HOLY FAMILY NURSING AND MIDWIFERY TRAINING COLLEGE-BEREKUM

A CLIENT /FAMILY CENTERED MATERNITY CARE STUDY ON

MADAM AKUA MANU

BY

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PREFACE

A family centred maternity care is a tool that allows the midwife to put into practice the skills and knowledge which has been acquired during her training to provide quality services to mother and baby. Improving this care, the individual is totally cared for, taking into consideration, her social, economic, physical, emotional, as well as spiritual aspect of life. The midwife identifies and manages the problems of the client by the use of nursing process through-out pregnancy, labour and puerperium. The care ensures that maximum and individualized care is given to expectant women and also help the client to have a live and healthy baby after the delivery process.

The client/family centred maternity care study is a requirement by the Nursing and Midwifery Council of Ghana as a partial fulfilment of the award of a Professional Registered Midwifery Certificate.

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INTRODUCTION

In our now contemporary era, efforts are being made to achieve the Sustainable Development Goal 3 that involves good health and wellbeing. A client and family centred maternity case study is a systematic approach rendering comprehensive obstetric care to an expectant mother and her family during pregnancy, labour, and puerperium without any complications to both mother and baby.

In achieving this objective, the client is given a comprehensive care considering her as a unique individual with special problems. This may include physical, emotional, financial, psychological or spiritual problems. By careful assessment of these problems and needs, the midwife is able to plan an appropriate care for the client and her family that could enable her to achieve her goal.

This client/family centred maternity care was rendered on Madam Akua Manu, a 26-year-old pregnant woman Gravida 2 para 1 alive who was met at the Subinso health centre on 7th November, 2022, at a gestation of 36 weeks.

Madam Akua commenced antenatal clinic on the 5th of April 2022 during which her gestation was 12 weeks. She had no history of any medical conditions such as hypertension, asthma, sickle cell and the like. She had been screened on Hepatitis B, malaria parasite and HIV/AIDS and all revealed negative. Her haemoglobin level was good and she was feeling well. Various health education on the danger signs of pregnancy which includes, bleeding, excess vomiting, severe headache and oedema were given to her.

The script is organized into four chapters, appendices, pharmacology of drugs administered, various records during puerperium, bibliography and signatories;

Chapter one; this gives details about how the midwife obtained information, collected data and every history about the client, family and community. This is a thorough assessment done on the client and her family to detect any deviation from normal and offer help if possible.

Chapter two; this entails first contact with the client, subsequent antenatal visits to the clinic, home visits, problems identified and short- and long-term goals and the nursing care plan.

Chapter 3; this talks about the four stages of labour and its management as well as

chapter four; this talks about puerperium during which mother and baby will be monitored. A nursing care plan is drawn at the end of chapters two, three, and four in order to identify the client's problems and manage them accordingly

LITERATURE REVIEW

PREGNANCY

Pregnancy: The state of carrying a developing embryo or fetus within the female body. This condition can be indicated by positive results on an over-the-counter urine test, and confirmed through a blood test, ultrasound, detection of fetal heartbeat, or an X-ray. Pregnancy lasts for about nine months, measured from the date of the woman's last menstrual period (LMP). It is conventionally divided into three trimesters, each roughly three months long (Davis, 2021). The most important tasks of basic fetal cell differentiation occur during the first trimester, so any harm done to the fetus during this period is most likely to result in miscarriage or serious disability. There is little to no chance that a first-trimester fetus can survive outside the womb, even with the best hospital care. Its systems are simply too undeveloped. This stage truly ends with the phenomenon of quickening: the mother's first perception of fetal movement. It is in the first trimester that some women experience "morning sickness," a form of nausea on awaking that usually passes within an hour. The breasts also begin to prepare for nursing, and painful soreness from hardening milk glands may result (Davis, 2021).

As the pregnancy progresses, the mother may experience many physical and emotional changes, ranging from increased moodiness to darkening of the skin in various areas. During the second trimester, the fetus undergoes a remarkable series of developments. Its physical parts become fully distinct and at least somewhat operational. With the best medical care, a second-trimester fetus born prematurely has at least some chance of survival, although developmental delays and other handicaps may emerge later. As the fetus grows in size, the mother's pregnant state will begin to be obvious. In the third trimester, the fetus enters the final stage of preparation for birth. It increases rapidly in weight, as does the mother (American College of Obstetricians and Gynecologist, 2018).

According to Davis (2021), conception to about the 12th week of pregnancy marks the first trimester. The second trimester is weeks 13 to 27 and the third trimester starts about 28 weeks and lasts until birth. Women gain weight all over their bodies while they are pregnant.

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

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

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

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

LABOR

Labor consists of a series of rhythmic, involuntary or medically induced contractions of the uterus that result in effacement (thinning and shortening) and dilation of the uterine cervix (Artal-Mittelmark, 2022). The World Health Organization (WHO) defined normal birth as "spontaneous in onset, low-risk at the start of labor and remaining so throughout labor and delivery. The infant is born spontaneously in the vertex position between 37 and 42 completed weeks of pregnancy. After birth, mother and infant are in good condition" (WHO, 2020).

The stimulus for labor is unknown, but digitally manipulating or mechanically stretching the cervix during examination enhances uterine contractile activity, most likely by stimulating release of oxytocin by the posterior pituitary gland (Artal-Mittelmark, 2022). Normal labor usually begins within 2 weeks (before or after) the estimated delivery date. In a first pregnancy, labor usually lasts 12 to 18 hours on average; subsequent labors are often shorter, averaging 6 to 8 hours (Artal-Mittelmark, 2022).

As discussed by Artal-Mittelmark (2022) rupture of the chorioamniotic membranes or bloody show is diagnostic for onset of labor. Labor begins with irregular uterine contractions of varying intensity; they apparently soften (ripen) the cervix, which begins to efface and dilate. As labor progresses, contractions increase in duration, intensity, and frequency. As sepcified by Marshall and Raynor (2014), the onset of labour is a process, not an event; therefore it is

very difficult to identify exactly when the painless (sometimes painful) contractions of prelabour develop into the progressive rhythmic contractions of established labour.

Traditionally, three stages of labour are described: the first, second and third stage, but this is a rather pedantic view, as labour is obviously a continuous process. It has also been acknowledged that there are more than three stages of labour, namely the latent, active and transitional phases, and these not only encompass specific physical changes but should also account for the emotional effects observed in women during this time (Marshall & Raynor, 2014).

1. **The 1st stage**—from onset of labor to full dilation of the cervix (about 10 cm). Begins with regular rhythmic uterine contractions to the full dilatation of the cervix and is managed by a partograph. The first stage lasts for about twelve to fourteen hours in primi Gravida and six to twelve hours in multigravida (Artal-Mittelmark, 2022).

    a. The **latent phase of labour** is prior to the active phase stage of labour and may last 6–8 hours in primigravidae when the cervix dilates from 0 cm to 4 cm dilated. The latent phase of labour is so subjective and poorly understood that a normal range is difficult to measure. According to Marshall and Raynor (2014), the cervical canal shortens from 3 cm long to <0.5 cm in length during this time. A woman may believe herself to be laboring, whereas sound midwifery judgement and understanding of the physiology of the first stage of labour may lead the midwife to the diagnosis of the latent phase of labour. Both the woman and midwife being aware of the latent phase of labour, and allowing this time to pass with no intervention, can prevent the medical diagnosis of poor progress or failure to progress later in labour. In a hospital setting, it is good practice not to commence the partogram until active labour has commenced. Assessing the active phase of

labour has been highlighted as essential in reducing interventions in normal labour (Marshall & Raynor, 2014).

b. The **active phase** within the first stage of labour is the time when the cervix usually undergoes more rapid dilatation. This begins when the cervix is at least 4 cm dilated and, in the presence of rhythmic contractions, progressively dilates to 10 cm or full dilatation. When in labour, contractions will often be accompanied or preceded by a bloodstained mucoid show: that is, the release of the operculum from the cervical canal as effacement and dilatation progresses. Occasionally, the membranes will rupture, at which stage the midwife may seek assurance that there are no significant changes in the fetal heart rate due to the rare complication of cord prolapse and that meconium is not present in the liquor, indicating fetal compromise (Marshall & Raynor, 2014).

c. The **transitional phase** of the first stage of labour is from when the cervix is around 8 cm dilated until it is fully dilated or until expulsive contractions associated with the second stage of labour are felt by the woman. There is often a brief lull in the intensity of uterine activity at this time. Many women may feel the urge to push during transition. In addition to physiological responses, women can experience a range of experiences and emotions. The woman may verbalize her distress, direct it at her birth partner(s), alternatively she may be quiet and contemplative (Marshall & Raynor, 2014).

2. The second stage of labour has traditionally been regarded as the phase between full dilatation of the cervical os, and the birth of the baby (Marshall & Raynor, 2014). On average, it lasts 2 hours in nulliparas (median 50 minutes) and 1 hour in multiparas (median 20 minutes). It may last another hour or more if conduction (epidural) analgesia or intense opioid sedation is used. For spontaneous delivery, women must

supplement uterine contractions by expulsively bearing down. In the 2nd stage, women should be attended constantly, and fetal heart sounds should be checked continuously or after every contraction. Contractions may be monitored by palpation or electronically (Artal-Mittelmark, 2022). During the 2nd stage of labor, perineal massage with lubricants and warm compresses may soften and stretch the perineum and thus reduce the rate of 3rd- and 4th-degree perineal tears (Aasheim, et al., 2017).

3. The **third stage** can be defined as the period from the birth of the baby to complete expulsion of the placenta and membranes. It involves the development of the relationship between mother, baby and father, the separation, descent and expulsion of the placenta and membranes, the control of haemorrhage from the placenta site, and sometimes, the initiation of breast-feeding. Although traditionally labour is divided into three distinct component parts to aid comprehension, it should be viewed as one continuous process. With this in mind, it is important to understand that the physiology of the third stage depends, in part, on what has happened during pregnancy as well as during the first and second stage of labour, and on the woman's basic level of health and wellbeing. The midwife's knowledge and evidence-based skills play a crucial role in ensuring that the care received by the woman works with, not against, physiological processes. The placenta may shear off during the final expulsive contractions accompanying the birth of the baby or remain adherent for some time. The third stage usually lasts between 5 and 15 minutes, but any period up to 1 hour may be considered normal (Marshall & Raynor, 2014).

PUERPERIUM

The words "postpartum" and "postnatal" are sometimes used interchangeably. In this report we use the word "postpartum", except in sections exclusively dealing with the infant. In those sections the word "postnatal" is used. The postpartum period (also called the puerperium)

according to Western textbook definitions starts shortly after the birth of the placenta (American College of Obstetricians and Gynecologist, 2018).

Following the birth of a baby, placenta and membranes, the newly birthed mother enters a period of physical and emotional/psychological recuperation. Skin-to-skin contact is advocated immediately following birth and during the postnatal period as there is clear evidence of benefit to the mother and father. The puerperium starts immediately after birth of the placenta and membranes and continues for 6 weeks. In many cultures around the world 40 days for recuperation is a time-honored practice. A general expectation is that by 6 weeks after birth a woman's body will have recovered sufficiently from the effects of pregnancy and the process of parturition. However, there has now been a recognition that the return to a non-pregnant state of health and wellbeing can take much longer (Marshall & Raynor, 2014).

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

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

During this time a number of physiological and psychological changes take place which are; The reproductive organs return to the non-pregnant state.

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

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

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

The transition to parenthood involves major adjustments within a family and some mothers will welcome and actively seek help and support from a midwife during the postnatal period, but some women, for a range of reasons, may not. Women from different cultural backgrounds may have traditions that conflict with the current management of postpartum care consider that they already have sufficient skills and experience. Not being able to speak or understand English may also prevent a woman from seeking help. Although a visit to the home might have been planned, there will also be times when women are not at home when the midwife visits. It is important to keep in mind individual circumstances and whether these might have any bearing on a no-access visit. For example, parents with a disability such as hearing loss or poor mobility might not hear a doorbell. It is, therefore, important to make arrangements for contact to be made by alternative means (e.g. using a visual alarm or telephone to alert the woman of the visit beforehand). The midwife needs to recognize situations where the mother perceives she has different priorities from those routinely provided by the healthcare services (Marshall & Raynor, 2014)

WHY CLIENT WAS CHOSEN

The client/family centred maternity care study is required by Nursing and Midwifery Council of Ghana from every student midwife to help contribute to the award of the professional Registered Midwifery Certificate.

Madam Akua was chosen as the client for the maternity care study on 7/11/2022, which happened to be her sixth visit. After a short education, it was noticed that the client lacked knowledge on Family Planning and she had a lot of misconceptions about family planning. Her pregnancy was without complications, with good past obstetric history and she met the criteria for selection after enquiries were made.

After going through the antenatal process, she gave the direction to her house and was promised of a visit.

CHAPTER ONE

CLIENT'S PARTICULARS

1.0 INTRODUCTION

This chapter gives details about how information was obtained through comprehensive history taking which consists of personal and social history, family history, medical history, surgical history, menstrual history, habits of daily living and past and present
Obstetric histories.

1.2 PERSONAL/SOCIAL HISTORY

Madam Akua a 26-year-old woman gravida 2 para 1 alive (G2P1A) was born on the 1st January, 1997 at Subinso under Wenchi municipality in the Bono Region. She lives in her marital home at Subinso in the Bono Region of Ghana with her husband and daughter. She is a Christian and her parents are both Christians. She is an Akan by tribe and speaks Twi and English. Madam Akua is tall, hairy and dark in complexion. She is a member of the Assemblies of God church Ghana. She had her formal education up to junior high school and she is now a farmer. She's married to Mr. Timothy who hails from Wenchi in the Bono Region of Ghana and is also a member of the Assemblies of God church Ghana, Wenchi Branch. According to the client, her next of king is her husband who is a farmer.

1.3 FAMILY HISTORY

Madam Akua is the eldest born of her parents, Mr. Manu and Madam Agnes, among three children. Both parents are famers. The father comes from Subinso, so as the mother. According to the client, her parents gave birth to 3 children 2 are females and 1 male. Madam Akua stated that there is no congenital abnormality in the family like cleft lip and palate, heart disease, and inherited conditions such as hypertension and diabetes mellitus, also there is no history of

multiple pregnancy in her family. Madam Akua said her family seek medical care from the hospital when sick and also, the cause of death in their family usually results from natural occurrence.

1.4 MEDICAL HISTORY

Madam Akua stated that, she has never suffered from any severe form of medical illness such as hypertension, diabetes mellitus and asthma but on some occasion suffer from headache, simple malaria, general body pains which are usually treated at the outpatient department (O.P.D). She has never been admitted in a hospital for any of the above-mentioned conditions beside Pregnancy and labour and she has never been transfused before. The client said that she has no known allergy.

1.5 SURGICAL HISTORY

Madam Akua said she has never under gone any surgical operation on the uterus such as caesarean section, laparotomy, pelvis, spine or the vagina neither has she had any accident involving the pelvis nor ever been transfused with blood.

1.6 MENSTRUAL HISTORY

Madam Akua had her first menstruation (menarche) at the age of 15 which created some kind of anxiety in her due to the fact that she knew nothing about menstruation. She told the mother about what she has seen and the mother educated her on that, she said she experiences 28 days cycle period lasting for 7days. She said she gets moderate flow for the first 5 days and slight flow for 2 days, and she uses sanitary pads which she changes 2 to 3 times a day. She used to have dysmenorrhea during her menstrual period but stop after she gave birth to the first child.

1.7 HABITS OF DAILY LIVING

According to Madam Akua, she usually wakes up around 5:30am says her morning prayer, cleans and tidies up the environment. She brushes her teeth and that of her daughter. She then prepares something for the family to eat and leaves for work around 8:00am

She reports from work to the house around 4:00pm and prepares supper. Around 6:30pm when they are done eating, she takes her bath and baths her daughter as well and normally goes to bed around 9:30pm. Client normally empties her bowel once daily and her bladder anytime it is full and takes her bath twice a day. During weekend, she does her laundry, tidies up her room and takes some rest because she works from Monday to Friday.

Madam Akua eats three times daily and her favourite food is Fufu and Groundnut soup.

During her leisure hours she takes a stroll with her husband and kids in their neighbourhood as they converse. Client neither drinks alcohol nor smokes.

1.8 PAST OBSTETRICAL HISTORY

Pregnancy

Madam Akua said she carried her first pregnancy[G2P1A] to term with no history of abortion or miscarriage. She had her first pregnancy in 2016 that is 6 years interval between the first and the current pregnancy. She had no complications such as pregnancy induced hypertension [PIH], hyperemesis gravidarium, antepartum haemorrhage and gestational diabetes among others. According to her, she experienced some of the minor disorders such as nausea, vomiting, back ache, leg cramps and frequent micturition which she reported to the hospital and they were explained to her as normal physiological changes in pregnancy which will resolve after childbirth.

She attended antenatal clinic for 8 times during her previous pregnancies and received all the doses of Sulphadoxine Pyrimethamine [SP] and her first and second doses of tetanus toxoid immunizations.

Labour

She laboured for 8 hours and had spontaneous vaginal delivery to a live female on 19th December 2016 at Subinso health centre.

The first child weighed 3.5kg at birth.

she was able to initiate breast feeding at the first minute and her conditions were stable. According to Madam Akua, her placenta was delivered completely and her amount of blood loss was 150ml as told by the midwife.

Puerperium

According to client, she went through puerperium without any complications. She started breastfeeding within the first 30 minutes of birth and breastfed her baby exclusively for six months. She introduced complementary foods after six months and she weaned when her at one year six months old. She resumed her normal menstruation after six months. She attended her postnatal visit at regular periods and her child was immunized against all the vaccine preventable diseases which included polio, measles, diphtheria, whooping cough and tetanus among others. She never made use of any artificial family planning method but used the calendar-based method after delivery to control or space birth.

1.9 PRESENT OBSTERTRIC HISTORY

Madam Akua's first visit to the Hospital was on the 5th of April, 2022 when she was in her 12th week of gestation. Her last menstrual period was 1st March 2022, and her EDD was calculated

as 8th December, 2022 but her first ultrasound scan gave expected date of delivery as 9th December, 2022. She said she noticed the movement of the foetus (quickening) at the 16th week of gestation and the movement became stronger as the pregnancy advanced.

According to the client she experienced minor disorders of pregnancy like nausea and vomiting, excessive salivation, pica and frequency of micturition which are normal physiological changes in pregnancy. She was educated on exercise, personal and environmental hygiene, malaria and nutrition. Her vital signs and other assessments were recorded as follows;

Temperature - 36.2°C

Pulse - 70bpm

Respiration - 19cpm

Blood Pressure - 127/76mmHg

Weight - 62kg

Height - 166cm

Haemoglobin - 11.7g/dl

Rhesus factor - Positive

Blood Grouping - O

Sickling - Negative

Human Immune Virus (HIV) - Non-reactive

Glucose 6 Phosphate Dehydrogenase - No defect

Stool culture - No abnormalities detected

Urine Albumin and Glucose - Negative

Hair to toe examination was carried out with no abnormalities detected. Symphysio fundal height measured 10cm. Client complained of backache and she was educated on sleep, rest and exercise.

She was given the following treatment;

Tablet ferrous sulphate: 200mg daily x 30 days, to treat low blood level of iron, which may lead to complications such as preterm delivery, low birth weight and infant mortality. Tablet multivitamin: 200mg daily x 30 days, for the health of the mother and good health of the baby. Tablet folic acid 5mg: daily x 30

30 days, it helps prevent neural tube defects such as spinal bifida and also reduce the risk of other birth defects such as cleft lip, cleft palate and heart defects, Tetanus diphtheria immunization 1st dose was given on 5/03/22 and the 2nd dose was on 25/05/22. Sulfadoxine-pyrimethamine (SP) 1st dose was given to her on the 29th June, 2022, when she was 20weeks of gestation because .She was told that (SP) wasn't available during her previous visits, second dose was given to her on the 19th of October, 2022, when she was 32 weeks of gestation, the third dose was given on 7th of November, 2022 when she was 336weeks of gestation, to protect her and the foetus against malaria.

CHAPTER TWO

ANTENATAL CARE

2.0 FIRST CONTACT WITH CLIENT

Madam Akua was first met on 7th November, 2022 which was Monday when she came for antenatal care and was looking cheerful. She was offered a seat, her maternal record card was collected and quickly glanced through and it was realized that she was 36 weeks of gestation, and her pregnancy was without any abnormality. The midwife in-charge was already informed about choosing a client for the client and family cantered maternity care study. After a short education on family planning, she asked questions that portrayed that she did not understand family planning as a whole and she had a lot of misconceptions about it. She was taken as a special client in order to educate her on the importance of family planning and also use the opportunity to provide focused antenatal care to her. Introduction was made to her as a student of Holy Family Nursing and Midwifery Training College, Berekum on community clinical practice who would like to take her as a client for a care study. All the necessary procedures that would be done on her throughout pregnancy, labour and puerperium were explained to her and she gladly accepted and promised to give maximum cooperation. She was also encouraged to bring up anything that bothered her mind, thus asking a lot of questions. She was the first person to come for assessment. When she entered, she was welcomed once again and offered a seat, hands were washed and her vital signs were checked and recorded as follows,

- Temperature 36.5^{0}C
- Blood pressure 117/80mmHg
- Pulse 80bpm
- Respiration 21cpm
- Weight 76kg

Importance of general examination was explained to her which include early detection of abnormalities, to ensure that both mother and baby are in good condition and also detect early complications during labour.

Urine testing

Client was asked to empty her bladder and midstream urine sample was taken from client and mackintosh apron and gloves were worn. The colour, odour and presence of sediments were checked and the colour was amber with no sediments. Strip for checking sugar and protein was dipped in the urine and removed immediately and tapped at the edge of the container. The strip was compared to the colour changes on the container. Findings were negative. Urine was discarded and protective clothing removed. Proper hand washing was done. All these findings were recorded in client's antenatal record booklet and findings explained to her.

After the above procedures, education was given to her on the following; warning signs of pregnancy like bleeding per vaginum, oedema and losing of liquor. Budgeting and layette, signs of impending labour, sleeping in an insecticide net to prevent malaria and good nutrition were emphasized.

Head to toe examination

Madam Akua's consent was sought to perform general head to toe examination, after she had emptied her bladder to prevent discomfort during the procedure and to prevent inaccurate measurements and findings. She was reassured that all findings would be communicated to her afterwards. Her gait was seen to be normal as she walked into the examination room. She was assisted to change into a gown, and was helped onto the examination couch by making her sit, she lied in a lateral position, then to a dorsal position and draped with clean sheet. Hand washing was performed with soap under running water and dried with clean hand towel. Palms

were warmed by rubbing them together. A head to toe examination was conducted under the supervision of the midwife in-charge.

On the head, her hair was neatly braided and the scalp was clean with no dandruff, lice and breakages found. The face looked cheerful without any oedema. The conjunctiva was pink, the sclera was clear without any jaundice. The eyes were without discharge. The ears and nose were inspected with no discharges. The mouth, teeth and tongue were clean with no dental caries or offensive odour. She had no cracks, pallor or inflammation of the lips. The neck was inspected and palpated for swelling, enlarged lymph nodes and distended veins and none were detected**.**

With the breast palpation, the breasts were exposed to check for size, shape, signs of pregnancy, dimpling and nipple retraction and condition of the skin. Then one breast was covered and she was asked to put the hand of the part to be examined under her head. The breast was palpated systematically in a circular manner starting from the axillary region using the inner aspect of the fingers and client was taught self - breast examination. She was advised to examine her breast regularly for early detection and reporting of any abnormalities. Areola was squeezed gently to examine the kind of discharge whether bloody or pussy. The same was done for the other breast and no abnormality was noted.

The Upper Extremities were inspected and she was asked if she feels any tingling and tightness of the fingers on making a fist. The hands and fingers were also inspected for oedema, pallor of palms, nail beds and capillary refill but no deviation from the normal was detected.

The Lower Extremities were inspected and palpated for oedema, tenderness in calf muscles, varicose veins and the size, equality and alignment of the legs but everything was in its rightful place.

Client was asked to lie in the lateral position for the back to be examined. At the back, there was no tenderness at the costovertebral angle, scoliosis, oedema of the sacral region and also the condition of the surrounding skin was noted and no abnormalities were identified.

Abdominal palpation

Inspection was done with shape of the abdomen noted to be ovoid and the size medium. The abdomen was inspected for scars, striae gravidarium, linear nigral, and in all, linear nigral and striae gravidarium was found with no scars.

Measurement of symphysio-fundal height was done by placing the zero end of the measuring tape on the fundus and then extended to the upper boarder of the symphysis pubis. The symphysio-fundal height was 35cm and gestational age was 36weeks +3 days of gestation.

Fundal Palpation was carried out while facing client, the fundal palpation was done with both palms curved inwards at the fundus of the uterus. Through the process, it was detected that the buttocks of the foetus were occupying the fundus since a soft mass was felt.

Lateral Palpation was completed with one hand used to stabilize the right side of the maternal uterus, the other hand was moved gently on the left side of the maternal uterus and rough parts were felt indicating limbs. This was repeated at the right side and a smooth part was felt, indicating the foetal back. This helped to locate where to place the fetoscope to listen to the foetal heart sound.

Pelvic Palpation was done by facing the lower limbs of the woman with her knees slightly flexed with slow breaths from the mouth, the palms were curved inward below the umbilicus and directed towards the symphysis pubis. A hard mass was felt indicating the presence of the head. The presentation was cephalic, lie was longitudinal and position was right occipito anterior.

Descent was assessed as the anterior shoulder of the foetus and the upper boarder of the symphysis pubis were located. Five fingers were admitted between the anterior shoulders and the symphysis pubis, indicating that descent was 5 /5th.

Auscultation followed with a fetoscope placed at the smooth surface which is an indication of back to listen to the foetal heart sounds, while comparing with the maternal pulse. Foetal heartbeat was 138 beats per minute with good rhythm. Client confirmed that foetal movements were felt.

Permission was then sought from Madam Akua to examine her perineum and genital area which she permitted. Client was assisted to relax on the examination bed. Hands were washed and dried with clean dry towel. A pair of examination gloves were worn before the examination was commenced. On inspection, the vulva was neatly shaved and no scar, oedema, genital warts, varicose veins and lesion were detected.

After the examination, she was helped to get off the examinations couch and was thanked for her cooperation. She was helped to dress up and offered a seat. Hands were washed and dried with clean towel. The findings were communicated to her after which, it was recorded into her maternal health record booklet. Birth preparedness and complication readiness was discussed with client. It comprehensively included intentions of putting in place necessary layette such as cot sheet, baby napkins or diapers, old clothes, baby oil, baby dress etc pack them so she will not leave out anything when labour sets in. Arrangements to be put in place with regards to delivery in a place where there is a skilled provider to attend to delivery, available means of transportation and other funds she can access when needed to pay for care during normal birth. She was encouraged to make provision for a support person of her choice to accompany her during transport and someone to care for her home and child during her absence and also blood donor to help in case it will be needed. She was made to understand these things were supposed to be in place to prevent any inconveniences in case of emergency. She was asked if she had

any problem and she verbalized that she was experiencing heart burns and walking difficulties. She was educated on the heart burns that it was due to the relaxation of the cardiac sphincter by the action of progesterone and the relaxation of the ligaments and joints by the hormone relaxin respectively. She was taught on how to manage these discomforts as avoiding the intake of oily food and spicy foods and avoid lifting heavy objects. After that she was encouraged to increase the intake of any protein food, green vegetable and fruits so that she can be healthy during the pregnancy, labour and puerperium. She was informed of her next date of visit to the clinic which was on 14th November 2022. Madam Akua was encouraged to visit the hospital if she feels unwell before the scheduled date. Her address was taken and a date for a visit to her house was scheduled which was on the 8th of November, 2022. She was served with her fifth dose of SP on DOT and the following drugs were served to be taken home. Tablets folic acid 5mg daily x 7 days but she was educated to take the folic acid 2 days later because of its interaction with the SP.

Tablets multivitamin 200mg daily x 7 days

Tablets iron ferrous sulphate 200mg daily x 7 days

She was escorted as she left the facility for her house.

2.1 FIRST ANTENATAL HOME VISIT

On the 8th of November, 2022, the first antenatal home visit to Madam Akua and her family was made at 4:00pm. The Journey was made by walking. Madam Akua was living closer to a saw-milling centre about 4 miles from the hospital. On arrival, a warm welcome was given and a seat and water were offered. She was in the house with her husband and her children.

An introduction was made to the husband as her personal midwife, since the husband was around, it made it convenient for an education on family planning to be given to the couple and

also to inspect her layette. But before then, a general inspection on her environment was made to help rule out any problem that may interfere with pregnancy, childbirth and puerperium.

Madam Akua with her daughter and her husband live in a nice brick house, two detached rooms roofed with iron sheets. The house is built with veranda large enough to contain the members. It has a bathroom and toilet roofed with iron sheets, windows and doors to provide proper ventilation, they used electricity as their source of light. Madam Akua's personal hygiene was good because she bathed at least twice daily and kept her surrounding clean and emptied their refuse in a nearby public refuse container in their area. They had a tap in their house which was their source of drinking water, and the client said she normally fetch the tap water into containers for future use because the tap sometimes does not flow for days. Permission was asked to inspect these containers and upon inspection they appeared neat and had lids too. She was asked to bring her layette for inspection but after inspecting the layette, it was realized that some necessary items were not included in the layette, so she was asked to include health insurance and also some money to support her at the hospital in case of any financial emergency. They were then educated on family planning. They were educated on the methods of family planning, importance of family planning and the benefits of family planning. Madam Akua and her husband were both involved in the discussion, they were told that some of the importance of family planning were; to prevent unwanted pregnancy, delay child bearing, space unwanted pregnancy and improve reproductive health. Some of the methods they were educated on were; the fertility awareness method and, artificial methods such oral contraceptives and barrier methods. After the discussion, the client said she will make up her mind on the method she wants when she is ready.

Madam Akua was asked how she was co-operating with the pregnancy and she said that she has backache and breathing difficulties. Explanation was made for her to understand that the backache was as a result of relaxation of the ligament by a hormone called relaxin and as a

result of descent of the fetus, she was reassured that she will deliver successfully to a healthy baby. She was educated that in order to minimize the backache she should assume a posture that will make her comfortable and also position herself well when on bed to avoid extreme physical exhaustion in order to minimize the breathing difficulties. When she was questioned of any problem, she said she had no more complains so they were congratulated for their cooperation throughout the interaction. Her husband was encouraged to give her all the necessary support after which they were informed on the next visit and she said she had no problem about the date and, permission was then sought to leave.

2.2 SECOND HOME VISIT

The client and family were visited on the 11/11/2022 at 3:30pm as scheduled. A warm welcome and a seat was offered. Greetings were exchanged. They were all in good condition. The aim for the visit was to check to ensure that, the layette is well prepared toward labour. The layette was inspected and it was well prepared. She was thought deep breathing exercise so she can practice during labour. Signs of true labour was emphasized as lower abdominal pain with painful uterine contractions and blood-stained mucus discharge thus ''show'' and she was also educated on the need for a support person. Also, the importance of exclusive breastfeeding was not left out, how to position and attach the baby to the breast and how to care for the baby was emphasized. She was educated to brush her teeth on each morning and evening, take her routine drugs regularly to boost up appetite, take fruits before meals and need for her to eat nutritious diet always but in bits. Permission was sought to leave.

2.3 SUBSEQUENT VISIT TO THE CLINIC

On the 14nd November, 2022, Madam Akua made her next visit to the antenatal clinic at 8:00am for the routine check- up at 37 weeks +3 day of gestation. She was welcomed and made comfortable, her vital signs were checked and recorded as;

- Blood pressure 114/70mmHg
- Temperature $36.0^{0}C$
- Respiration 20cpm
- Pulse 78bpm
- Weight 71kg

On palpation symphysio fundal height was 38cm, position was right occipito anterior, presentation was cephalic, lie was longitudinal and foetal heart rate 140bpm. Findings were communicated to her and recorded in the antenatal record book. Haemoglobin was repeated and the result was 11.3g/dL. Hands were washed and her routine drugs were served as follows, tablet ferrous sulphate, tablet folic acid and tablet multivitamin as once daily intake for seven days. She was asked if there was any complains and verbalized that she is suffering from constipation. She was reassured of relief and that it is due to the reduced peristalsis and relaxation of the large intestine by hormone progesterone. She was advised to take a lot of fruits and eat fibre diet which will soften the faecal matter and easy passage. She was encouraged to do minor exercise. Also, the importance of rest and sleep was stressed upon which includes; it aids in digestion, it increases circulation and blood supply to the vital organs such as brain, heart and also reduce maternal stress. She was also advised to report to the clinic if she experiences labour pains or any sickness before the next visit.

2.4 NURSING CARE PLAN DURING ANTENATAL CARE

Nursing care plan is written outline indicating the systematic method of identifying client's needs and then planning and providing a holistic individualized nursing care. It is aimed at identifying client's actual and potential needs and putting up a plan in solving such needs. The nursing care plan is derived from the nursing process which comprises five main stages and

these stages are the Assessment, Diagnosis, Planning, Implementation and Evaluation (Weller 2009)

2.5 PROBLEMS IDENTIFIED DURING THE ANTENATAL CARE INCLUDE

- Heart burns – 8th November 2022
- Backache – 11th November 2022
- Knowledge deficit on family planning- 8th November 2022
- Breathing difficulties – 11th November 2022
- Constipation - 14th November 2022

SHORT TERM OBJECTIVES

- Client will gain information on family planning within 24 hours
- Client will be relieved of heart burns within 24 hours
- Client will cope with backache within 24 hours
- Client will cope with breathing difficulties within 24 hours
- Client bowel elimination will improve within 24 hours

LONG TERM OBJECTIVE

Client will be physically and psychologically healthy throughout pregnancy, labour and puerperium without any complications to the mother and baby

TABLE 1: NURSING CARE PLAN DURING ANTENATAL

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
8/11/22 8:00am	Heart burns related to pressure of the growing foetus on the abdomen and relaxation of the cardiac sphincter.	Client will be relieved of heart burns within 24 hours as evidence by client verbalizing, she no more experiences heart burns.	1. Assure client. 2. Encourage client avoid foods that triggers heart burns. 3. Encourage client to eat little food at a time. 4. Encourage client to assume appropriate posture when sleeping. 5. Encourage client take in more water	1. Client was reassured that heartburns will resolve when managed accordingly. 2. Client was educated to minimize intake of oily and fatty foods and increase protein foods. 3. Client was encouraged to take in little food at a time 4. Client was encourage to elevate the head end of the bed when sleeping. 5. Client was encouraged to take in at least 8 cups of water in the day	8/11/22 8:00am	Goal fully met as evidence by client verbalizing relieve of heart burns.	**J.N**

TABLE 1: NURSING CARE PLAN DURING ANTENATAL CONT;

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES/ OUTCOME CRITERIA	NURSINGORDERS	NURSING INERVENTIONS	DATE/ TIME	EVALUATION	SIGN
11/11/22 at 4:00PM	Backache related to physiological changes in pregnancy	Client will cope with backache throughout pregnancy as evidence by client verbalizing that she is coping with the backache	1. Reassure client that with her cooperation, her condition will improve after delivery. 2. Encourage client to avoid long standing 3. Encourage client to have enough rest and sleep 4. Educate client on passive exercises 5. Educate client to avoid wearing high heels	**1.**Client was reassured that her condition will improve after delivery 2. Client was encouraged to avoid long standing. 3. Client was encouraged to have enough rest and sleep for about 2 hours in the afternoon and 8 hours at night 4. Educate client on passive exercises such as walking 5.Educate client to wear low heels and flaps	12/11/22 4:00pm	Goal fully met as evidenced by client verbalizing that the pain has reduced	**J.N**

TABLE 1: NURSING CARE PLAN DURING ANTENATAL

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVE/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
8/11/22 8:00am	Knowledge deficit on family planning related to inadequate information on family planning as evidenced by client talking about misconceptions	Client will have adequate knowledge on family planning within 24 hours as evidence by client verbalizing that she has cleared doubts on family planning misconceptions	1. Ressure client 2. . Educate client on methods of family planning to the client 3. Explain the importance of family planning to the client 4. Allow client to ask questions bothering her and answer appropriately 5. Assess client's level of understanding and ask for feedback	1. Client was reassured that family planning is a safe method in child spacing. 2. Client was educated on methods like oral contraceptives, barrier method, calendar base method and lactational amenorrhea method 3. Importance of family planning such as, prevention of unwanted pregnancy, delay in child bearing and improvement of reproductive health were explained to client. 4. Clients questions were answered appropriately 5. Clients understanding was assessed by client answering questions on the education that was done	8/11/22 8:00am	Goal fully met as evidence by client verbalizing that she no longer has misconceptions on family planning	J.N

TABLE 1: NURSING CARE PLAN DURING ANTENATALCONT;

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE /TIME	EVALUATION	SIGN
11/11/22 4:00pm	Breathing difficulty related to growing fetus exerting pressure on diaphragm	Client will cope with breathing difficulty within 24 hours as evidence by client verbalizing that she is coping	1.reassure client that with corperation there will be improvement 2.explain condition to client 3. encourage client to have enough rest 4. educate client on proper sleeping position 5. educate client to wear cotton and loose clothes	1. Client was reassured that breathing will improve when lightening occurs 2. Physiology of breathlessness was explained to client as related to pressure exerted on the diaphragm by the growing fetus. 3.Client was advised to have rest at least 2 hours during the day and 8 hours during the night. 4.Client was encouraged to prop herself up in bed 5. Client was educated to wear loose cotton clothes	12/11/22 3:00PM	Goal fully met as evidenced by client verbalizing breathing pattern has improved	

TABLE I; NURSING CARE PLAN DURING ANTENATAL CONT;

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVE OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
14/11/22 9:00am	Constipation related to inadequate fluid intake and lack of exercise	Client bowel elimination pattern will improve within 24 hours as evidence by the client verbalizing that she can empty her bowel.	1. Reassure client that it is a physiological change and it will soon be resolve 2. Educate client to take in more fluid 3. Educate client to take in foods that increases bowl movement 4. Encourage client to avoid eating late at night. 5. Encourage client to do mild exercises	1. Client was reassured that she will be relieved of constipation after interventions have been made. 2. Client was educated to take at least 8 glasses of water a day 3. Client was encouraged to take in fruits and vegetables 4. Client was encouraged to eat at least 2 hours earlier before bed time 5. Client was encouraged to do mild exercises like walking	15/12/22 9:00am	Goal fully achieved as evidence by client that she can eliminate her bowel.	J.N

CHAPTER THREE

LABOUR

3.0 INTRODUCTION

This chapter consists of how Madam Akua was admitted and managed during the first, second, third and fourth stages of labour. It emphasizes on the partograph and nursing care plan for the management of the problems identified and also elaborates on the immediate care of the baby at birth.

3.1 ADMISSION AND MANAGEMENT OF FIRST STAGE OF LABOUR

Admission

On the 27th of November, 2022, Madam Akua was brought to the clinic by her husband and a friend with the complaints of waist pain, backache and severe lower abdominal pain at 6:15am. She was welcomed and a seat was offered. According to her she started experiencing lower abdominal pains at 2:30am. She said she was having regular uterine contraction with waist pain and a mucoid discharge from the vagina. After taking the information from her, it was realized that it was true labour and her facial expression and responses indicated that she was in pain. Her maternal record book was taken and she was made to lie on a well-dressed bed. She was assisted to lie on her left to prevent supine hypotension. Routine examination was carried out and recorded as follows;

- Temperature 36.9°C
- Blood pressure 125/80mmHg
- Pulse rate 75bpm
- Respiration 23cpm

After checking her vital signs, she was then examined. Procedure for head to toe examination was explained to her and privacy was provided. Bed pan was served and she voided 100mls of urine. Midstream urine was taken and tested for protein and glucose; both were negative. She was asked of her last meal and bowel action and she said she took fufu with light soup as her supper at 5:00 pm and emptied her bowel 6:30pm before taking her bath that evening. She was also, asked if she took any medication to relieve her of the pains before reporting to the clinic but no medication was taken.

Permission was then sought for head to toe examination to be done. Hands were washed and head to toe examination was carried out without any abnormalities detected. On inspection the abdomen was globular in shape, foetal movement was visible and linear nigra was also present. No visible vein or scar was seen.

On palpation fundal height was 37cm, gestational age 38weeks, lie was longitudinal, presentation cephalic, position was right occipito anterior (ROA), head descent was 3/5th above pelvic brim, foetal heart rate auscultated was 136bpm, uterine contraction was 3 in ten lasting 30 seconds. Vaginal examination was explained to Madam Akua, It was carried out through aseptic technique at 6:30am to access the condition of the vagina and cervix to confirm true labour. Hands were quickly washe d and dried, sterile gloves were worn, enough cotton was then soaked in an antiseptic solution and dropped one by one in the left hand to swab the vulva anterio posteriorly.

On inspection of the vulva, it was neatly shaved and clean. There was no abnormality like vulva warts, varicose vein, oedema and scar. The index and middle finger were inserted, vagina was moist and warm. Cervical dilatation of 4cm, Membranes were intact and there was no moulding. The cervix was soft with the presenting part well applied to the cervix. Madam Akua was thanked for her cooperation and all findings were communicated to her. She was again

assisted into a left lateral position then hands were washed and dried and findings were recorded into her antenatal record book and partograph.

Preparation for birth

In preparing for birth, skilled and unskilled helpers were identified. The skilled helper identified was the midwife in-charge whiles Madam Akua's husband served as the unskilled helper. He was told he will help by running errands when needed and be called in case of any emergency. The emergency plan which includes transportation in case of any referral, an obstetrician or paediatrician was reviewed in case of emergency to advance care was put in place. The light was tested to check if it was working and the lamp was made available to be used in case of light out. The area for resuscitation and equipment were checked. The resuscitation bag, sucker and mask were tested and they were all in good shape for use. Delivery set, drugs and protective clothing [boots, goggle, face mask, cap and apron] were all made available for use. Head covering, scissors, cord clamp and sterile gloves were also made available.

Management of first stage of labour

She was encouraged to walk around to aid in descent of the head. She was served 200mls of porridge to restore her and also avoid dehydration. She was told that if she feels like bearing down at this stage, she should not push because if she does, her cervix will become oedematous and all her energy be exhausted. Madam Akua was closely monitored, the foetal heart rate, maternal pulse, and contractions were continuously checked and plotted on the partograph 4 hourly and vaginal examination, blood pressure and temperature were checked 4 hourly as well. She complained of frequency of micturition and it was explained to her that it's as a result of descent of the foetal head pressing on the urinary bladder. Her perineum was well cleaned any time she voided to prevent infections.

Madam Akua was reassured as she was worried about the outcome of labour. She was taken through the dilatation board for her to know how the cervix dilate before the baby can be born. She was given sacral massage to minimize her backache. Client again complained of thirst and was given 150mls of water.

At 10:30pm, client was due for the next vaginal examination, the examination performed revealed cervical dilatation was 9cm with intact membranes, moulding was one+, contractions were 4 in 10 minutes lasting between 40 to 45 seconds, foetal heart rate was 140beats per minutes, head descent was 1/5th above the pelvic brim. Maternal pulse was 80 beats per minutes, blood pressure 120/70mmHg and temperature 36.5 Degree Celsius. Client passed 120mls of urine and it tested negative to acetone and protein.

Trolley was set for the delivery.

Top Shelf

- ✓ Sterile Cord scissors — Injection vitamin K
- ✓ Sterile artery forceps — Delivery sheet
- ✓ Sterile sheets — Warm baby wrap
- ✓ Sterile gauze/cotton — A sterile gallipot for antiseptic lotion
- ✓ Two sterile gloves — Sterile receiver for placenta
- ✓ Oxytocin, syringe, needle — Sterile Perianal pad
- ✓ Sterile drapes for the woman — Gown for the Midwife
- ✓ Sterile episiotomy set — A gallipot with sterile cotton wool swabs

Bottom shelf

- ✓ Two urethral catheter — Extra perennial pads
- ✓ Mucus extractor and a bowl with water — Disposal gloves
- ✓ Extra cotton in container — Goggles

- ✓ Cheatle forceps Foetal stethoscope
- ✓ A jug to measure blood loss A swabbing lotion
- ✓ Identification band Savlon

At 11:00am, membranes ruptured spontaneously, it was clear, examination was done to exclude cord prolapse. Cervical dilatation was 10cm, descent was 0/5th above the pelvic brim and moulding was two++, contractions were 4 in 10 lasting 50seconds, fetal heart rate was 142 bpm Blood pressure was 120/70mmHg, and maternal pulse was 82 beats per minutes. Client then passed 100 mls of urine and complained of the urge to bear down. She was told it is time for the baby to be born and was told to cooperate. The midwife was called to confirm full dilatation.

3.2 MANAGEMENT OF SECOND STAGE OF LABOUR

Client was reassured, protective clothing's were worn. Her bladder was empty. Madam Akua chose to assume a supine position which she was allowed to use on the prepared delivery bed with knees flexed and thighs abducted. She was reminded that her baby will be delivered onto her abdomen. Hands were washed and sterile gloves were worn, sterile pad was placed at the anus to prevent contamination of the delivery field with faecal matter. Madam Akua was encouraged to bear down with each contraction and also take deep breath.

As the head advance with contraction a gentle flexion was applied on the occiput to enable the smallest diameter to distend the perineum. Immediately the head crowned, she was asked to stop pushing to prevent perennial tear so that the head and the rest of the body can be delivered by extension. The head was born. The neck was quickly felt for cord around neck and there was no cord around the neck. Eyes were cleaned with sterile gauze. Restitution of the head took place as soon as the head is delivered and time was allowed for external rotation of the head and internal rotation of the shoulders to occur. This indicated that shoulders have rotated into the anterior-posterior diameter and ready to be delivered. Holding the baby's head with

both hands at each side, she was asked to give a little push and the anterior shoulder was delivered in a downward traction towards the anus and posterior shoulder by upwards traction towards the symphysis pubis. The rest of the body was delivered by lateral flexion on to the mother's abdomen at 11:30pm on the 27th December 2022.

The baby cried lustily when she was finally out, pink in colour. The baby was quickly cleaned, sex identified by mother as a female, the baby was covered and kept on the mother's abdomen for skin to skin contact to promote bonding.

3.3 IMMEDIATE CARE OF THE BABY

This started as soon as the baby's head was delivered. The baby's face was cleaned and airway maintained, baby's cord was clamped and cut. The baby was cleaned and covered to prevent hypothermia. Apgar score for the first minute was 8/10 and for five minutes was 9/10. Identification band labelled with the mother's name, time of delivery, sex as well as baby's birth weight was applied on baby's wrist for easy identification. The baby was fixed to breast to ensure bonding between mother and baby and to enable the uterus to contract. Baby was put on to the mother's abdomen to initiate skin to skin contact.

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

3.4 MANAGEMENT OF THIRD STAGE OF LABOUR

The third stage of labour was actively managed with Madam Akua still in the supine position. All the procedures that were carried out on her were explained in order to allay her anxiety and gain her co-operation. The uterus was palpated to rule out any second baby and ten (10) units of oxytocin was injected intramuscularly on the mother's left thigh within the first minute by a staff midwife on duty to aid in the contraction of the uterus and separation of the placenta. A sterile receiver was placed at the perennial area to receive the placenta, its membranes and blood clot. The uterus was braced to prevent uterine inversion before controlled cord traction was done to deliver the placenta, and pressure was applied on the uterus in order to push the uterus backwards. The cord was re-clamped with an artery forceps near the vulva, the cord was gently held and pulled slowly and downwards to deliver the placenta. As the placenta advanced into the vulva it was cupped with both hands and by twisting, membranes were out and completed delivery at 11:35pm in to a receiver.

On examination the lobes were all present and cord was inserted in the centre with a vein and two arteries, membranes were also complete and intact. Uterus was immediately rubbed up to initiate contractions and all blood clots were expelled. The walls of the vaginal were cleaned and perineum was inspected for tears but no tear was detected. Estimated blood loss was 180mls. Madam Akua was cleaned up and a clean sanitary pad was applied on the vulva. She was congratulated for her cooperation throughout labour. Baby was still maintained skin to skin with mother with breastfeeding initiated.

3.4 EXAMINATION OF THE PLACENTA

The placenta was sent to the sluice room for examination, it was decontaminated by dipping it in a 0.5% chlorine solution. Firstly, the size and shape of placenta was inspected and was normal. The length of the cord was also normal. The placenta was held straight by the cord

with the non-dominant hand and the membranes hanged loosely. The dominant hand was inserted into the hole from which the baby came out and was spread through to visualize for extra holes and it had just a hole. The placenta was placed in the receiver and hand was strolled along the cord to identify true or false knots. The cut end of the cord was wiped with gauze to inspect the number of blood vessels; it had two arteries and one vein with the cord situated at the centre of the placenta. Circumference of the placenta was examined for radiating blood vessels and they were intact with no blood vessel radiating through it. Placenta was put on a flat surface to inspect for membranes and lobes which were intact. Amnion was stripped off the chorion to visualize chorion if torn or part retained and it was complete.

The maternal surface was examined, there were no infarcts. The colour was dark red with complete lobes. The foetal surface was bluish grey in colour and was smooth and shiny with blood vessels radiating on the surface and cord inserted at the centre. Blood clots from the maternal surface were added to the blood loss. With a measuring cup the blood loss was measured and it was 180mls. After the examination the placenta was discarded. The working surface was wiped with 0.5% chlorine solution. Used instruments were decontaminated in 0.5% chlorine solution for 10 minute and then, rinsed with clean water, washed with soap and water, rinsed under running water and dried and made ready for sterilization.

Gloved hands were immersed in 0.5% chlorine solution before removing and discarding. Hands were thoroughly washed with soap under running water and dried with clean towel. Findings were recorded on the partograph and completed. Delivery book and summary of delivery in the antenatal booklet were also recorded. The husband and mother in-law were informed about the safe delivery and sex of the baby that is a girl, for which they accepted and were very happy. They expressed gratitude for the patience and care.

3.5 MANAGEMENT OF FOURTH STAGE OF LABOUR

The fourth stage of labour begins from first hour to the sixth hour after delivery. This involves close monitoring and observation of both mother and baby to prevent any complication from arising.

Baby

Prevention of diseases

Hands were washed with soap under running water to prevent infection. The eye of the baby was treated by administering chloramphenicol eye drop (2 drops on each eye) to protect the eye against infection such as Ophthalmia Neonatorum. The cord was also dressed using cotton wool swabs soaked with methylated spirit. Injection vitamin K (1mg) was given intramuscularly on the right thigh to prevent the baby from bleeding disorders. Mother was educated to wash hands before and after breastfeeding baby, visiting the wash room and changing her perineal pad. The baby was covered to provide warmth.

Examination of the new born

Consent was sought from Madam Akua as the procedure was explained to her that the baby was going to be examined from head to toe to identify any birth defects for the necessary interventions to be taken whiles the findings will be communicated to her after the procedure and was encouraged to observe.

Hands were washed, dried and examination gloves put on. Baby was put on a warm flat surface and undressed but covered with a clean cot sheet. A quick general inspection on the baby revealed; the skin colour was pink and the muscle tone was good, then baby was covered with a clean cloth and was examined systematically;

The baby was pink in colour. There were no rashes or birthmarks seen. Lanugo hair was present and skin was intact and smooth with little vernix caseosa.

The face was pink with no birth mark. The head was examined and there was no caput succedaneum. The fontanels were not bulging or sunken and were pulsating normally with no widened sutures. The mother was encouraged not to use any hot water on the head. She was educated that the posterior fontanel will close within six weeks and anterior fontanel will also close within 18 months. The head circumference of the baby was measured using a tape measure to encircle the baby's head starting from the occipital protuberance to the supra-orbital ridges and it measured 34 centimetres.

The ears were normal sized and shaped and the cartilage of the pinna was medium in texture. The eyes were in normal alignment. The sclera and conjunctiva were pink in colour with no discharges or jaundice. The ears were patent. The nose was of normal size and shape with a normal central septum. The nostrils were patent. The lips and tongue were pink, no tongue-tie, no false teeth and no cleft lip or palate were detected. Rooting, suckling and swallowing reflexes were evident. The neck was palpated for swellings and enlarged lymph nodes or congenital goitre but there was none.

On the chest the trunk had a normal size. The breasts were normally situated with no engorgement or mass. The nipples were in alignment with no extra ones. Respiratory movement was normal.

The upper extremities were equal with no extra digits, clubbing, webbing, or a missing digit. The capillary refill did not delay at all when finger was pressed. There were palmer creases and movement present. Grasping and Moro reflexes of baby were present.

The abdomen felt soft and round not distended and without any palpable masses. The cord was situated centrally and no bleeding was seen. The abdomen was of normal shape and size. The cord had one vein and two arteries.

The lower extremities were equal. There was no extra digit, webbing, clubbing or forefoot adduction. There was no dislocation of the hip. Knee jerk and planter reflexes were normal.

The back and spine were also examined for any abnormal curvature, swellings, and injuries but none was detected. There were no abnormalities of the back such as spina bifida or meningomyocele detected.

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

The length, head circumference, weight and temperature of the baby were taken and recorded.

Finally, the gloves were removed and disposed of according to infection prevention protocol.

Vital signs and other assessment checked were communicated to the mother and documented as follows:

Head circumference	-	34 cm
Length	-	48cm
Weight	-	2.9kg
Apex beat	-	142 bpm
Temperature	-	36.4^0C
Respiration	-	42 cpm

The baby was wrapped nicely and the findings were communicated to the mother that there were no abnormalities detected. She was educated on how to maintain good personal hygiene of the baby and herself by washing her hands with soap and water frequently, changing baby's diaper whenever soiled and not applying any herbs on babies' cord to avoid any infection and also to keep the baby warm so as to prevent hypothermia.

Mother

Madam Akua was then monitored for the first one hour and transferred into the lying-in ward and was served with mashed kenkey. She was encouraged to put baby to breast as early as possible to initiate bonding and establish lactation. She was educated on the importance of breastfeeding such as it enhancing the release of oxytocin which helps in the contraction of the

uterus and drainage of lochia, control of haemorrhage and also as a form of family planning. She was encouraged to empty her bladder frequently to aid in the contraction of the uterus. Post-delivery vital signs were checked every 15 minutes for the first two hours, every 30 minutes for the next one hour and then hourly for the last three hours, both mother and baby's condition were good. Madam Akua's perineal pad was inspected at regular intervals for amount, consistency, colour and odour of lochia. The discharge was without a foul smell and was dark red in colour (lochia rubra).

The uterus was well contracted with symphysio fundal height measuring 16 centimetres

Madam Akua was encouraged to report if she experiences any profuse bleeding. She was also asked to change her pad when soiled in order to prevent infection and hands washed afterwards. All findings were within the normal range.

Critical and careful observation were made on the mother and baby for 15minutes for the first one hour and recorded as follows;

MOTHER

Temperature	36.2^0C	36.0^0C	36.4^0C	36.2^0C
Blood pressure	120/70mmHg	120/70mmHg	110/70mmHg	100/60mmHg
Pulse	81cpm	85bpm	81bpm	82bpm
Respiration	20cpm	21cpm	20cpm	20cpm
Fundal height	16cm	16cm	16cm	16cm

BABY

Temperature	36.0^0C	36.2^0C	36.0^0C	36.2^0C
Pulse	120bpm	126bpm	128bpm	130bpm
Respiration	40cpm	48cpm	46cpm	50cpm

Mother's breast milk was slow in flow within the first one hour after delivery but became normal after two hours' time, the condition of both mother and baby was satisfactory throughout the fourth stage.

3.6 SUMMARY OF LABOUR AND DELIVERY

Date of delivery	27th November , 2022
Time of delivery	11:30pm
Time of placenta expulsion and membranes	11:35pm
Type of delivery	Spontaneous vagina delivery
Estimated blood loss	180mls
Duration of labour	
First stage of labour	4hours 30minutes
Second stage of labour	30 minutes
Third stage of labour	5 minutes
Total duration of labour	5 hours 5minutes
Condition of baby	
Sex	Female
Birth weight	2.9kg
Apgar score at 1st minute	8/10
Apgar score at 5th minutes	9/10
Full lengths	48cm
Head circumference	34cm
Meconium	Passed
Urine	Passed
Abnormality	None detected

General condition		Satisfactory

Condition of mother

Blood pressure	125/65mmHg
Pulse	73bpm
Respiration	24cpm
Temperature	36.2°C
Uterus	Contracted
SFH	16cm
Lochia	Rubra
Condition	Satisfactory

Condition of placenta

Maternal surface	-	Normal (Dark red)
Foetal surface	-	Normal (Bluish grey)
Lobes and membranes	-	Complete and healthy
Blood vessels	-	2 Arteries, 1 vein
Cord situation	-	Central

3.7 PROBLEMS IDENTIFIED DURING LABOUR

27/11/22

- Lower abdominal pains
- Anxiety
- Waist pain
- Backache

SHORT TERM OBJECTIVE

- Client will cope with lower abdominal pain within 2 hours
- Client’s anxiety will be relieved within1 hour
- Client will understand and cope with waist pains within 4 hours
- Client will cope with backache within 4 hours

LONG TERM OBJECTIVE

Client will deliver normally without any complication to neither baby nor mother.

TABLE 2: NURSING CARE PLAN DURING LABOUR

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
27/11/22 6:20am	Lower abdominal pain related to strong uterine contractions	Client will cope with lower abdominal pains within 2 hours as evidence by client verbalizing that she is coping with labour pains	1. Reassure client that with her co-operation she will regain her normal body comfort after labour. 2. Educate client on the cause of the lower abdominal pain 3. Assist client to assume a comfortable position 4. Encourage client on the frequent emptying of the bladder 5. Examine the vagina to confirm true labour.	1. Client was reassured that with her co-operation, she will regain her normal body comfort after labour. 2. Client was educated on the cause of lower abdominal pains as relating to the strong uterine contractions 3. Client was assisted to assume the left lateral position 4. Client was encouraged to empty her bladder at least every 2 hours. 5. Vaginal examination was done to confirm true labour and was repeated four hourly	27/11/22 8:20am	Goal fully met as client said she was coping with the pains.	J.N

TABLE 2: NURSING CARE PLAN FOR LABOUR CONT;

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	TIME/ DATE	EVALUATION	SIGN
27/11/22 6:20am	Anxiety related to unknown outcome of labour	Client will be relieved of anxiety within 1hour as evidence by client verbalizing that she is no longer anxious.	1. Reassure client. 2. Educate client on the effect of anxiety on labour 3. Explain the stages of labour to the client 4. Explain every procedure to be carried on client 5. Update client on the progress of labour	1. Client was reassured that she is in the hands of competent midwives 2. Client was educated on the effect of anxiety on labour such as, It prolongs labour 3. The stages of labour were explained to the client 4. Every procedure carried on client was explained to her 5. Client was updated on the progress of labour by using the dilatation board to prompt her as to the extent of the dilation she has gotten to	27/11/22 7:20am	Goal met as client verbalized that she was no more anxious	

TABLE 2: NURSING CARE PLAN DURING LABOUR CONT

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
27/11/22 6:20am	Waist pain related to descent of the foetal head	Client will cope with waist pain within 4 hours as evidence by client verbalizing that she is coping with the waist pains	1. Reassure client that with her co-operation, her condition will improve after delivery. 2. Give client a sacral massage 3. Explain the physiology of the waist pain to the client 4. Allow client to adopt a comfortable position 5. Encourage client to urinate frequently	1. Client was reassured 2. Sacral massage was done for client 3. Physiology of waist pain was explained to client as a result of pressure of the foetal head pressing on the sacral nerves 4. Client adopted to a left lateral position 5. Client urinated frequently to allow descent of the fetal head	27/11/22 12:00pm	Goal fully met as client verbalized that she was coping with waist pain	J. N

TABLE 2: NURSING CARE PLAN FOR LABOUR CONT;

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
27/11/22 6:20am	Backache related to head descent of the foetus	Client will cope with backache within 4hours as evidence by client verbalizing that she is coping with the backache	1. Reassure client. 2. Educate client on the cause of backache 3. Give sacral massage 4. Help client assume a favourable position 5. Give client analgesics such as paracetamol	1. Client was reassured that with her co-operation she will soon be relieved of backache 2. Client was educated on the cause of the backache as relating to descent of the foetal head 3. Sacral massage was done for client 4. Client assumed the left lateral position 5. 1gram paracetamol was served	27/11/22 12:00pm	Goal fully met as evidence by client verbalizing that she is coping with the backache	J.N

CHAPTER FOUR

PUERPERIUM

4.0 INTRODUCTION

This chapter talks about how Madam Akua and her baby were managed and cared for during the period of puerperium. It also throws more light on the subsequent care of the baby, preparation towards discharge, subsequent post-delivery assessment, home visits, postnatal review and the nursing care plan drawn for the management of problems encountered during puerperium

4.1 DAY OF DELIVERY

Madam Akua and her baby´s general condition after delivery were assessed before they were transferred to the lying in for continuous observation. A bed was made for mother and baby. She was educated and demonstrated how to fix baby to breast and was encouraged on breastfeeding on demands. Hand washing with soap and water after visiting the toilet and changing perinea pads was stressed on to prevent cross infection from the mother to child. Her vital signs were checked and recorded as follows;

Mother

- Temperature 36.3^{0}C
- Blood pressure 110/60mmHg
- Pulse 80bpm
- Respiration 20cpm

Baby

- o Temperature 36.2^{0}C
- o Apex beat 130bpm

- Respiration 46cpm

Baby bathing and cord dressing

After six hours of birth, procedure was explained to the mother, permission was sought and Madam Akua gladly accepted. A tray was then set, Items to be used for the procedure were assembled, these included:

Top Shelf

- Sterile cotton wool swabs and gauze in a galipot
- Surgical gloves
- Sterile water in a galipot
- Baby's diapers
- Baby's dress
- Baby's towel and cot sheet to wrap 0the baby
- Baby's oil or Vaseline
- Baby's sponge
- Baby soap in a soap dish

Bottom Shelf

- Disposable gloves
- Methylated spirit
- Jug of hot water
- Jug of cold water
- A bowl for mixing water
- Kidney dish for used gauze and swab
- A receptacle for used water

- Mackintosh apron

The plastic apron was worn. Hand washing was done with soap under running water and dried with clean towel. The cold and hot water were mixed and the temperature was tested using the elbow. Gloves were worn and the baby was placed on a flat surface protected with mackintosh and cot sheet. Baby was undressed. A quick head to toe examination was done and no abnormality was detected. Baby was wrapped with a cot sheet leaving the face.

Baby's eyes were cleaned with cotton wool swabs soaked in sterile water from the inner canthus to outer canthus. Her face was cleaned by damping with a face towel and dried. The sponge was lathered with soap. Baby's neck was supported with the left hand using two fingers to plug the ears and the head was washed with the soapy sponge with the body resting on the flat surface. Baby was carried with the body resting on the elbow and still supporting the nape. She was place at the edge of the bowl to rinse the soap off the head and dried.

Baby was exposed; arms and front of trunk were washed paying attention to skin folds. The baby's back was turned with one hand supporting the chest and washed back down to feet paying attention to the skin folds. She was immersed in a bath of warm water with the head above the water and rinsed thoroughly. The baby was place on a flat surface covered with clean sheet. She was dried by using a clean small towel paying attention to the skin folds and oiled. She was then dressed but the cord was left exposed, hand hygiene was performed, the cord was inspected for bleeding but there was none.

The cord was dressed with methylated spirit by holding the cord clamp with a swab. The base was cleaned with a swab in a circular manner. Both posterior and anterior sides of the cord were cleaned from the base upwards with different cotton wool swabs. The tip was also cleaned with a separate swab. The cord was exposed to air dry, baby was wrapped and given to mother to breastfeed. The waste materials were discarded. Gloves were removed and disposed of.

Hands were washed with soap and water. All findings were communicated to client and documentation was done.

Since Madam Akua was to be discharged on the next day after the day of delivery, she spent the night at the hospital so she was taken care of. And the vital signs of Madam Akua and the baby were checked and recorded as follows;

Mother

- Temperature 36.5^{0}C
- Blood pressure 120/700mmHg
- Pulse 80bpm
- Respiration 21cpm

Baby

  - Temperature 36.5^{0}C
  - Apex beat 132bpm
  - Respiration 47cpm

4.2 FIRST DAY POST DELIVERY CARE AND DISCHARGE

Madam Akua had a normal delivery on 27 ^{the} of November, 2022, and was discharged the next day that was on the 28th of November ,2022. On that day she was informed of her possible discharge and she took her bath and took a cup of warm porridge for her breakfast. The mother and baby's vital signs were checked and other assessments were recorded as follows;

MOTHER

- Temperature 36.2^{0}C
- Pulse 80bpm
- Respiration 20cpm

- Blood pressure 96/60mmHg
- Fundal height 15cm
- Lochia Red [rubra]

BABY

- Temperature 37.1^0C
- Apex beat 130bpm
- Respiration 40cpm
- Cord dry
- Weight 2.8kg

General examination was conducted on the mother after procedure was explained to her and no abnormalities were detected. Her breast was heavy with prominent nipples and there was the presence of colostrum. Perineal pad was inspected for the colour of lochia which was red with moderate flow and no offensive smell, her perineum was examined and it was in good condition. She was reminded of frequent emptying of her bladder.

Madam Akua's baby was top and tailed on 28th of November at 7:50am. After procedure was explained to her and all items needed for the procedure were assembled, Madam Akua was asked to observe what was been done and encouraged to ask questions. The cord was also dressed using methylated spirit.

She was encouraged to ask questions to clarify her doubt but she said there was no question. The baby was groomed, wrapped and handed over to the mother. Client was thanked for her cooperation and findings were communicated to her that there were no abnormalities detected so findings were documented.

After which Madam Akua was educated to have adequate rest and sleep, she was also educated to practice exclusive breast feeding and proper position of the baby to breast and also to practice good Personal and environmental hygiene such as regular and proper hand washing.

She was also educated on the proper care of the baby such as keeping baby warm always to prevent hypothermia, washing baby's clothing separately to prevent cross infection and also ensuring that baby sleeps under a treated mosquito net to prevent malaria. She was educated on the baby's cord care that no chemical should be applied to the cord except dry dressing with methylated spirit and that she should avoid pulling the cord forceful since it will fall off by itself. She was also encouraged on the first- and sixth-week postnatal visits to the clinic as well as signs and symptoms of infection to the baby.

The baby was given immunizations on Bacillus Calmette Guerin (BCG) and polio 0 (opv0) on 28th November,2022. Madam Akua's husband and support persons were encouraged to support her during this period in order to enable her care for the baby appropriately. After that they were congratulated for their cooperation and helped them packed their belongings. She was informed of the next visit in the evening and she accepted, she was assisted in packing her things and they were and bid good bye.

4.3 FIRST POSTNATAL HOME VISIT

A follow up home visit was made in the evening since the morning was spent in the hospital to the family at 4:00pm to render domiciliary midwifery care to mother and her baby. On arrival, Madam Akua was neatly dressed in white clothes while the mother in-law was preparing groundnut soup and the entire environment was also clean. A warm welcome was given and a seat was offered, introduction was then made to her mother-in-law as her personal midwife. The baby was topped and tailed and cord was dressed after general examination was done. After that, the mother was examined from hair to toe but there was no abnormality. The perineal pad was inspected for lochia and it was rubra.

Both mother and baby were in good condition. On enquiry, mother complained of lower abdominal pain and she was reassured and made to understand that it was due to uterine

contraction and this will enable the uterus to return to its pre-gravid state. She was also reminded of exclusive breastfeeding to prevent neonatal infection and to promote baby's growth and the need for adequate nutrition to replace worn out tissues. The family members were encouraged to give her their support. Below were the findings for both mother and baby on 28th November 2022 in the evening.

MOTHER

- Temperature 36.3^{0}C
- Pulse 76bpm
- Respiration 20cbm
- Blood pressure 100/60mmHg
- Lochia Rubra

BABY

- Temperature 36.6^{0}C
- Apex beat 134bpm
- Respiration 40cpm
- Stool meconium
- Weight 2.8kg
- Urine Passed

4.4 SECOND POSTNATAL HOME VISITS

On 29th November, 2022 at 7:30am and 5:30pm, Madam Akua and her baby were visited. The baby was topped and tailed and cord dressed with general examination done on both mother and baby but there were no abnormalities detected, with the mother, fundal height was 14cm,

breast was lactating and lochia was rubra, with the baby, stools were meconium, she passed urine and weight was 2.7kg and the findings were communicated to the mother and the vital signs checked recorded as follows;

Observation on the 29th November, 2022

MOTHER

VITAL SIGNS	MORNING
Temperature	$36.0^{0}{}_{C}$
Pulse	72bpm
Respiration	23cpm
Blood pressure	125/80mmHg

BABY

VITAL SIGNS	MORNING
Temperature	$37.0^{0}{}_{C}$
Respiration	41cpm
Pulse	138bpm

On the 29th November, 2022, Madam Akua complained of backache and she was reassured that the pain will soon be over and encouraged her to avoid prolonged standing or sitting, she should maintain good posture and also make sure that she sits on a chair with a straight back rest during breast feeding. She was taught how to properly attach the baby to breast. Her family members were encouraged to help her in taking care of the baby to enable mother have enough rest. The evening visit to Madam Akua and her baby was made at 5:30pm and their vitals were checked and recorded as follows:

MOTHER

VITAL SIGNS	EVENING
Temperature	36.8ºC
Pulse	76bpm
Respiration	21cpm
Blood Pressure	125/80mmHg

BABY

VITAL SIGNS	EVENING
TEMPERATURE	$36.8^{0}{}_{C}$
Respiration	42cpm
Pulse	126bpm

The baby was then topped and tailed and cord dressed, physical examination was done on both mother and baby but no abnormalities were detected she was then asked of any complains and she said no complains but the backache she complained of in the morning has reduced.

THIRD POSTNATAL HOME VISIT

On the 30th of November, 2022, the third visit was made to Madam Akua and the baby in the morning to continue the care. Examination revealed that both mother and baby were in good condition, fundal height was 14cm, breast was lactating, lochia was serosa and uterus had contracted. Baby was also topped and tailed and cord was cleaned. Stool was yellowish-brown, urine was passed, suckling was good, skin was pink, cord was shrinking and weight was 2.6kg. Madam Akua complained of fatigue. She was reassured that the fatigue is as a result of stress

and strains of labour, She will regain her comfort as soon as possible, she was encouraged to have enough rest during the day and night and also encouraged her family members to help in her daily activities to provide her adequate time to rest in order to improve her health. They should also help in taking care of the baby so that the woman can have enough rest. The evening visit to Madam Akua was also made at 5:30pm and the vital signs was checked and recorded as follows;

MOTHER

VITAL SIGNS	**MORNING**
Temperature	36.8^{0}C
Pulse rate	80bpm
Respiration	22cpm
Blood pressure	115/70mmHg

BABY

VITAL SIGNS	**MORNING**
Temperature	37.0^{0}C
Pulse	130bpm
Respiration	40cpm

MOTHER

VITAL SIGNS	**EVENING**
Temperature	36.5^{0}C
Pulse rate	80bpm
Respiration	22cpm
Blood pressure	117/70mmHg

BABY

VITAL SIGNS	EVENING
Temperature	36.8^0C
Pulse	132bpm
Respiration	40cpm

4.5 FOURTH POSTNATAL HOME VISIT

On the 1st December, 2022, the fourth day home visit to Madam Akua and family was made at 7:30am to render postnatal care to her and her baby. By then she had already taken her bath and was well dressed. The baby was topped and tailed and the cord was dressed using methylated spirit and then baby was properly dressed. The procedure of general examination was explained to the mother and both mother and baby were examined from head to toe. The mother's perineal pad was inspected for lochia, and it was bright red with no foul smell, the baby's umbilical cord was already dry. The need to avoid using chemicals on the umbilical cord to prevent infections was re-emphasized. On examination it was observed that mothers' breast was engorged and on enquiry, she complained of pain. She was reassured and educated on position and attachment of the baby to breast which will enable flow of the breast milk to relieve engorgement. Her husband was encouraged to give her emotional support and also help in taking care of the baby. The findings were communicated to the mother and the family.

Vital signs were checked and recorded as follows;

MOTHER

- Temperature 36.5^0C
- Respiration 19cpm
- Pulse 82bpm

- Blood pressure 98/60mmHg
- Fundal height 13cm
- Lochia Serosa

BABY

- Temperature 36.7^{0}C
- Respiration 41cpm
- Apex beat 140bpm
- Cord shrinking
- Stool Yellowish -brown
- Urine Passed
- Weight 2.6kg

4.6 FIFTH POSTNATAL HOME VISIT

On the 2nd of December, 2022, the fifth day postnatal visit was made to the client and her family at 8:00am to render the fifth day postnatal care. When the baby was undressed, it was observed that the cord was off without infection. They had already bathed the baby and the cord was dressed. Madam Akua and her family were informed that the care will be terminated after they made their first [1st] postnatal visit to the clinic, Madam Akua was asked if there were any complaint and she complained of difficulty in sleeping at night due to stress and life changes**.** Madam Akua was reassured and encouraged to have enough rest and sleep during the day time when the baby is sleeping so that the baby can be breast fed well during the night. Observation made on the client and her baby were communicated to her and the family members and were recorded as follows;

MOTHER

- Temperature 36.5 °C
- Respiration 19cpm
- Pulse rate 82bpm
- Blood pressure 100/60mmHg
- Fundal height 12cm
- Lochia Serosa

BABY

- Temperature 36.7°C
- Respiration 40cpm
- Apex beat 136bpm
- Stool yellowish-brown
- Urine Passed
- Weight 2.7kg

4.7 SIXTH DAY POSTNATAL CARE HOME VISIT

The sixth day post-natal visit to Madam Akua and her family was on 3rd December 2022, at 7:30am. The baby was bathed and neatly dressed .All necessary examinations were made on both baby and mother, they were both healthy .No complaint was made, observation made on the client and the baby were communicated to them and recorded at follows;

MOTHER

Temperature- 36.2

Pulse -76bpm

Respiration -22cpm

Blood pressure -120/80 mmHg

Lochia –Serosa

Fundal height – 11cm

BABY

Temp-36.2

Respiration 40cpm

Apex heart beat 125

Weight 2.8kg

Suckling –good

Cord – healed

Stool- yellowish

Madam Akua was made aware that the next day home visit was going to be the last postnatal home visit to her.

4.8 SEVENTH POST NATAL HOME VISIT

The last home visit to the client and her family was on the 13th December, 2022 at 7:00am. The baby was bathed and neatly dressed after that Madam Akua was educated on proper care of the baby by changing of her diapers to prevent infection or sore buttocks, washing baby's

clothing separately to prevent cross infection. She was also educated on the need for regular exercise to promote health.

Mother and the family were reminded about the termination of the care after the first day postnatal visit to the clinic. Madam Akua and the entire family were thanked for their cooperation and support throughout this study. The observations made were recorded as follows;

MOTHER

- Temperature 36.0^{0}C
- Respiration 22cpm
- Pulse rate 83bpm
- Blood pressure 122/83mmHg
- Fundal height 9cm
- Lochia Alba

BABY

- Temperature 36.6^{0}C
- Respiration 50bpm
- Apex beat 124bpm
- Stool yellow
- Urine Passed
- Weight 2.9kg

4.9 FIRST POSTNATAL VISIT TO THE CLINIC

On the 4th December, 2022, Madam Akua and her husband reported to the postnatal clinic at 9:00am and both mother and baby were neatly dressed in white clothing. They were warmly welcomed and a seat was offered. The purpose of the visit was to access the mother and baby

during puerperium. After a brief conversation, their vital signs were checked and they were examined physically from head to toe. Madam Akua and her baby's vital signs were checked and recorded as follows;

MOTHER

- Temperature 37.1^{0}C
- Pulse rate 80bpm
- Respiration 20cpm
- Blood pressure 110/70mmHg
- Weight 98.0kg

BABY

- Temperature 36.5^{0}C
- Respiration 46cpm
- Apex beat 134bpm
- Weight 3.0kg

After the mother and baby's vital signs were checked, mother was asked to empty her bladder and enter into the examination room. The baby was handed over to the father, privacy was provided and Mother was assisted onto the examination couch.

On inspection, her hair looked healthy and was neatly plaited which was free from dandruff, her eyes were clear and conjunctiva was pink and free from discharge, her mouth was clean and there were no abnormalities like lump or enlarged thyroid gland on the neck.

On the chest examination, respiratory pattern was normal, breast examination was done and there was no lump, cracked or sore nipple on the breast, lactation was well established. The upper extremities were also equal in size and length and free from Oedema, the abdomen was flat and uterus was not palpable, on vulva examination, it was neat and free from odour. There

was no abnormal discharge noticed apart from lochia which was slight and whitish in colour. The lower extremities were also equal in size and length and no abnormality was detected. After the examination, she was thanked for her cooperation and helped out of the examination couch, findings were then communicated to her, hands were washed and findings were documented.

The baby was then taken from the father for general examination.

On examination of the baby, sutures and fontanels were normal. The face was clear and eyes opened with white sclera and pink conjunctiva. There were no discharges from the eyes, nose or mouth. The neck was also free from abnormality such as inflamed thyroid gland or lymph nodes. The chest was normal, no lumps were found in breast and no discharge was found, the abdomen was soft and not distended. The umbilical cord stump had healed completely. The upper extremities were equal in length, size and shape. The lower extremities were also equal in length, size and shape without any abnormalities. Examination of the back revealed a normal spinal cord and absence of sore buttocks.

The baby was dressed up after the examination. She was handed over to her mother and thanked for her cooperation. All findings were communicated to her. After which hands were then washed and dried and findings were recorded and also client was then handed to the Midwife in-charge for continuity of care. Client and husband were educated on child immunization. Exclusive breast feeding as well as adequate nutrition were re-emphasized. Madam Akua was very grateful and promised to go by the education given and she was also reminded that it was the last encounter with them and that they should not forget about the family planning which they agreed to start with the Depo-provera which is for three months. They were told to report to the facility if any problem arises. Madam Akua and her husband were both thanked for their cooperation and the successful completion of this care study.

Madam Akua and her baby were directed to the birth and death registry for registration of the baby's name into the register of life births and also to acquire a birth certificate for the baby.

4.10 SECOND POSTNATAL VISIT TO THE CLINIC

According to the midwife in-charge, the six weeks postnatal visit was made on the 15th of January, 2023 at about 10:00 am. Head to toe examination to be done on both mother and baby and no abnormalities were detected. Vital signs were checked on mother and recorded as below.

Temperature	36.0
Pulse	80bpm
Respiration	20cpm
Blood pressure	110/70 mmHg
Weight	98kg

4.11 TERMINATION OF CARE

On 15th of January 2023, madam Akua and her baby were handed over to the child welfare clinic and family planning unit for 6 weeks immunization.

Baby was immunized with the following vaccines, Polio 1 2 drops, Rotavirus 1 2drops, pneumococcal 1 0.5milligrams and Pentavalent [diphtheria, pertussis, tetanus, hepatitis, hepatitis B, haemophilus influenza]. Mother was reminded on family planning and breastfeeding exclusively, rest and sleep, exercise and nutritious diet. She was encouraged to ask questions bothering her but she said there was none.

Client was also advised to report to any health facility in case she encountered any health-related problem. Client was then handed over to the public health nurse for continuity of care. She and the family were bid farewell.

PROBLEMS IDENTIFIED DURING PEURPERIUM

- Lower abdominal pain (After pains) – 28th November 2020
- Backache- 29th November 2022
- Fatigue- 30th November 2022
- Breast engorgement-1st December 2022
- Sleep disturbance- 2nd December 2022

SHORT TERM OBJECTIVES

- Client will be relieved of after pains within 48 hours.
- Client will be relieved of backache within 24 hours.
- Client will be relieved of fatigue within 24 hours.
- Client will be relieved of engorged breast within 48 hours
- Client will have adequate sleep within 24 hours.

LONG TERM OBJECTIVE

Client will experience normal puerperium without any complication

TABLE 3: NURSING CARE PLAN DURING PUERPERIUM

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES /OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	EVALUATION	DATE TIME	SIGN
28/11/22 4:00pm	After pain related to contractions of the uterus.	Client will be relieved of after pain within 48 hours as evidence by client verbalizing there are no more pains.	1. Reassure client. 2. Explain the cause of after pains to client. 3. Encourage client to do mild exercise. 4. Educate client on the intake of nutritious diet. 5. Serve prescribe analgesics.	1. Client was reassured that pain will be over as soon as possible. 2. It was explained to client that the pain was due to contractions of the uterus. 3. Client was encouraged to do mild exercise, example walking around. 4. Client was educated on nutritious diet 5. Tab paracetamol 1g was served	Goal fully met as evidenced by client verbalizing no more pains.	29/11/22 At 4:00am	J. N

TABLE 3: NURSING CARE PLAN DURING PUERPERIUM

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	EVALUATION	DATE/ TIME	SIGN
29/11/22 at 4:00pm	Sleep disturbance related to baby's frequent demand of breast milk at night	Client will have adequate sleep within 24 hours as evidenced by client verbalizing that she has adequate sleep.	1. Reassure client that with her co-operation she will be fine. 2. Encourage client to feed baby well at all times. 3. Encourage client to have enough sleep. 4. Encourage mother to change baby's diapers frequently. 5. Encourage family members to help mother in taking care of the baby.	1. Client was reassured that she will be fine. 2. Client was encouraged to breastfeed baby at least 8 to 12 times in a day. 3. Client was encouraged to have enough sleep in the day time while baby is sleeping. 4. Mother was encouraged to change baby's diapers when soiled 5. Husband was encouraged to help mother in taking care of the baby	Goal fully met as evidenced by client verbalizing that she was able to sleep well	30/11/22 At 4:00am	N.J

TABLE 3: NURSING CARE PLAN DURING PUERPERIUM

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	EVALUAT-ION	DATE TIME	SIGN
30/11/22 7:30am	Backache related to improper positioning during breastfeeding.	Client will be relieved of backache within 24 hours as evidence by client's facial expression and Client verbalizing no more backache.	1. Reassure client that with her co-operation, she will soon be relieved from her backache. 2. Encourage client to assume good posture. 3. Encourage client to have enough rest and sleep. 4. Encourage client to do postnatal exercises. 5. Serve prescribed analgesics.	1. Client was reassured on her condition. 2. Client was encouraged to sit straight when breastfeeding 3. Client was encouraged to have enough rest and sleep. 4. Client was encouraged to do postnatal exercise. [pelvic tilts] 5. Paracetamol 1g three times daily was served.	Goals met as evidenced by client`s facial expression and verbalizing she has no more pains.	1/12/22 7:30 am	J.N

TABLE 3: NURSING CARE PLAN DURING PUERPERIUM

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTIONS	EVALUATIONS	TIME	
1/12/22 at 7:00am	Fatigue related to care of the baby.	Client will be relieved of fatigue within 48 hours as evidenced by client verbalizing no more fatigue	1. Reassure client that with her co-operation, she will regain her comfort as soon as possible. 2. Encourage client to have enough rest during the day while baby is sleeping. 3. Encourage client family members to help in her daily activities. 4. Encourage client to take well balanced diet rich in proteins, vitamins and mineral salt. 5. Encourage client on good body mechanics	1. Client was reassured that she will regain her comfort as soon as possible. 2. Client was encouraged to have enough rest during the day while baby is sleeping 3. Client family members were encouraged to support her in daily activities. 4. Client was encouraged to take well balance diet rich in protein, vitamins and mineral salt. 5. Client was encouraged to avoid bending while washing.	Goal fully met as evidenced by client verbalizing no more fatigue.	2/12/22 at 7:00am	J.N

TABLE 3: NURSING CARE PLAN DURING PUERPERIUM

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	EVALUAT-ION	DATE TIME	SIGN
1/12/22 at 8:30am	Engorged breast related to infrequent emptying of the breast.	Client will be relieved of breast engorgement within 48 hours as evidence by reduction in breast swelling.	1. Reassure client and let her know the causes of her condition. 2. Assist client to fix and position baby to breast to feed correctly. 3. Encourage client on demand feeding and night feeding. 4. Advice client on complete emptying of one breast before giving the other breast to the baby. 5. Put warm compresses on the breast to relieve pain.	1. Client was reassured on the causes of her condition. 2. Client was assisted to fix and position baby to breast to feed correctly. 3. Client was encouraged on demand feeding and night feeding. 4. Client was advised on complete emptying of one breast before giving the other to the baby. 5. Warm compresses was done on the client breast to relieve engorgement.	Goal fully met as evidenced by client verbalizing that the baby was able to empty the breasts completely during feeding.	2/12/22 at 8:30am	J.N

SUMMARY

Madam Akua Gravida 2 para 1 alive (G2P1A) is from Subinso community, she was born on January, 1st 1997. Her first antenatal visit to the clinic was on April 5th, 2022. She was a regular attendant at the Subinso health centre at the antenatal unit. The first meeting was on 7th November, 2022, on her visit to the antenatal clinic, she was 36 weeks pregnant. During the interaction, she had all her necessary investigations done, medications served and various immunizations were given. She had an individualized care and passed through pregnancy, labour and puerperium without any complication. During the first encounter, she said she had never practiced family planning. In the beginning some interventions such as health education to enable her improve her health while pregnant, pieces of advices were also given to her and scheduled home visits.

Due to the good advice given and well applied by Madam Akua, she was able to go through normal and successful delivery on the 27th of November, 2022 at 11:30pm to a healthy baby girl weighing 2.9kg without injuries on both mother and baby. Placenta and membrane were completely expelled at 11:35pm with blood loss approximately 180mls. During examination of the perineum, the vulva, vagina and cervix were all intact. Mother and baby were all cared for and their condition was satisfactory.

Examination during puerperium was done on fundus, inspection of lochia and vital signs checked to be within normal values. Services were provided to them throughout in the lying-in period. She was counselled on family planning, exclusive breastfeeding and postnatal exercises. Madam Akua and her family were informed on the 5th day postnatal home visit that the care will be terminated when they made their first day postnatal visit to the clinic.

The client and baby were handed over to the public health nurse on 4th January, 2022 for continuity of care.

In conclusion, the interaction with Madam Akua and her family has made it effective organization for this narrative report, which has enabled me to put into practice all the knowledge and skills that I have acquired theoretically and practically from the classroom and clinical sites. Also, through pieces of advices, education, and monitoring, a comprehensive care plan was drawn and that enabled me to achieve my objectives.

The family centred maternity care study has also helped me to develop my skills and confidence in caring for women during pregnancy, labour and puerperium. With the knowledge and skills acquired, I would be able to manage other expectant Mothers in the near future as unique individuals with specific problems and needs.

APPENDIX I

MATERNAL ANTENATAL RECORD BOOK

Date	Weight (Kg)	Blood Pressure (mmHg)	Urine Protein/ Sugar	Gestation Age In Weeks	Fundal Height (Cm)	Presentation	Descent	Foetal heart (bpm)	Complaints
5/04/22	62kg	130/80	Negative	12	10	-	-	-	No complains
25/05/22	62kg	120/70	Negative	16	14	Cephalic	5/5	128	No complaint
29/06/22	65kg	130/70	Negative	20	18	Cephalic	5/5	130	No complaint
30/0722	68kgs	120/80	Negative	24	21	Cephalic	5/5	131	No complains
19/10/22	70kgs	120/60	Negative	32	34	Cephalic	5/5	133	Anxiety
7/11/22	76Kg	110/70	Negative	36+3	35	Cephalic	5/5	132	No complains
14/11/22	71kg	120/70	Negative	37+5	38	Cephalic	5/5	140	Well
21/11/22	70kg	127/76	Negative	38+5	39	Cephalic	5/5	146	Constipation

APPENDIX II

DIAGNOSTIC MEASURES

DATE	SPECIMEN	INVESTIGATIONS	NORMAL VALUE	INVESTIGATION RESULT	REMARKS
5/04/22	Blood	Haemoglobin level Sickling Blooding grouping Rhesus factor Antibodyscreen, mps HBSAG VDRL Syphilis PMTCT	11.5-14g/dl Negative AB, A, B ,O Negative No Defect parasite seen Non-reactive Non-reactive Non-reactive Non-reactive	11.7g/dl Negative O negative Negative Negative Non-reactive Non-reactive Non-reactive Negative	Normal Normal Normal Normal Normal Normal Normal Normal Normal
25/05/22	Urine	Protein, Acetone Sugar	Negative Negative Negative	Negative Negative Negative	Normal Normal Normal
	Stool R/E	Worms	Negative	No ova detected	Normal
29/06/22	Urine	Protein Sugar	Negative Negative	Negative Negative	Normal
30/07/22	Stool	Worms	No ova Detected	No ova detected	Normal
19/10/22	Urine	Protein Sugar	Negative Negative	Negative Negative	Normal Normal
	Blood	Haemoglobin level	11.5-14g/dl	12.4g/dl	
7/11/22	Urine	Sugar Protein	Negative Negative	Negative Negative	Normal Normal
	Blood	Haemoglobin	11.5-14g/dl	12.4g/dl	Normal
14/11/22	Urine	Sugar Protein	Negative Negative	Negative Negative	Normal Normal
	Blood	Haemoglobin	11.5- 14g/dl	12.4g/dl	Normal
21/11/22	Urine	Sugar Protein	Negative Negative	Negative Negative	Normal Normal
	Blood	Haemoglobin	11.5-14g/dl	12.4g/dl	Normal

APPENDIX III; PHARMACOLOGY OF DRUGS USED

DRUGS	CLASSIFICATION	DOSAGE	ROUTE	ACTION	SIDE EFFECT	ANTIDOTE	EFFECTS ON CLIENT
Tablet Multivitamin	Vitamin preparation	1 tablet daily x 7 days	Orally	Improvement of appetite	Frequent stools	Phenergan	Improved her appetite
Tablet fersolate	Hematinic	200mg daily x 30 days	Orally	Stimulates red blood cells maturation thus increasing haemoglobin	Black stool, frequent stools and abnormal discomfort	Gastric lavage	Increased haemoglobin level
Tablet vitamin B complex	Vitamin	1 tablet daily for 30 days	Orally	Formation and functioning of red blood cells	Nausea and vomiting	None	Promoted carbohydrate metabolism
Tablet folic acid	Haematinic	5 tablet daily for 30 days	Orally	Formation and maturation of red blood cells	Gastro intestinal disturbances e.g vomiting	Oral rehydration salt	Maintained her blood cell level thus preventing anaemia

APPENDIX III

PHARMACOLOGY OF DRUGS USED CONT;

DRUGS	CLASSIFICATION	DOSAGE	ROUTE	ACTION	SIDE EFECT	ANTIDOTE	EFFECTS ON CLIENT
Tablet paracetamol	Analgesic and antipyretic	1 gram tid x 7days	Orally	Relieve client of pains without any side effect	Rare but over dose causes liver damage	Magnesium sulphate	Relieved client of pains without any side effects
Tablet [SP] sulfadoxine pyrimethamine	Anti-malaria	3 doses stat from 16 weeks or after quickening and the remaining doses within 4 weeks interval until she delivers.	Orally	Protect client and fetus from malaria	Nausea, dizziness	Phenergan	Protected client and fetus from malaria
Tetanol diphtheria injection	Anti-tetanus vaccine	o.5ml	Intramuscularly	Provides immunity against tetanus	Uriticarial rash, fever and chills	None	Provided immunity for mother and baby against tetanus
Injection oxytocin	Oxytocic drug	10 units	Intramuscular or intravenous	Acts on the uterine muscles to produce effective contractions and control bleeding	Gastrointestinal disturbances, raised blood pressure, vasoconstrictive	Promethazine	Stimulated uterine contraction and controlled bleeding after delivery

APPENDIX III; PHARMACOLOGY OF DRUGS USED CONT;

DRUGS	CLASSIFICATION	DOSAGE	ROUTE	ACTION	SIDE EFFECTS	ANTIDOTE	EFFECTS ON CLIENT
Injection bacillus Calmette Guerin [BCG]	Vaccine [antigen]	0.05mls	Intradermal	Promote active immunity against tuberculosis, To prevent poliomyelitis	Bacillus Calmette Guerin nodules, Vomiting	None	Baby is protected with tuberculosis, None observed
Polio O	Vaccine[antigen]	2 drops	Orally	To produce active immunity against poliomyelitis	Nausea, Vomiting and Diarrhoea	Oral rehydration salt	Bay had immunity against poliomyelitis
Injection vitamin K	Coagulant	1mg	Intra muscular	Prophylaxis against vitamin K deficiency bleeding	None	Warfarin and heparin	Baby was protected against bleeding
Chloramphenicol eye drop	Antiseptic	Two drops into each eye	Topical	For the treatment of eye infections, by stopping the growth of bacteria	Swollen eyes pains in the eyes	None	None observed

APPENDIX III; PHARMACOLOGY OF DRUGS USED CONT;

DRUGS	CLASSIFICATION	DOSAGE	ROUTE	ACTION	SIDE EFFECT	ANTIDOTE	EFFECTS ON CLIENT
Methylated spirit	Antiseptic	70 percent alcohol	Topical	Quick drying effect for sterile procedure for cleaning and dressing wound and for dressing baby cord	Cold burn at applied side	None	Prevent sepsis and promote healing of the baby's cord

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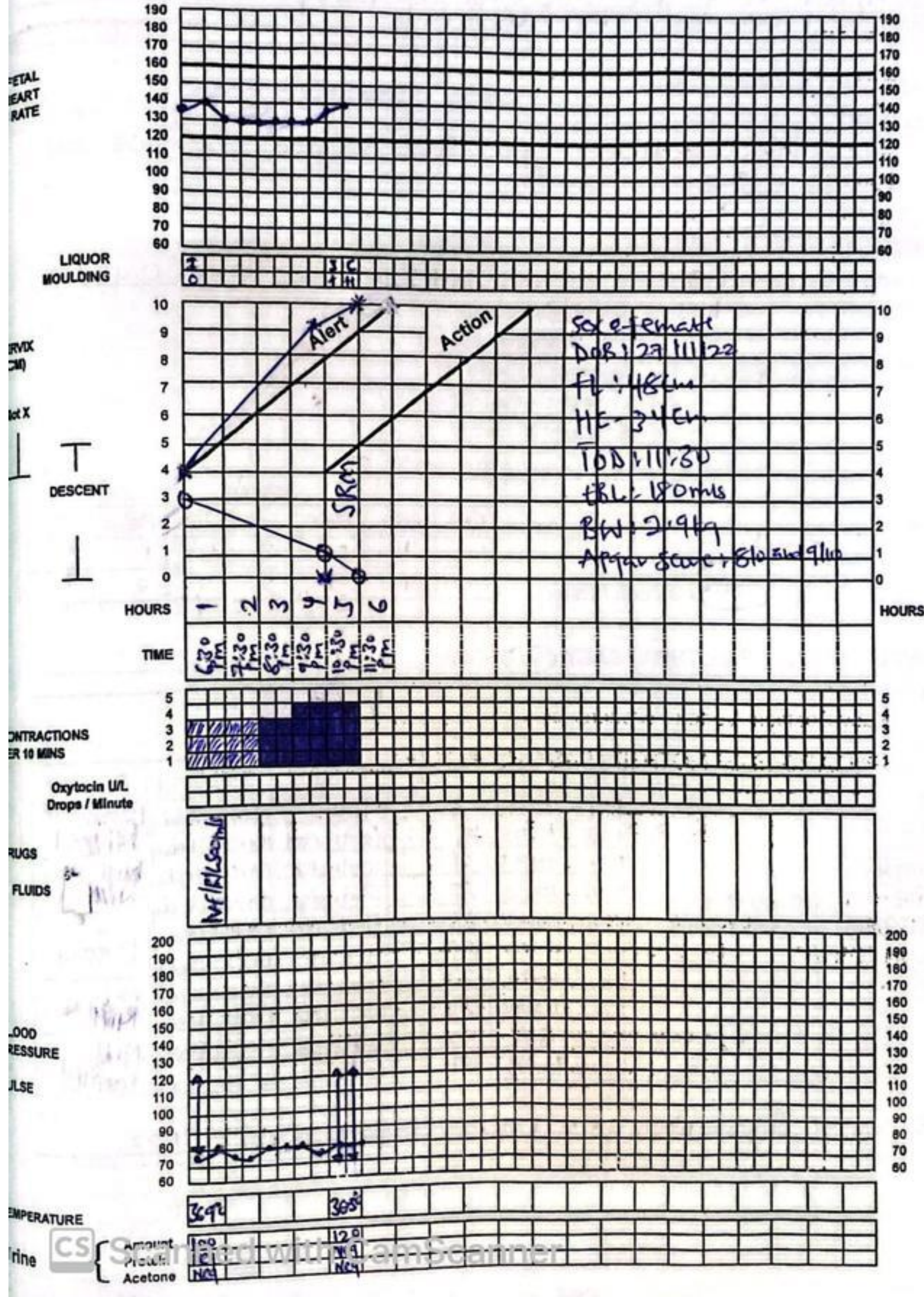

WHO Modified Partograph

Registration No. 028/22 Name (Last, First) Akua Manu Age 25yrs
Date 27/11/22 Parity/Gravida 2 / 1 LMP 1/03/22 EDD 8/12/22 Gestation (wks) 38wks
ROM (Time, Date) 11/10 pm Labour Durable (Hrs) [illegible] Facility/Clinic Name Sulinsu Health Centre

FETAL HEART RATE: 190, 180, 170, 160, 150, 140, 130, 120, 110, 100, 90, 80, 70, 60

LIQUOR / MOULDING: I / 0; C / +III

CERVIX (CM) Plot X: 10, 9, 8, 7, 6, 5, 4, 3, 2, 1, 0 — Alert — Action — SRM

DESCENT

Sex = female
DOB: 27/11/22
FL: 48cm
HC: 34cm
TOD: 11:30
EBL: 180mls
BW: 2.9kg
Apgar score: 8/10 and 9/10

HOURS: 1, 2, 3, 4, 5, 6

TIME: 6:30 pm, 7:30 pm, 8:30 pm, 9:30 pm, 10:30 pm, 11:30 pm

CONTRACTIONS PER 10 MINS: 5, 4, 3, 2, 1

Oxytocin U/L Drops / Minute

DRUGS / FLUIDS: IVF [illegible]

BLOOD PRESSURE / PULSE: 200, 190, 180, 170, 160, 150, 140, 130, 120, 110, 100, 90, 80, 70, 60

TEMPERATURE: 36.9°, 36.8°

Urine { Amount / Protein / Acetone: 100 / Neg / Neg; 120 / Neg / Neg

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LABOR NOTES

At 11:20pm client of G2P1 advance into the 2nd stage of labour and delivered an alive female baby per vaginum without any abnormalities at 11:30pm with apgar score 8/10 and 9/10 in the 1st and 5th minutes respectively. 10 unit of Oxytocin given Im Placenta and membranes delivered by control cord traction. Estimate blood loose 180mls. Perineum intact and uterus contracted. Skin to skin done and breastfeeding initiated. Mother and baby were made comfortable in bed.

Please circle or write responses.

DELIVERY

DATE: 27/11/22 TIME: 11:30pm METHOD: Spontaneous / Vacuum Extraction / C/S / Other

PERINEUM: (Intact) / Episiotomy / Laceration

ANESTHESIA: (None) / Local / General

THIRD STAGE

Active Management: (Yes) / No · Medication: Time 11:30pm Type/Dose 10 unit Oxytocin

PLACENTA: TIME: 11:35 (Complete) / Incomplete

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

BABY

Weight: 2.9 kg

Sex: Male / (Female)

Baby Position: (Vertex) / Breech / Other

APGAR

Time	Color	Breath	Heart	Tone	Reflex	TOTAL
1min	1	2	2	2	1	8
5min	1	2	2	2	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	11:40	120/70	81	16cm	Not active bleeding	120mls
	11:55	120/70	85	Contracted	Not active bleeding	Nill
	12:10	110/70	81	Contracted	Not active bleeding	Nill
	12:25	100/60	82	Contracted	Not active bleeding	Nill
	12:40	110/70	83	Contracted	Not active bleeding	Nill emptied
	12:55	120/80	85	Contracted	Not active bleeding	
	1:10	110/80	78	Contracted	Not active bleeding	Nill
	1:20	110/60	80	Contracted	Not active bleeding	Nill
Every 30 minutes For 1 hour	1:50	115/85	92	Contracted	Not active bleeding	Nill
	2:20	100/75	81	Contracted	Not active bleeding	voided 100mls

Birth Attendant Juliana Novinyo and Madam Georgina Aboulo Date 27/11/22

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MATERNITY CHART

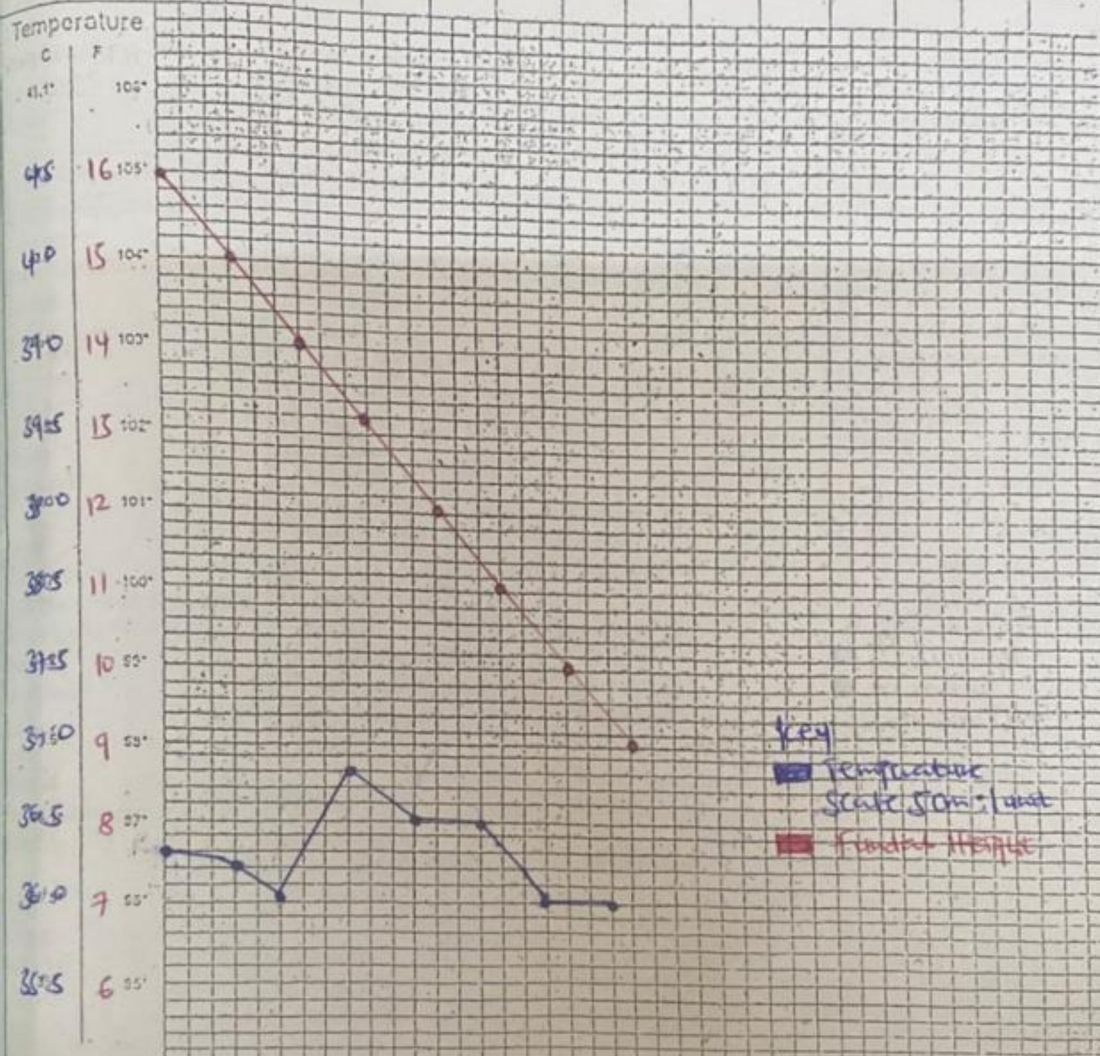
NAME: Akua Manu

AGE: 26 yrs

P NO.: 028/22 WARD: Lying in Ward

BED NO.: 5

Date	27/11/22	28/11/22	29/11/22	30/11/22	1/12/22	2/12/22	3/12/22	4/12/22
Days in Hospital	DOD	D1	D2	D3	D4	D5	D6	D7
Days P. O.								
Hour am			7:30	7:30	7:30	8:00	7:30	7:00
Hour pm	5:30	4:00	5:30	5:30				



Pulse

Resp.	20	20 19	20 21	22 22	19	19	22	22
B.M.								
Urine	passed	passed	passed	passed	passed	passed	passed	passed
B.P. AM			[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	120/83
B.P. PM	96/60	110/70	125/80	117/90				

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NEW BORN EXAMINATION FORM

Name: Baby Akosua   Date of Assessment: 29/11/22   Time: 11:45pm

Date of Birth: 29/11/22   Time of Birth: 11:30pm   Sex: [ ] M [x] F   Age at time of Assessment (days/hrs) 15mins

Gestational Age [ ] 38wks [ ]   Mode of Delivery: [x] Vaginal   Assisted Vaginal   C-Section

APGAR: 1min [8] 5min [9]   Birth Weight: [ ] 2.9 kg [ ]   Length: 48 cm   Head Circumference: 34 cm

Temperature at time of Assessment: 36.4 °C   Urine passed: Yes No   Meconium passed: Yes No

Name of Assessor (Midwife/Doctor): Juliana Novinyo

Respiration

Rate ______
- [ ] Rate < 30 b/m *
- [ ] Rate < 60 b/m *
- [ ] 30-60 b/m
- [ ] Retractions *
- [ ] Grunting *
- [ ] Stridor *

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

18. Heart rate

Rate: ______
- [x] Normal (100-160)
- [ ] <100 *
- [ ] >160*

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

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

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

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

23. Genitalia

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

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

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

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

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

*May indicate severe disease that requires urgent referral

Diagnoses (if known) Term Baby

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

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

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NEW BORN EXAMINATION FORM

Name: Baby Akosua Date of Assessment: 27/11/23 Time: 11:45pm

Date of Birth: ______ Time of Birth: 11:30pm Sex: [ ] M [x] F Age at time of Assessment (days/hrs) 15mins

Astational Age [ ] 38wks [ ] Mode of Delivery: [x] Vaginal Assisted Vaginal C-Section

APGAR: 1min [8] 5min [9] Birth Weight: [ ] 2.9kg [ ] Length: 48 cm Head Circumference: 34 cm

Temperature at time of Assessment: 36.4 °C Urine passed: Yes No Meconium passed: Yes No

Name of Assessor (Midwife/Doctor): Juliana Novinyo

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

23. Genitalia

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

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

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

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

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

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

Diagnoses (if known) Term Baby

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

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

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NEW BORN CHART

Name: Baby Akosua .... No: 028/22 .... Birth Weight: 2.9 kg ....

Sex: Female .... Mother's No: 028/22 .... Length: 48cm ....

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

Date of Birth 27/11/22 .... Time: 11:30 pm .... Date of Discharge: 28/11/22 ....

Date	27/11/22		28/11/22		29/11/22		30/11/22		1/12/22		2/12/22		3/12/22		4/12/22							
No. of Days	DoD		D1		D2		D3		D4		D5		D6		D7							
Weight	2.9kg		2.8kg		2.7kg		2.6kg		2.6kg		2.7kg		2.8kg		2.9kg							
	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM
Temperature		36.2°c		36.6°c	37.0°c	36.8°c	37.0°c	36.5°c	36.9°c		36.7°c		36.2°c		36.6°c							
Stools		passed		passed	passed	passed	passed	passed	passed		passed		passed		passed							
Urine		passed		passed	passed	passed	passed	passed	passed		passed		passed		passed							

Remarks: Head, Neck, Trunk, Genitalia — No abnormalities detected

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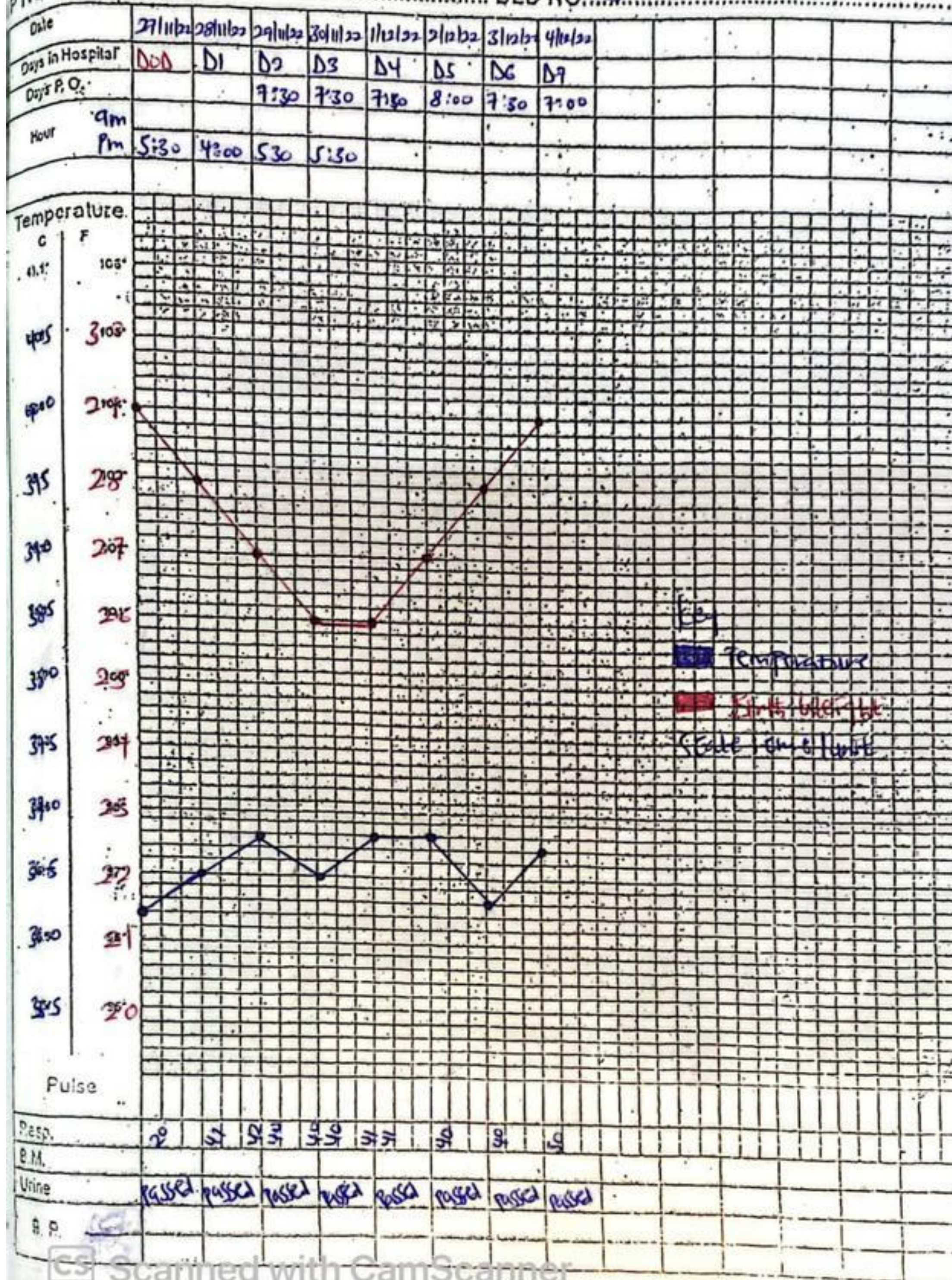
TEMPERATURE CHART

NAME: Baby Akosua

AGE: Newborn .... WARD: Lying in Ward

IP NO.: 028/22 .... BED NO.: 5



Date	27/11/22	28/11/22	29/11/22	30/11/22	1/12/22	2/12/22	3/12/22	4/12/22
Days in Hospital	DOD	D1	D2	D3	D4	D5	D6	D7
Day's P. O.			7:30	7:30	7:30	8:00	7:30	7:00
Hour 9m								
Hour Pm	5:30	4:00	5:30	5:30				

Resp.	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
B.M.								
Urine	passed	passed	passed	passed	passed	passed	passed	passed
B.P.								

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SIGNATORIES

THE STUDENT MIDWIFE

NAME: JULIANA NOVINYO

SIGNATURE:

DATE: 1st June, 2023

THE MIDWIFE IN-CHARGE (SUBINSO HEALTH CENTER)

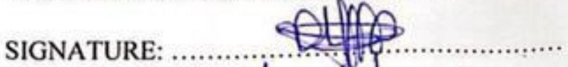
NAME; MS GOERGINA ADORVLO

SIGNATURE;

DATE; 07/06/2023

THE SUPERVISOR

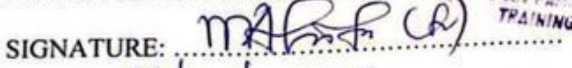
NAME: MS. UBAIDA ABDUL- KARIM

SIGNATURE: 

DATE: 07/06/2023

THE PRINCIPAL

NAME: MONICA NKRUMAH

SIGNATURE: 

DATE: 17/06/2023

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