TO THE NURISING AND MIDWIFERY COUNCIL OF GHANA INPARTIAL FULFILMENT TOWARDS THE AWARDS OF THE LICENSE TO PRATICE AS A PROFESSIONAL MIDWIFE (DIPLOMA).

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TABLE OF CONTENTS

PREFACE

Good health is an essential aspect of life which everyone dreams of having, including expectant mothers who want to have healthy babies. The family centered maternity care study is a comprehensive nursing and midwifery care rendered to a pregnant woman, her family and the community members at large to enable her to go through pregnancy, labour and puerperium safely using complete midwifery measures.

In rendering this type of care, the individual is cared for in all aspects of life including spiritual, social, and psychological as well as her physical wellbeing which are considered within the frame work of the family and the community at large.

The family centered care study is also an academic work which gives the student midwife the opportunity to choose a pregnant woman and nurse her through late pregnancy, labour and puerperium, putting into practice the knowledge and skills she has acquired during her training to care for the client.

The family centered maternity care study is also a requirement of the Nursing and Midwifery council (NMC) as a partial fulfilment of the assessment to become a qualified midwife.

ACKNOWLEDGEMENT

I would like to acknowledge the immense contribution of the following people towards the success of this care study. My profound gratitude goes to the Almighty God for seeing me through this great exercise by providing me wisdom, knowledge and strength.

My sincere gratitude goes to the Principal of the college, Monica Nkrumah for guidance, kindness and patience that she granted to me during this study. I wish to express my sincere gratitude to all the teaching and non- teaching staff of The Holy Family Nursing and Midwifery Training College, Berekum in Bono Region of Ghana for their encouragement. 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 Agyemang Ataa Yaa Junior 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. Abrafi Sophia the midwife in charge at Mim Health Center in the Ahafo 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 parents Mr. and Mrs. Darkwah and my siblings 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 psychological support 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, I am grateful.

INTRODUCTION

The family centered maternity care study consists of the nursing care given to an expectant mother, her family and Community during late pregnancy, labour and early puerperium. This family centered maternity was carried out on Madam Agyemang Ataa Yaa Junior, aged 23 years, gravida 3 para 2 all alive. She was nursed from 38 weeks of gestation throughout pregnancy, labour and puerperium at Mim Health Centre. The study began on the 24th November, 2022 and lasted for 4weeks in which delivery and postnatal care was given to her without any complications to her and the baby.

The care study consists of four chapters. Chapter one deals with personal history, medical history, surgical history, past obstetrical history, present obstetrical history, family history and home environment (physical and psychosocial). The chapter two entails antenatal care and problems identified during the care and their interventions. The chapter three also consist of management of labour and identified problems with their interventions. The chapter four also involves management of the puerperium, problems identified and interventions.

LITERATURE REVIEW

Perry (2014) defines pregnancy as a period of physical and psychological preparation for birth and parenthood. Prenatal visit ideally begins soon after the first missed menstrual period to ensure good health of the expectant mother and the fetus. He also said that, normal pregnancy lasts for 40 weeks or 280days and health care providers refer to early, middle and late pregnancy as trimesters. The first trimester lasts from week 1 to week 13, the second from week 14 through to week 26 and the third from week 27 through to week 40. A pregnancy is considered to be term if advances to 38 and 40 weeks.

According to Marshall J. And RaynorM. (2014), pregnancy is a period of having an embryo in the uterus. During the period of pregnancy, there are some anatomical and physiological changes that affect every system in the body due to the alteration of pregnancy hormones like progesterone, estrogen, and human chorionic gonadotropin. Some of these physiological changes are nausea and vomiting, constipation, heartburns, headache, leg cramps, frequent micturition, anorexia and waist pains which occurs as minor disorders of pregnancy. The hormonal effects also cause a change in the woman's emotional state. This helps in the development of the fetus, prepares the expectant mother for labour as well as puerperium. The book further explains that every pregnancy is a unique experience for every woman. It is therefore important for the midwife to have knowledge and understanding of the minor disorders of pregnancy in order to educate the woman to understand the physiology of that disorder and how to manage it. Some Signs of pregnancy include; Possible (presumptive) signs: Early breast changes (unreliable in multigravida), amenorrhea, morning sickness, bladder irritability, quickening. Probable signs: Presence of human chorionic gonadotrophin (HCG) in urine and blood, softened isthmus (Hegar's sign), bluing of vagina (Chadwick's sign), pulsation of fornices (Osiander's sign), uterine growth, changes in skin pigmentation, Braxton Hicks contractions, ballottement of fetus. Positive signs: visualization of gestational sac by transvaginal and transabdominal ultrasound, auscultation fetal heart sound by transvaginal and transabdominal ultrasound, fetal heart sounds by Doppler and fetal stethoscope. Fetal movement both palpable and visible, visualization of fetus by ultrasound scans. The aim of antenatal care is to monitor the progress of pregnancy to 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. This process requires engagement by the Midwife, as outlined below; Developing a trusting relationship with

the woman. Providing a holistic approach to the woman's care that meets her individual need. Making a comprehensive assessment of the woman's health and social status, accessing all relevant sources of information. Promoting an awareness of the public health issues for the woman and her family. Exchanging information with the woman and her family, enabling them to make informed choices about pregnancy and birth. Being an advocate for the woman and her family during her pregnancy, supporting her right to choose care appropriate for her own needs and those of her family. Identifying potential risk factors and taking the appropriate measures to minimize them. Timely sharing of information with relevant agencies and professionals. Accurate, contemporaneous documentation of assessments, plans, care and evaluation. Recognizing complication of pregnancy and appropriately referring women to the obstetric team or relevant professionals or other organizations. Preparing the woman and family to meet the challenges of labour and birth and facilitating the development of a birth plan. Facilitating the woman to make an informed choice about methods of infant feeding and giving appropriate and sensitive advice to support her decision. Offering parenthood education with a planned programme or on an individual basis.

According to Konar H. (2015), pregnancy last between nine and ten months. The duration of pregnancy is divided in three trimesters

First trimester 1st week- 12th weeks

Second trimester 13th week- 28th weeks

Third trimester 29th week – 40th weeks

Fraser & Cooper (2013) Pregnancy is the period when the fertilized ovum embeds in the maternal uterus until it is born thus the state of conception till the delivery of the foetus. The

normal duration is 280 days or 40weeks counting from the last day of the menstrual period, she further states that uterine blood flow in pregnancy supplies the myometrium, endometrium and placenta, with the latter receiving nearly 90% of the total uterine blood flow near term. It further states that, the anatomical and physiological adaptations occurring throughout pregnancy affect virtually every body system. The timing and intensity of the changes vary between systems but all are designed to support foetal growth and development and prepare the mother for birth and motherhood. The uterus protects and supports the foetus, placenta and amniotic fluid. For most of the 40 weeks of pregnancy, the uterus expands to accommodate the growing foetus and remains relatively quiescent, yet at the time of labour it is able to contract regularly and forcibly to expel the foetus due to its unique properties of contractility and elasticity. She also says, the vagina also increases vascularity which results in the violet colour characteristic of Chadwick's sign. There is increased volume of vaginal secretions due to high level of oestrogen resulting in thick, white discharge known as leucorrhoea. Larger amount of glycogen is deposited in the vaginal epithelium due to high oestrogen availability. The glycogen is metabolized to lactic acid by the lactobacillus acidophilus, (Doderlein's bacillus), and this leads to increase vaginal acidity.

Ricci, (2016) said that, the client is usually the first person to suspect pregnancy. Her suspicion is often based on the fact that she has missed her period. The amenorrhea occurs because, after implantation of the fertilized ovum, the increase secretion of estrogen and progesterone by the ovary converts the endometrium of the uterus to decidua of pregnancy and menstruation ceases.

He further mentioned that, the morning sickness, continuous enlargement of the breasts, fetal movement, painless contractions, and others are some of the signs and symptoms that occurs at different stages of pregnancy.

Weller (2014) defines pregnancy as being with child, the condition from conception to the expulsion of the fetus. During this period, a lot of physiological and psychological changes take place in the woman. This affects the entire system as a result of hormonal influence, some women suffer minor disorders like vomiting, heart burns, constipation, waist pains, nausea, ptyalism (excessive salivation), food craving and others which most of these changes go away after delivery. Also, if these are not treated early, they can lead to severe complications which could be life threatening, therefore, it is important for the pregnant woman to attend antenatal clinics as soon as she realizes she is pregnant, for supervision, observations, investigations, and examinations for early detection and treatment of any deviation from normal. During this period, the expectant mother needs special education, encouragement and care, in order to cope with these minor disorders. These educations are given at the antenatal clinics by the attending midwife. Antenatal care is a special care to promote a healthy mother and fetus. Focus antenatal is a special care given to a pregnant woman by the attending midwife and an obstetrician, during pregnancy to ensure that, maternal and fetal health are normal. The aim of focus antenatal is to detect early and treat any abnormalities, prevent complications, promote health and educate mothers on complication readiness.

LABOUR

According to Konar (2015), labour is characterized by the presence of regular uterine contractions with cervical effacement and dilatation, descent and expulsion of products of conception. Konar also describes labour as normal if it fulfills the following criteria; spontaneous in onset and at term, with vertex presentation, without undue prolongation, natural termination with no aid and without any complications affecting maternal and/or baby's health. He stated under rest and ambulation; if the membranes are intact, the patient is allowed to walk. The attitude prevents venacaval compression and encourages descent of the head. Ambulation can reduce the duration of labour is monitored electronically of analgesic drug (epidural analgesia) is given, she should be in bed.

He further went on to state that, assessment of progress of labour and partograph recording are also done. Partograph is the tool that allows labour progress to be graphically recorded and visually assessed. They aid in the early detection of abnormal labour progress and are credited by some for decreasing rates of prolonged abnormal, oxytocin use, caesarean sections and intrapartum morbidity/ mortality as compared to usual care. Use of the partograph is initiated during presumed active labour.

Marshall J. & RaynorM. (2014) says immersion in a warm bath or birthing pool can be an effective form of pain relief for laboring women that facilitates increased mobility with no increased incidence of adverse outcome for the woman or fetus. The midwife should invite the woman who is mobile to have a bath or shower whenever she wishes during labour.

Elizabeth (2013) says series of event that takes place in the genital organs in an effort to expel the viable product of conception out of the womb through the vagina into the outer world is

called labour. The added that labour is said to be normal if it fufill the following: Spontaneous in onset and at term

With vertex presentation

Without undue prolongation

Natural termination with minimal and without having any complications affecting the health of the mother and baby. She continues to say that management of labour aims at minimal observation with minimal active intervention. The idea is to maintain the normalcy and detect any deviation from normal at the earliest possible movement.

PUERPERIUM

According to Marshall J. and Raynor M. (2014) puerperium starts immediately after delivery of the placenta and membranes and continues for six weeks. It further states that the overall expectation is that by the end of the sixth weeks after birth all the system in the woman's body will have recovered from the effects of pregnancy and the process of parturition.

He also added that, the average amount of discharge for the first 5-6 days is estimated to be 250mls. Normal duration may extend up to 3 weeks.

Henderson and Redshaw (2013) state that, 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 H. 2015) also defines puerperium as the period following childbirth during which the body tissues, especially the pelvic organs revert back approximately to their pre pregnant state both anatomically and physiologically. He further explained that, lochia is the vaginal discharge for the first fortnight during puerperium. The discharge originates from the uterine body, cervix and vagina. Depending on the variation in the colour of the discharge, it is named as:

Lochia Rubra: consists of blood, shreds of fetal membranes and decidua, vernix caseosa, lanugo and meconium. It is red in color and it last for the first 1-4 days. Lochia Serosa:

consists of less red blood cells but more leukocytes, wound exudate, mucous from the cervix and microorganisms. It lasts for 5-9 days and it is yellowish or pink or pale brownish.

Lochia Alba: contains plenty decidua cells, leukocytes, mucous, cholesteryl crystals, fatty and granular epithelial cells. It lasts for 10-15 days and it is pale white in color.

The American Academy of Pediatrics (2014) stated the essential Care for Every Baby as all babies must be given eye care by instillation of tetracycline/chloramphenicol eye drops/ointment to prevent eye infections and also administering of vitamin k injection to prevent haemorrhagic

disease of the newborn as well as cord dressing.

WHY CLIENT WAS CHOSEN

Madam Agyemang Atta Yaa Junior reported to the antenatal clinic on the 24th November 2022 at Mim Health Centre at 9:30am where she came for her usual antenatal visit. She was 38 weeks pregnant. During the normal antenatal care routine, client complained of difficulty in passing stools. She explained that her previous pregnancy was not like that and she was indeed worried about it. It was observed that client had minimal knowledge on the minor disorders of pregnancy. Client was advised that each and every pregnancy is unique and different and it was a minor disorder of pregnancy which will resolve after delivery. The physiology of constipation was then explained to her. The midwife in-charge was informed about the intention to use Madam Ataa Yaa for the care study which permission was granted. Care study and what it entailed was explained to Madam Ataa Yaa and she readily agreed to be used and promised to give all she could to help throughout the study. She was assured of confidentiality and quality healthcare. Client gave out directions to her house and phone number to help make visits to her house easier

CHAPTER ONE

ASSESEMENT OF CLIENT AND FAMILY

INTRODUCTION

This chapter gives an overview about the client and the family. It comprises social, family, ;medical, surgical, menstrual, client lifestyle, past and presents obstetrical histories.

1.0 SOCIAL HISTORY

Madam Agyemang Ataa Yaa Junior G3p2 all alive was born on 5th December, 1998 and is 24 years of age. She is a native of the Ashanti tribe but resides at Bediako in the Aunafo North district of the Ahafo region. Madam Ataa Yaa is fluent in Twi and English. According to her, she had

her formal education up to junior High School. She is a seamstress and happily married to Mr. Ismael Larbi who had his formal education up junior high school. They have been married for seven years and are blessed with two children; both are boys. The first born is seven years old and the second born is four years old.

The couple, together with their children are Christian by religion and always go to church every Sunday to worship God. According to her, her husband as well as her mother are very supportive during and after her period of pregnancies. Madam Ataa Yaa said her next of kin is her husband who is electrician by profession. She intends to deliver at Mim Health Centre.

1.1 MEDICAL HISTORY

According to Madam Ataa Yaa, she has never suffered from conditions like heart diseases, hypertension, diabetes mellitus, kidney disease, sickle cell disease, and prolong cough . She has no known allergies such as food, drugs, and other substances. She is not on any medication except her routine drugs. She has never been admitted in the hospital before she mentioned that she sometimes experiences minor illness is which treated on Out Patient Department .

1.2 FAMILY HISTORY

Client, according to her is the last born of Mr James Agyemang and Madam Akua Donko. Madam Ataa Yaa has two older siblings; Mr. Samuel Agyemang and Mr. Oppong Jacob. They work as a Teacher and a Trader respectively. According to my client, there is no known history of hypertension, HIV/AIDS, asthma, heart disease, sickle cell disease, mental illness, birth defects

and diabetes mellitus but has a history of multiple pregnancy .Madam Ataa Yaa said any death in their family normally occurs naturally.

1.3 SURGICAL HISTORY

Madam Ataa Yaa said she had never undergone any surgical procedure neither had she ever been involved in any road traffic accident that had affected her pelvis or any of her reproductive organs, which may affect the diameters of the pelvis, making labour difficult. Also, she had never received blood nor has not been transfused before.

1.4 PAST OBSTETRIC HISTORY

PREGNACY

Madam Ataa Yaa gravida 3 para 2 all alive carried all her pregnancies to term without any history of complications such as still birth, abortion or ectopic pregnancy . According to Madam Ataa Yaa, she carried both her pregnancies to term without any ill health like antepartum hemorrhage, pregnancy induced hypertension, anemia and pre-eclampsia. Madam AtaaYaa said she had all her three doses of Sulphadoxine Pyrimethamine (SP) as an intermittent preventive treatment (IPT) against Malaria for each pregnancy. She said she received her first and second doses of tetanol diphtheria immunization during her first pregnancy and her third dose during her second pregnancy.

LABOUR

Madam Ataa Yaa had spontaneous vaginal delivery for both of her babies with no assistance like caesarean section, vacuum extraction, forceps delivery or episiotomy. She gave birth to her first child on 28th march ,2016 and her second child on 11th march,2019. Intervals between her previous

pregnancy is three years . According to her, during her last pregnancy, her labour did not exceed 18 hours and she did not experience any complication like prolonged labour, obstructed labour or cord prolapse. Placenta was delivered completely without any retained products with moderate blood losses in both deliveries. She had an intact perineum following the delivery of her babies. She did not experience any ill health such as post-partum hemorrhage, maternal shock, uterine rupture, amniotic fluid embolism or disseminated intravascular coagulopathy following each delivery. Both babies as well as mother were in good health after delivery and did not encounter any ill health condition after delivery. Her first baby who was a boy weighed 3.5kg and the second baby who is also a boy weighed 3.4kg.

PUERPERIUM

She also did not have any problems during puerperium as such puerperal psychosis, puerperal sepsis or infection. Madam AtaaYaa, according to her, practiced exclusive breastfeeding for both her children and continued for 1year 2months for both children. She gave her children normal diet immediately after weaning them. She resumed menstruation in six months after the delivery of both children. She did not practice any artificial family planning method but rather the natural family planning method which is the calendar method. According to Madam Ataa Yaa, her babies were fully immunized against the various vaccine preventable childhood diseases like tetanus, measles, diphtheria and others. Her mother was around to support her in the household chores and her husband also supported her financially.

1.5 MENSTRUAL HISTORY

According to Madam Ataa Yaa she attained her menarche at the age of fourteen (14) years and has a regular menstrual cycle of twenty-eight days. Client`s menstrual flow is moderate and lasts for seven days with no dysmenorrhea. Madam Ataa Yaa had never experienced any menstrual disorder.

1.6 PRESENT OBSTETRIC HISTORY

As recorded in Madam Ataa Yaa's antenatal card, she first reported to Mim Health Centre on 14th July, 2022 when her gestation was 18 weeks. According to Madam Ataa Yaa, her last menstrual period was on 8th March, 2022 and her expected date was calculated as 15th December, 2022. Her first fetal movement according to Madam Ataa was felt at the 16th weeks. According to Madam Ataa Yaa, in all her pregnancies she craves for unnatural food substances like dust and clay. During

Madam Ataa Yaa's antenatal visit, past and present obstetrical history were taken. Vital signs, physical examination and monitoring revealed the following; Blood pressure 110/70mmHg, Temperature 36.2°C, Pulse 82bpm, Respiration 22cpm, Weight 62kg, Laboratory investigations results; Haemoglobin 11.2g/dl, Rhesus factor; Positive, Sickling; Negative, VRDL; Negative, Blood group O positive, Urine for glucose/protein; Negative, HIV screening; Negative, Blood film for Malaria parasite; No malaria parasite seen, HBsAg; Non-reactive, Glucose 6 phosphate dehydrogenase; No defect. Physical assessments were carried out and no abnormalities such as oedema of the extremities, pallor and varicosities were detected. Abdominal examination was done. On inspection straie gravidarum and linear nigra were presence. From her records, she complained of lower abdominal pains and waist pains, she was encouraged to have adequate rest, sleep and also avoid strenuous work. She was served the following routine drugs.

Tablet Folic Acid - 5mg daily x 30days

Tablet multivitamin - 200mg once daily x 30days

Tablet fersolate - 200mg tds x 30days

She has received her third doses of tetanol diphtheria and also received her monthly Sulphadoxine Pyrimethamine on direct observational therapies as required.

1.7 CLENT LIFESTYLE AND HOBBIES

Madam Ataa Yaa is a woman who sleeps around 9:00pm and wakes up around 5:00am. According to her, when she wakes up in the morning, she and her family pray and thank God. After that, she brushes her teeth, sweeps her room and compound, throw her rubbish away at the dumpsite, which is five minutes' walk away from her house, washes her dishes and also prepare her children for school. Client expressed that she normally prepares breakfast for the family before the children

goes to school. After preparing breakfast, she takes her bath and takes her children to school. Client said she eats three times daily, but ever since she became pregnant she eats on demand. She also said that she prepares supper at 4:00pm and becomes ready for the family to enjoy around 5:40pm. She said they all sit together and take their supper around 5:42pm. The husband normally baths her children and takes his bath after supper. Thereafter he supervises the kids to do their homework. At 8:30pm, she sees to it that her children go to bed. Madam Ataa Yaa said she normally engages herself in a family chat with her family every night on phone as a means of strengthening their family bond. she likes fufu with light soap and rice with beans stew.

CHAPTER TWO

ANTENATAL CARE

2.0 INTRODUCTION

Antenatal care is the specialized care that is given to a pregnant woman from the time that conception is confirmed until the beginning of labour in other to maintain a state of good health of the woman and to improve her chances of delivering a healthy baby at term. This chapter talks about the first contact with client, first and second home visits, her subsequent visits to the clinic, problems identified, care plan drawn for the resolution of problems. Antenatal services are important to prevent and promote health care.

2.1 FIRST INTERACTION WITH CLIENT

On24th November, 2022at 9:30am, client was met at the Mim Health Centre, where client was a regular attendant. Her antenatal booklet was collected and read to note the previous recording. It was realized she was 38 weeks pregnant and gravida 3 para 2 all alive. I introduced myself as a student midwife from Holy family Nursing and Midwifery Training Berekum to use her as a client for the centered maternity care study. The midwife in charge was already

informed about a quest to find a client who met the criteria to be used for the client and family centered maternity care study and the midwife in-charge explained and sought consent from the client to be used for the study, the client was found to have met the criteria. Madam Agyemang Ataa Yaa Junior was assisted through the routine laboratory investigations after vital signs were checked and recorded. Client's weight was 63kilograms. Her vital signs and weight were

checked and recorded as: Temperature 36.2°C, Pulse 82 bpm, Respiration 22 cpm, Blood pressure 110/70mmHg, Body weight 63kg, Haemoglobin 11.5g/dl and HIV screening result negative.

URINE TESTING

After all these procedures, she was asked

to empty her bladder and specimen bottle was given to her to collect mid-stream specimen of urine to test for urine protein and glucose. Protective clothing like apron and gloves were worn. The quantity, colour, odour, smell and present of sediments were checked and the colour was amber. A chemically prepared strip was picked and dipped into the urine sample. The strip was immediately removed and the edge of the strip taped against side of the urine container to prevent spilling of urine onto the clothes. After one (1) minute, the stick was compared with the corresponding colour on the container. There was no change in colour of the strip indicating a negative result when compared closely with the corresponding colour chart on the container. Findings were recorded and discussed with both midwife in-charge and client. Gloves and apron were removed and hands were washed with soap under running water with a clean dry towel. Client's permission was sought to perform physical examination from head to toe and the procedure was explained to her. Bladder was emptied, privacy was ensured and she was helped to undress, assisted to lie on the examination couch and covered with a clean cloth. Hands were washed with soap under running water and dried with clean dry towel. Client was examined from head to toe, under supervision of the midwife in charge.

Head to toe Examination

Head; the head was examined first during the physical examination. Client hair was examined for cleanliness, lice dandruff, ringworms, alopecia, skin infection and any other abnormalities but

none was detected. Madam Agyemang Ataa Yaa Junior was congratulated and praised for keeping her hair clean and advised to keep it up. Client's face was then inspected for edema, rashes and chloasma and nothing abnormal was detected. Her eyes were also inspected for pallor of the conjunctiva; yellowish (jaundice) of the sclera but no abnormality was detected. The ears were also inspected for discharge and alignment with the eyes and nothing abnormal was detected. The mouth was inspected for dryness, cracks, and infection of the lips. The gum and tongue for pallor, sores or lesions and the teeth for decay but no abnormality was detected. She was encouraged to brush her teeth two daily and rinse her mouth after each meal. The neck was palpated for enlarged thyroid gland, distended neck vein and enlarged lymph nodes and no abnormality was detected.

Breast examination; the procedure was explained to client and consent was sought before her breast was exposed. The breast was exposed to check for size, shape, signs of pregnancy, dimpling and nipple retraction and condition of the skin. One breast was covered and she was asked to put her hand of the part to be examined under her head. The breast was palpated systematically in a circular manner using the inner aspect of the fingers and client was taught self brest -examination. Nipples were squeezed gently for colostrum and were examine for odour, blood which were cleaned with a clean cotton wool swab. The same procedure was done for the other breast and no abnormality was noted. Client breastfeeding history was inquired and client verified desire to breastfeed exclusively 6 months as it was done for her son. Client was reminded to examine breast at home as it was done at the facility frequently and if she sees any abnormality she should report to the health Centre.

Extremities: Madam Agyemang Ataa Yaa Junior was asked of tingling and tightness of the finger on making a fist, the hands and fingers were inspected for edema, pallor in the palm and nail bed and no abnormality was noted. The finger nails were well trimmed. The legs were inspected for

size and equality and palpated for edema, tenderness in the calf muscles, size, and equally but no abnormality was detected. She was encouraged to avoid prolonged standing and to perform regular exercise like walking to enhance proper circulation to prevent varicosity .Back was examined for deformity of the spine (scoliosis), edema of the sacral region and no abnormality was detected

Abdominal examination

The procedure and the reason for this examination were explained to the client's understanding. The purpose for this examination is to observe the signs of pregnancy, assess fetal size and growth, auscultate for fetal heart, locate fetal parts, and detect any deviation from normal. She was assisted to lie in a dorsal position with arms by her side to relax the abdominal muscles. Hand were washed with soap and water and dried with clean towel. Standing on her right hand side the abdomen was exposed. On general palpation of the abdomen there was no tenderness, masses, enlargement of the spleen and liver as well as supra pubic tenderness.

Inspection; during inspection of the abdomen it was observed to be ovoid in shape and medium in size. There was the presence of linea nigra and striae gravidarum. No scars were found on the abdomen which indicates signs of previous surgical procedure performed on the abdomen such as caesarean section and myomectomy. On questioning client about the presences of quickening, Madam Agyemang Ataa Yaa Junior said she felt fetal movement.

Measurement of symphysio fundal height; to measure the symphysio fundal height the hands were warmed by rubbing palms together before the upper border of the symphysis pubic and the uterine fundus were located. The zero part of the tape measure was placed on the fundus and extended

along on the contour of the abdomen along the midline to the upper border of the symphysis pubis. The tape measure was recorded in centimeters. The symphysio fundal height was 35cm

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Fundal palpation; the procedure was explained to the client and permission was granted. The palm was warmed. The client palm was faced and the palm was placed on either side of the fundus after warming them. The fingers were curved around top of the fundus to determine what lies in the fundus or upper pole of the uterus. A soft mass was felt in the fundus which indicated the buttocks. The fundal height was compared with gestational age. The symphysio fundal height measured 35cm and gestational age was 38 weeks .

Lateral palpation:

With one hand stabilizing the right side of the uterus ,the other hand was moved gently on the left side where rough mass were felt indicating limbs .This was repeated at the right side and a smooth round mass was palpated indicating the foetal back.

Pelvic palpation; the woman's feet were faced and she was asked to bend knees slightly in order to relax the abdominal muscle. She was helped to relax by guiding her to breathe out slowly. The palms of the hands were placed on either sides of the uterus, with the palms just below the level of the umbilicus and the fingers directed towards the symphysis pubic and thumbs almost meeting. A hard mass was felt at the lower pole of the uterus which indicated the head.

Descent palpation; by abdominal palpation, descent was assessed in term of fifths of fetal head palpable above the symphysis pubic. The anterior shoulder was located below the umbilicus and two fingers were placed over the anterior shoulder. Symphysis pubic was located and the right ulna border was placed just above the symphysis pubis and the anterior shoulder. Five finger breath were accommodated which is 5/5th. Therefore from the above ,it can be concluded that the lie of the feotus was longitudinal ,presentation was cephalic and the position was right occipito anterior.

Auscultation; the fetal feotoscope was warmed by rubbing in palm and placed on the right side of the mother's abdomen. Maternal pulse was located. The ear was placed against the feotoscope to listen to fetal heart beat for one minute comparing with maternal pulse. The rhythm and volume was recorded. The fetal heart rate was 136 beats per minute strong and regular. Madam Agyemang Ataa Yaa Junior said she felt fetal movement when she was

Vulva examination: Client permission was sought for vulva inspection and she agreed. A pillow was placed under her head and covered by blanket to provide warmth. The vulva was well shaved and clean. Hands were washed with soap under running water and was dried with a clean towel,

gloves were worn on both hands , the vulva and the perineum was examined for abnormal discharges, rashes, warty growth and ulcers, episiotomy scars and varicose veins. The labia major was examined for size and shape, redness, swelling and tenderness and nothing abnormal was detected.

Madam Agyemang Ataa Yaa Junior was thanked for her cooperation and all findings were communicated to her. All equipment's used were decontaminated appropriately. The gloves were removes and also discarded. Hands were washed thoroughly with soap under running water and dried with a dried towel. Client was encouraged to have enough rest and also taught how to perform exercise in pregnancy such as pelvic rock which will help relieve backache, head and shoulder lift which strengthens abdominal muscles, kegel exercise which strengthens pelvic floor muscles that makes delivery easier and rib cage lift which strengthen leg muscles and also it improves breathing. Client was also encouraged to her drugs as prescribed. Health was given on birth preparedness and complication readiness plan, eating of nutritious diet that is food that contains energy given food, body building food and protective food to prevent anemia. The following drugs were given to Madam Agyemang Ataa Yaa Junior.

1. Tab Ferrous Sulphate 200mg daily for 7 days
2. Tab Multivitamin 200mg daily for 7 days
3. Tab Folic acid 5mg daily for 7 days
4. She gave directions to her house and phone numbers were exchanged. Having agreed to be used for the study, arrangement was made to visit her house on16th November, 2022. She was thanked and saw her off to the exit of the clinic.

2.2 FIRST ANTENATAL HOME VISIT

The first visit to Madam Agyemang Atta Yaa Junior's house was on 26th November, 2022 at 4:30pm at her house Bediakorn, a suburb of Mim in the Ahafo Region . The main aim of the visit was to know where she lived and meet other members of her family ,psychosocial physical assessment and also talk about birth preparedness and complication readiness plan. On the way to her house, it was observed that the road leading to her house was tarred in good shape and easily accessible by vehicles. It was not too difficult locating the client's house by using the directions given, just behind the primary school .On arrival at madam Ataa Yaa's house, a seat and a cup of water were offered, it was observed that all members of the family were at home . There was establishment of rapport which interaction with her started.

PHYSICAL ENVIRONMENT

Madam Ataa Yaa lived with her husband and two children in a well roofed, cream painted block house. The house had enough windows for adequate ventilation. She was educated to open the windows everyday so as to ensure that there was enough fresh air circulating in the room to help prevent the spread of diseases. Their source of water is from a borehole. Madam Ataa Yaa had a big barrel with a well-fitting lid in which she stores her water and use when there is a water shortage. She was educated to have her barrel cleaned regularly with soap and water to prevent the barrel from harboring germs that may contaminate the water stored and cause diseases. Her compound was clean and there was a well-covered dustbin at the corner of her house where she disposed her rubbish. Client stated that it was emptied daily at a nearby refuse dump. They had a very good drainage system. Madam Ataa Yaa and her family sleepes under well hanged treated

mosquito net. She was commended on the cleanliness of her environment and was encouraged to always keep her surroundings clean to prevent diseases and breeding mosquitoes. Her husband was encouraged to ensure Madam Ataa Yaa keeps physically active during pregnancy so as to help her stay healthy and prevent excessive weight gain and also the exercise should not be strenuous and she should take breaks between activities so as to avoid unnecessary stress. Her family was encouraged to help her in household chores so she could have enough rest. Items for delivery were brought for inspection and it was complete. She was congratulated for purchasing all the items and was encouraged to add her National Health Insurance card and some money along not forgetting her antenatal booklet. Enquiries about her previous complains of constipation and heartburns were made and she said she had regained her normal bowel movement and is coping with the heartburns as well. She again complained of mild backache. It was explained to her that it was a physiological disorder during pregnancy and that, it was due to the effects of estrogen and relaxin hormones which relax the sacroiliac ligaments and the exaggeration of the lumber curve by the weight of the gravid uterus. She was then encouraged to have enough rest, practice good posture and wear low heeled shoes to help relieve the backache and to take her drugs as prescribed. She and her family were thanked for their cooperation and left with the promise of visiting her again. She was also reminded of her next visit to the hospital which was on1st December, 2022.

PSYCHOSOCIAL HISTORY

Madam Agyemang Ataa Yaa Junior lives with her husband ,mother and two children. Her relationship with her family and her neighbours was a good one as she introduced me to them as a midwife who will be taking care of her till she delivers. She eats together with her family at

every meal time. Madam Agyemang Ataa Yaa Junior attend wedding, funerals and festivals with her husband anytime when the need arises. According to client ,she solves any problems that arises with her husband solely because they see themselves as one and therefore they should be united. She attends meeting in her church all the time and does not miss Sunday church services.

2.3 SECOND ANTENATAL HOME VISIT

The second home visit to Madam Ataa Yaa Junior was on 30th November, 2022 around 3:30pm. Greetings were exchanged. Her husband was around and her mum and her children were present. The compound was observed and it was clean. She was congratulated on that and told her to keep it up. Enquiries about the rest of the things for confinement was made and it was realized that they were completed and neatly packed. Reinforcement on the education given previously on eating a healthy diet, exercise, enough rest and sleep was done. She was also educated on deep breathing exercises which she will be using during labour. She was reminded on the signs of true labour, birth preparedness and complication readiness. She was asked if she had any complains and she mentioned she had been having frequent urination and fatigue as well. The physiology was explained to her that it was as a result of pressure of the enlarging uterus on the urinary bladder reducing the capacity of the bladder and thus making her urinate frequently and it was as a result of the stress of pregnancy that made her feel tired(fatigue). She was educated to have enough rest and sleep. Permission was sought to leave. She was thanked for her co-operation.

2.4 SUBSEQUENT VISIT TO THE CLINIC

Madam Ataa Yaa Junior reported to the clinic on 1st December, 2022. She was warmly welcomed and asked of her health and that of the family members which she responded they were in good health. She was taken through the routine examination and made the following observations which

was recorded as; Temperature 36.2°C, Pulse 84bpm, Respiration 24cpm, Blood pressure 110/80mmHg, Body weight 63kg, Urine for sugar and protein; negative.

Madam Ataa Yaa was asked to empty her bladder. She was instructed to collect the midstream urine which she did. The urine sample was tested for protein and glucose which both came out as negative. Privacy was provided for her and she was assisted to undress and lie dorsal on the couch. Hand hygiene was performed and under the supervision of the midwife in-charge, she was examined and no abnormalities were detected**.**

During the inspection of the mouth, she was asked if she had consumed any non-nutritious substance and she said no. She was congratulated for complying with the education that was given to her. An examination was done on her abdomen. On fundal palpation, the symphysio fundal height was 38cm with gestational age of 39 weeks. Position was right occipito anterior, the lie was longitudinal on lateral palpation and presentation was cephalic. The descent was 5/5th above the pelvic brim on pelvic palpation. On auscultation, fetal heart rate was 140bpm with regular and a good volume. She was helped to get off the couch to dress up. All findings were communicated to her and was recorded in the antenatal record book. About her previous complains on back pains, she said she is coping with the pains. She was able to summarize the education given on backache during the last visit. She was encouraged to take her routine drugs and was also educated to report to the clinic if there is any problem. She was thanked and reminded of her next visit and was accompanied to the road side .Her next visit was on 8th December 2022.

SUBSEQUENT ANTENATAL VISIT TO THE CLINIC

On 8thDecember 2022, Madam Ataa Yaa Junior reported to the clinic. She was received warmly and offered a seat. She was asked of her health and that of her family and she said they were all doing well. Client was taken through the routine examination and the following observations were

made and recorded as: Temperature 36.3°C, Pulse 82bpm, Respiration 22cpm, Blood pressure 122/70mmHg, Weight 64kg.

Madam Ataa Yaa was asked to empty her bladder and take a sample of her urine for protein and glucose testing. Both tests came out negative. The general physical examination that was performed on her revealed no abnormalities. On abdominal examination, fundal height was 39cm. The lie was longitudinal, presentation was cephalic and descent was 5/5th palpable abdominally and gestational age was 40 weeks**.** On auscultation, fetal heart rate was 135bpm and regular with good volume. Madam Ataa Yaa was helped off the couch and all findings were communicated to her and recorded in her antenatal card. She had no complains and made known that she was coping with the frequent micturition and fatigue. She was then told to continue with her routine drugs. She was thanked for her cooperation and advised to report to the hospital anytime labour sets in and then saw her off to the gate.

2.5 NURSING CARE PLAN DURING ANTENATAL

Nursing care plan is a guide to nursing care rendered to a client as an individual with specific needs that ought to be addressed. It involves identifying problems, analyzing them, setting objectives and implementing interventions that will meet the objectives. Evaluation is part of the process and it is carried out to ascertain whether the goals or objectives set have been achieved.

PROBLEMS IDENTIFIED DURING ANTENATAL CLINIC

1.Heartburns (24th November,2022)

2.Constipation (24th November,2022)

3. Backache (26th November,2022)

4. Fatigue (4th December,2022)

5. Frequent micturition (4th December,2022)

SHORT TERM OBJECTIVES

1. Client's heartburns will be reduced and cope with throughout pregnancy within 24hours.

2. Client will regain her bowel movement within 24hours.

3. Client will cope with backache throughout pregnancy within 24 hours.

4. Client's fatigue will be reduced and coped throughout pregnancy.

5. Client will cope with frequent micturition throughout pregnancy.

LONG TERM OBJECTIVES

Client will go through pregnancy, labour and puerperium successfully without any complication to herself and the baby with all the support needed.

TABLE 1: NUSING CARE PLAN DURING ANTENATAL

DATE / TIME	NURSING DIAGNOSIS	NURSING OBJECTIVE/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE / TIME	EVALUATION	SIGN
24/11/22 9:00am	Heartburns related to regurgitation of stomach's content.	Client's heartburns will be reduced within 24hours and cope with it throughout pregnancy as evidenced by; 1.client verbalizing that the heartburns has reduced	1.Reassure client. 2. Explain the physiology of heartburns to client. 3.Encourage client to elevate the head end of the bed. 4.Encourage Client to minimize the intake of fatty and spicy meals. 5.Encourage client to minimize the intake of caffeinated drinks and acidic foods. 6.Serve prescribed drugs.	1.Client was reassured that her heartburns will resolve by the end of the pregnancy. 2. The physiology of heartburns was explained to client. 3. The head end of her bed was elevated with pillows. 4. Client was encouraged to minimize the intake of fatty and spicy meals. 5.Client was encouraged to minimize the intake of caffeinated drinks and acidic foods. 6. Prescribed drugs was served.	25/12/22 9:00am	Goal fully met as evidenced by; client's action	M.D

TABLE 2: NURSING CARE PLAN DURING ANTENATAL

DATE / TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES	NURSING ORDERS	NURSING INTERVENTIONS	DATE / TIME	EVALUATION	SIGN
24/11/22 4:20pm	Constipation related to slow intestinal peristaltic movement.	Client will be able to have free bowel within 48hours as evidenced by 1.client verbalizing that she has being able empty her bowel.	1.Explain the physiology of constipation to client. 2.Encourage client to take in 8 sachet of water every day. 3.Encourage client to take in foods rich in fiber and roughages three times a day. 4.Encourage client to engage in exercise.	1. The physiology of constipation in late pregnancy was explained to client. 2.Client was encouraged to take in 8 sachet of water every day. 3.Client was encouraged to take in fruits and vegetables three times a day. 4.Client was encouraged to engage exercises such as walking.	26/11/22 4:20pm	Goal fully met as client verbalized that she has now empty her bowel within 48 hours.	M.D

TABLE 3: NURSING CARE PLAN DURING ANTENATAL

DATE / TIME	N URSING DIAGNOSIS	NURSING OBJECTIVE	NURSING ORDERS	NURSING INTERVENTIONS	DATE / TIME	EVALUATION	SIGN
26/11/22 4:20pm	Backache related to relaxation of the pelvic ligaments by the hormone relaxin.	Client will cope with backache within 24hours as evidenced by 1.client verbalizing that her pains is reduced.	1.Reassure client. 2.Teach client good body mechanisms. 3.Explain the physiology of the backache to client. 4.Give client sacral massage. 5.Serve prescribed analgesics.	1.Client was reassured that she will be relieved after delivery. 2.Client was taught good body mechanisms. 3.Physiology of backache was explained to client. 4.Sacral massage was given to client. 5.Prescribed analgesics was served.	27/11/22 4:20pm	Goal fully met as evidenced by client reported to the midwife that her backache has reduced.	M.D

TABLE 4: NURSING CARE PLAN DURING ANTENATAL

DATE / TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES	NURSING ORDERS	NURSING INTERVENTION	DATE / TIME	EVALUATION	SIGN
04/12/22 9:00am	Frequent micturition related to descending fetal head pressing on the bladder .	Client will cope with frequent micturition throughout pregnancy as evidenced by 1.client verbalizing that she is free from frequent micturition.	1.Explain the physiology of frequency of micturition to client. 2.Encourage client to reduce the intake of fluids when she is about to go to bed. 3.Reassure client. 4.Encourage client to place a pail close to her for easy access. 5.Educate client on personal hygiene.	1. Physiology of frequency in micturition was explained to client. 2.Client was encouraged to reduce fluid intake when she is about to go to bed. 3.Client was reassured of normal micturition after child birth. 4.A pail was put at client's reach. 5.Client was counseled to clean her perineum from front to back.	08/12/22 9:30pm	Goal fully met as evidenced by 1.client verbalizing that she from frequent micturition	M.D

TABLE 5: NURSING CARE PLAN DURING ANTENATAL

TIME/DATE	NURSING DIAGNOSIS	NURSING OBJECTIVES	NURSING ORDERS	NURSING INTERVENTIONS	DATE / TIME	EVALUATION	SIGN
04/12/22 9:00am	Fatigue related to stress from pregnancy.	Client's fatigue will be reduced within 48hour as e videnced by 1.client verbalizing that she free from fatigue.	1. Reassure client. 2. Encourage relatives to assist in household chores. 3. Educate client to rest in between activities. 4. Encourage client to reduce household activities. 5. Teach client good body mechanisms.	1. Client was reassured. 2. Client's husband was encouraged to assist his wife in household chores. 3. Client had rest and sleep for 2hours in between activities 4. Client was encouraged to reduce household activities 5. Client was taught good body mechanisms.	6/12/22 9:00am	Goal fully met as evidenced by client said she is free from fatigue.	M.D

CHAPTER THREE

MANAGEMENT OF LABOUR

3.0 INTRODUCTION

This chapter talks about labour and involves management of the first stage of labour, management of second stage of labour, immediate care of the baby at birth, management of third stage of labour, examination of the placenta and membranes and management of fourth stage of labour, nursing care plane and management of the problem identified.

3.1 ADMISSION AND MANAGEMENT OF FIRST STAGE OF LABOUR

Madam Agyemang Ataa Yaa Junior reported to the hospital on 12th December, 2022 at 4:15am. Madam Ataa Yaa was accompanied by her husband together with her mother and complained of severe waist pains, lower abdominal pain and painful rhythmic uterine contraction. They were warmly welcomed, offered a seat. Her antenatal card was collected and quickly glanced through. Her labour history was taken and according to Madam Ataa Yaa she started seeing signs of labour such as show and painful uterine contractions around 12:00am. She was inquired about any intake of drugs at home before coming to the hospital and she said no. She also said she didn't take any food before coming. She was asked if she felt the fetal movement and she said yes. She was also asked if her membranes had ruptured and she said no. She was then admitted into the admission and discharge book and recorded all history and findings as well as documentation of her details in the ward state. Madam Ataa Yaa's delivery items were checked and labeled. She appeared anxious and looked tired. She was reassured that she was in safe hands and that she will be taken care of by competent and hardworking staff. She was asked to empty her bladder and the amount of urine passed was 150mls. Her urine was then collected and tested for protein and glucose which

both came out as negative. She was provided privacy at her bed side and was assisted to change into an examination gown and assisted to lie in a left lateral position and her vital signs was checked and recorded as follows; Temperature 36.3ºC, Pulse 90bpm, Respiration 24cpm, Blood pressure 100/70mmHg

A tray for head to toe examination and another for vaginal examination were set. The procedure was then explained to her which she had knowledge about because she had been previously educated on. Hand hygiene was performed. The hands were warmed and placed on her fundus to time her contractions for 10minutes. Her contractions were 2 in 10 lasting 30 seconds. On auscultation with the fetoscope, the fetal heart rate was 134bpm with good volume and regular rhythm. She was examined from head to toe and there were no abnormalities. She was informed that she had to be examined on her abdomen using inspection and palpation. She was assisted to lie in a dorsal position for the abdominal examination. On inspection, the abdomen was globular in shape with no scars and the size corresponded to the gestational age which was 40+4days. Straie gravidarum and linear nigra were present. Fetal movement was also present. Symphysio- fundal height was 36cm. Fundal palpation was done with the fetal buttock occupying it. On lateral palpation, fetal back was at the right side indicating right occipito anterior position. With her legs bent slightly, she was asked to breathe through the mouth. Pelvic palpation was done on her which revealed the presentation to be cephalic and descent was 3/5th palpable abdominally. Permission from Madam Ataa Yaa to perform vaginal examination was sought and she agreed. Still in the dorsal position, she was instructed to flex her knees. Hand hygiene was done and sterile gloves were put on. On inspection, the vulva was clean and the mons veneris was shaved. There was no scar from previous birth, oedema, vulva warts or varicose veins. The perineum was intact. The vulva with sterile cotton wool swabs soaked in savlon solution. The middle and index finger were

into her vagina. The vagina was warm, moist and its walls were easily distensible. The cervix was soft, elastic and effaced. The cervix was situated at the posterior fornix of the vagina. The presenting part was well applied to the cervix. The cervical dilatation was 4cm with the membranes intact, no molding felt. Ischial spines were blunt and pubic arch was wide, sacral promontory was not reached. There was a blood stained mucoid (Show) on the examining fingers. The midwife in-charge confirmed the findings that Madam Ataa Yaa was in true labor. The vulva was then cleaned and she was asked to apply a new clean pad. She was then made comfortable in bed and assisted to lie at the left lateral position to prevent supine hypotension syndrome. The findings were communicated to her and recorded on the partograph and in the nurse's notes. She was thanked for her cooperation and informed that monitoring of her contractions would be done, fetal heart rate and maternal pulse would be checked every 30minutes. It was added that, her cervical dilatation, descent, blood pressure and temperature will also be checked every 4 hourly. It was also made known to her that her urine will be checked anytime it was passed out. She was encouraged to empty her bladder frequently to facilitate the descent of the fetal head and improve uterine contractions. She was also encouraged to change her perineal pad whenever it was soiled to prevent infection, to walk around to aid in descent and also told to lie on her left side to allow increased blood supply to the placenta site. She was encouraged to walk around to help alleviate the pain and help labor progress. Client was thanked for her cooperation and was reassured of competent care. Findings were documented as at 4:20am; uterine contractions were 2:10 lasting 30seconds, fetal heart rate 134bpm, maternal pulse 90bpm, maternal blood pressure 110/70mmHg, membranes intact, descent $3/5^{th}$, molding (0), temperature 36.3.

PREPARATION FOR BIRTH

In preparing for birth, helpers were identified including the skilled and unskilled personnel. The midwife in-charge was identified as the skilled personnel and the client's mother was identified as the unskilled personnel. The doctor on call was notified about the client's admission. Client's brother had donated blood at the blood bank when an enquiry was made. Emergency boxes (like PPH and Eclampsia) with their appropriate items were available. The delivery room had been already cleaned. Client was encouraged to wash hands and she was informed that the windows will be shut and fans will also be put off to provide a warm environment for the baby when it is time for delivered of which she agreed. Room was well lighted and ventilated. Madam Agyemang Ataa Yaa was also educated that the baby would be delivered onto her abdomen on a sterile towel and she will have to support the baby. She was also informed that her abdomen will be cleaned for skin-to-skin care with the baby. The resuscitation box had all the items needed such as a stethoscope, scissors, cord clamp, sucker, self -inflating bag and mask of different sizes. The self-inflating bag was tested to see whether it was functioning, also the radiant bulb was switched on to provide warmth to the cot. Other items like cot sheets were also made available. Referral centers and their numbers as well as ambulance and its driver were all checked to be available. Delivery items were also made available. Client was encouraged to assume any position favorable but not harmful to her. She was encouraged to possibly assume a left lateral position to increase placental perfusion and prevent supine hypotension. She was encouraged to ambulate to aid in the descent of the fetal head. A bed pan was provided for her and was encouraged to urinate when she feels the urge to further aid in descent of the fetal head. Client was encouraged to take in water or any sweetened fluid to prevent dehydration. Madam Ataa Yaa was reminded of the deep breathing

exercises so as to conserve energy for the second stage. Sacral region was massaged during contractions to relieve her from pain and was continuously and closely monitored on the partograph throughout the first stage of labour, maternal and fetal conditions were recorded and labour progressed well. Client was monitored on the partograph as follows; fetal heart rate, uterine contractions and maternal pulse were checked every thirty (30) minutes. The cervical dilation, descent, membranes, molding, blood pressure and temperature were checked every four (4) hours. Urine test for protein and acetone was done every four (4) hours. Client was reassured again of competent care to be rendered and all procedures were explained before their performance. All findings were communicated to her. Madam Ataa Yaa complained of lower abdominal pains, she was reassured and the physiology of the abdominal pains was explained to her. She was asked to take deep breathing exercise with each contraction and rest in between. The client was continuously monitored; foetal heart rate, uterine contractions and maternal pulse were checked every thirty (30) minutes. The cervical dilatation, descent, membranes, moulding, blood pressure and temperature were checked every four (4) hours.

At 8:20am uterine contraction was 3:10 lasting 40 seconds, fetal heart rate 142bpm, maternal pulse 82bpm. Vaginal examination was done on her under aseptic technique and the cervical dilation was 8cm with descent of $2/5^{th}$ with membranes intact. There was no molding. Client passed 200mls of urine which was tested for protein and glucose. Both were negative. Vital signs were checked and recorded as blood pressure 120/70mmHg, temperature 36.5ºC, maternal pulse 86bpm. Client was sweating profusely during the peak of contractions. Her face was wiped with a damp towel and she was also given about 200mls of water to drink which she vomited about 100mls.

Madam Ataa Yaa complained of feeling the urge to bear down as well as passing faeces at 10:20am uterine contractions were 4 ;10 lasting 45 seconds, fetal heart rate 144bpm, maternal pulse 88bpm.

She was informed that it was almost time for the baby to be born. She was encouraged to continue with the breathing exercises and not to push until she was told to do so. Descent was 0/5th palpable abdominally. Vaginal examination was repeated and cervical dilatation was 10cm which indicated full dilatation. Membranes ruptured spontaneously with clear liquor and ++ molding. The client was encouraged to breathe through her mouth. The perineum was quickly examined, the vulva and anus were gaping, perineum was bulging and a trickle of blood was evident. Progress of labour was communicated to the midwife in-charge which she confirmed client was ready to be delivered. All findings were plotted on the partograph and explained to client. Madam Ataa Yaa was transferred to the second stage room and helped onto the couch. She was reassured of competent working staff.

3.2 MANAGEMENT OF SECOND STAGE OF LABOUR

Madam Ataa Yaa was sent to the second stage room at and was helped to get onto the delivery bed and positioned in a dorsal position. A sterile delivery trolley was sent to her bedside. Her knees were flexed with thighs wide apart and feet on the stirrups as she lay on the delivery bed. All procedures were explained to Madam Ataa Yaa and she was reassured. Her abdomen was covered with a sterile cot sheet. Protective clothing was worn (mackintosh apron, safety boots, goggles, and nose mask). Handwashing was done and two pairs of sterile gloves were put on. Madam Ataa Yaa vulva was swabbed with sterile swabs soaked in savlon solution. A clean pad was applied to her anal region to prevent fecal contamination of the delivery area. She was then told that her baby will be delivered onto her abdomen and reassured her again to help allay her anxiety. Madam Ataa Yaa encouraged to push with each contraction and rest between contractions to prevent exhaustion. The fetal heart rate and maternal pulse were checked in-between contractions. This was to detect any deviation from normal and give early treatment but all were normal. The fetal

head advanced gradually with each contraction. The index and middle fingers of the right hand were placed on the advancing head to maintain flexion in order to allow the diameter of the fetal skull to distend the perineum and vulva while supporting the perineum with a pad in the left hand. Descent of the head continued till the head crowned. After crowning, Madam Ataa Yaa was told not to push but pant to prevent rapid expulsion of the head which can result in the perineum to tear. The head was delivered by extension as the sinciput, face and chin swept the perineum. Cord around the neck was checked but there was none. The eyes were cleaned with sterile swabs from the inner canthus to outer canthus. There was restitution of the head, internal rotation of the shoulders and external rotation of the head. Hands was placed on both lateral aspects of the head and Madam AtaaYaa was asked to push gently with the next contraction while a gentle downward traction was applied and the anterior shoulder was delivered. The posterior shoulder was also delivered right after the anterior shoulder. The rest of the body was delivered by lateral flexion onto Madam Ataa Yaa's abdomen at 10:35am. The baby delivered was a live female infant and she cried soon after birth with an APGAR score in the first minutes of 8/10. Client was congratulated on the safe birth of her new born and thanked her for her cooperation and effort throughout the delivery.

IMMEDIATE CARE OF THE BABY

Immediately the baby was born, the face was cleaned with sterile gauze. There was no suctioning of the mouth and nose since the baby had a good breath and cried as soon as she was delivered. This indicated patency of airway. A cap was placed on her head and socks on her feet to prevent hypothermia. The baby was placed skin to skin on her mother's abdomen to promote bonding and provide warmth. The baby was then covered with a warm clean sheet. After three minutes of birth,

the first gloves which was by then soiled was removed in order to use the second gloves. The cord was clamped with cord clamp about 3cm away from the abdomen of the baby and the artery forceps was clamped 2cm away from the first clamp. The cord was covered with gauze to prevent splashing of blood and was cut to separate the baby from the mother. The baby was showed to the mother to identify the sex which she confirmed to be a female. Client was assisted to initiate breastfeeding. This was to also aid in the delivery of the placenta. An identification band bearing mother's name, sex of baby, date and time of delivery was placed on the wrist of the newborn. The APGAR score assessed in the first and fifth minute read as follows;

Time	**Appearance**	**Pulse**	**Grimace**	**Activity**	**Respiration**	**TOTAL**
1 minute	1	2	2	1	2	8
5 minute	2	2	2	1	2	9

3.3 MANAGEMENT OF THIRD STAGE OF LABOUR

The third stage of labour starts after delivery of the baby and ends with complete expulsion of the placenta, membranes and control of bleeding was actively managed. The cut end of the cord was placed in a sterile receiver near the perineum to collect placenta, membranes and blood loss. Her abdomen was palpated for an undiagnosed twin but there was none. Client was then given injection oxytocin 10 units intra-muscularly on her thigh within one minute to help in the active management of 3rd stage. Uterine contraction was felt for and was well contracted. The left hand was placed

above the level of symphysis pubis with the palm facing the umbilicus, pressure was exerted on the upward direction whilst the clamped end of the cord was held with the right hand. Using controlled cord traction, the cord was pulled on gently until the placenta was visible at the vulva. It was cupped with both hands to ease pressure on the friable membranes. The placenta and membranes were pulled gently until they were completely expelled at 10:43am into a kidney dish for further examination. The uterus was massaged immediately after the delivery of the placenta to aid uterine contraction, arresting hemorrhage as well as expelling clots. Consent was sought from client that her cervix, vagina, perineum and vulva would be examined. A good light source was directed to the perineum. Two sterile gauze were wrapped on the index finger for inspection using clockwise method. The vagina and cervix were inspected thoroughly to determine laceration but there was none. Afterwards, the lateral sides were also examined and they were intact. The vulva, perineum and upper thigh were cleaned and a clean perineal pad was applied. Client was wiped off blood and a clean perinea pad was applied to make her comfortable. She was congratulated and her baby was shown to her and she confirmed the sex of the baby. Blood loss estimated was approximately 200millilitres. Instruments used was decontaminated in 0.5% chlorine solution for ten minutes after which the instruments were washed and sterilized. She was encouraged to urinate frequently whenever she had she urge to, so that the uterus can be well contracted and involute to prevent post- partum hemorrhage.

Examination of The Placenta and Membranes

A thorough inspection of the placenta and membranes is done in order to ensure that no part of it being retained during delivery. The placenta was immersed in 0.5% chlorine solution and it was examined. The placenta was held by the cord with the membranes hanging and the membranes were examined for completeness and it was intact. The placenta was then laid on a flat surface

for further examination. The amnion was peeled from the chorion up to the umbilical cord and was fully viewed, the lobes fitted together without any gab and edges also forming uniform circle at the maternal surface and this indicated there was no missing lobe, there were no white patches on the maternal surface, there was also no blood vessels radiating into the membranes which indicated absence of succenturiate lobe. The cord was situated at the center of the placenta with one vein and two arteries which were seen in the cord. There was no abnormality detected. The placenta was discarded after decontaminating it according to the protocol of the facility. The instruments and equipments used were soaked in 0.5% chlorine solution for ten minutes and washed, rinsed, dried and repacked for sterilization. Hands were dipped in chlorine solution before discarding the gloves Hand hygiene was performed and documentation was done as well.

3.4 Management of Fourth Stage 0f Labour

The fourth stage of labour is a period of close monitoring and observations of mother and baby for the next six hours following the delivery of the placenta, membranes and subsequent arrest of hemorrhage. Client and her baby were transferred to the lying in ward after putting the baby skin to skin for an hour. Monitoring of Madam Ataa Yaa and the baby continued strictly for the first 6 hours after expulsion of the placenta and membranes and arresting of hemorrhage. Vital signs were checked every 15minutes for 2hours, 30 minutes for 1hour and one hourly for the remaining three hours and recorded. Post- delivery vital signs were checked and recorded as follows; Mother**;** Temperature 36.4 degree Celsius, Blood pressure 110/70mmhg, Respiratory rate 22cpm, Pulse 82bpm and Baby**;** Temperature 36.3degree Celsius, Respiratory rate 40cpm, Heart rate 132bpm. Madam Ataa Yaa was asked to empty her bladder frequently in order to help contractions of the uterus. She was educated on how breastfeeding enhances the release of oxytocin which would improve uterine contractions, drainage of lochia, control of hemorrhage and also as a form of

family planning. The uterus was well contracted with the symphysio fundal height 16cm. Her perineal pad was inspected for amount and colour of lochia. On inspection, the lochia was bright red, moderate blood loss and not offensive. Client was encouraged to change her pad frequently when it's soaked and to wash her hands before handling the baby. She was given porridge with bread after which she continued breast feeding. Baby was put to breast and the mother was reminded again on the importance of exclusive breastfeeding and to also breastfeed on demand.

Examination of The New Born

The procedure was explained vividly to the client, examination gloves were worn and the baby was examined head to toe to detect any deviation from normal. Baby was put on a flat surface, Baby was exposed and the general condition, respiration and skin colour was noted and covered again to be examined from head to toe.

On examination of the head, the sutures and fontanelles were examined with no abnormality detected. There was no laceration on the scalp and no caput succedaneum as well. The head circumference was measured and it was 32 cm. The pinna of the ears was well formed and there were no discharges from the ear. The eyes were in alignment with the ears. There was no pallor of the conjunctiva or jaundice on the sclera. The nose was well formed with septum dividing it. Nose was patent with no discharges. The mouth was examined for the presence of false teeth, cleft palate and tongue tie but there was none. Rooting, suckling and swallowing reflexes were present. There was no enlargement of lymph nodes, rigidity, congenital goiter and swelling of the neck.

On breast examination, there was no engorgement of the breast. The nipple was at the center of the areolar. There was no distention of the abdomen, enlarged spleen or liver as well as bleeding of the cord. There were three blood vessels that run through the cord which indicated two arterial

cord vessels and a cord vein. The spine was examined with the baby lying in prone position. The back was palpated for swellings, spinal bifida or a missing vertebra, meningomyelocele but there was none. The skin was examined for skin colour, vernix caseosa, and lanugo, peeling of the skin, rashes and birth mark. There were no abnormalities with some amount of vernix caseosa. The upper extremities were equal with no extra digits. There were palmer creases and no webbed fingers. Grasping and Moro reflexes were present.

The lower extremities were also equal without an extra digit. Both legs were examined with no talips and congenital dislocation of the hip. Knee flexes were normal. On inspection of the genitalia, the labia minora and majora were inspected with no abnormalities dectected. Baby passed meconium and urinated soon after birth indicating the patency of the anus and urethra.

Prevention of Diseases

Baby Ataa Yaa was given vitamin K1 to prevent bleeding. Gentamycin eye drop was applied on the eyes to prevent infections. The cord was also dressed with chlohexidine gel. Again, two drops of polio 'O' was given by mouth and injection BCG 0.05ml was administered intradermal to prevent polio and tuberculosis. Client was also educated not to apply anything on the injection site. In all no abnormality was detected. Gloves were removed and disposed of according infection prevention protocol proper hand washing was performed and dried with a clean towel. Baby was given to his mother. All findings were communicated to the mother and recorded. Madam. Ataa Yaa was thanked. The baby's vital signs and weight were checked and recorded as follow Temperature 36 .3 ºC, Apex beat 132 bpm, Respiration 40 cpm, Weight 3.0 kg. She was also told that the baby may have swelling at the site of injection which would subside. Baby was wrapped in clean dry sheet and put to breast.

SUMMARY OF LABOUR

Date of delivery	12th December, 2022
Time of delivery	10:35am
Mode of delivery	Spontaneous vaginal delivery
Time placenta and membranes delivered	10: 40am

DURATION OF OBSERVABLE LABOUR

1st stage	6 hours 25 minutes
2nd stage	15 minutes
3rd stage	8 minutes
Total	6 hours 48minutes

GENERAL CONDITION OF THE MOTHER

Blood pressure	-	110/70mmHg
Temperature	-	36.4ºC
Pulse	-	82bpm
Respiration	-	22cpm
Fundal height	-	16cm
Condition of perineum	-	Intact
Blood loss	-	Approximately 200mls
Condition of mother		Good

GENERAL CONDITION OF THE BABY

Sex	Female
Weight	3.0kg

Head circumference	32cm
Length	49cm
Condition of the baby	Good
Apgar score 1st and 5th minutes	8/10,9/10
Abnormalities	No abnormality detected

CONDITION OF THE PLACENTA

Lobes and membranes	Complete and healthy
Cord vessels	Two arteries one vein
Fetal surface	Greyish blue
Maternal surface	Dark red
Placenta and membrane	Healthy
Date of delivery	12/12/2022
Time of delivery	10:35am

3.5 NURSING CARE PLAN DURING LABOUR

PROBLEMS IDENTIFIED

1. Waist pain.
2. Lower abdominal pain.
3. Vomiting
4. Anxiety

SHORT TERM OBJECTIVES

1. Client will cope with waist pains throughout labour.
2. Client will cope with lower abdominal throughout labour.

3. Client will be relieved of vomiting within 3 hours.

4. Client will be allayed of anxiety an hour after delivery.

LONG TERM OBJECTIVES

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

TABLE 1: NURSING CARE PLAN DURING LABOUR

DATE / TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES	NURSING ORDERS	NURSING INTERVENTIONS	DATE / TIME	EVALUATION	SIGN
12/12/2022 5:30am	Waist pain related to descent of fetal head.	Client will cope with the waist pain throughout labour as evidenced by client's action.	1.Reassure client. 2.Explain the physiology of waist pain to client. 3.Encourage client to adopt a comfortable but harmless position. 4.Perform sacral massage. 5.Encourage deep breathing exercise.	1.Client was reassured. 2.Physiology of the waist pain was explained to client. 3.Client was helped to adopt a comfortable but harmless position. 4.Sacral massage was performed to reduce pain. 5.Client was encouraged to do deep breathing exercise with each contraction and rest in between.	12/12/2022 5:30pm	Goal fully met as evidenced by client said she was coping with pain.	M.D

TABLE 2: NURSING CARE PLAN DURING LABOUR

DATE / TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTIONS	DATE / TIME	EVALUATION	SIGN
12/12/2022 5:30am	Lower abdominal pain related to regular, painful rhythmic uterine contractions.	Client will cope with lower abdominal pains within 24hours as evidenced by 1. client verbalizing that she is coping with lower abdominal pains.	1. Explain the physiology of lower abdominal pain. 2. Reassure client. 3. Perform sacral massage. 4. Encourage client to adopt a comfortable but harmless position. 5. Encourage client to do deep breathing exercise.	1. Physiology of lower abdominal pain was explained to client. 2. Client was reassured. 3. Sacral massage was performed for client to relieve pain. 4. Client was encouraged to adopt a comfortable but harmless position. 5. Client was encouraged to do deep breathing exercise with each contraction and rest in between.	13/12/2022 5:30am	Goal fully met as evidenced by client said she coping with abdominal pain.	M.D

TABLE 3: NURSING CARE PLAN DURING LABOUR

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES/OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTIONS	DATE / TIME	EVALUATION	SIGN
12/12/2022 08:00am	Vomiting related to hormonal changes.	Client will be relieved of vomiting within 3 hours as evidenced by: 1.client verbalizing that she no longer vomit. 2.Midwife witnessing that client has stopped vomiting.	1. Reassure client. 2. Explain the physiology associated with vomiting. 3. Remove any nauseating items from client. 4.Provide mouth care after each vomiting. 5.Encourage client to reduce the intake	1.Client was reassured. 2. The physiology of vomiting was explained to her. 3. All nauseating items were moved away from client. 4.Mouth care was given after each vomiting. 5.Client was encouraged on the need to reduce the intake of oily and spicy food.	12/12/2022 11:00am	Goal fully met as client verbalized that vomiting has stopped.	M.D

			of oily and spicy food.				

TABLE 4; NURSING CARE PLAN DURING LABOUR

DATE / TIME	NURSING DIAGNOSIS	NURSING OBJECTIVE	NURSING ORDERS	NURSING INTERVENTIONS	DATE / TIME	EVALUATION	SIGN
12/12/2022 5:30am	Anxiety related to unknown outcome of labour.	Client will be allayed of anxiety an hour after delivery as evidenced by client that she is no longer anxious.	1.Reassure client. 2.Explain the physiology of labour to the client. 3.Explain every procedure to be carried out to client. 4.Encourage client to ask questions.	1. Client was reassured. 2. Physiology of labour was explained to client 3. Every procedure to be carried out was explained to client 4.Client was encouraged to ask questions.	12/12/2022 6:30am	Goal fully met as evidenced by client said she is no more anxious.	M.D

			5.Communicate findings to client.	5.Findings were communicated to client.			

CHAPTER FOUR

PUERPERIUM

4.0 INTRODUCTION

This chapter describes care of the mother during puerperium thus from the period of delivery to discharge, the management of both mother and baby from day one to sixth week postnatal. Care plans drawn for the management of problems encountered during puerperium. During this period, the reproductive organs return to their non-pregnant stage and lactation initiated. Also health education, counseling, assessment, support for infant feeding and immunization service for baby was done.

4.1 DAY OF DELIVERY

EXAMINATION AND SUBSEQUENT CARE OF THE MOTHER

Madam Ataa Yaa was informed of the procedure to be carried on her. Privacy was provided for her and she was asked to empty her bladder. Handwashing was performed. On observation, she looked healthy and there was no sign of postpartum blues. She was helped to lie in a dorsal position afterwards. Her hair was well kept. Upon inspection, her eyes and her conjunctiva were pink with white sclera, with no abnormalities detected in her mouth. Her hands were normally situated and equal upon inspection of her upper extremities. Her palm was pink with shortened finger nails. Both breasts were inspected and were of almost equal in size with normal shapes. The left breast was palpated first as she supported her occiput with her right palm. Same was done for the right breast and did not detect any abnormalities. Her nipple was prominent and there was no discharge. She was taught self-breast examinations for early detection of any abnormality. Her breast was soft and there was no redness or cracks on the nipple. No lumps were felt and colostrum was

expressed. During inspection of the abdomen, it looked firm and straie gravidarum and linear nigra were present. The uterus was palpated and it felt firm and well contracted. Her symphysio-fundal height was 16cm. Her back was inspected for any rash, edema and tenderness but there was none found. Her lower extremities were examined and they were equal, normal, and free from oedema and pain. Permission was sought from Madam Ataa Yaa to carry out a vulva examination on her which she readily agreed to. Hands were washed, dried and surgical gloves were worn. Her pad was removed and inspected for the colour which was bright red. The amount of blood flow was moderate. The odour of the lochia had no foul smell. A new pad was placed on her vulva and the old one was discarded. The used gloves were removed and discarded, hands were washed. Vital signs were checked and recorded as: Respiration 22cpm, Temperature 36.4, Blood pressure 110/70mmHg, Pulse 82bpm. All findings were communicated to her and recorded in the nurse's note. Client was encouraged to urinate frequently to aid in uterine involution. Client was told to change her perineal pad as frequently as it gets soiled to prevent infections. Again, she was encouraged breastfeed her baby on demand and to eat well balanced diets and drink lots of fluids to replenish the fluids lost through labour. It was added that she should have enough rest and sleep in order for her to recover from the stress of labour.

4.2 SUBSEQUENT CARE OF THE BABY

The baby was examined to exclude any abnormalities or birth injuries in the mother's presence. Before the procedure began, what to be done and the importance of doing the were vividly and clearly explained to the mother. Nearby windows and doors were closed to prevent hypothermia and provide privacy. Hand hygiene was performed and sterile gloves were put on. The baby was placed on a clean flat surface, undressed and wrapped with a cot sheet to prevent hypothermia. The skin was inspected and noted her skin color was pink covered by small vernix caseosa without

any birth mark or lacerations. On examination of the head, there was no caput succedaneum or cephahematoma formed, sutures and fontanels were present and normal. Her eyes were normally situated with no yellowish discoloration on the sclera or swelling of the conjunctiva. The nose was evenly placed in relation to the eyes and the ears were in their normal position. The pinnae of the ears were well formed and level with the cantus of the eye. The mouth had no cleft lip or cleft palate and there was no tongue tie or forced teeth. Rooting, suckling and reflexes were present. The neck was normal, easily rotated and no swelling or lymph node felt. The breast tissue was palpated and there were no masses or engorgement. The nipples were centrally situated. On examination of her abdomen, it was round, soft and prominent. Her cord was centrally situated with two arteries and one vein and it was not bleeding. On examining her upper extremities, they were both of equal size and length and she did not have any webbed or extra digits. Palmer creases as well as grasping reflexes was also present. Her legs were well flexed and there was no congenital hip dislocation. Her toes were not webbed and no extra digits detected. The vertebrae were also normal and no spinal bifida detected. Her vagina was normal after it had been examined and so was her urethral orifice. Baby passed urine and meconium which indicated that the urethral and anal orifices were patent. All findings were communicated to the client and recorded them in the nurse's notes. The baby was wrapped and put to her mother's breast to initiate lactation and bonding.

BABY'S FIRST BATH AND CORD DRESSING

The baby was given her first bath after 6 hours post-delivery at 4:55pm. The procedure was explained to Madam Ataa Yaa. Preparation for the baby's bath was made and it included setting up a trolley with baby's sponge, face towel, baby's soap, baby's drape, baby oil, powder, bath thermometer, two clean cot sheet, baby's dress, gallipot containing sterile water, cotton wool

swabs, jug of cold water, jug of warm water, chlorhexidine gel on the top shelf and plastic apron, bucket for dirty water, bathing towel, disposable gloves, container for used linen on the bottom shelf. Nearby windows and doors were closed and ensured that mother was present before the procedure was started. The jugs of water were mixed and tested with the bath thermometer. Plastic apron was worn, handwashing was performed, and gloves were put on. The baby was put on a clean flat surface and undressed. The baby was wrapped with a cot sheet. The baby's eyes were cleaned with cotton wool swabs soaked in sterile water from the inner cantus to the outer cantus and then cleaned her face with a damp face towel and dried it after. The nape of the baby's neck was supported with the left hand and plucked her ears with two fingers of the left hand supporting baby's head. Her head was washed with a soapy sponge. The baby was lifted off the flat surface, supporting the nape of the neck and body resting on the elbow to the edge of the bowl. Her head was rinsed off the soap and dried it with a clean towel. The baby was put back on the flat surface afterwards and exposed her body. Her arms and front of her trunk were washed, paying attention to the skin folds. The baby was turned with one arm supporting the chest and hand holding the distal arm of the baby. Her back was washed down to her feet, paying attention to the skin folds. The baby was supported firmly and was immersed in a bath of warm water, with her head above the water and rinsed her thoroughly. The baby was placed afterwards on the flat surface and was covered with a clean cot sheet. A small towel was used to dry the baby. The used gloves were removed afterwards and was discarded. Handwashing was done and new gloves were put on. The tip of the cord clamp was held with a cotton swab and applied Chlohexidine gel thoroughly on the base, stem and cut end of the umbilicus. The cord was exposed to dry and heal. The baby was smeared with her oil, powder and was dressed up. The baby was given to Madam Ataa Yaa to fix her to breast. The working area was tidied and disposed of waste materials. After the procedure,

handwashing was done and all findings were communicated to Madam Ataa Yaa and documented as well.

4.3 FIRST DAY POST DELIVERY (DAY OF DISCHARGE)

PREPARATION AND EDUCATION ON DISCHARGE

On 13th December, 2022, at 7:00 am Madam Ataa Yaa woke up healthy with cheerfully looking facial expression. All procedure to be carried out on both mother and baby were explained. Mother then took a warm bath and was served with oats and bread. Permission was sought from client and head to toe examination was done with no abnormalities detected. The breast was soft and lactating. Client complained of interrupted sleep since baby cries a lot. She was encouraged to take naps whenever the baby sleeps. She was also encouraged to breastfeed baby frequently to aid involution. Client vital signs and other observation made and recorded as, Temperature 36.6 degree Celsius, Respiration 22 cpm, Pulse 82bpm, Blood pressure 110/60 mmHg, Lochia Rubra, Fundal height 15cm, Condition of uterus; contracted. The baby was top and tailed and examined from head to toe with no abnormalities detected. The cord was dressed with chlorhexidine gel in the presence of mother. The cord was quite fresh with no odour. Madam Ataa Yaa was taught how to dress the cord. The baby was assessed and recorded as; Temperature 36.5˚C, Apex heart rate 134bpm Respiration 40cpm, Skin Colour Pink, Cord bleeding -Nil, Condition of cord -Dry, Suckling – Good, Weight 2.9kg, Stool Colour -Greenish.

An opportunity was taken to demonstrate to the mother how to bath the baby. The baby was top and tailed, dressed and wrapped nicely in the presence of the mother and family. The baby passed urine and meconium which was normal. The mother was educated not to apply hot compress on the fontanelles with the intension of closing it as they go home. The baby was then handed over to the mother for breastfeeding. Proper positioning and attachment to the breast was encouraged.

Client was reminded on the intake of nutritious diet, fruit and frequent breastfeeding of the baby. Education was given on the change of perineal pad when soiled and the need to wash her hands after removal and before breastfeeding the baby to prevent infections. Client was also educated on postnatal exercises such as kegel, ambulation and family planning as well as exclusive breastfeeding, change of napkins or diapers frequently, wash and dry them in sun and keeping the baby warm always. She was asked to register the baby at the birth and death registry. Madam Ataa Yaa was informed about the continuity of care and that she would be visited at home for seven days to check on her condition and that of the baby. Her husband was encouraged to take good care of her and also provide her with physical, emotional, psychological and financial support. She was again educated on the prescribed drugs, its route of administration, dosage and effects.

The baby was reassessed by the Midwife -In- Charge and no abnormality noticed and she confirmed they were ready for discharge was given the following:

Tablet Folic Acid	5mg daily for 14 days
Tablet Ferrous Sulphate	200mg daily for 14days
Tablet Multivitamin	200mg daily for 14 days
Tablet Paracetamol	1g tid for 3days

Client was discharged at 12:00pm on the 13th of December, 2022 and was helped to pack belongings after serving her medications. Her hospital bills were settled by the National Health Insurance Scheme. Client was reminded that she will be visited in the evening and it will continue for seven days. Client was congratulated and bade farewell.

HOME VISITS

FIRST POSTNATAL HOME VISIT.

In the evening of 13th December, 2022 at 5:30pm, Madam Ataa Yaa and her baby were visited for the first time after delivery. They were both in good condition as well as her family. Permission was sought from my client and also explained procedure to her to examine the baby and herself of which she agreed. She was asked to empty her bladder. Madam Ataa Yaa and her baby were examined from head to toe and there were no abnormalities. Her fundus was well contracted. The baby was top and tail and the cord was dressed afterwards. Madam Ataa Yaa put the baby to her breast and it was noticed that the baby suckled well. Client complained of headache and fatigue. She was reassured and was told that it was due to the stress of labour. Client was encouraged to have enough rest and sleep and also educated her on the need to sleep under treated mosquito net to prevent mosquito bites and malaria. The following are the observations made on both mother and baby: Mother; temperature 36.2 °C, Pulse 82bpm**,** Respiration 21cpm, Blood pressure 100/70mmHg, stool/urine passed, Fundal height 15cm, uterus contracted, breast lactating. Baby**:** Temperature 36.5°C, heartrate 134bpm, respiration 38cpm, stool/urine passed, weight 2.9kg.

Mother's Vital signs were checked and recorded

Vital Signs	Morning	Evening
Temperature	36.2°C	36.6°C
Pulse	82bpm	84bpm
Respiration	21cpm	24cpm
Blood Pressure	100/70mmHg	110/60mmHg

Baby 's vital signs were checked and recorded

Vital Signs	Morning	Evening
Temperature	36.5°C	36.2°C
Heart Rate	134bpm	136bpm
Respiration	38cpm	40cpm
Weight	2.9kg	2.9kg

SECOND POSTNATAL HOME VISIT

On 14th December, 2022, Madam Ataa Yaa was visited in the morning at7:30am and in the evening at 4:00pm. She and the baby and family were all doing well. A head to toe examination on both the mother and the baby was done and there were no abnormalities. Enquires about her previous complain (headache and fatigue) was made, she said she had been relieved but had difficulty in sleeping. She was encouraged to feed the baby on demand even at night and to take a rest during the day when baby is asleep. Her husband was encouraged to help in the care of the baby and also in the household chores together with her mother so that Madam Ataa Yaa could have some rest and sleep to promote her wellbeing. And also encouraged her to comply with the drugs given to her. The was baby bathed and her cord was dressed aseptically. Vital signs of the baby and mother together with observations made were recorded as follows; Baby: Temperature 36.3°C, pulse 134bpm, respiration 42cpm, weight 2.8kg, stools passed. Mother: temperature 36.2°C, pulse 78bpm, respiration 22cpm, Blood pressure 100/70mmHg, fundal height 14cm.

In the evening, findings were not different from the morning visitation.

Mother's vital signs were checked and recorded

Vital Signs	Morning	Evening
Temperature	36.2°C	36.3°C

Pulse	78bpm	80bpm
Respiration	22cpm	23cpm
Blood Pressure	110/70mmHg	120/80mmHg

Baby ‘s vital signs were checked and recorded

Vital Signs	Morning	Evening
Temperature	36.2°C	36.3°C
Heart rate	134bpm	136bpm
Respiration	42cpm	45cpm
Weight	2.8kg	2.8kg

THIRD DAY POSTNATAL HOME VISIT

On the 15th December, 2022 Madam Ataa Yaa was visited in morning at 8:00am and in the evening at 4:30pm. Greetings were exchanged and a warm welcome and seat was offered. She was asked about her health and that of her family and responded that they are all well. Permission was sought from Madam Ataa Yaa to examine her which she agreed. After hand washing was done with soap under running water and dried. The perinea pad was checked and the colour of the lochia was bright red with no foul smell and scanty in amount. The breast was lactating well. There were no observed abnormalities. Her vital signs were checked and recorded as follows: Mother**:** temperature 36.6°C, pulse 80bpm, respiration 20cpm, Blood pressure 110/70mmHg, fundal height 13cm. Baby :temperature 36.5°C, pulse 140bpm, respiration 42cpm, weight 2.7kg

In the evening, findings were not different from the morning visitation.

Mother's vital signs were checked and recorded

Vital Signs	Morning	Evening
Temperature	36.6°C	36.7°C
Pulse	80bpm	82bpm
Respiration	20cpm	21cpm
Blood Pressure	110/70mmHg	110/80mmHg

Baby 's vital signs were checked and recorde

Vital Signs	Morning	Evening
Temperature	36.5°C	36.6°C
Heart rate	140bpm	144bpm
Respiration	42cpm	42cpm
Weight	2.7kg	2.7kg

FOURTH DAY POSTNATAL HOME VISIT

From the 4th day onwards, Madam Ataa Yaa was visited to continue the care. The visits were only in the morning. Both Madam Ataa Yaa and the baby were doing well. On the 4th day which was 16th December, 2022 at 8:00am, Madam Ataa Yaa was taken through the routine examinations including a head to toe examination. The uterus remained firm and well contracted. Lochia was serosa with moderate flow. All findings after the examinations were within normal ranges. and communicated my findings to her. Baby was bathed and dressed the cord with

chlorhexidine gel. The cord was almost off. The cord was dry and loose. Madam Ataa Yaa was educated not to pull it off or apply herbs but wait for it to fall off itself. The baby was examined from head to toe in the presence of Madam Ataa Yaa and did not detect any abnormalities. The baby was normal and healthy. Madam Ataa Yaa was told to put the baby to breast and the baby suckled well on the breast. Enquiries about previous complain of loss of appetite was made and she said she is now able to eat half of her meals. Vital signs and observations made for mother and baby are as follows; Baby: Temperature 36.6ºC, pulse 133bpm, Respiration 34cpm, Stool Passed Urine Passed, Weight 2.7kg. Mother**:** Temperature 36.7ºC, Pulse 80bpm, Respiration 23cpm, Blood Pressure 110/70mmHg, Fundal Height12cm, Urine and stool passed, Breasts lactating.

Mother's vital signs were checked and recorded

Vital Signs	Morning
Temperature	36.7°C
Pulse	80bpm
Respiration	23cpm
Blood Pressure	110/70mmHg

Baby 's vital signs were checked and recorded

Vital Signs	Morning
Temperature	36.6°C
Heart rate	133bpm
Respiration	34cpm
Weight	2.7kg

FIFTH DAY POSTNATAL HOME VISIT

On 17th December, 2022, Madam Ataa Yaa and her family were visited. Both Madam Ataa Yaa and the baby were doing well. Madam Ataa Yaa and the baby were taken through the routines and all findings were in the normal ranges. They were both healthy. Findings were communicated to her and enquiries about her previous complaints were made which she said she had had enough rest and sleep that day. Baby was examined from head to toe in the presence of Madam Ataa Yaa and detected no abnormalities. Baby was normal and healthy. The baby suckled well on the breast. Madam Ataa Yaa said that she passes urine at least three times a day and empties her bowel daily. Madam Ataa Yaa were examined from head to toe and there were no abnormalities seen. The uterus remained firm and well contracted. Lochia was serosa with moderate flow. They were thanked and left after informing them that, my next visit would be my last visit to their homes. Mother and baby's vital signs and recorded observations made as follows; Baby: Temperature 36.6ºC, pulse 125bpm, Respiration 35cpm, Stool passed, Urine passed, Weight 2.8kg. Mother**:** Temperature 36.6ºC, Respiration 22cpm, Blood pressure 110/80mmHg, Pulse 87bpm and Fundal height 11cm.

Mother 's vital signs were checked and recorded

Vital Signs	Morning
Temperature	36.6°C
Pulse	87bpm
Respiration	22cpm
Blood Pressure	110/80mmHg

Baby ‘s vital signs were checked recorded

Vital Signs	Morning
Temperature	36.6°C
Heart rate	125bpm
Respiration	35cpm
Weight	2.8kg

SIXTH DAY POSTNATAL HOME VISIT

On 18th December, 2022, which was the sixth day, Madam Ataa Yaa and her family were visited. Madam Ataa Yaa and the baby were doing well they warmly welcomed me. the health of the mother and the baby and the response was positive. Madam Ataa Yaa and baby were examined and there were no abnormalities detected. They were both healthy. Madam Ataa Yaa perineal pad and lochia ware inspected which the colour was serous, moderate with no offensive oduor. Baby was toiled and tailed and in the process the cord fell off. baby was dress neatly and gave the baby to the mother to breastfeed. Baby suckled well on the breast. Madam Ataa Yaa and baby’s vital signs were checked and recorded the observations were as follows; Baby**:** Temperature 36.8ºC, Pulse 145bpm, Respiration 35cpm, Stool passed, Urine passed, Weight 2.9kg. Mother**:** Temperature 36.8ºC, Pulse 90bpm, Respiration 24cpm, Blood Pressure 110/70mmHg, Fundal Height 10cm

Mother ‘s vital signs were checked and recorded

Vital Signs	Morning
Temperature	36.8°C
Pulse	90bpm

Respiration	24cpm
Blood Pressure	110/70mmHg

Baby ‘s vital signs were checked and recorded

Vital Signs	Morning
Temperature	36.8°C
Heart rate	145bpm
Respiration	35cpm
Weight	2.9kg

SEVENTH DAY POSTNATAL HOME VISIT

On the 19th December,2022 around 9:00am, Madam Ataa Yaa was visited, the baby was doing well as well as the family. Routine examination was carried out on both the mother and baby from head to toe and there was no abnormality detected on any of them. The perineal pad was inspected the lochia was serosa with no odour. The baby was bathed with warm water and kept in a cot sheet. The umbilical cord was dressed well with chlorhexidine gel, urine and stool were also passed. Client made no complains. Client was reminded of the first postnatal visit to the clinic which was on the 19th December,2022 . Client was thanked and permission was sought to leave. Observations as well as vital signs for both mother and baby were also recorded as follows: Mother: Temperature 36.4ºC, Pulse 78bpm, Respiration 23cpm, Blood Pressure 110/70mmHg, Fundal Height 9cm. Baby: Temperature 36.5ºC, Pulse 130bpm, Respiration 42cpm, Stool passed, Urine passed, Weight 3.0kg

Mother ‘s vital signs were checked and recorded

Vital Signs	Morning
Temperature	36.8°C
Pulse	78bpm
Respiration	23cpm
Blood pressure	110/70mmHg

Baby ‘s vital signs were checked and recorded

Vital Signs	Morning
Temperature	36.5°C
Heart rate	130bpm
Respiration	42cpm
Weight	3.0kg

4.5 FIRST POSTNATAL VISIT TO THE CLINIC

Madam Ataa Yaa and her baby arrived at the clinic for postnatal care on the 20th December, 2022 accompanied by her mother. Client was neatly dressed and looked cheerful. They were welcomed and given a comfortable seat. Health educations on nutrition, immunization against preventable childhood diseases and family planning as well as care of the baby was given. Client was asked about her condition and that of the baby and she said they were doing well. Client said her baby was able to feed well and always sleeps well. Madam Ataa Yaa also confirmed that the baby passed urine and stools regularly. Permission was sought from Madam Ataa Yaa to examine the baby generally. She granted the permission and the procedure was explained to her. The baby was taken,

undressed and then wrapped with a clean cot sheet and placed on a flat surface for the examination in the presence of the mother. There were no skin rashes detected on the baby as well as no discharges from the eyes, nose and ears. No discoloration of the mucus membranes, palms, eyes, conjunctiva and feet were observed during inspection. Baby's abdomen was not distended and the umbilical stump was almost healed. The baby was neatly wrapped and was given back to the client's mother for Madam Ataa Yaa to be examined too. The baby's vital signs were checked and recorded as follows; Temperature 36.7^0 C, Apex beat 134 bpm, Respiration 42 cpm, Weight 3.1kg. Permission was sought from Madam Ataa Yaa to examine her from head to toe. The procedure was explained and she was asked to empty her bladder and a sample of urine was taken and tested for glucose and protein and all tested negative. Privacy was then provided. Hands were washed and dried and examination was commenced. On inspection, it was observed that the conjunctiva of the eyes was not pale, the nose was not discharging. Client's breasts were soft with no cracks or sore on the nipples. There was also no abdominal tenderness and the Fundus height was 8cm. Hands were washed and dried. There was no drainage of Lochia on inspection. After that findings were communicated to her. Her vital signs checked and recorded as; Temperature 37.2 degree Celsius, pulse 84, respiration 24 and Blood pressure 110/70mmHg. Madam Ataa Yaa was advised to complete all immunization scheduled. Client was reminded of her second postnatal visit to the clinic It was explained to Madam Ataa Yaa the care being given to her by me has come to an end since the period of the study was over. Madam Ataa Yaa and her entire family were thanked for their co-operation and for helping me to achieve my aim. Baby was registered at the Births and Deaths Registry and client was handed over to the public health nurse for continuity of care.

Mother 's vital signs were checked and recorded

Vital Signs	Morning
Temperature	37.2°C
Pulse	84bpm
Respiration	24cpm
Blood pressure	110/70mmHg

Baby ‘s vital signs were checked and recorded

Vital Signs	Morning
Temperature	36.7°C
Heart rate	134bpm
Respiration	42cpm
Weight	3.1kg

4.6 SECOND POST-NATAL VISIT TO THE CLINIC

According to the midwife in charge, on th23rd, January, 2023. Madam AtaaYaa came to the clinic for six weeks visit. They were warmly welcome and they all looked very healthy. General examination was conducted on the client from head to toe as well as vital signs after her permission was sought. Her vital signs and weight were checked and recorded as follows: Temperature 36.5ºC, Pulse 80bpm, Respiration 20cpm, Blood Pressure 110/70mmHg, Weight 67kg. Madam Ataa Yaa was given a urine sample container to provide some urine to be sent to the laboratory for urine analysis to be performed. She was educated on the need and procedure to provide midstream urine

for the examination. A sample of blood was also taken from Madam Ataa Yaa with her consent to be sent to the laboratory for her haemoglobin level to be tested. The results were explained to her as follows; Haemoglobin 14.6g/Dl, Urine protein Negative, Glucose Negative. Madam Ataa Yaa was sent to the palpation room where privacy was provided by drawing the curtains and closing doors and windows. She was helped to lie on the examination bed. Hands were washed with soap under running water and dried with a clean dry towel. Head to toe examination was done on her. On the head, hair was neat and well styled. The conjunctiva was pink and there were no discharges from the eyes, nose and ear. No abnormality was found on the mouth and neck. On the breast, no abnormalities such as sore nipple, engorgement, cracked nipple and mastitis were detected and the breasts were lactating well. On examining the abdomen, no abnormality such as sub involution, tenderness, enlargement of liver and spleen was detected. No scars were found and uterus was not palpable. With the lower extremities, certain condition such as oedema was looked out for. It was detected that she showed no abnormality. Speculum examination revealed no bruises on the cervix but showed slit-like appearance. She had not resumed her menses when asked. She was educated on the need to start a family planning method to prevent unwanted pregnancy. Her baby was also examined from head to toe to look out for abnormalities. On the head, the anterior fontanelle was palpated for pulsation and it was normal. The posterior fontanelle had closed. There were no discharges from the eyes and nose. The skin was nice with no rashes. The chest, upper and lower extremities were normal. The umbilical stump was inspected and it had healed. The lower extremities were normal. The findings on the baby were as follows: Temperature 36.2ºC, Respiration 24cpm, Apex heart beat 142bpm, Weight 5.1kg. Madam Ataa Yaa and her baby were handed over to the child welfare clinic and family planning unit for the six weeks' immunization against diphtheria, pertussis, tetanus, hemophilic influenza and hepatitis B. She was encouraged

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

. **NURSING CARE PLAN DURING PUERPERIUM**

PROBLEMS IDENTIFIED

1. Headache

2. Fatigue

3. Insomnia

4. Loss of appetite

SHORT TERM OBJECTIVES

1. Client will be relieved of headache within 24 hours.

2. Client will be relieved of the fatigue within 72 hours.

3. Client will be able to sleep for 4 hours within 48 hours.

4. Client will be able to eat half of her meals served within 24 hours.

LONG TERM OBJECTIVE GOALS

Client will go through the puerperal period without any complications to herself and her baby.

TABLE 1: NURSING CARE PLAN DURING PUERPERIUM

DATE / TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES/OUTCOME CRITERIA	NURSING ORDERS	NJURSING INTERVENTIONS	DATE / TIME	EVALUATION	SIGN
13/12/22 4:00pm	Headache related to labour stress.	Client will be relieved of headache within 24 hours as evidenced by: 1.Client verbalizing the absence of headache.	1.Reassure client. 2.Educate client to rest. 3.Encourage support Person to assist client in activities 4.Serve prescribed analgesic.	1.Client was reassured. 2.Client was educated to sleep during daytime while baby is asleep. 3.Support person was encouraged to take care of the baby to allow client have some rest. 4.Prescribed analgesic was served.	14/12/22 4:00pm	Goal fully met as client verbalized the absence of the headache.	M.D

TABLE 2: NURSING CARE PLAN DURING PUERPERIUM

DATE / TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES	NURSING ORDERS	NURSING INTERVENTIONS	DATE / TIME	EVALUATION	SIGN
13/12/22 4:00pm	Fatigue related to stress of labour.	Client will be relieved of the fatigue within 48 hours as evidenced by client verbalizing the absence of fatigue.	1. Reassure client 2. Educate client to have some rest during the day. 3.Encourage support person to assist client in taking care of the baby. 4. Educate client to eat well balanced diet.	1.Client was reassured. 2. Client was educated to rest during the day especially when baby sleeps. 3. Partner was encouraged to help with taking care of baby and chores so that mother could have enough rest. 4..Client was encouraged to eat healthy meals rich in protein, calories, vitamins and iron to get enough energy and drink lots of water.	15/12/22 4:00am	Goal fully met as client verbalized that she has been relieved of fatigue.	M.D

TABLE 3: NURSING CARE PLAN DURING PUERPERIUM

DA-TE / TI-ME	NUR-SING DIA-GNOSIS	NURSING OBJECTIVES/OUT-COME CRITERIA	NURSING ORDERS	NURSING INTERVENTIONS	DATE / TIME	EVALUA-TION	SIGN
14/12/22 7:30am	Insomnia related to stress of labour.	Client will be able to sleep for 10 hours within 24 hours as evidenced by client verbalizing that she can sleep.	1.Reassure client 2.Encourage support person to help with taking care of the baby. 3.Ensure a noise free and calm environment. 4.Encourage client to restrict visitors. 5.Encourage client to sleep whenever baby sleeps.	1.Client was reassured. 2.Support person was encouraged to assist client to take care of the baby. 3.Mother's room was kept calm and conducive for sleep 4. Client was encouraged to restrict visitors to help her sleep. 5.Client was encouraged to sleep immediately baby sleeps.	15/12/22 7:30am	Goal fully met as client verbalized that she can sleep.	M.D

TABLE 4: NURSING CARE PLAN DURING PUERPERIUM

DATE /TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES	NURSING ORDERS	NURSING INTERVENTION	DATE / TIME	EVALUATION	SIGN
15/12/22 8:00am	Loss of appetite related to labour stress.	Client will be able to eat half of her meals served within 24 hours as evidenced by support person observing client eating half of her meals served.	1. Reassure client. 2.Encourage client to practice oral hygiene. 3. Serve client's favorite food. 4. Serve client's food attractively. 5.Serve prescribed medications.	1.Client was reassured. 2.Client was encouraged to practice oral hygiene by brushing her teeth at least twice daily to increase her appetite. 3.Client was served with her favorite food. 4.Clients food was served attractively by garnishing the food. 5.Prescribed medication was served.	16/12/22 8:00am	Goal fully met as support person observing client eating half of her meals served.	M.D

SUMMARY AND CONCLUSION

The Client/Family Centred Maternity Care Study was conducted on Madam Agyemang Ataa Yaa Junior 23years-old gravida 3 para 2 and her entire family throughout pregnancy, labour and puerperium and she went through these processes safely without any complications. Madam Ataa Yaa became a regular attendant to the clinic since 14th July, 2022. She was managed through pregnancy, labour and puerperium safely through which all minor disorders were taken care of using the nursing care plan and goals were met when evaluated. She had a spontaneous vaginal delivery to a life female baby on 12th December, 2022 and discharged the next day. Client and family were visited for the first seven days after delivery. She visited the clinic on her first week and six weeks postnatal. Madam Ataa Yaa was given a focused and comprehensive care throughout her pregnancy, labour and puerperium. Madam Ataa Yaa and her baby were in a healthy condition and they were handed over to the Midwife-In-Charge for continuity of care. Client and her family were much grateful at the end of the study. The care rendered to Madam Ataa Yaa has helped in the equipment of skills necessary to meet the needs of pregnant, labouring and puerperal women. It has also established between us a good interpersonal relationship. The care study is an important and managerial tool which gives opportunity to student midwives to put into practice theoretical knowledge and to be able to deal with obstetric problems as midwifery professional.

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APPENDIX I

MOTHER'S ANTENATAL RECORDS

DATE	WEIGHT (KG)	BP (mmHg)	URINE FOR GLUCOSE AND PROTEIN	PRESENTATION AND POSITION	FETAL HEART RATE (bpm)	GESTATIONAL AGE IN WEEKS	FUNDAL HEIGHT (cm)	DESCENT	COM-PLAINS	TREAT-MENT	SIGN
14/07/22	65	100/60	Negative/Negative	_	+	18	19	_	Nausea and vomiting	Routine drugs	
04/08/22	65	100/70	Negative/Negative	_	+	22	24	_	No complains	Routine drugs	

01/09/22	**66**	**100/60**	**Negative/Negative**	**Cephalic**	**+**	**26**	**28**	**_**	**No complains**	**Routine drugs**	
29/09/22	**65**	**100/60**	**Negative/Negative**	**Cephalic**	**+**	**30**	**31**	**_**	**Insomnia**	**Routine drugs**	
24/10/22	**63**	**110/70**	**Negative/Negative**	**Cephalic**	**136**	**38**	**35**	**5/5th**	**Constipation, heart-burns**	**Routine drugs**	
01/12/22	**63**	**110/80**	**Negative/Negative**	**Cephalic**	**140**	**39**	**38**	**5/5th**	**No complains**	**Continue treatment**	
08/12/22	**64**	**122/70**	**Negative/Negative**	**Cephalic**	**135**	**40**	**39**	**5/5th**	**No complains**	**Continue treatment**	

APPENDIX II

LABORATORY INVESTIGATIONS

DATE	SPECIMEN	INVESTIGATIONS	NORMAL VALUE	INVESTIGATION RESULT	REMARKS
14/07/22	Blood	Haemoglobin level Sickling Blooding grouping Rhesus factor Antibody screen, MPs HBSAG VDRL Syphilis PMTCT	11.5-14g/dl Negative AB, A, B, O Positive No Defect parasite seen Non-reactive Non-reactive Non-reactive Non-reactive	11.7g/dl Negative B positive Positive Negative Non-reactive Non-reactive Non-reactive Negative	Normal Normal Normal Normal Normal Normal Normal Normal Normal
	Urine	Protein, Acetone Sugar	Negative Negative Negative	Negative Negative Negative	Normal Normal Normal
	Stool R/E	Worms	Negative	No ova detected	Normal
04/08/22	Urine	Protein Sugar	Negative Negative	Negative Negative	Normal
01/09/22	Stool	Worms	No ova Detected	No ova detected	Normal
29/09/22	Urine	Protein Sugar	Negative Negative	Negative Negative	Normal Normal
	Blood	Haemoglobin level	11.5-14g/dl	12.4g/dl	
24/10/22	Urine	Sugar Protein	Negative Negative	Negative Negative	Normal Normal
	Blood	Haemoglobin	11.5-14g/dl	12.2g/dl	Normal

LABORATORY INVESTIGATIONS

24/11/22	Urine	Sugar Protein	Negative Negative	Negative Negative	Normal Normal
	Blood	Haemoglobin	11.5- 14g/dl	12.4g/dl	Normal
01/12/22	Urine	Sugar Protein	Negative Negative	Negative Negative	Normal Normal
	Blood	Haemoglobin	11.5-14g/dl	12.4g/dl	Normal

APPENDIX III

PHARMACOLOGY OF DRUGS (MOTHER)

NAME OF DRUGS	CLASSIFICAT-ION	DOSAGE	ROUTE OF ADMINISTRAT-ION	ACTION & USE	ACTUAL EFFECTS	SIDE EFFECT OF DRUGS	SIDE EFFECT EXPERI ENCED
Tablet folic acid	Haematinics	5 milligrams once daily	Orally	Proper formation and function of red blood cell	Haemoglob in level increased	Nausea and vomiting	None
Tablet multivitamin	Vitamin preparation	200 milligrams twice daily	Orally	Increased appetite. Helps in the formation of red blood cell	Increase appetite.	Gastro intestinal disturbances	None
Tablet ferrous sulphate	Iron supplement	200 milligrams 2 twice	Orally	Help in formation of haemoglobin and red blood	Haemoglob in level increased	Gastrointest inal disturbance	Dark stool

PHARMACOLOGY OF DRUGS USED(MOTHER)

NAME OF DRUGS	CLASSIFICATION	DOSAGE	ROUTE OF ADMINISTRATION	ACTION & USE	ACTUAL EFFECTS	SIDE EFFECT OF DRUGS	SIDE EFFECT EXPERIENCED
Tablet sulphadoxin epyrimetha mine	Anti-malaria and prophylaxis	3 doses stat from 16 weeks or after quickening and the remaining doses within 4 weeks interval until she delivers.	Orally	Treatment and prevention of malaria	Malaria prevention	Itching, nausea, dizziness, headache	None
Injection tetanol	anti-tetanus	0.5 milligrams	Subcutaneously	Helps in the prevention of tetanus	Client protected against tetanus	slight fever and chills	None

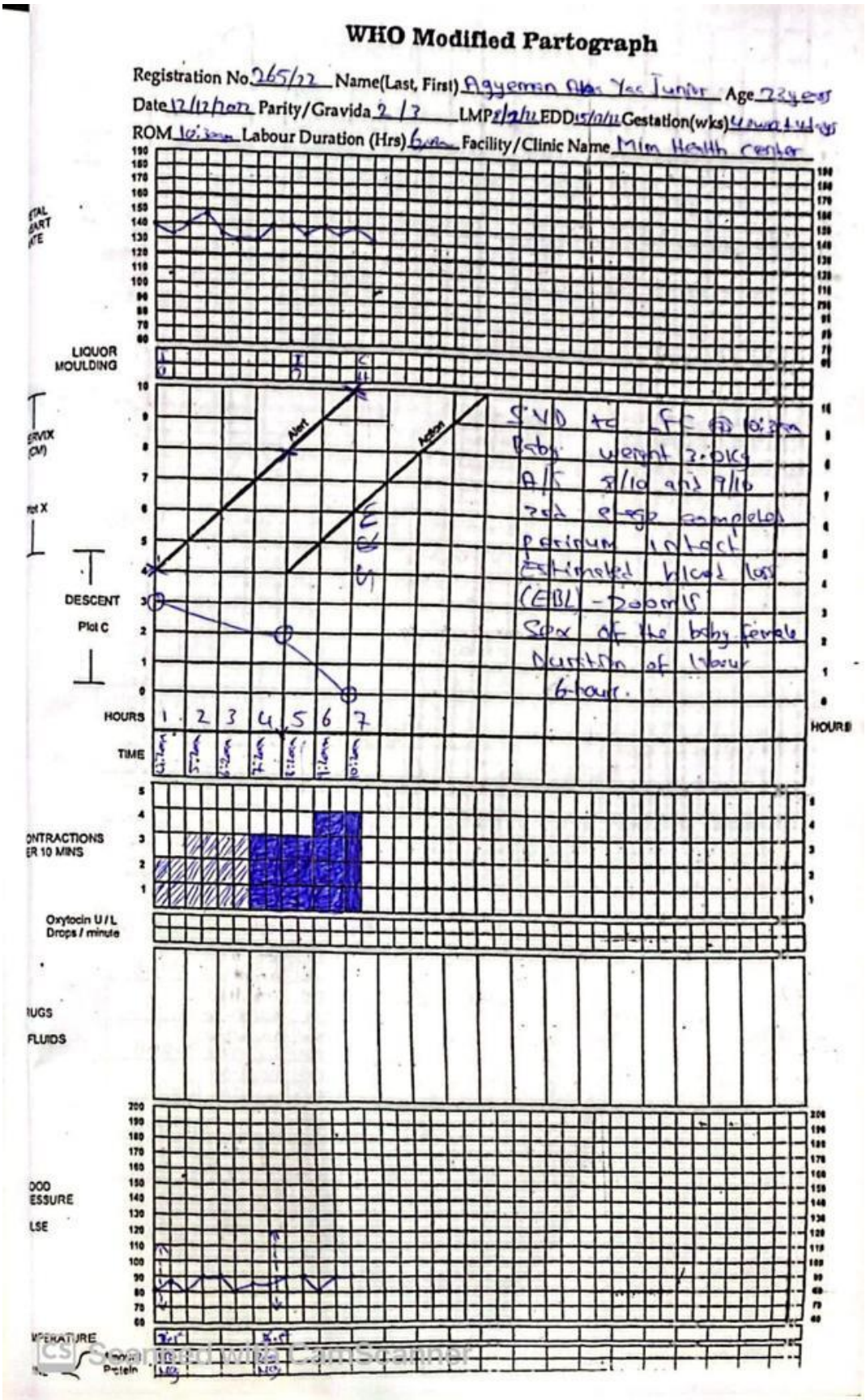
APPENDIX IV

PHARMACOLOGY OF DRUGS USED (BABY)

NAME OF DRUGS	CLASSIFICATION	DOSAGE	ROUTE OF ADMINISTRATION	ACTION & USE	ACTUAL EFFECTS	SIDE EFFECT OF DRUGS	SIDE EFFECT EXPERIENCED
Vitamin K	Group K vitamins (coagulant)	1.0mg	Intramuscular	Production of prothrombin which aids in clotting	No bleeding	None	None
Gentamycin eye drop.	Antibiotics	2 drops	Instillation	To prevent infection	Infection of the eye was prevented	None	None
Poliomyelitis	Antigen vaccine	2 drops	Orally	Production of antibodies	Baby is under observation	There may be diarrhea	None
Injection Bacillus Calmette Guerin	Antigen vaccine	0.5 Milligrams	Intradermal	Production of antibodies for prevention of tuberculosis	Baby is under observation	Blister formation	None

PHARMACOLOGY OF DRUGS USED (BABY) CONTIUED

Pneumococcal 1	Antigen	0.5 ml	Intramuscular right thigh	Vaccinates neonate against pneumonia	Under observation	Redness at the sight of injection and fever.	None observed
Pentavalent 1 (5 in 1)	Antigen	0.5 ml	Intramuscular left thigh	Vaccinates neonate against diphtheria, pertussis (whooping cough), tetanus, hepatitis B, homophiles influenza B	Under observation	Low grade fever	None observed
Rotavirus 1	Antigen	1.5 ml	Oral	Prevention of gastroenteritis	Under observation	None	None


WHO Modified Partograph
Registration No 265/22 Name(Last, First) Agyeman Yaa Junior Age 23yrs
Date 12/12/2022 Parity/Gravida 2/3 LMP 2/3/22 EDD 15/10/22 Gestation(wks) 41wks 4days
ROM 10:30am Labour Duration (Hrs) 6hrs Facility/Clinic Name Mim Health center
LIQUOR
MOULDING
CERVIX (CM)
Plot X
DESCENT
Plot C
Alert
Action
HOURS 1 2 3 4 5 6 7
TIME 4:30pm 5:30pm 6:30pm 7:30pm 8:30pm 9:30pm 10:30pm
S.V.D at FF @ 10:30pm
Baby went 3.0kg
A/S 5/10 and 9/10
3rd stage completed
perineum intact
Estimated blood loss (EBL) - 300mls
Sex of the baby female
Duration of labour 6 hour.
CONTRACTIONS PER 10 MINS
Oxytocin U/L
Drops / minute
DRUGS
FLUIDS
BLOOD PRESSURE
PULSE
TEMPERATURE
Urine Protein
Scanned with CamScanner

LABOR NOTES

Client progressed well into 2nd stage of labour and had LFC @ 10:25pm with fifth minutes B/S 8/10 and fifth minutes B/S -9/10. placenta and membranes delivered at 10:45pm EBL =120mls. Lovenite of oxytocin was given to the mother. perineum was intact. skin to skin done and breast-feeding was initiated for the first 30minutes. Essential care was done for the baby. Baby was wrapped in a clean sheet. Both mother and baby are made comfortable in bed.

Please circle or write responses.

DELIVERY

DATE: 12/12/2022 TIME: 10:25pm METHOD: (Spontaneous) / Vacuum Extraction / C/S / Other

PERINEUM: (Intact) / Episiotomy / Laceration

ANESTHESIA: (None) / Local / General

THIRD STAGE

Active Management: Yes / No Medication: Time 10:26pm Type/Dose oxytocin lovenite

PLACENTA: TIME: 10:45pm (Complete) / Incomplete

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

BABY

Weight: 3.0kg

Sex: Male / (Female)

Baby Position: (Vertex) / Breech / Other

APGAR

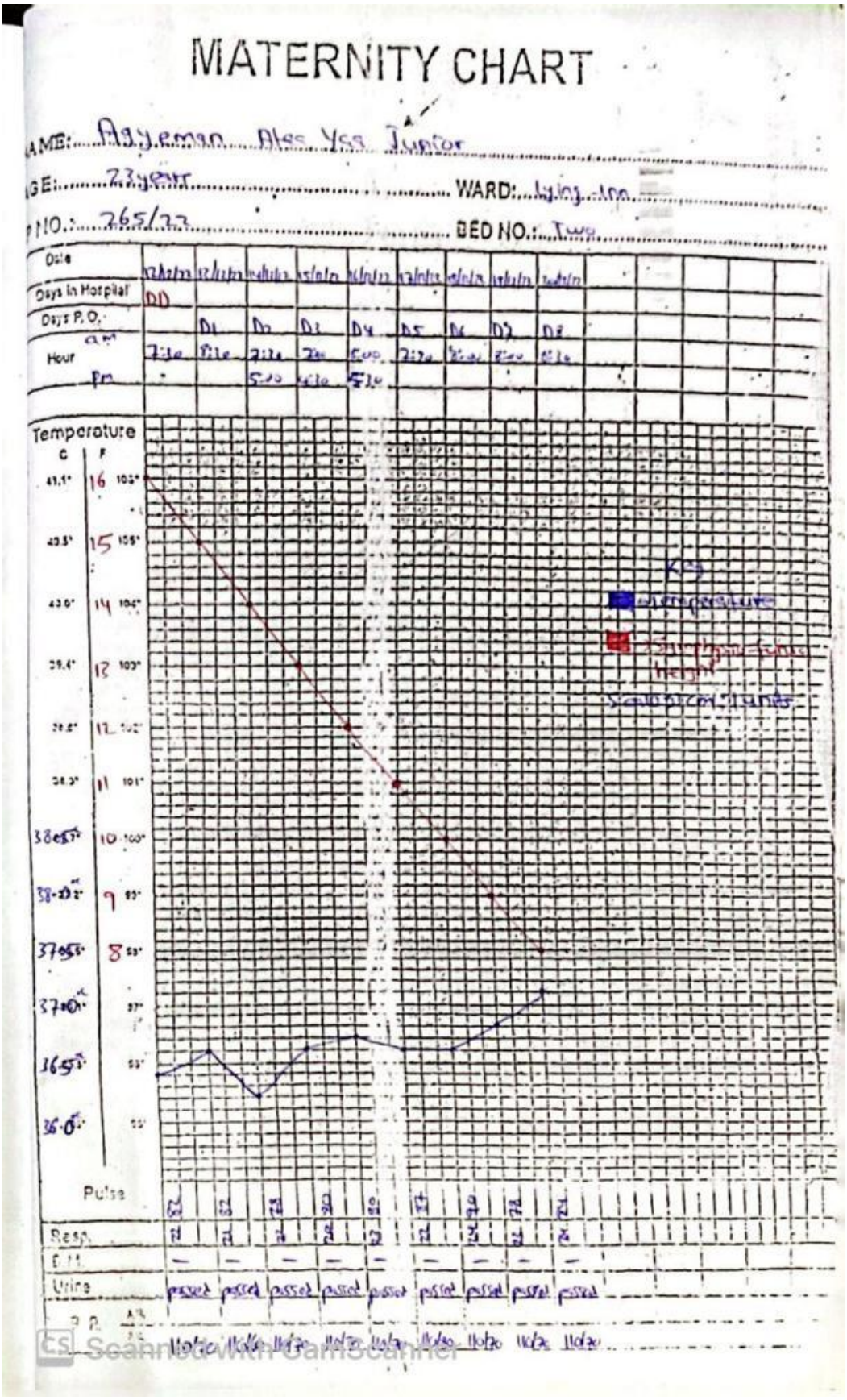
Time	Color	Breath	Heart	Tone	Reflex	TOTAL
1 min	2	2	2	1	1	8
5 min	2	2	2	1	2	9

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

FOURTH STAGE MONITORING

Frequency	Time	B/P	Pulse	Fundus	Bleeding	Bladder
Every 15 minutes first 2 hours	11:00pm	120/60	75	IL	not active	150mls
	11:15pm	120/60	78	contracted	not active	
	11:30pm	120/60	75	contracted	not active	—
	11:45pm	120/60	75	contracted	not active	
	12:00pm	110/70	75	contracted	not active	
	12:15pm	110/70	93	contracted	not active	100mls
	12:30pm	110/70	77	contracted	not active	
	12:45pm	120/80	80	contracted	not active	—
Every 30 minutes For 1 hour	1:15pm	120/60	80	contracted	not active	
	1:45pm	120/70	80	contracted	not active	100mls

Birth Attendant Mary Darkwah (student midwife) Date 12/12/2022


MATERNITY CHART
NAME: Aggeman Alex Yes Junior
AGE: 23year
WARD: Living room
PNO.: 765/22
BED NO.: Two
Date
Days in Hospital
Days P.O.
Hour
Temperature
Pulse
Resp.
Urine
Key
Temperature
Pulse
Respiration
Urine
passed
Water
Scanned with CamScanner

NEW BORN EXAMINATION FORM

Name: Baby Agyeman Aka Yaa Tuntar Date of Assessment: 12/12/2022 Time: 12:04pm
Date of Birth: 12/12/2022 Time of Birth: 10:25am Sex: ☐ M ☑ F Age at time of Assessment (days/hrs) 1hour 39m
Astational Age ☐ 40+3wk ☐ Mode of Delivery: ☑ Vaginal Assisted Vaginal C-Section
APGAR: 1min 9/10 ☐ 5min ☐ 9/10 Birth Weight: ☐ 3.0 kg ☐ Length: 49 cm Head Circumference: 32 cm
Temperature at time of Assessment: 36.8 °C Urine passed: Yes No Meconium passed: Yes No
Name of Assessor (Midwife/Doctor): Darkwah Mary

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

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

3. Tone
☑ Normal
☐ Floppy *
☐ Increased *

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

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

6. Cry
☑ Normal
☐ Shrill *
☐ Absent *

7. Suck
☑ Good
☐ Weak
☐ Absent

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

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

10. Fontanel
☑ Normal
☐ Sunken *
☐ Raised *
☐ Wide (>3cm)*

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

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

13. Mouth
☑ Normal
☐ Cleft palate
☐ Cleft Lip
☐ Other:_____

15. Neck
☑ Normal
☐ Swelling
☐ Webbed
☐ Other:_____

16. Clavicle
☑ Normal
☐ Swelling/Fracture

17. Chest
☑ Normal (Shape/movement)
☐ Abnormal_____

18. Heart rate
Rate: 140
☑ Normal (100-160)
☐ <100 *
☐ >160*

19. Femoral pulse
☑ Present
☐ Not palpable*

20. Abdomen
☑ Normal
☐ Distended*
☐ Scarphoid*
☐ Abdominal defect*
☐ Masses:_____
☐ Other_____

21. Back (spine)
☑ Normal
☐ Abnormal Swelling *
☐ Hairly patch over spine
☐ Abnormal dimple
☐ Abnormal curvature

22. Limbs
☑ Normal
☐ Abnormal_____

23. Genitalia
Male Genitalia
☐ Normal
☐ Undescended testes
☐ Abnormal meatus
☐ Hernia
☐ Other:_____

Female Genitalia
☑ Normal
☐ Fistula(meconium/urine through abnormal opening in vagina) *
☐ Large clitoris *
☐ Other:_____

24. Anus
☑ Patent
☐ Imperforate*

25. Resuscitation provided
☑ One
☐ Suction/stimulation
☐ Bag and mask
☐ Endotracheal Tube
☐ Ventilator/CPAP

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

*May indicate severe disease that requires urgent referral
Diagnoses (if known) Spontaneous vaginal delivery

Classification: (Overall assessment) [ ] Normal [ ] Baby with a Problem [ ] Danger Sign/ <1500g/ severe Jaundice
Plan: [ ] Routine Care[ ]Problem. Continue supportive in-patient care [ ] Urgent Referral Advanced Care[ ] Discharge

NEW BORN EXAMINATION FORM

Name: Baby Agyeman Bless Yaa Tundar Date of Assessment: 12/12/2022 Time: 17
Date of Birth: 12/12/2022 Time of Birth: 16:25pm Sex: ☐ M ☑ F Age at time of Assessment (days/hrs) ___
Astational Age ___ ☐ Mode of Delivery: ☑ Vaginal Assisted Vaginal C-Section
APGAR: 1min 8 ☐ 5min ☐ 9/10 Birth Weight: ☐ 3.0 kg ☐ Length: 49 cm Head Circumference: 32 cm
Temperature at time of Assessment: 36.2 °C Urine passed: Yes No Meconium passed: Yes
Name of Assessor (Midwife/Doctor): Dauwah Mary

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

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

3. Tone
☑ Normal
☐ Floppy *
☐ Increased *

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

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

6. Cry
☑ Normal
☐ Shrill *
☐ Absent *

7. Suck
☑ Good
☐ Weak
☐ Absent

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

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

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

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

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

13. Mouth
☑ Normal
☐ Cleft palate
☐ Cleft Lip
☐ Other: ___

15. Neck
☑ Normal
☐ Swelling
☐ Webbed
☐ Other: ___

16. Clavicle
☑ Normal
☐ Swelling/Fracture

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

18. Heart rate
Rate: 140
☑ Normal (100-160)
☐ <100 *
☐ >160*

19. Femoral pulse
☑ Present
☐ Not palpable*

20. Abdomen
☑ Normal
☐ Distended*
☐ Scaphoid*
☐ Abdominal defect*
☐ Masses: ___
☐ Other ___

21. Back (spine)
☑ Normal
☐ Abnormal Swelling *
☐ Hairly patch over spine
☐ Abnormal dimple
☐ Abnormal curvature

22. Limbs
☑ Normal
☐ Abnormal ___

23. Genitalia
Male Genitalia
☐ Normal
☐ Undescended testes
☐ Abnormal meatus
☐ Hernia
☐ Other: ___

Female Genitalia
☑ Normal
☐ Fistula(meconium/urine through abnormal openin vagina) *
☐ Large clitoris *
☐ Other: ___

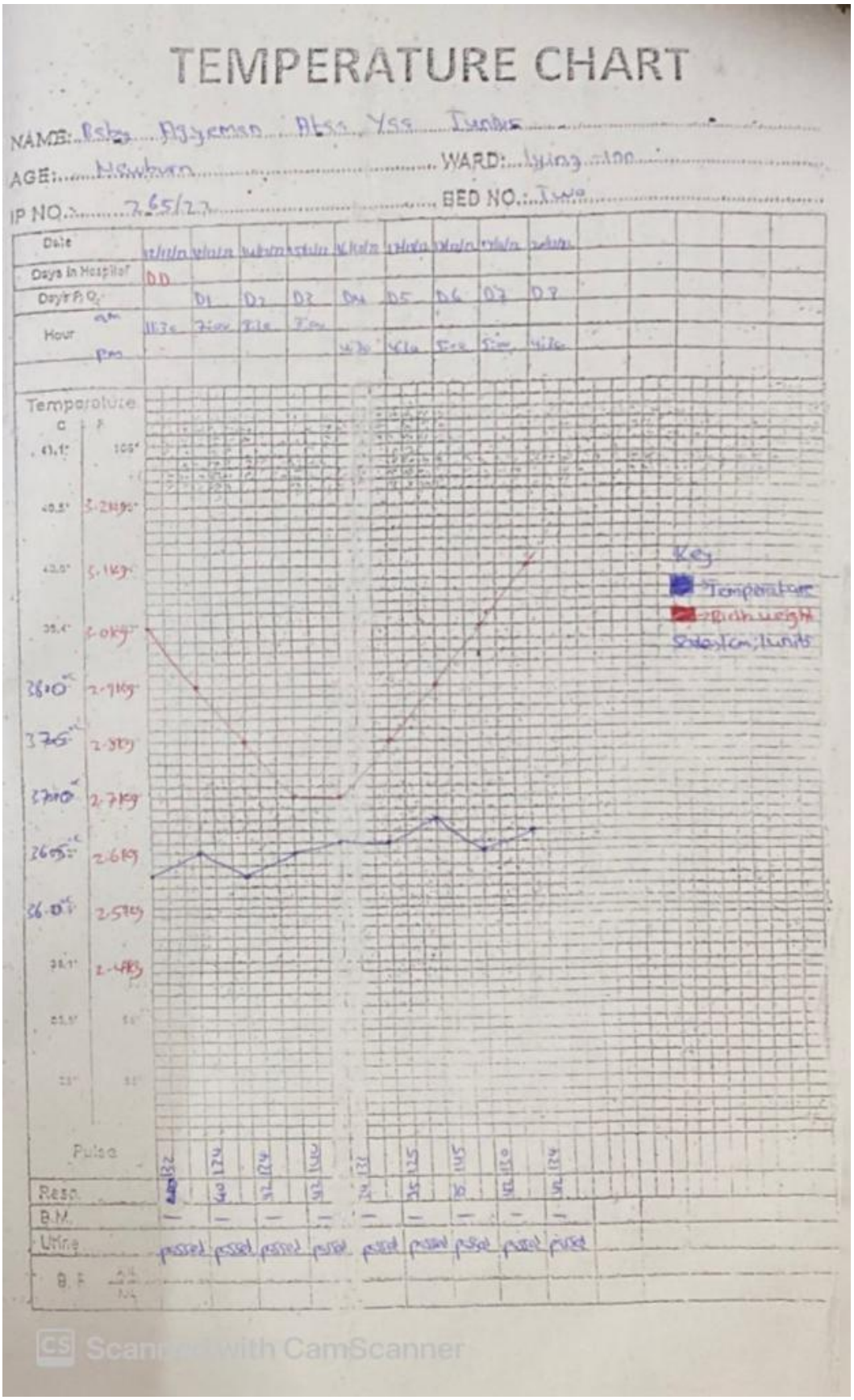
24. Anus
☑ Patent
☐ Imperforate*

25. Resuscitation provic
☑ One
☐ Suction/stimulation
☐ Bag and mask
☐ Endotracheal Tube
☐ Ventilator/CPAP

26. Services provided
☑ Vitamin K1 given
☑ Eye care provided
☑ Cord care provided
☑ Breastfeeding initiated
☑ Breastfeeding establishe
☑ Immunization (BCG Pol
☑ BCG ☑ Polio Immuniz
☑ Antibiotics in mother
☐ Antenatal corticosteroid

*May indicate severe disease that requires urgent referral
Diagnoses (if known) Spontaneous Vaginal delivery

Classification: (Overall assessment) [ ] Normal [ ] Baby with a Problem [ ] Danger Sign/ <1500g/ severe Jaundice
Plan: [ ] Routine Care [ ]Problem. Continue supportive in-patient care [ ] Urgent Referral Advanced Care [ ] Discharg


TEMPERATURE CHART
NAME:
AGE: Newborn
WARD: Lying in
IP NO.: 765/22
BED NO.: Two
Date
Days in Hospital
Day's P.O.
Hour
Temperature
C
F
Pulse
Resp.
B.M.
Urine
B.P.
Key
Temperature
Birth weight
Scale: 1 unit
passed
Scanned with CamScanner

NEW BORN CHART

Name: Baby Ogyeman Akos Yaa Jnoor ..... No: ..... Birth Weight: 3.0kg .....

Sex: Female ..... Mother's No: ..... Length: 49.5cm .....

Nature of Delivery: Spontaneous vaginal delivery ..... Diagnosis: Term baby .....

Date of Birth: 12/12/2022 ..... Time: 10:35 am ..... Date of Discharge: 13/12/2022 .....

Date	12/12/22		13/12/22		14/12/22		15/12/22		16/12/22		17/12/22		18/12/22		19/12/22		20/12/22					
No. of Days	DOD		D1		D2		D3		D4		D5		D6		D7		D8					
Weight	3.0kg		2.9kg		2.8kg		2.7kg		2.7kg		2.8kg		2.9kg		3.0kg		3.1kg					
	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM
Temperature	36.3°C	36.5°C	36.5°C	36.2°C	36.2°C	36.5°C	36.5°C	36.6°C	36.6°C		36.6°C		36.8°C		36.5°C		36.7°C					
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 Genitalia — No Abnormalities Detected.																					

SIGNATORIES

THE STUDENT

NAME: MISS. MARY DARKWAH

SIGNATURE .....

DATE .....6/07/2023.....

THE MIDWIFE IN-CHARGE – MIM HEALTH CENTRE

NAME: MRS. SOPHIA ABRAFI

SIGNATURE: .....

DATE.....14/07/2023.....

THE SUPERVISOR

NAME: MS MONICA BOAKYE

SIGNATURE .....

DATE .....6/07/2023.....

THE PRINCIPAL

NAME: MONICA NKURUMAH

SIGNATURE.....

DATE.....14/07/2023.....

ACADEMIC COORDINATOR - NURSING
FAMILY NURSING & MIDWIFERY
TRAINING COLLEGE, MIM-PLAM