HOLY FAMILY NURSING AND MIDWIFERY TRAINING COLLEGE

BEREKUM

A CLIENT/FAMILY CENTERED MATERNITY CARE STUDY

ON

MADAM ESTHER ADWOA APPIAH

BY

CHRISTABEL DOFUAA ABA

4122220077

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PREFACE

Birth is a dynamic and transforming experience, both on an individual and the societal level, and has the power to profoundly affect the lives of those involved. It is a physiological process characterized by non-intervention, a supportive environment and empowerment of the woman.

A family centered maternity care is a tool that allows the student 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 helps the client to have a live and healthy baby after the delivery process.

Client and family are assured of confidentiality of information.

It again helps the student midwife to use tools such as the partograph in the management of labour.

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

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My heartfelt gratitude goes to the midwife in-charge

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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 centered 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. 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.

A client and family centered maternity care study is a systematic holistic obstetric care to the expectant mothers, their family and community as a whole, based on thoughtful understanding of the client as a unique individual with specific needs and problems.

The client and family centered care study started from pregnancy, labour and puerperium and during this period the clients physical, psychological, spiritual and social changes were considered with the framework of her family and community. The care help the student midwife to put into practice the skills and knowledge she has acquired during the training to care for the client and family to have safe mother and healthy baby at the end of pregnancy.

The client and family centered maternity care study was carried on Madam Esther Adwoa Appiah 30 years old expectant mother, gravida3 Para2 all alive(G3P2) during pregnancy, labour and puerperium. The interaction with her started on 18th August 2023, during her 8th visit to Dormaa West District Hospital, Nkrankwanta at the Antenatal unit for review and

selected for the care study since she qualified for the criteria. She was 37 weeks plus 4days of gestation during the first encounter.

Madam Esther commenced antenatal clinic on 21ST of Feburary,2023 during which her gestation was 12 weeks. She had no history of any medical conditions such as hypertension, asthma, sickle cell, diabetes, heart diseases, epilepsy, allergies. Client's ANC card reveals that 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, excessive vomiting, severe headache and oedema were given to her.

The report of the study is compiled into a document in partial fulfillment for the award of a professional certificate to practice midwifery by the Nurses and Midwives Council of Ghana. There are four chapters outline in this script.

Chapter one talks about client's particulars such as social, family, medical, surgical, menstrual, lifestyle, past and present obstetrical history.

Chapter two talks about the antenatal care the client received and home visits made to client.

Chapter three talks about labour and its management.

Chapter four is about puerperium which involves an elaborate care given to Madam Hannah, the baby and the family after delivery. A care plan was drawn at the end of pregnancy, labour and puerperium to identify and solve problems of the client and also to prevent complication from occurring. Summary, conclusion, bibliography, appendix, antenatal records and signatories are also included.

LITERATURE REVIEW

This literature review gives information about what authors of different books report on pregnancy, labour and puerperium.

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 partograph 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 nulliparous (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.

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 hemorrhage 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

Madam Esther was met at the Nkrankwanta hospital on one of her usual visits to the ANC on 18th August 2023. Client was the last person to be attended to and was asked the reason for coming so late to which she said she has to sew a customer's cloth and deliver it before 11:00am before coming ANC. She was educated on the importance of attending ANC on time and was also advised to reduce the workload especially in her state of pregnancy. After going through antenatal card, she was 37weeks plus 4 days pregnant client was qualified to be used for the care study, thus, client has no complications in her previous Pregnancy. Labour, Puerperium.

She therefore fit into the criteria for selection of the study. Client was informed about the intention to use her for this study after explanation of the study was given. She gladly accepted but said the final decision would come from her husband after she has informed him. She therefore took my contact to be given feedback later.

Routine procedures were carried out, and the midwife in-charge after her assessment approved of client to be used.

At 06:30pm, a call was received from the client and she said her husband had agreed for her to be used for the study. Direction to her house was given and home visit appointment was booked.

CHAPTER ONE

ASSESSMENT OF CLIENT/FAMILY

1.0 INTRODUCTION

This chapter entails information about the client, her family and community. It gives an account of the assessment on Madam Esther, her family and the community in which she lived.

1.1 PERSONAL AND SOCIAL HISTORY

Madam Esther is a 30year-old seamstress who comes from Wamfie but stay at Nkrankwanta in the Bono Region of Ghana. She stays near the Methodist church at Nkrankwanta in the Bono region of Ghana with house number BD-011-0626. She is dark in complexion and weights75kg, 161cm tall. She speaks Twi. She has been in a relationship with Mr. Appiah for 13 years but has been married for 9years now. She is blessed with two children, Naomi and Theresah. Madam Esther had her education up to primary level and now sewing is what she does for a living. Madam Esther is a Christian and worships at Christian Divine Church (CDC) and is very religious. She does not smoke or take in alcoholic beverages.

1.2 FAMILY HISTORY

Madam Esther said there are no hereditary diseases like sickle cell disease, diabetes, hypertension, heart disease, asthma or mental illness in her family. She reported history of no twin pregnancies in the family and no congenital abnormality in the family. Her parents are alive and her mother Madam Georgina, a farmer resides in with her husband, Mr. Anane who is a farmer by profession. They are all Christians. She has six siblings, two boys and four girls of which she is the fourth child among them. Death occurs naturally in their family as far she is concerned.

1.3 MEDICAL HISTORY

Madam Esther said she has not been on admission at the hospital before but receives medical treatment on out-patient basis, whenever she is ill.

According to Madam Esther she has no existing condition like hypertension, sickle cell, heart disease, diabetes, asthma, glucose 6 phosphate dehydrogenase (G6PD) defect and mental illness.

She has no known allergies to food or any drugs. She has never been transfused nor donated any blood.

1.4 SURGICAL HISTORY

Madam Esther has not been involved in any accident neither has she undergone any surgical operation on the pelvis, spine, reproductive tract, caesarean section, laparotomy and infertility treatment before. She has no history of abortion. She has never undergone any blood donation exercise nor has been transfused.

1.5 MENSTRUAL HISTORY

Madam Esther had her menarche at the age of seventeen (17). Her menstrual cycle is 28 days lasting usually for 5 days and she does not have dysmenorrhea during this period according to her. She uses sanitary pads during her menstrual period and changes it twice daily. She gave her last menstrual period as 24/11/2022 and her EDD was calculated to be 31/08/2023.

1.6 CLIENT'S LIFESTLE AND HOBBIES

Madam Esther wakes up around 5:30am and goes to bed around 9:00pm. She usually does her household duties as a wife every morning and then cleans up and prepares her children for school. Afterwards, she goes to work. Bathing and bowel movement is twice daily and empty's the bladder four to five times in her current state. She comes home around 4:30pm. She does a general cleaning on the weekends. She eats three square meals a day. She usually eats porridge and bread in the morning, rice and stew as lunch, and fufu with soup for supper. Her favorite food is banku with okro stew. Her hobbies are watching telenovelas on TV.

1.7 PAST OBSTERTIC HISTORY

PREGNANCY

Madam Esther has had two pregnancies and they are all females (G2P2). She has no history of abortion. Madam Esther began her first antenatal clinic session at Dormaa West District Hospital, Nkrankwanta during pregnancy at ten (10) weeks gestation for her first pregnancy and 14 weeks for the second pregnancy. She carried her pregnancies to term without any complication like ante-partum hemorrhage, urinary tract infection, malaria or anemia in pregnancy except some minor disorders of pregnancy like waist pain, frequency of micturition, lower abdomen for both pregnancies. She also had no pregnancy induced diseases like hypertension and diabetes. Her second child was five years when she had her current pregnancy. She had three doses of tetanus diphtheria and five doses of Sulfadoxine pyrimethamine for her first pregnancy and five doses of Sulfadoxine pyrimethamine for the second pregnancy.

LABOUR

Madam Esther said both children were delivered spontaneously at Dormaa West Hospital, Nkrankwanta. Client said her duration of labour for her first pregnancy lasted for about eight (8) hours and 6 hours 45minutes for her second pregnancy. Client said the placenta was delivered few minutes after delivery her babies and blood loss was moderate. According to client, she said she was not given any episiotomy neither did she sustain tear. (There were no complications such as post-partum hemorrhage and she was in good condition after the delivery of her baby and breastfeeding was initiated not long after the delivery, before she was transferred to the lying- in- ward. The weight of her first baby was 3.0kilograms and second baby was 2.8kilograms. Client added that her children cried at birth with no congenital abnormalities and in a good condition

PUERPERIUM

Client claimed her puerperium was without any complications such as post-partum hemorrhage, infection and depression. She practiced exclusive breastfeeding for 6months and continued with complementary feeds like Nan 2, other foods taken by the family and weaned her first baby for 1 and half year and the second baby was weaned for 2 years after which she stopped breastfeeding. Her children received care and all immunizations during her postnatal visits to the clinic. Both mother and babies did not suffer any ailment during puerperium. Client received support from her mother and sister during puerperium. According to her, she has never used any artificial family planning method but was practicing the natural family planning method.

1.8 PRESENT OBSTETRICAL HISTORY

Madam Esther G3P2 reported to Dormaa West Hospital, Nkrankwanta for booking on 18/03/2023 with 16weeks plus 4days cyesis. She said her last menstrual period was on 24/11/2022, thus her expected date of delivery was calculated to be 2/09/23. Detailed information about her personal, menstrual, obstetrical, lactational, medical, surgical, family and contraceptive histories were taken. Her weight was 70kilograms and height was 161cm. Vital signs checked and recorded as follows.

OBSERVATIONS	**VALUES**
Temperature	36.3 degree Celsius
Pulse	87 beat per minute
Respiration	22 cycles per minute
Blood Pressure	120/80 millimetre of mercury

- Urine test showed negative for both protein and sugar.

Client's laboratory investigations were also done and recorded below as;

- Haemoglobin level - 11.2 grams per deciliter.
- Blood group - B
- Rhesus factor - Positive
- HIV status (PMTCT) - Negative.
- Hepatitis B - Negative.
- G6PD - No defect.
- Sickling - Negative.
- Stool (cyst, protozoa, ova) - No abnormality detected.
- VDRL - Non reactive.
- MPs - No MPs seen.

Physical examination conducted revealed no detection of abnormalities. Symphysio-fundal height was not palpable. Madam Esther had no complains. Client was served with routine drugs as below;

- Tablet folic acid 5mg daily for 30 days
- Tablet ferrous sulphate 200mg daily for 30 days
- Tablet multivitamin 200mg daily for 30 days

Client made her next appointment on 18th August, 2023 and since then has honoured her appointment as of the 36th week she was met.

CHAPTER TWO

ANTENATAL CARE

2.0 INTRODUCTION

This chapter elaborates the care that was rendered during pregnancy. This care started from the time of conception and continued throughout pregnancy. This include first contact with client, subsequent visit by client to the clinic, home visits during antenatal period and care plan drawn to solve problems encountered by client.

2.1 FIRST CONTACT WITH CLIENT

Madam Esther was welcomed to the Nkrankwanta hospital for a medical review on the 18th of August, 2023. A brief introduction was made as a student Midwife from Nursing and Midwifery Training College, Berekum, stationed at the medical establishment for a period of 6 weeks to undergo clinical and write up a case study on a chosen patient. Further explanation was done after the patient was offered a seat to expound on the nature of the study plan whiles going through her antenatal booklet and records. Madam Esther met the criteria to become a subject in coming up with a case study as she was a regular patient at the hospital, is multigravida and had good obstetric history. Madam Esther. She had previously complained of heartburns to a fellow attendee and education was given prior to the introduction. Further procedures were done whiles explaining each one of them to her and with her consent, she was encouraged to ask questions or tell us to stop if she feels uncomfortable.

Madam Esther was assisted through the routine laboratory investigation after vital signs checked and recorded. Her haemoglobin level was 11.9g/dl and her HIV screening result was negative. Her vital signs and weight were checked and recorded as:

OBSERVATIONS	VALUES
Temperature	36.7 degree Celsius
Respiration	24 cycles of minute
Pulse	80 beat per minute
Blood Pressure	121/74 millimetres of mercury
Weight	70 kilograms

After all these procedures, she was asked to empty her bladder and specimen bottle was given to her to collect mid-stream urine to test for urine protein and glucose. Protective clothing like apron and gloves were worn. The quantity, color, odour and sediments were noted. A urine reagent strip prepared was picked and dipped into the urine sample. The strip was immediately removed and the edge of the strip taped against side of the urine container to prevent spilling of urine onto the clothes. After one (1) minute, the strip was compared with the corresponding color on the container. There was no change in color of the strip indicating a negative result when compared closely with the corresponding color chart on the container.

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

PHYSICAL EXAMINATION.

Under the supervision of the midwife in charge, head to toe examination was correctly done. All necessary equipment needed for the examination was gathered on a tray comprising of the following items;

- A sterile gallipot with sterile cotton wool swabs
- A receiver for used swabs
- A tape measures

- A fetal stethoscope
- A watch with a second hand
- Examination gloves

The procedure involved in physical examination was explained to her and she consented. Privacy was provided by closing doors and nearby windows and curtains drawn, hand washing was done and client was asked to empty her bladder. Madam Esther was assisted to sit on the bed, lie on her right side and then assume a supine position after client has been assisted to undressed.

The head was examined first during the physical examination. Client's hair was examined for cleanliness, lice, dandruff, ringworm, alopecia, skin infection and any other abnormalities and no abnormality was detected. Madam Esther was congratulated and praised for keeping the hair clean and tidy and advised to keep it up.

Client's face was then inspected for oedema, rashes and chloasma and nothing abnormal was detected. Her eyes were also inspected for pallor of the conjunctiva, yellowish or jaundice of the sclera but no abnormality was detected. The ears were also inspected for discharges and alignment with the eyes and nothing abnormal was detected. The mouth was inspected for dryness, cracks and infection of the lips. The gums and tongue for pallor, sores or lesions and the teeth for decay but no abnormalities were detected. She was encouraged to brush her teeth two times daily and rinse her mouth after each meal.

The neck was palpated for enlarged thyroid gland, distended neck veins and enlarged lymph nodes and no abnormality was noted.

BREAST EXAMINATION.

The procedure was explained to client and consent sought before breast was exposed. Both breast were exposed to check for size, shape, signs of pregnancy, dimpling and nipple retraction, and condition of the skin. On breast examination both breasts were present, the shape and size were normal, the areolar was very dark in color, and the skin of the breast were smooth with the nipple well projected. The breast nearer was covered and the other one farther was exposed to be examined. The client was asked to put the hand of the part to be examined under her head and with the left hand supporting the breast, the right hand was used to palpate the breast systematically in a circular manner using the inner aspect of the fingers for masses, enlarged axillary lymph nodes but no abnormality was detected. The areolar was also squeezed gently with cotton wool to expressed for abnormal discharges of which there was no abnormality detected. Client's breastfeeding history was inquired and client verified desire to breastfeed exclusively for 6 months for her current child because she was not practicing exclusive breastfeeding. She was made comfortable and covered up. Findings were explained to client. Client was reminded to examine breast at home after she resumes her menses as it was done at the facility frequently and report any abnormalities.

EXTREMITIES

UPPER EXTREMITIES**:** Madam Esther was asked for tingling and tightness of the finger on making a fist, the hands and fingers were inspected for oedema, pallor of palms and nail bed and no abnormality was noted. The finger nails were well trimmed and equal

LOWER EXTREMITIES: The legs were inspected for size and equality in the calf muscles and palpated for oedema, tenderness and no abnormality was detected. Client was encouraged to rest in between sitting and standing, avoid prolonged standing and to perform mild exercise like walking to enhance proper circulation to prevent varicosity.

The back was examined for deformity of the spine (scoliosis), oedema of the sacral region and no abnormality was detected.

ABDOMINAL PALPATION.

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

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

Measuring of symphysio-fundal height: The zero end of the measuring tape was placed on the fundus of the uterus and the tape extended to the upper boarder of the symphysis pubis and the symphysio-fundal height measured 37cm and gestational age of 36weeks plus 4days.

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

Lateral palpation: With one hand stabilizing the right side of the uterus, the other hand was moved gently in a circular manner on the left side where rough parts were felt indicating the fetal limbs. This was repeated at the right side and a smooth round part was palpated indicating back of the fetus.

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

the head. In brief, the palpation the lie was longitudinal, presentation was cephalic and the position was right occipito-anterior.

Descent: The anterior shoulder was located 2.5cm below the umbilicus and with the ulna border on the upper border of the symphysis pubis, five fingers occupied the space indicating descent of $5/5^{th}$.

Auscultation: The fetal heart was auscultated by warming and placing fetal stethoscope (fetoscope) on the area where the back was located; the ear was placed against the fetoscope, making sure hands were not touching the fetoscope and the fetal heart beat was counted. Comparing the rate with the maternal pulse and counting how many beats were heard for one minute, it was 140beat per minute with regular rhythm.

Vulva Examination

Permission was sought to inspect her vulva after hand washing was done. Client's vulva was inspected after the examination light was turned towards the genital area for clear view. The vulva was well shaved and clean. The perineum, labia and clitoris were inspected and it was clean, they had no abnormalities such as swollen tissue, rashes, warts or blisters and there was no indication of female genital mutilation, and no abnormal discharges found. Hands were washed and dried. Findings were communicated to her and she was congratulated for her co-operation. She was thanked and was helped to turn to her left side before getting off the bed and to do so any time she rises from bed. She was assisted to dress up. Madam Esther was offered a seat and she was asked if she had any complains, but she gave no complain. Client was encouraged to continue maintaining personal hygiene and also to have enough rest and sleep. She was told to get all her items needed for delivery ready and well packed. This was done after being educated on the signs of labour. Danger signs of labour in pregnancy like severe headache, vaginal bleeding, swellings of the lower limbs, severe abdominal pains,

excessive vomiting were explained to her so as to help her identify any danger signs and report immediately since she was in her late weeks. She was served with her routine drugs as below;

- Tablet folic acid 5mg daily for 7 days
- Tablet ferrous sulphate 200mg daily for 7 days
- Tablet multivitamin 200mg daily for 7 days

We discussed home visits and she gave directions to her house after which contacts were exchanged and she was seen off. The date for her next appointment (25th August, 2023) was given to her.

2.2 FIRST ANTENATAL HOME VISIT

The first home visit to Madam Esther was on the 19th August, 2023 by foot according to directions given. Madam Esther and the family gave a warm welcome in the house. After greetings were exchanged, she offered a seat and introduction was made to her household members and the family. The mission for the visit was made known to her, that is how she was fairing and to also assess the environment which she lives.

PHYSICAL ENVIRONMENT

On entering the house, it was observed that Madam Esther lives in a rented room. Client then led the way to her pouch and offered a seat and a sachet of water. During interaction with the family, the following observations were made; it was observed that the room was a single room with a spacious veranda in front. Client stays there with her children. Client cooks in their kitchen which is in front of her room and her cooking utensils were well arranged on a table in one corner of the kitchen whilst her cylinder is on a table at another corner. In other to view the environment well client was asked to let us sit outside with the excuse that it was hot on the veranda.

Client lives in a compound house which contains seven rooms. The house was built with blocks and cement, painted violet and roofed with aluminum sheets. There is a standing pipe outside the compound which serve as their source of water from which all the family have access to. Client fetches water from the pipe and stores it in a large sized barrel with a well-fitting lid. The compound is very neat and their bathroom is located within the house together with KVIP latrine detached from the house. She keeps her refuse in a dustbin without a lid and disposes it daily in the community refuse dump. Madam Esther was educated to cover her dustbin to prevent flies from settling on the rubbish then on uncovered food which can cause infection. Client uses Charcoal and firewood as her source of fuel for cooking when her gas is finished.

Client's room is divided into two by a curtain, part used as the bedroom and the other part used as the sitting room. The room was neat with items well arranged. She sleeps on a mattress under treated mosquito net. The room was a bit spacious with adequate ventilation. The windows were covered with net which prevented flies and mosquito from entering the room. Client was asked about who has been cleaning the bath house and the toilet and was told it was cleaned twice a week by neighbors in turns. She was advised on the use of antiseptic solution in and on the toilet seat before using, since she was at risk of urinary tract infection, and also to wash her hands with soap under running water after visiting the toilet. Client had her husband's number which she can call when needed. Education was given to her on the signs of true labour which were, rhythmic uterine contractions which will be felt as tightening discomfort or actual pain, a blood-stained mucoid discharge from the vagina, and sometimes rupture of membranes. She was encouraged to visit the hospital immediately if she experienced any of these signs and take her drugs as prescribed. Later during our interactions her mother showed up from the market, an introduction was made again to her, she was very happy of the visit to educate her daughter on certain things. Client's family was encouraged to support client in the performance of household chores. The family were encouraged to continue eating nutritious diet.

PSYCHOSOCIAL

Client lives very well with her children, co-tenant and has a warm relationship with her neighbors. Her friends most of the time visit her and she also visit them at her leisure time. Client behaves nice and cracks jokes. She has respect for all manner of people. She also attends social gathering like wedding, naming ceremonies and funeral.

Client was thanked for her time and hospitality, she was informed of the second visit to the house on 21st August, 2023, and permission was then sought to leave.

2.3 SECOND ANTENATAL HOME VISIT. The second antenatal home visit to Esther house was on the 21th August, 2023 at 5:30pm as scheduled where client has returned from work and rested for some time. The purpose of the visit was to inquire about their health. Madam Esther and her family gave a warm welcomed. An enquiry was made about client's health status and a positive response was given. Client however complained of having constipation and fatigue. She was therefore encouraged to take in enough fluids (at least 8 cups daily) and eat diet containing fiber and roughages to manage the constipation. Education was given on personal hygiene to prevent infections. Client was again educated on the fatigue and it was explained to her that it was one of the physiological changes that occur in the later part of pregnancy. It was further explained that, it was due to the weight of product of conception and inadequate rest related to gravid uterus. Madam Esther was encouraged to take up a little work, have adequate rest during the day and avoid strenuous activities. Client was asked about her preparations towards delivery and her layette was inspected, everything on the delivery list was intact and was neatly arranged in a luggage, and also to get contacts of drivers who could transport her to the hospital when labour sets in at an odd hour and support person was also identified as her elder sister who lived in the same house and her husband. Madam Esther was encouraged to save money in her purse

and add her antenatal book to her bag. Client's environment was clean and tidy and the refuse had been emptied. Inspection of the client's rooms was done and it was observed that everything was well arranged.

Madam Esther was reminded of the next visit to the clinic on the25nd August, 2023. She was thanked and bid fare well.

2.4 SUBSEQUENT VISIT TO THE CLINIC

On the 25th August, 2023, Madam Esther came to the clinic, which was the third (2nd) contact with her at the clinic but her twelve(12th) visit to the clinic. Client was warmly welcomed and offered a seat. Madam Esther was asked about her general condition and she confirmed she was well. She was then taken through the routine care; urine sample was taken to test for the presence of protein and glucose but was tested negative. Her vital signs were checked and recorded as follows;

OBSERVATIONS	**VALUES**
Temperature	36.6 degree Celsius
Pulse	82 beat per minute
Respiration	22 cycles per minute
Blood Pressure	110/80 millimeters of mercury
Weight	70kilograms

Permission was sought to examine her. Having urinated earlier, privacy was provided and she was helped onto the bed on her left side. Hands were washed with soap, water and dried. On physical examination from head to toe, no abnormality was detected. Hands was rubbed together to make them warm and abdominal examination were performed with the following findings; the abdomen was ovoid and fetal movements detected. the symphysio fundal height

was measured to be 37cm. On fundal palpation an irregular soft mass was felt which indicated that the fetal buttocks of the upper pole of the uterus. On lateral palpation the right side of the abdomen revealed a smooth curved mass indicating the back of the fetus. On pelvic palpation a smooth hard mass was felt indicating fetal head at the lower pole of the uterus. It was therefore concluded that, the presentation was cephalic and position was right occipito-anterior with the descent of 5/5th. On auscultation the fetal heart rate was 142 beats per minute with regular rhythm. Client was assisted to get up from the bed and a seat was offered to her. Hands were washed and dried. Findings were documented and communicated to her. She was asked of any complaints or questions and client complained of lower abdominal pains and heart burns. It was explained to her that lower abdominal pains is due to the stretching of the pelvic ligament. Client was educated to understand that, since she's getting to term the descent of the fetal head may put pressure on her pelvic ligament, so she should try to cope with it and have enough rest and sleep. Client was advice d to prevent prolonged standing when doing chores to prevent tension on the abdominal muscles. On Heart burns, it was explained to her that it was the action of progesterone on the smooth muscle causing relaxation of the cardiac sphincter of the stomach leading to reflux of gastric contents. Client was encouraged to avoid taken spicy and oily foods, stop bending down to work especially after eating and also lie on her side and lie down with many pillows to prop her up. In the absence of any further questions, she was encouraged to continue taken her routing drugs. Routine drugs were given to her as usual which included:

Tablets multivitamins 200mg twice daily for 7 days

Tablets folic acid 5mg daily for 7 days

Tablets ferrous sulphate 200mg daily for 7 days.

Client was asked to come for antenatal visit in a week time if she had not delivered by then. The next antenatal visit schedule which was 1st September, 2023 was reviewed.

Madam Esther was thanked for cooperating, reminded of next home visit and escorted to the road side.

NURSING CARE PLAN ON ANTENATAL CARE.

PROBLEMS IDENTIFIED

1. On 19/08/23 Frequency of micturition.

2. On 22/08/23, Client complained of constipation

3. On 25/08/23, Client complained of lower abdominal cramps.

4. On 28/08/23, Client complained of heartburns

SHORT TERM OBJECTIVES

1. Client will cope with frequency of micturition within 24 hours.
2. Client will regain her normal bowel action (twice daily) within 24hours.
3. Madam Esther lower abdominal pains will resolve within 24hours.
4. Client heartburn will subside within 24hours.

LONG TERM OBJECTIVES

Madam Esther would maintain physical, social and emotional wellbeing throughout pregnancy without any complications to both mother and the foetus.

NURSING CARE PLAN FOR ANTENATAL

DATE / TIME	NURSING DIAGNOSIS	NURSING OBJECTIVE /OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTIONS	DATE/ TIME	EVALUATION	SIGN
19/08/23 at 12:30pm	Frequent micturition related to normal physiology of pregnancy	Client will feel comfortable within 24 hours by understanding and coping with condition as evidence by client verbalizing that she can cope with the frequent micturition.	1. Assure client that is a normal physiology of pregnancy. 2. Educate client on the causes of frequency of micturition. 3. Educate client to decrease intake of natural diuretics. 4. Encourage client to lean forward when voiding. 5. Encourage client to keep a clean covered chamber pot at bedside.	1. Client was reassured that it will resolve after birth. 2. Client was educated that it was due to the pregnant uterus competing space with the bladder causes frequency of micturition. 3. Client was educated to decreased intake of natural diuretics like coffee and tea. 4. Client was encouraged to lean forward when voiding to help empty bladder completely. 5. Client was encouraged to keep a clean covered chamber pot at bedside to promote comfort at bedtime.	20/08/23 at 12:30pm	Goal was fully met as client reported that she can cope with frequency of micturition.	**D.C.A**

DATE / TIME	NURSING DIAGNOSIS	NURSING OBJECTIVE /OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTIONS	DATE/ TIME	EVALUATION	SIGN
22/08/ 23 at 2:30pm	Constipation related to inadequate intake of fluids	Client will empty her bowel at least once daily within 24 hours as evidenced by 1. Client verbalizing that she has no difficulty in emptying her bowel. 2. Midwife Observing that client is free from constipation	1. Reassure client of relieve from constipation 2. Explain physiological basis of constipation to client that is due to relaxation of the intestines which is caused by progesterone 3. Encourage client to increase intake of fruits and vegetables. 4. Encourage client to take in least about 500mls of warm fluids on empty stomach preferably in the morning. 5. Encourage to engage in passive exercises to increase bowel movement	1. Client was reassured on free bowel movement. 2. Physiological basis of constipation was explained to client. 3. Client was encouraged to increase intake of fruits and vegetables. 4. Client was encouraged to take in 500mls of warm fluids on empty stomach preferably in the morning. 5. Client was encouraged to engage in passive exercises to increase bowel movement	22/08/ 23 at 2:30 pm	Goal achieved as client said she had normal bowel movement and the midwife visualizing client is relieved of the constipation.	**D.C.A**

NURSING CARE PLAN DURING ANTENATAL CARE.

Date/ Time	**Nursing Diagnosis**	**Objectives / outcome Criteria**	**Nursing Orders**	**Nursing Intervention**	**Date/ Time**	**Evaluation**	**Sign**
25/08/23 at 9:50am	Lower abdominal cramps related to pressure from the presenting part.	Madam Esther will cope with lower abdominal cramps within 24 hours as evidenced by; 1. Client verbalizing that she is coping with the lower abdominal pains. 2. Midwife observing client with relax facial expression	1. Reassure client. 2. Educate client on the physiology of lower abdominal and waist pains. 3. Encourage client to wear low heeled sole shoes. 4. Advise client to have enough rest. 5. Serve client with prescribed analgesics.	1. Client was reassured that pain will subside after delivery. 2.Client was educated that the lower abdominal pain was as a result of pressure from the presenting part. 3. Client was encouraged to wear low heeled sole shoes. 4. Client was advised to rest between activities or 2 hours rest during the day. 5. Client was given 1g of paracetamol tds x 7days to be taken home.	23/08/23 at 9:50am	Goal was fully met as client coped well with lower abdominal pain.	**D.C.A**

ANTENATAL CARE PLAN

DATE /TIME	NURSING DIAGNOSIS	OBJECTIVES/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
28/08/23 at 8:45am	Heart burns related to relaxing the cardiac sphincter	Madam Esther heartburns will resolve within 24 hours as evidenced by; 1. Client verbalizing absent of heartburns. 2. Midwife visualizing that client's facial expression is full of smiles as she used to be.	1. Reassure client. 2. Encourage client to elevate the head end of the bed by 6 inches. 3. Instruct client not to sleep or lie down immediately after eating. 4. Encourage client to minimize fatty and spicy meals and increase protein intake. 5. Encourage client to avoid the intake of food that triggers heart burns eg caffeinated drinks, chocolate	1. Client was reassured that her heart burns will be relieved. 2.Client was encouraged to elevate the head end of the bed with pillows. 3. Client was encouraged to sit up for at least 30 minutes after eating 4. Client was encouraged to minimize the intake of fatty and spicy meals and increase protein intake. 5. Client was encouraged to minimized the intake of caffeinated drinks, chocolate and acidic foods.	29/08/23 at 8:45am	Goal fully met as client's heartburn was resolved.	**D.C.A**

CHAPTER THREE

LABOUR

3.0 INTRODUCTION

This chapter consists of the Madam Esther admission and management during the first, second, third and fourth stages of labour. It emphasizes on the use of partograph and nursing care plan for the management of 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

Madam Esther reported to the Nkrankwanta hospital at 4:00pm on the 31stAugust, 2023 accompanied by her husband. They were warmly welcomed and offered a seat. Madam Esther said she had noticed some mucoid blood stain vaginal discharged (show) around 3pm before coming. She was asked to provide her antenatal health record booklet and it was read through with the help of the midwife in-charge.

According to her maternal health record book, her expected date of delivery was 31st August, 2023, and she was 38 weeks and 2 days pregnant. Madam Esther's items for delivery were taken. An enquiry about her last meal was made and she said she had her last meal a 1:00pm and it was Rice with vegetable stew. All procedures to be carried out on her were explained to her to gain her co-operation and consent.

Madam Esther's husband was asked to wait outside of the maternity unit and made comfortable. Client's vital signs were checked and recorded as follows;

Temperature - 36.3

Pulse rate - 94bpm

Respiration - 22cpm

Blood pressure - 121/82mmHg

Madam Esther was taken to the labour admission room for monitoring. Items needed for delivery were sent to the labour room and the remaining sent to her bed side. She was asked to urinate before the head-to-toe examination starts to prevent interruption. Midstream urine was taken for glucose and albumin to be tested and it was both negative. 115ml of urine was excreted which was amber in Colour and no was no offensive smell. (An intravenous cannula was passed as per facility's protocol.)

Client was assisted to undress and was draped with a cover cloth. Privacy was provided and client was helped onto the examination couch sideways then to a lithotomy position. Hand washing was done with soap under running water, dried and warmed by rubbing both hands together.

The head-to-toe examination was done and there was no abnormality, so the examination procedure to the abdomen. under the supervision of the midwife in-charge. The hair was free from dandruff and lice, it was clean, her face was a bit tensed because of the painful contractions. Her sclera was clear, conjunctiva was pinkish with no discharges found, her nose was with no discharges, Her mouth was with no dental carries and tooth decay. Her ears were clean with no discharges and the neck without any palpable lymph nodes. The breast was firm on the chest with no engorgement or inversion of the nipple and the arms were proportionate in length, the nails were also short and clean. edema nor jaundice. The hands were warmed again by rubbing them together.

Abdominal Examination

Client's abdomen was ovoid in shape and medium in size. Striae gravidarum, linear nigra and fetal movement were present but no scar was found. Palpation revealed the lie to be longitudinal, presentation was cephalic, descent was $3/5^{th}$ and the symphysio-fundal height

was 36 centimeters. The fetal heart rate was auscultated and recorded as 140 beats per minute with good rhythm and volume. The contractions were 3 in 10 minutes lasting for 35seconds.

Vaginal Examination

Permission was asked to perform vaginal examination of which she agreed. Procedure for vagina examination was explained to her in order to gain consent, promote comfort and seek her co-operation. A sterile tray was set containing two gallipots, one containing savlon antiseptic solution, the other gallipot with sterile cotton wool swabs, a pair of surgical gloves and a receiver for used swabs and all was covered with a sterile towel.

Privacy was ensured. Hands was washed with soap under running water and dried with a clean towel.

Client was then helped into a lithotomy position with her knees flexed and thighs apart. Examination gloves were worn and soiled pad removed and discarded with the left hand. Pair of surgical gloves was worn. The vulva was well shaved though soiled with the blood-stained mucous (show). The vulva was then inspected for scars, sores, warts, oedema and clitoridectomy, abnormal discharge but none was present, it had no abnormalities. A sterile cotton wool swab was picked with the right hand dipped into the gallipot containing savlon solution. The swab was dropped from the right hand into the left hand and used to swab the labia majora and the minora using a swab for each. With the left hand parting the minora, the last swab in the right hand was used to clean the vestibule from anterior to posterior. Client was informed that, the middle finger followed by the index finger will be put into her vagina to assess the condition of the vagina and cervix and that she will feel a bit uncomfortable. With the labia minora still separated, the right middle finger was inserted into the vagina gently but firmly pressing downward whilst the index finger was added into the vagina in order to relax the vagina wall and muscles.

On vaginal examination, the vagina was warm and moist, the sacrum was well curved, the ischial spines were blunt, the sacral promontory was not reached and cervix was thin, soft, elastic and cervical Os was 5cm dilated. The presenting part was well applied to the cervix with intact membranes. Moulding could not be assessed because of intact membranes. The pubic arch was wide, and the rectum was empty. On withdrawal of the fingers, observation was made on the examining fingers and they were clear and not offensive. The vulva was cleaned and a clean perineal pad was applied. Client was covered with a cloth and made comfortable in bed. She was also encouraged to ambulate and to lie on her left when she felt tired. Client was then informed about the findings and after this, findings were recorded.

Madam Esther was encouraged to empty her bladder when she felt the urge as that will aid in the descent of the fetal head and effective contractions. She was also asked to change her perineal pad when it got soiled. Her sacral region was massaged during contractions to reduce pain. She was cautioned not to push when she felt the pains because that would make the cervix edematous and thereby prolonging labour. She was educated on the importance of deep breathing exercise and how to do it. She was asked if she felt hungry and she replied in the negative. Client's support person was offered a seat at the waiting area and they were reassured. All instruments used were decontaminated in 0.5% chlorine solution. Hands were washed and dried after the gloves were discarded.

Preparation for birth

In preparing for birth, skilled and unskilled helpers were identified. The skilled helper identified was the midwife in-charge whiles client's husband served as an unskilled helper. Client's husband was told she would 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 a pediatrician was reviewed in case of emergency to advance care.

Emergency packs (like PPH and Eclampsia) with their appropriate items were available. The delivery room had been already cleaned. Client was encouraged to wash hands and she was informed that the windows will be shut and fans will also be put off to provide a warm environment for the baby when it is delivered of which she agreed. Room was well lighted and ventilated. Madam Hannah was also educated that the baby would be delivered onto her abdomen on a sterile towel and she will have to support the baby. She was also informed that her abdomen will be cleaned for skin-to-skin care with the baby. The resuscitation pack had all the items needed such as a stethoscope, scissors, cord clamp, sucker, self -inflating bag and mask of different sizes. The self-inflating bag was tested to see whether it was functioning, also the radiant bulb was switched on to provide warmth to the cot. Other items like cot sheets were also made available. Delivery items were also made available.

The light was tested to check if it was working and lamp was made available to be used in case of light out. The area for resuscitation and equipment were checked. The ventilation bag, sucker and mask were tested and they were 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. The equipment needed for resuscitation were assembled and tested for functioning and they were in good condition. The equipment included head cover, scissors, ambo bag and mask, timer, suction device, stethoscope, source of light.

3.2 MANAGEMENT OF FIRST STAGE OF LABOUR

Madam Esther was given emotional support by reassurance that she is doing well, will soon have her baby and all conditions will resolve. She again complained of the lower abdominal and back pains. A sacral massage was given as she was also encouraged to void in order to enhance the fetal head to descend into the pelvis.

Madam Esther was closely monitored and managed on the partograph throughout the first stage of labour. The fetal heart rate, maternal pulse and contractions were checked every 30 minutes. Temperature, blood pressure, vaginal examination, descent and urine test were done 4 hourly and the results plotted on the partograph with findings communicated and explained to client. A bed pan was provided for her and she was encouraged to urinate anytime she felt the urge to. Madam Esther wanted to lie down so she was asked to lie on her left lateral side to prevent postural hypotension. Client was reminded about the deep breathing exercises as to conserve energy for the second stage. Sips of water were served to keep her hydrated.

At 9 pm, client was due for the next vaginal examination. The vagina was warm and moist, cervical Os was 9cm dilated, cervix was thin, soft, membranes were intact with moulding as two ++. The descent of the head was $1/5^{th}$ above the pelvic brim. Contractions were 4 in 10minutes lasting 55 seconds, fetal heart rate was 144bpm and maternal pulse was 74bpm, blood pressure 109/64mmHg and temperature 36.7^{0}C whilst urine measured 100mls and protein and sugar in urine tested negative. Trolley was set for delivery.

Top shelve

- Sterile Cord scissors
- Sterile Artery forceps
- Sterile sheets
- Sterile gauze
- Sterile Cord clamp
- Two Sterile gloves
- Oxytocin; syringe/needle
- Sterile Drapes for the woman
- Sterile episiotomy pack

Injection vitamin K
Delivery sheet
Warm baby wrap
A Sterile galipot for antiseptic lotion
Sterile receiver for placenta
Sterile Perianal pad
Gown for the midwife
A galipot with sterile cotton wool swabs

Bottom shelve

- Two urethral Catheter
- Mucous extractor and a bowl with water
- A jug to measure blood loss
- Extra cotton in a container
- Cheatle forceps
- Extra perianal pad
- Identification band
- Disposable gloves
- Goggles
- Fetal stethoscope
- A swabbing lotion
- Identification band
- Savlon

At 9:38pm there was spontaneous rupture of membrane and liquor was clear, so vaginal examination was done to confirm cervical dilatation and to exclude cord prolapsed. Cervical Os dilatation was 10cm, molding was two++. Contractions were 4 in 10minutes lasting 55seconds, descent was 0/5, foetal heart rate – 146bpm with good volume and rhythm, pulse-80bpm, BP – 126/74mmHg. The midwife in-charge was called to confirm full dilatation. All findings were communicated to the client.

She was informed that the baby would be delivered onto her abdomen to establish bonding and provide warmth so she will have to support the baby to which she agreed.

The area for delivery was prepared by closing the windows to provide warmth and all fans were switched off to receive the new born into a warm room.

3.3 MANAGEMENT OF THE SECOND STAGE OF LABOUR

Madam Esther was assisted into the second stage couch covered with mackintosh and a clean sheet. Hand washing was done with soap under running water and dried with clean towel. Protective clothing (mackintosh apron, safety boots, goggles, face mask) were worn. Having washed client's abdomen and thighs with antiseptic solution, her thighs and under buttocks were draped and her hands washed. All these were done to keep her clean for the baby's arrival.

A perineal pad was applied to the anus to prevent faecal matter from contaminating the delivery field hence infecting the baby.

Madam Esther complained of severe bearing down sensations with the uterine contractions becoming more expulsive and stronger at around 9:45pm. The anus was gapping with the perineum bulging. Client continuously lifted her buttock off the couch due to intense pain. Client was instructed to keep the buttocks on the couch and to bear down with contractions and rest in between contractions while practicing deep breathing exercise as she was taught to prevent perineal tear. Maternal pulse and fetal heart rate were checked after each uterine contraction to know the condition of both mother and fetus. Uterine contraction was 4 in 10 minutes lasting 45seconds and descent of fetal head was $0/5^{th.}$

Labour progressed successfully as the head advanced gradually. Flexion was aided by gently pressing the occiput downwards with the right index and middle fingers in order to allow the smallest diameter of the head distends the vulva and the perineum. The vagina was roomy so there was no need for an episiotomy. Flexion of the fetal head continued till crowning of the head occurred, she was asked to stop pushing, and pant at this stage to prevent rapid expulsion of the head which could lead to perinea tear and intracranial injury to the baby. The head was delivered by extension by allowing the sinciput, the face and chin to sweep the perineum to be delivered. The baby's eyes were cleaned with sterile gauze swabs from the inner canthus to the outer canthus to prevent infection using one swab for each eye. There was no cord around the baby's neck when felt for.

Restitution took place and few seconds later there was external rotation of the head which indicated that there has been internal rotation of the shoulders. This brought the shoulders into the anterior-posterior diameter of the pelvic outlet. She was asked to push gently with the next contractions. The palms were placed on either side of the parietal bone and with gentle downward traction on the fetal head towards the anus the anterior shoulder escaped under the

symphysis pubis. Upward traction was done for the posterior shoulder to sweep the perineum and was delivered. The rest of the body was delivered by lateral flexion following the curve of carus unto the mother's abdomen at 10:05pm to initiate bonding and provide warmth. Mother was congratulated.

3.4 IMMEDIATE CARE OF THE BABY

As soon as the head was born, the immediate care of the baby began. Baby's face was wiped with sterile gauze. The eyes were swabbed from the inner canthus to the outer canthus with different sterile cotton wool swabs. The index and the middle finger of the dominant hand were slide around the neck of baby to feel for cord around neck which was absent. The mouth and nostrils were not suctioned because the air way was clear and patent. Baby was dried thoroughly as soon as it was delivered unto mother's abdomen to prevent heat loss.

The wet cot sheet was removed and was replaced with a clean cot sheet. The cord was clamped within 3 minutes as it was measured 2 finger breaths from the baby's abdomen and clamped with the cord clamp and measuring 3 finger breaths above the clamp, there was a second clamp this time around with a forceps.

The cord was cut with covered forceps with sterile scissor to prevent splashing of blood. Baby was separated unto mother's abdomen. The cut end of the cord with artery forceps was placed in a sterile receiver. Baby was shown to the mother to identify the sex. An identification band was placed on the baby's wrist with mother's name, sex, date and time of delivery to identify the baby. Baby was placed on the mother's abdomen to initiate skin to skin contact which will last for an hour as means of providing warmth.

APGAR	**FIRST MINUTE**	**FIFTH MINUTE**
Appearance	2	2
Pulse	2	2

Grimace	1	1
Activity	1	2
Respiration	2	2
TOTAL	8/10	9/10

3.5 MANAGEMENT OF THE THIRD STAGE OF LABOUR

Madam Esther was informed and procedure was explained to her. The uterus was palpated for any undiagnosed twin, after which injection oxytocin 10 units was administered on her left lateral thigh at exactly 10:10pm after palpating the uterus. The cut end of the cord was re-clamped closer to the client's vulva with a forceps; a sterile receiver was placed close to the perineum to collect the placenta, membranes as well as blood

The non-dominant hand (left) was placed on the uterus to feel for contractions. When contractions were felt, the dominant hand (right) held the cord with the clamp. With contractions, the left hand was removed and placed just above the symphysis pubis with the palm facing the mother's umbilicus. The placenta was delivered by firmly grasping the cord and applying the controlled cord traction in downward direction while counter traction was applied with the left hand to prevent inversion of the uterus. Steady traction was maintained until the placenta became visible at the vulva.

Both hands were removed simultaneously to cup the placenta. In teasing movement to ease pressure on the membranes to prevent tearing, the placenta and membranes were completely delivered at 10:15pm

A quick assessment of the placenta was made with lobes intact and complete membranes. The placenta was put in the receiver for thorough examination later. The uterus was massaged and blood clots were expelled.

The client's vagina, cervix and perineum were examined after consent was sought from client under a good light source. The index and middle finger were wrapped with sterile gauze to view the cervix, the anterior and posterior vaginal walls in clockwise direction. The same was done laterally for tears at the vaginal walls but there was none. Client was cleaned, and a new pad placed at her perineum, she was transferred to detention room and made comfortable in bed. She was taught and encouraged to massage her uterus. She was encouraged to change her pad to prevent infection and urinate whenever she has the urge to prevent post-partum hemorrhage. She was congratulated for her cooperation. Baby was still maintained in skin-to skin with mother with breastfeeding initiated. She was asked to report to midwives in case she sees any changes.

3.6 EXAMINATION OF THE PLACENTA AND MEMBRANES

Protective clothing like Mackintosh apron, cap, sterile gloves was worn and a thorough inspection of the placenta and membranes was done in order to ensure no part of it have been retained during its delivery after it had been sent to the sluice room. The placenta was removed from the 0.5% chlorine solution and it was held by the cord allowing the membranes to hang loosely downwards. The cord was of normal size and the cut edge was cleaned with cotton wool which revealed two arteries and one vein. It was surrounded by Wharton's jelly. The cord insertion was central; it had no false or true knots. The foetal surface was shinny and smooth

with its color being bluish grey. The branches of the cord vessels were seen radiating on its' surface. The placenta was placed on a flat surface with the maternal surface facing upward. Through inspection, the Colour was dark red and the cotyledons were intact. There were no infarcts or extra lobes on the maternal surface and neither was it oedematous. It was then disposed off appropriately. The instruments and equipment used were soaked in 0.5% chlorine solution for ten minutes and washed, rinsed, dried and repacked for sterilization. Hands were dipped in chlorine solution before discarding the gloves.

Findings were recorded on the labour ward sheet, delivery book and summary of delivery in the antenatal booklet. The partograph was also 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.

3.7 MANAGEMENT OF THE FOURTH STAGE OF LABOUR

Fourth stage of labour begins after delivery of placenta and membranes to six (6) hours of observing both mother and baby. During this period, the baby and mother are closely monitored for any changes. Vital signs of mother and baby were checked and recorded every 15 minutes for the first two hours and 30 minutes for an hour and hourly for three hours.

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 6 cotton wool swabs soaked with methylated spirit. Injection vitamin K (0.5ml) 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 Esther 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;

Skin

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.

Head and neck

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 fontanelle would close within six weeks and anterior fontanelle would 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 32 centimeters.

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.

Extremities 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

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

Chest and Abdomen

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. 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.

Back

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 spinal bifida or meningomyelocele detected.

Genitalia and anus

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 - 32 cm

Length - 47 cm

Weight - 3.0 kg

Apex beat - 136 bpm

Temperature - 36.7^0C

Respiration - 48 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 baby's cord to avoid any infection and also to keep the baby warm so as to prevent hypothermia.

MOTHER

Madam Esther was sent into the detention room and made comfortable in bed. She was congratulated for her co-operation. She was served with mashed kenkey as she complained of fatigue and hunger. Client was taught and encouraged to continue breastfeeding the baby exclusively and on demands to maintain lactation.

She was educated on the importance of breastfeeding such as it enhances the release of oxytocin which helps in the contraction of the uterus and drainage of lochia, control of hemorrhage and also as a form of family planning. She was examined from head to toe, her conjunctiva was pink and no abnormality detected. Uterus was palpated and it was well contracted. Symphysio-fundal height was 16cm. Vaginal bleeding was small and lochia was red (rubra). There was no offensive odour and perineum intact. Madam Esther 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 wash hands afterwards. She was encouraged to urinate frequently as this will aid contraction of the uterus and involution. 60mls of urine was passed in about an hour later.

Vital signs were checked every 15 minutes for two hours, 30 minutes for one hour and one hourly for the remaining three hours and recorded in the observation chart. All findings were within the normal range. Her vital signs and assessment were checked and recorded as follows;

Temperature	-	36.4^0c
Pulse	-	87bpm
Respiration	-	23cpm
Blood Pressure	-	120/ 76mmHg

3.8 SUMMARY OF LABOUR AND DELIVERY

Date of delivery	31st August, 2023.
Time of delivery	10:05pm
Time of placenta expulsion and membranes	10:15 pm
Type of delivery	Spontaneous vagina delivery
Estimate blood loss	150mls
Duration of labour	
First stage of labour	5 hours 10 minutes
Second stage of labour	27minutes
Third stage of labour	8 minutes
Total duration of labour	5 hours 53 minutes
Condition of baby	
Sex	Female
Birth weight	3.0kg
Apgar score at 1st minute	8/10
Apgar score at 5th minutes	9/10
Full lengths	47cm

Head circumference	32cm
Chest circumference	33cm
Meconium	Passed
Urine	Passed
Abnormality	None detected
General condition	Satisfactory

3.9 Condition of mother

Blood pressure	122/63mmHg
Pulse	83bpm
Respiration	21cpm
Temperature	36.5^{o}C
Uterus	Contracted
SFH	16cm
Lochia	Rubra
Condition	Satisfactory

Condition of placenta

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

31st August,2023

3.10 NURSING CARE PLAN DURING LABOUR

PROBLEMS IDENTIFIED

Client complained of:

- Lower abdominal pains
- Backache
- Fatigue
- Risk for perineal tear
- Risk for infection

Short Term Objectives

- Client will cope with lower abdominal pains within 3 hours.
- Client will cope with backache within 3 hours of labour.
- Client will be relieved of fatigue within three hours.
- Client will go through 2nd stage of labour successfully without perineal tear.
- Client will be free from infections throughout labour.

Long Term Objectives

Labour will progress normally and end successfully without any complication to both mother and baby.

LABOUR CARE PLAN

DATE/ TIME	NURSING DIAGNOSIS	OBJECTIVES/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE /TIME	EVALUATION	SIGN
31/08/23 at 5:04pm	Lower abdominal pain related to painful uterine contractions.	Client will cope with lower abdominal pains within 3 hours and throughout labour as evidenced by 1. Client verbalizing she is coping with the pain. 2. Midwife observing a relaxed facial expression in between contractions.	1. Reassure client. 2. Encourage her to adopt a comfortable position. 3. Encourage client to do deep breathing exercise. 4. Involve client in a conversation. 5. Perform sacral massage for client.	1. Client was reassured that pains would resolve after delivery. 2. Client was encouraged to lie on her left lateral to cope with the pain. 3. Client was encouraged to do deep breathing exercise during contractions. 4. Client was involved in a conversation to divert her mind off the pain. 5. Sacral region was massaged for client during contractions.	31/08/23 at 7:18pm	Goal fully met as client said that she is coping with pain.	**D.C.A**

LABOUR CARE PLAN CONT.

DATE/ TIME	NURSING DIAGNOSIS	OBJECTIVES/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE /TIME	EVALUATION	SIGN
31/08/23 at 5:05pm	Backache related to relaxed pelvic ligament and descent of the fetal head	Client will cope with backache within 3 hours of labour as evidenced by 1. Client verbalizing her ability to cope with backache. 2. Midwife observing client adapt coping mechanisms.	1. Reassure client. 2. Explain the physiology behind backache in labour to client. 3. Encourage client to adopt a suitable position. 4. Massage sacral region 5. Teach and encourage client to do deep breathing exercise.	1. Client was reassured that the backache will resolve after delivery. 2. It was explained to client that the backache was due to pressure on sacral nerves. 3. Client was encouraged adopted the left lateral position 4. The sacral region of client was massaged during contractions. 5. Client was encouraged to do deep breathing exercise during contractions.	31/08/23 at 8:35pm	Goal fully met as client reported that she has been able to cope with backache.	**D.C.A**

LABOUR CARE PLAN CONT.

DATE/ TIME	NURSING DIAGNOSIS	OBJECTIVES/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE /TIME	EVALUATION	SIGN
31/08/23 at 8:38pm	Fatigue related to effects of labour pains and contractions.	Client will be relieved of fatigue within an hour as evidenced by 1. Client verbalizing that she feels less tired. 2. Midwife observing client been refreshed and show no signs of tiredness.	1. Assure client. 2. Explain to her why she feels tired. 3. Encourage client to rest in between contractions 4. Advice client to avoid shouting to prevent maternal exhaustion. 5. Encourage client to take in sips of malt beverage and water to replenish lost glucose stores and also for rehydration.	1. Client was reassured that the situation can be managed. 2. Client was told her tiredness was due to the labour pains and contractions. 3. Client was encouraged to rest when no contractions to prevent further exhaustion. 4. Client was advised to avoid shouting to prevent maternal exhaustion and was encouraged to do deep breathing exercise 5. Client was encouraged to take sips of her favourite malt beverage and water to replenish lost glucose stores and also for rehydration.	31/08/23 at 9:10pm	Goal was fully met as client verbalized she was feeling less tired.	**D.C.A**

LABOUR CARE PLAN CONT.

DATE/ TIME	NURSING DIAGNOSIS	OBJECTIVES/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE /TIME	EVALUATION	SIGN
31/08/23 at 7:35pm	Risk for infection related to invasive procedure.	Client would be free from infections within 5 hours of labour as evidenced by; 1. Midwife observing client with no infection. 2. Client not exhibiting signs and symptoms of infection.	1. Assure client. 2. Practice aseptic technique during invasive procedures. 3. Encourage client on proper hygiene. 4. Encourage client to keep hands away from the cannula. 5. Educate client on the need to prevent infection as post-partum infection will have negative effect on her wellbeing.	1. Client was assured that she would have no infection from the cannula passed. 2. Gloves were worn and site cleaned before the procedure was done. 3. Client was encouraged not to allow water get access to the cannula site when bathing. 4. Client's was encouraged to keep hands from the cannula and not to touch it to prevent dirt from entering the site. 5. Client was educated on the need to adhere to information given to prevent infection as post- partum infection will have negative effect on her wellbeing.	31/08/23 at 9:45pm	Goal fully met as midwife observing client had no infections.	**D.C.A**

LABOUR CARE PLAN CONT.

DATE/ TIME	NURSING DIAGNOSIS	OBJECTIVES/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE /TIME	EVALUATION	SIGN
31/08/23 at 8:45pm	Risk for perineal tear related to overstretching of the perineum and perineal muscles	Client will go through 2nd stage of labour successfully for 1 hour without any perineal tear as evidenced by: 1. Midwife observing intact perineum at the end of the labour. 2. Client observing and verbalizing the absence of a tear at the end of labour	1. Assure client. 2. Encourage client to only push when cervix is fully dilated. 3. Encourage client to place buttocks on the couch 4. Encourage client to pant when the head crowns. 5. The midwife should aid flexion of the fetal head by placing the middle and index finger on the advancing head.	1. Client was assured that she is in the hands of skilled and competent midwives. 2. Client was encouraged to push only when the cervix is 10cm dilated. 3. Client was encouraged to not to lift buttock off the couch during contractions. 4. Client was told to breathe through the mouth when the head crowns to prevent rapid expulsion of the fetal head. 5. The midwife placed her middle and index finger on the advancing head to aid flexion and allow the smallest diameter of the fetal head to distend the vulva	31/08/23 at 9:45pm	Goal was fully met as client expressed relaxed face and verbalized that she is relieved	**D.C.A**

CHAPTER FOUR

PUERPERIUM

4.0 INTRODUCTION

This chapter highlights on the care and management given to both mother and baby from delivery to six week's post-partum and care plans drawn for the management of problem identified during puerperium.

4.1 DAY OF DELIVERY

Madam Esther Appiah Adowa delivered on 31st August, 2023 and was sent to the lying ward at 11:30pm where her baby was nicely wrapped and placed beside her. Madam Esther was educated again on the need to ensure personal hygiene and empty her bladder more often to prevent post-partum hemorrhage and uterine sub- involution. she was taught and made aware that changing of pad when soiled is very imperative to goo

d health during her postpartum period.

Madam Esther was encouraged to feed baby more often and practice an exclusive breastfeeding and also taught how to fix baby to breast very well. There were other mandatory personal hygiene daily educations like washing of hands properly after visiting the washroom and changing the baby's napkins to prevent infections. Symphysio-fundal height and vitals were examined and recorded every 15minutes to two hours, below is a record of her vital signs, and it reads as follows;

Temperature	-	36.4 Degrees Celsius (°C)
Pulse	-	87 beats per minute (bpm)
Respiration	-	23 cycle per minute

Blood pressure - 120/76 millimeters of mercury (mmHg)

Symphysio fundal height - 16 centimeters (cm)

Client was again congratulated on her effort and was allowed to rest.

4.2 SUBSEQUENT CARE OF THE BABY

Madam Esther consent was sought to bath the baby and general examination of the baby, and she agreed. The baby's cord was observed for bleeding but there was none. The color of the baby was pink. Urine and meconium were passed and all reflexes were normal. Below indicates baby's vital signs and weight;

Temperature - 36.2 Degree Celsius (^{o}C)

Apex heart beat - 132 beats per minute (bpm)

Respiration - 46 cycles per minute

Baby's weight - 3.0 kilograms (kg)

Baby's height - 47cm

BABY BATH AND CORD DRESSING

REQUIREMENTS

TOP SHELF

4 Sterile cotton wool swabs and gauze in a gallipot

Surgical gloves

Sterile water in gallipot

Methylated spirit

Baby's diaper

Baby dress

Baby's towel and cot sheet to wrap the baby

Baby's cap and socks

Soap in a soap dish

Baby's sponge

Bottom shelf

Disposable gloves

Jug of hot water

A bowl for mixing water

Kidney dish for used gauze and swab

A receptacle for used water

Mackintosh apron

Cream (powder)

A warm bath is given to the baby to prevent hypothermia. The client was made to understand the process and reasons why it's necessary to prevent hypothermia. The warm water was prepared, it was mixed and tested for using the elbow to check its temperature.an apron was worn and hand washing was performed using soap and water and dried. Baby was carried and put on a flat protected surface to undress it and she was then wrapped in a cot sheet. Gloves were worn and eyes of the baby were cleaned, using cotton wool swabs dipped in sterile water and the face was cleaned with damp face towel and dried. The nape of the baby's neck was supported with one hand and plugging the ears with two fingers, the head and was washed with

soapy sponge. Baby was lifted of the flat surface, and with the hand still supporting the nape of the neck and the body resting in the elbow to the edge of the bowl, the baby was laid on a protected flat surface. Baby's arm and front of trunk were washed, laying emphasis and paying attention to the skin folds. The baby's back was turned with one arm supporting the chest with one hand and holding the distal arm of the baby. From behind it was washed down to the feet, paying attention to the skin folds. Holding the baby firmly, she was immersed in a basin of warm water with head above the water and rinsed thoroughly. The baby was covered with a clean sheet and was put on a flat surface. A towel was used on the baby to Dry and clean and pay attention to the skin folds, baby oil was applied on the skin. Gloves used in the above procedure were taken off and discarded.

CORD DRESSING

The cord was dressed by wrapping the baby in a towel to keep him warm. Mother was asked to protect her on the table. The tray containing six dry and clean cotton wool swabs in a gallipot containing antiseptic solution which was methylated spirit and a receiver for the used swabs was already set. Hands were thoroughly washed again with soap and under running water and dried in a clean towel. The cord was inspected for bleeding but there was none. The tip of the cord was held with one swab in the non-dominant hand. The base of the cord was cleaned with another cotton wool swab and was discarded. The whole cord was cleaned using four of the cotton wool swabs from the base upwards. One cotton wool swap was used to clean the anterior part, two (one each) for the lateral sides and another one was also used to clean the posterior part of the cord. The tip of the cord was dried with the swab that was used to hold it.

The cord was left expose to air Dry and clean. Baby was dressed after diaper was put on. The baby was wrapped with clean Dry and clean cot sheet to maintain her temperature and given to her mother. Findings were communicated to the mother and she was thanked for her co-

operation and she was accompanied to the bedside. The working surface and the instruments were decontaminated with 0.5% chlorine solution for 10 minutes; it was then washed. The gloves were removed and hands washed and dried and the procedure was documented.

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

4.3 FIRST DAY POST DELIVERY AND DISCHARGE

On 1st September 2023, Madam Esther and her baby look healthy. Client was informed she was going to be discharged that morning. Procedures and step to be taken on both mother and baby were explained. A head- to -toe examination was done with no health abnormities detected. On palpation, uterus was well contracted and the symphysio fundal height was 17cm. perineal pad was inspected for the flow of lochia which was small and red in colour with no odour. Client complains of lower abdominal pain while breastfeeding. She was reassured and educated on the physiology of after pain that, it is normal physiology that is the suckling triggers the release of oxytocin which causes uterine contraction and therefore causes after pain. She was given paracetamol 1 gram to reduce the pain. Client took a warm shower and was served with porridge and bread. Client was encouraged to breastfeed baby more often to aid involution. Client's vital signs were observed and recorded as;

Mother

Vital Signs	Morning
Blood pressure	110/60mmhg
Lochia	Rubra
Fundal Height	14cm
Condition of uterus	Well contracted

Pulse	86bpm
Respiration	20cpm
Temperature	36.7

Baby received an initial immunization which was Bacillus Calmette Guerine (BCG) vaccine 0.05ml intradermal at the right upper arm to prevent tuberculosis and oral polio vaccine 0 (OPV0) 2 drops at the back of the tongue to prevent poliomyelitis which was administered by the staff midwife. The baby was top and tailed and observed from head to toe with no abnormalities detected. cotton wool swab and methylated spirit was used to dress the cord in the presence of the client. Below are the baby's vital records;

BABY

Vital Signs	Morning
Temperature	36.6°c
Apex Heart Beat	130bpm
Respiration	40cpm
Condition of the cord	Dry and clean
Suckling	Good
Weight	3.0kg
Stool Colour	Greenish

The baby was wrapped in a clean and warm cot sheet and handed over to the mother for breastfeeding. Good positioning and attachment to the breast was encouraged. Mother was educated on the intake of a balanced diet. Several educations were given to client on the changes in perineal pad when soiled and the need to wash her hands after removal and before

breastfeeding the baby to prevent infections. Mother was educated on postnatal exercises such as Kegel, ambulation and family planning, and the need for diapers to be changed frequently, keep the baby warm always. Client was asked to register the baby at the birth and death registry. The baby was reassessed by me in and no abnormality noticed and she confirmed they were ready for discharge and was giving the following medications;

Tablet Folic Acid	5mg daily for 30 days
Tablet Ferrous Sulphate	200mg bd for 30days
Tablet Multivitamin	200mg tds for 30 days
Tablet Paracetamol	1g tds for 3days

Client was assisted to pack up her belongings and was discharged at 10:30am after serving her medications. Her bills were settled with the use of national health insurance scheme. Client was reminded of the several home visits the next seven days and she agreed.

Client was congratulated and bid farewell.

4.4 FIRST POSTNATAL HOME VISIT

Madam Esther and her family were visited in their home on 1st September,2023at 4:00pm. Greetings were exchange on arrival and was asked how she and the baby were faring and she said they were doing well. Permission was asked to perform head to toe examination on both mother and baby which she agreed. She was asked to empty her bladder and made comfortable in bed. No abnormality was detected on head- to -toe examination. The breast was lactating. The abdomen was soft, uterus was contracted, the symphysio fundal height measured 14centimeters. Perineal pad was inspected and moderate amount of lochia rubra which was not offensive. Her vital signs were checked and recorded as;

mother

Vitals signs	Evening
Blood pressure	112/60mmhg
Lochia	Rubra
Fundal height	14cm
Condition of uterus	Well contacted
Pulse	87bpm
Respiration	21cpm
Temperature	36.3

Permission was sought to top and tail the baby and it was granted. Hands were washed with soap under running water and dried with clean towel. Head to toe examination was conducted on the baby and no abnormality was identified. As the baby was being top and tailed with warm water, it passed urine and meconium. The cord was also dress with cotton wool and methylate spirit, it was clean but feels fresh. Baby's vital signs and weight were checked and recorded as follows;

Vitals signs	Evening
Temperature	36.3
Apex Heart Beat	131bpm
Respiration	40cpm
Condition of cord	Dry and Clean
Suckling	Good
Weight	2.9kg
Stool Colour	Greenish

Baby was wrapped nicely with a sheet and was given to the mother to breastfeed. All findings were communicated to madam Esther. Client has no complains, another visit was scheduled for the next day and permission was sought to leave which was granted.

4.5 SECOND POSTNATAL HOME VISIT

On 2nd September, 2023 at 7:30am and 4:30pm was another day of home visit as agreed and schedule with madam Esther. Client and baby was were in good health. Head to toe examination was done and no abnormality was identified. The cord was dressed with cotton wool swab and methylated sprit. Uterus was palpated and it was well contracted, symphysio fundal height measured 12centimeters. Client complained of headache and loss of appetite, Madam Esther was urge and encouraged to rest in a serene environment and also cut down some chores and avoid activities that will stress her. Client was asked about her afterpain and she asserted that the pain is becoming bearable with time. There were several recommendations for the client's husband after he requested for a blood pressure check. Below is the mother's and baby's vital signs;

MOTHER

OBSERVATION	MORNING	EVENING
Temperature	36.3℃	36.7℃
Pulse	78bpm	90bpm
Respiration	21cpm	18cpm
Blood pressure	114/78mmhg	121/84mmhg
Lochia	Rubra	Rubra
Fundal height	12cm	12cm
Condition of uterus	Well contracted	Well contracting

Breast	Lactating	Lactating

BABY

OBSERVATION	MORNING	EVENING
Temperature	36.8℃	37.1℃
Pulse	138bpm	137bpm
Respiration	45cpm	44cpm
Weight	2.8kg	2.8kg

4.6 THIRD POSTNATAL HOMEVISIT

On 3rd September, 2023 at 7:30am and 4:00pm was another day of home visit as agreed and scheduled with Madam Esther. Client and relatives of the clients were in good health when it was inquired. Inspection of perineal pad was done and the flow of lochia was small and red in colour. No abnormalities were detected. Head to toe assessment was carried out on the mother without any abnormality detected. Vital signs of Madam Esther were recorded as follows;

Observation	Morning	Evening
Temperature	37.7°c	36.7°c
Pulse	82bpm	80bpm
Respiration	22cpm	20cpm
Blood Pressure	100/60mmhg	100/70mmhg
Lochia	Rubra	Rubra
Fundal Height	10cm	10cm

Condition of uterus	Contracted	Contracted

The baby was assessed from head to toe and no abnormality was detected. The baby had passed meconium which was greenish in colour and urine while breastfeeding.

Client complained of fullness of breast and she was educated on the need to apply a warm compress on the breast, need to put on well- Client complained of fullness of breast and she was urged to position the baby well to breast fitting brassier to help ease fullness and also ensure the complete emptying of each breast during breastfeeding. Madam Esther was educated to continue breastfeeding. The cord was dressed with cotton wool swab and the mother was educated not to apply herbs on the cord. When asked about the after pain client said she was relieved as various recommendations helped. The baby was assessed again and no abnormality was found.

Below are the baby's vital signs, weight and other assessment made:

Observation	Morning	Evening
Temperature	36.8	36.8
Pulse	126bpm	126bpm
Respiration	51cpm	40cpm
Condition of cord	Dry and clean	Dry and clean
Suckling	Good	Good
Weight	2.8kg	2.8kg
Stool Colour	Greenish	Greenish

The baby was wrapped in a warm towel and was given to the mother for breastfeeding. Mother was reminded of next visit, thanked and permission was sought to leave.

4.7 FOURTH POST NATAL HOME VISIT

Client was visited again on the 4th September, 2020 at 7:30am and 4:30pm respectively. Madam Esther was very hospitable. General condition of both mother and daughter was good. Madam Esther's complaints of loss of appetite and headache during the second post-natal visit have been resolved when asked. Madam Esther emphasized that she had a sound sleep as compared to the previous nights. The procedure of general examination was explained to mother and both mother and baby were examined from head to toe. The mother's perianal pad was inspected for lochia and it was bright red with no foul smell.

Below are the results accrued on assessments on the mother;

Observation	Morning	Evening
Temperature	36.8°c	36.7°c
Pulse	74bpm	80bpm
Respiration	20cpm	18cpm
Blood Pressure	100/60mmhg	100/70mmhg
Lochia	Rubra	Rubra
Fundal Height	8cm	8cm
Condition of uterus	Contracted	Contracted

Baby was assessed and examined and no abnormality was detected, baby was top and tailed and passed urine and greenish stool. Cord was examined and it was Dry and clean, the cord was dressed with sterile cotton and methylated spirit.

Below is the vital sign and observation record of the baby;

Observation	Morning	Evening
Temperature	36.8°c	36.5°c
Pulse	128bpm	124bpm
Respiration	42cpm	44cpm
Condition of cord	Dry and clean	Dry and clean
Suckling	Good	Good
Weight	2.9kg	2.9kg
Stool colour	Greenish	Greenish

4.8 FIFTH POST NATAL VISIT

On the 5th September, 2023, the fourth visit was made to Madam Esther's house at 7:30am. She was in a good health condition together with her family, her environment was well kept and tidy. Client's family was also lauded for taking good care of the baby. Madam Esther laid emphasis on her complaint on the pain she felt in her breast had eventually subsidized immensely. Client was asked to top and tail baby under supervision and she executed it very well. Baby passed yellowish stool and urine. Cord was dressed with sterile cotton and methylated spirit. The cord was Dry and clean and had begun to detach.

The symphysio fundal height was measured and recorded as 6 centimeters and lochia was inspected and it was pink in color

Mother was assessed and findings were recorded;

Observation	Morning
Temperature	37.0°c

Pulse	78bpm
Respiration	16cpm
Blood pressure	100/78mmhg
Lochia	Serosa
Fundal Height	6cm
Condition of uterus	Contracted

Vital information and findings recorded for the baby were

Observation	MORNING
Temperature	36.4°c
Pulse	130bpm
Respiration	50cpm
Suckling	Good
Weight	3.0kg
Condition of cord	Dry and clean
Stool colour	Dark yellow

After staying interactive for some time client together with her family was very happy and thanked for the visit.

4.9 SIXTH POST NATAL VISIT

Client was visited again on the fifth day postnatal, 6th September, 2023 at exactly 7:30am. The health condition of Madam Esther together with her family was good, head to toe examination was done and there were no abnormalities detected. Madam Esther lochia was pink in colour

with moderate flow not offensive. Madam Esther was assessed and asked whether she was able to sleep at least six hours in the night and two hours during the day, her feedback was positive and clear, she had no issues in sleeping in both day and night. The family was urged to assist client on some domestic activities. Esther husband agreed to assist her take care in instances of changing diaper and etc.

Below is a vital sign and observations made of the fifth postnatal visit day

Observation	MORNING
Temperature	36.7°c
Pulse	92bpm
Respiration	16cpm
Blood Pressure	120/82mmhg
Lochia	Serosa
Fundal Height	4cm
Condition of Uterus	Contracted

The baby was examined and recorded as;

Observation	Morning
Temperature	37.0°c
Apex Heart Beat	136bpm
Respiration	51cpm
Suckling	Good
Weight	3.05kg
Condition of cord	Shrunken
Stool colour	Brownish yellow

Client said her both her headache and breast engorgement has been resolved. Madam Esther was advised to breastfeed baby on regular basis. Permission was sort to leave and client's house was exited.

4.10 SEVENTH POST NATAL VISIT HOME VISIT

The seventh day postnatal home visit was made to client house on 7thSeptember, 2023 at 7:30am. There were no health complaints or issues associated with Madam Esther. Client complained of heat rashes on the baby's skin and client was assured through education to dress the baby in accordance to weather and use talcum powder on the baby's skin. Hands were washed and assessment from head to toe was done and no abnormality was detected. The stump of the cord was dress with cotton and methylated spirit client was again advised not to put anything on it to prevent infection. On- head to- toe examination, no abnormalities were seen on the mother. Her breast was lactating well, symphysio fundal height was 2centimeters. lochia was pink(serosa) with no odour.

Vital signs were recorded as;

Pulse	70pbm
Respiration	21cpm
Blood Pressure	112/72mmHg
Lochia	Serosa
Fundal height	2cm
Conditions of Uterus	Contracted
Breast	Lactating
Temperature	37.1℃

The vitals for the evening were all within normal range.

Vitals Signs of the baby were checked recorded as

Temperature	36.3°c
Apex heart beat	128bpm
Respiration	41cpm
Skin colour	Pink
Condition of Cord	Fallen off
Suckling	Good
Weight	3.1kg
Stool colour	Brownish yellow

The baby was handed over to the mother to cuddling with her for a while and dressed for breastfeeding. Madam Esther was thoroughly educated on perineal care and the intake of a balanced diet. Madam Esther was asked to continue breastfeeding for six months. Client was thanked and reminded of her first week postnatal visit to the clinic which happened to be the next day. Client affirmed she would be in attendance. Since it was my last day, Clients family was thanked for their cooperation throughout my entire journey with them of which they were informed some days again.

4.11 FIRST POST NATAL VISIT TO THE CLINIC

Madam Esther visited the facility on 8th September, 2023 for the first post-natal examination. Client and baby were healthy and well dressed. Client was welcomed at the hospital. Every process to be initiated was explained to the client.

Vital signs and other observation were recorded as well;

Temperature 36.6^{o}C

Pulse	82bpm
Respiration	20cpm
Blood pressure	104/89mmHg
Lochia	Serosa
Fundal height	Not Palpable
Condition of uterus	Well Contracted
Breast	Lactating
Weight	76kg

Because it was her first postnatal clinic visit, it was very imperative that she needed to be sent to the laboratory for another investigation Madam Esther was given a specimen bottle to collect midstream urine to test for protein and glucose. Blood sample was taken and client's hemoglobin level was tested.

Haemoglobin	13.5g/dl
Urine protein	negative
Glucose	negative

Madam Esther was asked to lie straight on the bed head to toe physical examination while maintaining privacy. Before the commencement of the examination hands were washed with soap under running water and dried with towel. client was made to empty her bladder. On the head, the hair was nicely and neatly braided. There were of sign of jaundice in the eye and no discharges and the ear too had no discharges. Tongue was neither coated or pale, no foul smell, no visible tooth decay was noted after the mouth check. The neck was palpated for inflammation of lymph nodes and goiter but nothing was detected. Client's chest and breast was examined for mass, engorgement and sore nipple but none was detected. After the abdominal examination, there were no tenderness, enlarged liver or spleen but the uterus was

not palpable. The vulva was examined for infections, scars, and lochia but none was seen. With the permission of the mother, the baby was taken and examined from head to toe and nothing abnormal was detected.

The baby's vitals were observed as recorded as;

Temperature	36.7^{o}C
Apex heart rate	120bpm
Respiration	40cpm
Skin colour	Pink
Stump	Healed
Condition of cord	Fallen off and stamp healing
Suckling	Good
Weight	3.1kg
Stool colour	yellow

Client was thanked for her cooperation and handed over to the midwife in charge.

4.12 SECOND POSTNATAL VISIT TO THE CLINIC

According to the midwife in charge, client visited the facility on the 10th of September, 2023 for her sixth week postnatal visit. The midwife indicated that, both mother and baby were assessed and no abnormalities were detected. Baby was given the due immuniunization. They were handed over to the child welfare clinic and family planning unit for continuity of care.

4.13 CARE PLAN DURING PUERPERIUM

PROBLEMS IDENTIFIED DURING PUERPERIUM

1. 1/09/23 - Client complained of after pain
2. 2/09/ 23 - Client complained of headache
3. 3/09/23 - Client complained of fullness of breast.
4. 4/09/23 - Client complained of loss of appetite.
5. 7/09/23 - Skin rashes were observed on the baby

SHORT TERM OBJECTIVES

- Client will be relieved of after pain within 72 hours.
- Client will be relieved of headache within 24 hours
- Client will regain her appetite within 24 hours
- Client's engorge breast will resolve within 48 hours
- Client's baby rashes will resolve with 72 hours

LONG TERM OBJECTIVES

Madam Esther will go through puerperium successfully without any complications to herself or the baby.

PUERPERIUM CARE PLAN

DATE/ TIME	NURSING DIAGNOSIS	OBJECTIVE/OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
1/9/23 at 9:00am	After pain related to involution of the uterus	Client will be relieved of after pain within 72 hours as evidenced by a. Client verbalizing that she's no longer in pain. b. Client's husband saying his wife no longer complains of the said pain.	1. Reassure client. 2. Explain the physiology of pain to client. 3. Encourage client to assume any comfortable position to help cope with pain. 4. Encourage client to empty her bladder frequently. 5. Serve her with prescribed analgesics	1. Client was assured that pain is temporal. 2. The client was told that the pain is as a result of the contraction of the uterus. 3. Client assumed a prone position with pillow under her lower abdomen. 4. Client emptied her bladder frequently to allow space for the uterus to contract. 5. Client was served with analgesic (paracetamol)	3/9/23 at 9:00am	Goal fully met as client verbalized her pain has drastically resolved.	**D.C.A**

PUERPERIUM CARE PLAN

DATE/ TIME	NURSING DIAGNOSIS	OBJECTIVE/ OUTCOME CRITERIA	NURSING ORDERS NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION EVALUATION	SIGN
2/9/23 at 7:40am	Headache related to stresses of puerperium.	Client headache will be relieved within 24 hours as evidenced by a. client verbalizing that she is relieved from her headache. b. Client's husband confirm that client stopped complaining of headache	1. Reassure client. 2. Educate mother to have some rest during the day. 3. Encourage support person to assists client in taking care of the baby. 4. Educate mother to limit number of visitors. 5. Serve prescribed analgesic e.g. paracetamol 1gram when necessary.	1.Client was assured that her headache will resolve 2.Mother was educated to sleep during day time while baby is asleep 3. Support person was encouraged to take care of the baby to allow client have some rest 4. Mother was educated to limit visitors so that she can rest a little. 5. Tab paracetamol 1g was served when necessary.	3/9/23 at 7:40am	Goal met as client said that her headache has subsided.	**D.C.A**

PUERPERIUM CARE PLAN CONTINUED

DATE/ TIME	NURSING DIAGNOSIS	OBJECTIVE/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
3/9/23 at 7:30am	Loss of appetite related to stresses of labour.	Client will regain her normal eating pattern within 24 hours as evidenced by a. client verbalizing that, she is able to eat b. support person observing client eating half of meal served.	1. Reassure client. 2. Encourage her to practice oral hygiene to help increase her appetite 3. Serve client's favorite food. 4. Serve clients food attractively 5. Administer vitamin supplements.	1. Client was assured that her eating pattern would return to normal. 2. Client was encouraged to practice oral hygiene by brushing her teeth at least twice daily to increase her appetite. 3. Client's was served with two balls of banku with okro stew. 4. Client's food was served attractively by garnishing the food. 5. Vitamin supplements such as folic acid, multivitamin was administered to client.	4/9/23 at 7:30am	Goal achieved as Client said she ate half of meal served. Support person reported that client ate more than half of meal served.	**D.C.A**

PUERPERIUM CARE PLAN CONTINUED

DATE/ TIME	NURSING DIAGNOSIS	OBJECTIVE/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
4/9/23 at 7:30am	Breast engorgement related to inability to empty the breast completely.	Clients engorged breast will resolve within 48 hours as evidence by a. Client verbalizing that she feels comfortable in her breast and b. Midwife visualizing that	1. Assure client that breast feeding baby on demand help in resolving the fullness. 2. Encourage client to support the breast with well-fitting brazzier or breast binder. 3. Educate client on how to position and fix baby well when breastfeeding.	1. Client was assured that breastfeeding baby on demand help resolve the fullness so she should always put baby to breast. 2. Client was encouraged to support the breast with well-fitting brazzier or breast binder. 3.Client was educated on how to position baby to breast thus more of the areolar should enter into baby's mouth, the baby's abdomen to touch mothers and also mother should support her back when breastfeeding baby. 4. Client was educated to take warm bath to aid in circulation and also to apply cold	6/9/22 At 7:30am	Goal fully met as client said that she felt comfortable and midwife reported that fullness of client's breast has resolve.	**D.C.A**

		the fullness has resolved.	4. Educate client to apply cold compress on the breast 5. Encourage client to do gentle manual expression of the breast.	compress on the breast to help in resolving pain. 5. Client was encouraged to do manual expression of the breast in to the cup and also to use breast pump to help in complete emptying.			

PUERPERIUM CARE PLAN CONTINUED

DATE/ TIME	NURSING DIAGNOSIS	OBJECTIVE/OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
5/9/23 at 7:30am	Skin rashes on baby related to excessive dressing of baby.	Baby will have no skin rash within 72 hours as evidenced by; a. Client verbalizing that baby skin rashes has resolved. b. Midwife observing that baby is having no rash.	1. Assure client. 2. Educate client on the need to cloth baby according to weather. 3. Encourage mother not to scratch the rashes to prevent infection. 4. Encourage and teach mother how to use prescribed powder. E.g. Listerine powder and Vaseline or Shea butter to protect baby's skin. 5. Encourage mother to open windows for good ventilation.	1. Client was assured of competent care and she was comfortable. 2. Client was educated dress baby in warm cotton cloths and according to the weather changes. 3.Mother was encouraged not scratch the rashes as it would cause more pain and infection 4. Mother was encouraged use the medications given for the rashes. That is the Vaseline and Listerine powder. 5. Mother was encouraged windows for good ventilation.	7/9/23 at 7:30am	Goal fully met as client informed the midwife that baby's skin rashes has resolved.	D.C.A

SUMMARY AND CONCLUSION

The client and family centered Maternity care study was conducted on Madam Esther, a 30years old G3P2 client who was met on 18th August,2022 at St. Dormaa District Hospital, Nkrankwanta. Client was given an individualized care from the time she was met through labour and to the end of puerperium. This was achieved through good interpersonal relationship and acquiring accurate data from her.

Client gave the opportunity to be visited in her house and became familiar with the family members. She was also seen through her labour and she had a spontaneous vaginal delivery to a female child. Mother and child were discharged a day after delivery. Client and baby were visited for seven continuous days at home. Baby was bathed and cord was dressed, weighed and vital signs were also taken and recorded daily and her symphysio-fundal height measured and recorded as well. During pregnancy, she experienced some minor disorders of which the necessary management and education were given to her. She was also educated on environmental hygiene, birth preparedness and complication readiness. She adhered to all educations given to her and went through pregnancy successfully.

During labour, she encountered problems of which necessary interventions were given and managed appropriately.

After delivery, she experienced loss of appetite, breast engorgement and headache among others as some disorders associated with puerperium. She was managed accordingly and they resolved within the shortest possible time. Finally, it was observed that the care study is an important managerial tool in which theoretical knowledge was put into practice and also deals with maternity problems as midwifery professionals. Client and her family were cooperative, supportive and adhered to any form of education given to them. Through home visits, a close

monitoring was made throughout puerperium and education was given on how to care for herself and the baby.

Education was given on diet and breastfeeding. Mother and child were examined from head to toe during the first and second post-natal visits and educated on immunization. Madam Esther and her baby were very healthy and they were in good condition, when the interaction ended. Client and baby were handed over to the midwife in-charge and later to the public health nurse for continuity of care.

In conclusion, this care study has helped and enabled the writer to give comprehensive nursing care to client at antenatal, labour and postnatal, therefore she will be confident to take care of client with similar problem in future. It has also helped the writer to use nursing care plan to nurse a client successfully.

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MOTHER'S ANTENATAL (APPENDIX I)

DATE	WEIGHT (KG)	BLOOD PRESSURE	URINE FOR PROTEIN/ SUGAR	GESTATIONAL AGE IN WEEKS	FUNDAL HEIGHT (CM)	PRESENTATION	DESCENT OF FETAL HEAD	FETAL HEART RATE (FH)	TREATMENT GIVEN	COMPLAINS	SIGN
21/2/23	75kg	120/80mmHg	Positive/ Negative	12 weeks plus 4days	Not palpable	-	-	-	Routine drugs	No complains	V.K
17/3/23	70kg	109/76mmHg	negative/ negative	16weeks plus 4days	Not palpable	-	-	-	Routine drugs	Doing well	M.T
14/4/23	68.9kg	119/80mmHg	negative/ negative	20weeks	18cm	-	-	124bpm	Routine drugs.	Doing well	R.M
12/5/23	69kg	105/64mmHg	Negative/ negative	24+2weeks	19cm	-	-	130bpm	Routine drugs.	Feels well	N.O

DATE	WEIGHT (KG)	BLOOD PRESSURE	URINE FOR PROTEIN/ SUGAR	GESTATIONAL AGE IN WEEKS	FUNDAL HEIGHT (CM)	PRESENTA-TION	DESCENT OF FETAL HEAD	FETAL HEART RATE (FH)	TREATMENT GIVEN	COMPLAIN	SIGN
16/6/23	69kg	9O/60mm Hg	negative/ negative	28 weeks	25 cm	-	-	132	Routine drugs.	Doing well	R.M
14/7/23	69kg	115/80mm Hg	negative/ negative	32+4weeks	30cm	Cephalic	-	138	Routine Drugs	Waist pains	V.S
21/7/23	69.5kg	105/66mm Hg	Trace/ Negative	33+4days	31cm	Cephalic	5/5th	135b pm	Routine Drugs	No complaints	O.A
11/8/23	72kg	123/57mm Hg	negative/ negative	36+4days	33cm	Cephalic	5/5th	130bpm	Routine drugs	Vaginal itching	V.S
18/8/23	75kg	136/81mm Hg	negative/ negative	37+4days	36cm	Cephalic	5/5th	135bpm	Routine Drugs	No complains	D.C.A

DATE	WEIGHT (KG)	BLOOD PRESSURE	URINE FOR PROTEIN⁄ SUGAR	GESTATIONAL AGE IN WEEKS	FUNDAL HEIGHT (CM)	PRESENTA-TION	DESCENT OF FETAL HEAD	FETAL HEART RATE (FH)	TREAT-MENT GIVEN	COMPLAIN	SIGN
25/8/23	75kg	120/80mmHg	Trace /negative	38+2days	38cm	Cephalic	5/5th	129bpm	Routine drugs	Doing well	D.C.A
31/8/22	75kg	121/74mmHg	Negative/negative	39+2weeks	38cm	Cephalic	5/5th	143bpm	Routine drugs	constipation	D.C.A

INTERMITTENT PREVENTIVE TREATMENT (IPT)FOR Malaria	1ST dose SP* 3 tabs (Directly Observed Therapy) 14/04/23	Gestation age In weeks 20weeks	2nd dose (1 month after 1st dose (Directly Observed Therapy) 12/05/2023	Gestation age In weeks 24weeks	3rd dose (1 month after 2nd dose (Directly Observed Therapy)16/06/23	Gestational age in weeks 28weeks
	4th dose 3 tabs (Direct observed therapy)14/07/23	Gestation age in weeks 32+2days	5th dose 3 tabs (Direct Observed Therapy)07/11/22	Gestation age in weeks 36+2days		

*NB: Sulfadoxine _Pyrimethamine – (SP) should be given to pregnant women after 16 weeks or when mother feels baby's movement (after quickening) till delivery and should be given at least 1month after last dose.

APPENDIX II

COMPLETE DIAGNOSTIC INVESTIGATIONS

DATE	SPECIMEN	IVESTIGATION	NORMAL VALUES	FINDINGS	REMARKS
21/04/22	1. Blood	Haemoglobin level	12g/dl-16g/dl	11.2g⁄dl	Low
		Sickling status	Negative	Negative	Normal
		Grouping and Rhesus	A, B, AB, and O	B	Normal
		factor	Positive and negative	Positive	Normal
		HIV status	None reactive	Negative	Normal
		VDRL	None reactive	Non-defect	Normal
		Hepatitis status	Negative	Negative	Normal
		G6PD status	None reactive	Non-defect	Normal
	2. Urine	Sugar	Negative	Negative	Normal
		Protein	Negative	Negative	Normal
12/03/23	1. Urine	Sugar	Negative	Negative	Normal
		Protein	Negative	Negative	Normal

14/04/23	1.Urine Protein	Sugar Protein	Negative Negative	Negative Negative	Normal Normal
12/05/23	1.Urine	Sugar Protein	Negative Negative	Negative Negative	Normal Normal
16/06/23	1.Urine Blood	Sugar Protein Haemoglobin level	Negative Negative 12g/dl-16g/dl	Negative Negative 10.0g/dl	Normal Normal Low
14/07/23	1.Urine 2. Blood	Sugar Protein	Negative Negative 12g/dl-16g/dl	Negative Negative 10.2g/dl	Normal Normal Low
21/07/23	1.Urine 1. Urine 2.Blood	Sugar Protein Haemoglobin level	Negative Negative 12g/dl-16g/dl	Negative Negative 9.2g/dl	Normal Normal Low

11/08/23	1.Urine	Sugar Protein	Negative Negative	Negative Negative	Normal Normal
18/08/23	1.Urine 2. Blood	Sugar Protein Haemoglobin level	Negative Negative 12g/dl-16g/dl	Negative Negative 12.5g/dl	Normal Normal Normal
25/08/23	1. Urine 2.Blood	Sugar Protein Haemoglobin level	Negative Negative 12g/dl-16gdl	Negative Negative 10.2g/dl	Normal Normal Low

APPENDIX III

PHARMACOLOGY OF DRUGS (MOTHER)

Drugs	Classification	Dosage	Route	Actions and Uses	Actual Effect	Side Effect	Side Effects Experienced
Ferrous Tablet	Haematinics	200mg daily	Orally	Aids in Red Blood Cell formation	Increase in haemoglobin level	Black stool, diarrhoea and constipation	None observed
Folic Acid Tablet	Vitamin preparation	5mg daily	Orally	Helps in the formation of blood cell	Increase in haemoglobin level	Nausea, vomiting, diarrhoea and constipation	None observed
Multivitamin Tablet	Vitamin preparation	200mg daily	Orally	Increases appetite and helps in the formation of Red Blood – Cells	Increase in appetite	Gastrointestinal disturbance	None observed

Paracetamol Tablet	Antipyretics/ Analgesic	1g tds x 3	Orally	Reduces mild to moderate pain	Client pain was relieved	Liver damage due to prolong use	None observed
Tetanus Injection	Anti-tetanus drugs	0.5mg	Intra-muscular	Protect mother and foetus against infections	Client was protected against tetanus infection	Mild fever, Malaria	None observed
Metronidazole tablet	Anti-infective	400mg tds x 30	Orally	Prevention of infection	Infection was prevented.	Dizziness, headache, nausea,	None Observed
Sulfadoxinepyramethamine Tablet	Anti-malaria prophylaxis	3 start 16 weeks after	Orally	Prevention - of malaria	Malaria was-prevented	Urticaria rash, dizziness, nausea, stomatitis	None observed

		quickening till delivery and it was given at 1month after last dose.					
Oxytocin injection	Oxytocin drug	10 units	Intra-muscular	Increase uterine contraction and control bleeding	Client had good uterine contraction	Vomiting, uterine spasm and raised blood pressure	None observed
Vitamin A capsule	Group A vitamin supplement	200,000 units for 2 days	Orally	Growth development	Normal vision and healthy skin	Vomiting	None observed

				and proper vision			
Amoxicillin tablet	Antibiotics	500mg for 7 days thrice daily	Orally	Treat all kinds of infections	Treated infections.	Nausea, vomiting, diarrhoea, rash, vaginal yeast infection	None observed

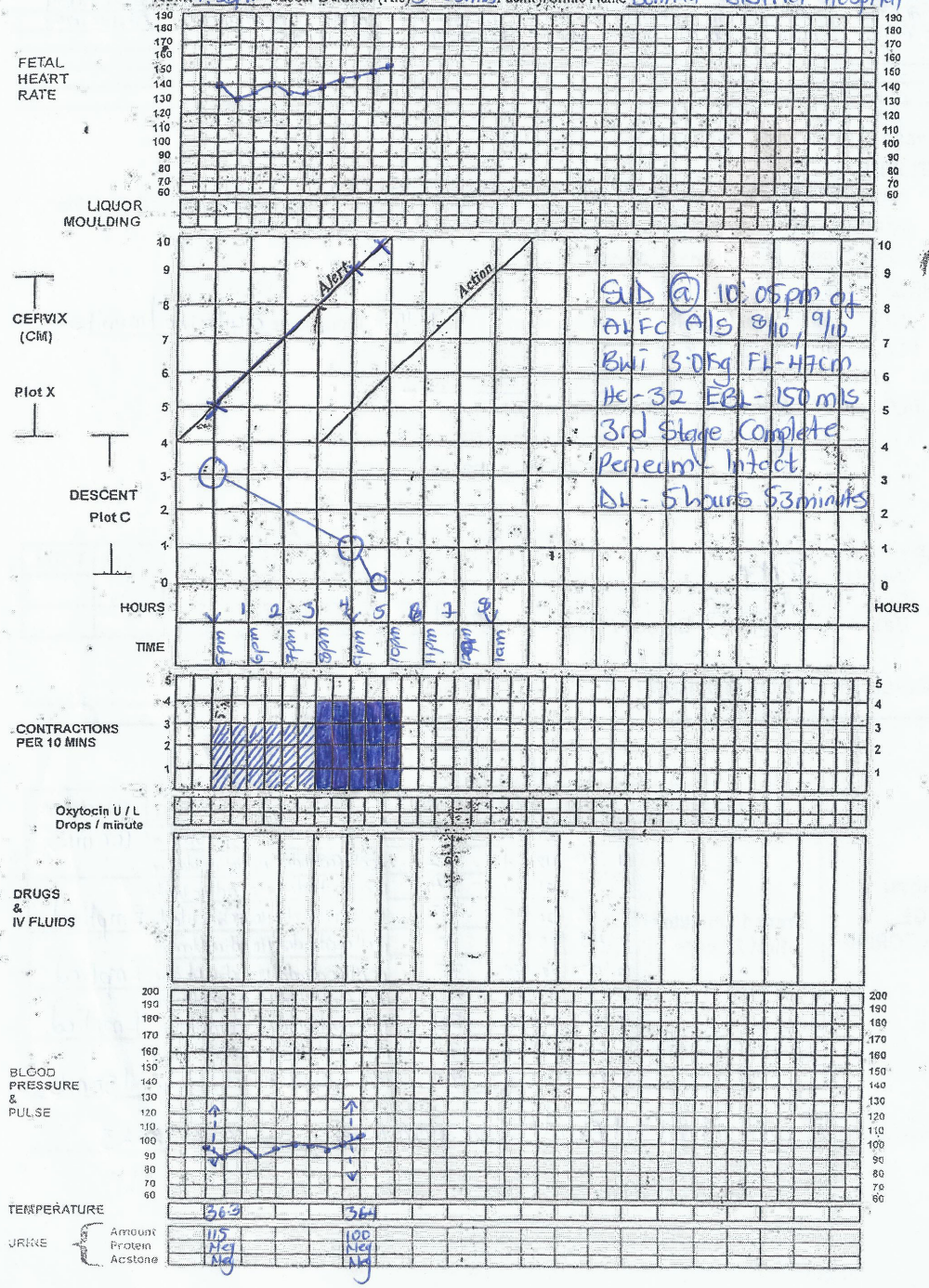
PHARMACOLOGY OF DRUGS (BABY)

Drugs	Classification	Dosage	Route	Actions and uses	Actual Effect	Side Effect	Side Effects Experienced
Vitamin K	Group K vitamin	1.0mg	Intra-muscular	Prevent haemolytic diseases	No bleeding	Risk of haemolysis in people with G6PD, rashes and brain damage	None observed
Chloramphenicol	Antibiotics	2 drops	Instillation	Prevent eye infection	Increase risk of a plastic anaemia	Ototoxicity and nephrotoxicity	None observed
Bacillus Calmette Guerin injection	Antigen	0.5mg	Intra-dermal	Immunity against tuberculosis	Under observation	Mild fever, swelling of injection site and blister formation	Blister noticed
Polio O	Antigen	2 drops	Orally	Production of antibodies to prevent poliomyelitis	Under observation	There may be diarrhoea	None observed

Hepatitis B vaccines	Antigen	0.5ml	Subcutaneous	Immunity against hepatitis B virus	Under observation	Fever	None observed
Diphtheria pertussis tetanus	Antigen	0.5ml	Subcutaneous	Immunity against Diphtheria pertussis tetanus	Under observation	Fever	None observed
Haemophilus influenza Hepatitis B	Antigen	0.5ml	Subcutaneous	Immunity against Haemophilus influenza Hepatitis B	Under observation	Fever	None observed

WHO Modified Partograph

Registration No.: 162/23 Name(Last, First) Madam Esther Age: 30 years
Date: 31/08/23 Parity/Gravida 2/3 LMP 24/11/23 EDD 31/08/23 Gestation(wks) 37+2d
ROM: 9.35pm Labour Duration (Hrs) 5h 53mins Facility/Clinic Name Donna District Hospital



LABOR NOTES

31/08/23 @ 10:05pm Spontaneous Vaginal delivery of a live female neonate delivered with APGAR Score 8/10, 9/10 for 1st and 5th minutes respectively Placenta completely delivered with membranes after intramuscular oxytocine 10 units administered. Estimated blood loss is 150mls

Please circle or write responses.

DELIVERY

DATE: 31/08/23 TIME: 10:05pm METHOD: (Spontaneous) / Vacuum Extraction / C/S / Other

PERINEUM: (Intact) / Episiotomy / Laceration

ANESTHESIA: (None) / Local / General

THIRD STAGE

Active Management: (Yes) / No Medication: Time 10:10pm Type/Dose oxytocine / 10units

PLACENTA: TIME: 10:15pm Complete / Incomplete

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

BABY

Weight: 3.0kg

Sex: Male / (Female)

Baby Position: (Vertex) / Breech / Other

APGAR

Time	Color	Breath	Heart	Tone	Reflex	TOTAL
1min						
5min						

COMPLICATIONS OF MOTHER / BABY: None / Other:

FOURTH STAGE MONITORING

Frequency	Time	B/P.	Pulse	Fundus	Bleeding	Bladder
Every 15 minutes first 2 hours	10:45	120/76	87	16cm	No active bleeding	100mls
	11:00	118/64	82	well contracted	No active bleeding	
	11:15	121/61	84	well contracted	No active bleeding	
	11:30	120/75	75	well contracted	No active bleeding	Emptied
	11:45	115/67	70	well contracted	No active bleeding	
	12:00	118/70	75	well Contracted	No active bleeding	Emptied
	12:15	120/70	80	well Contracted	No active bleeding	
	12:30	121/72	83	well Contracted	No active bleeding	Emptied
Every 30 minutes For 1 hour	1:00	115/65	78	well Contracted	No active bleeding	
	1:30	114/65	81	well Contracted	No active bleeding	150mls

Birth Attendant: Dorcas Christabel Aka / Midwife Nana Afua Date: 01/09/2023

MATERNITY CHART

NAME: Madam Esther

AGE: 30 years WARD: Maternity

P NO.: 162/23 BED NO.: 1

Date	3/8/23	1/9/23	2/9/23	3/9/23	4/9/23	5/9/23	6/9/23	7/9/23
Days in Hospital	DD							
Days P.O.D.		D1	D2	D3	D4	D5	D6	D7
Hour am		7:30	7:30	7:30	7:30	7:30	7:30	7:30
Hour pm	10:05	4:30	4:30	4:30	4:30	4:30	4:30	4:30
Temperature C								
Temperature F								
Pulse								
Resp.								
B.M.	Passed	Passed	Passed	Passed	Passed	Passed	Passed	Passed
Urine	Passed	Passed	Passed	Passed	Passed	Passed	Passed	Passed
B.P. AM		110/60	114/75	100/60	100/60	100/75	120/82	112/72
B.P. PM	122/66	112/60	121/84	100/70	100/70			

Fundal Height

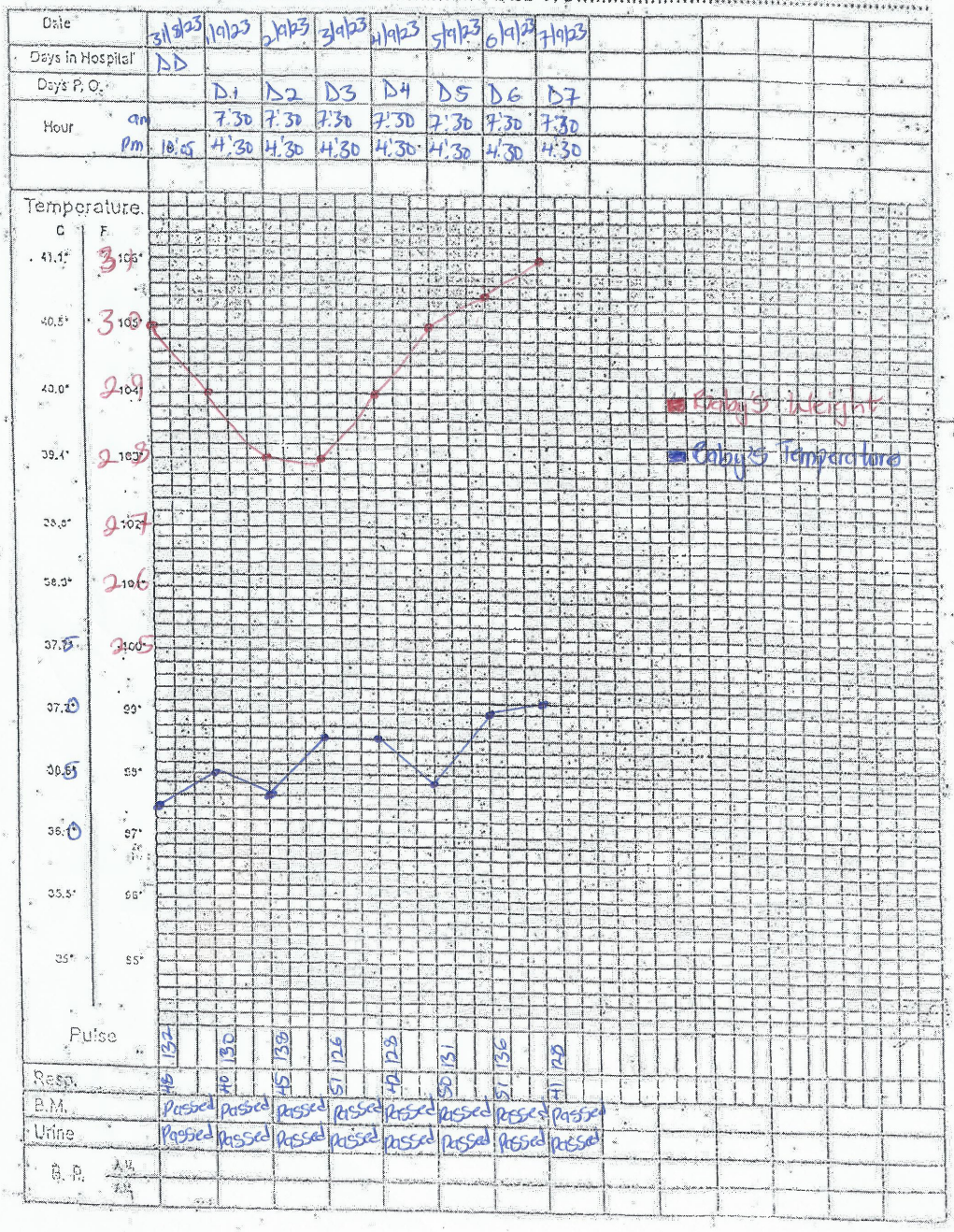
Temperature

TEMPERATURE CHART

NAME: Baby Of Esther

AGE: ..... WARD: Maternity

IP NO.: ..... BED NO.: 1



NEW BORN CHART

Name: Baby of Esther No: Birth Weight: 3.0kg

Sex: Female Mother's No: 162/23 Length: 47cm

Nature of Delivery: Spontaneous Vaginal Delivery Diagnosis:

Date of Birth: 31/08/23 Time: 10:05pm Date of Discharge: 01/09/23

Date	31/09/23		1/09/23		2/09/23		3/09/23		4/09/23		5/09/23		6/09/23		7/09/23							
No. of Days	D0		D1		D2		D3		D4		D5		D6		D7							
Weight	3.0kg		2.9kg		2.8kg		2.8kg		2.9kg		3.0kg		3.05kg		3.1kg							
Temperature	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM
		36.7°C	36.6°C	36.3°C	36.8°C	37.0°C	36.8°C	36.8°C	36.8°C	36.5°C	37.0°C		36.7°C		36.3°C							
Stools		Passed	Passed	Passed	Passed	Passed	Passed	Passed	Passed	Passed	Passed		Passed		Passed							
Urine		Passed	Passed	Passed	Passed	Passed	Passed	Passed	Passed	Passed	Passed		Passed		Passed							
Remarks	Head Neck Trunk Genitalia Limbs — NAD																					

NEW BORN EXAMINATION FORM

Name: Baby of Esther Date of Assessment: 31/08/23 Time: 11:35

Date of Birth: 31/08/2023 Time of Birth: 10:05pm Sex: ☐ M ☑ F Age at time of Assessment (days/hrs) 90 mins

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

APGAR: 1min 9/10 ☐ 5min ☐ 9/10 Birth Weight: ☐ 3.0kg ☐ Length: 47 cm Head Circumference: 32 cm

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

Name of Assessor (Midwife/Doctor): Dogwa Christabel Abg

1. Respiration
Rate 41 cpm
☐ Rate < 30 b/m *
☑ Rate < 60 b/m *
☐ 30-60 b/m
☐ Retractions *
☐ Grunting *
☐ Stridor *

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

3. Tone
☑ Normal
☐ Floppy *
☐ Increased *

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

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

6. Cry
☑ Normal
☐ Shrill *
☐ Absent *

7. Suck
☑ Good
☐ Weak
☐ Absent

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

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

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

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

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

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

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

16. Clavicle
☑ Normal
☐ Swelling/Fracture

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

18. Heart rate
Rate: 132 bpm
☑ Normal (100-160)
☐ <100 *
☐ >160*

19. Femoral pulse
☑ Present
☐ Not palpable*

20. Abdomen
☑ Normal
☐ Distended*
☐ Scarphoid*
☐ Abdominal defect*
☐ Maases: _____
☐ Other _____

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

22. Limbs
☑ Normal
☐ Abnormal _____

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

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

24. Anus
☑ Patent
☐ Imperforate*

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

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

*May indicate severe disease that requires urgent referral

Diagnoses (if known) _____

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

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

NEW BORN EXAMINATION FORM

Name: Baby of Esther Date of Assessment: 01/09/2023 Time: 8:00am
Date of Birth: 31/08/23 Time of Birth: 10:05pm Sex: ☐ M ☑ F Age at time of Assessment (days/hrs) 11 hours
Astational Age ☐ ☐ Mode of Delivery: ☑ Vaginal Assisted Vaginal C-Section
APGAR: 1min 9/10 ☐ 5min ☐ 9/10 Birth Weight: ☐ 3.0kg ☐ Length: 47 cm Head Circumference: 32 cm
Temperature at time of Assessment: 36.4 °C Urine passed: (Yes) No Meconium passed: (Yes) No
Name of Assessor (Midwife/Doctor): Dogbo Christabel ABA

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

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

3. Tone
☑ Normal
☐ Floppy *
☐ Increased *

4. Colour
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☑ No swelling

9. Sutures
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13. Mouth
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☐ Cleft palate
☐ Cleft Lip
☐ Other: _____

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

16. Clavicle
☑ Normal
☐ Swelling/Fracture

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

18. Heart rate
Rate: 136bpm
☑ Normal (100-160)
☐ <100 *
☐ >160*

19. Femoral pulse
☑ Present
☐ Not palpable*

20. Abdomen
☑ Normal
☐ Distended*
☐ Scarphoid*
☐ Abdominal defect*
☐ Maases: _____
☐ Other _____

21. Back (spine)
☑ Normal
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☐ Other: _____

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☑ Breastfeeding established
☑ Immunization (BCG/Polio)
☑ BCG ☑ Polio Immunization
☐ Antibiotics in mother
☐ Antenatal corticosteroids

***May indicate severe disease that requires urgent referral**
Diagnoses (if known) _____

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

SIGNATORIES

THE STUDENT MIDWIFE

NAME: DOFUAA CHRISTABEL ABA

SIGNATURE:.....

DATE: 07/06/2024

THE MIDWIFE IN-CHARGE: DORMAA DISTRICT HOSPITAL(NKRANKANTA)

NAME: MS. CONSTANCE YEBOAH

SIGNATURE:.....

DATE: 07/06/2024

THE SUPERVISOR

NAME: MS. ERNESTINA MENSAH

SIGNATURE:.....

DATE: 07 - 06 - 2024

THE PRINCIPAL

NAME: MONICA NKRUMAH

PRINCIPAL
HOLY FAMILY NURSING AND
MIDWIFERY TRAINING COLLEGE
BEREKUM

SIGNATURE:.....

DATE: 10/06/2024