HOLY FAMILY NURSING AND MIDWIFERY TRAINING COLLEGE, BEREKUM

A CLIENT/FAMILY CENTERED MATERNITY CARE STUDY ON

MADAM APPIAH ABIGAIL

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

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PREFACE

Child bearing was believed to be normal experiences, consequently more attention was not given to it during pregnancy, labor and puerperium. Which eventually lead to high maternal and neonatal mortality in Ghana. This therefore led to further research to upgrade the standard of midwifery in recent years. In view of this the client was assessed and assisted to solve problems that may arise during the course of the study, using the nursing care plan approach. The nursing care plan is defined as the sum of all activities rendered to attain and maintain high level of wellness for the client. The aim of this care study is to establish good rapport and relationship between the client and family and to help her through antenatal care, solve some of the problems that may arise during pregnancy, labor and puerperium to ensure safe delivery of normal baby. The family centered maternity care study is a requirement by the nursing and midwifery counsel of Ghana serving as a partial fulfilment towards the award of midwifery certificate to the student midwife at the end of her training which will enable her to practice as a midwife. The family centered maternity care study is a required study that every final year student of the midwifery training school is supposed to undertake to satisfy the nurses and the midwives council of Ghana

It is a comprehensive care given to a client and family from pregnancy till puerperium. Home visits are also made to ensure continuity of care. The study is necessary because it enables the student midwife put what she has learnt in the classroom into reality and help render holistic care to the client, family and the community at large. The study again helps the student gain knowledge and become conversant with the care given to a woman from pregnancy till end of puerperium. The student uses her knowledge from other areas like pharmacology and nutrition in order to meet the needs of the client and family.

ACKNOWLEDGEMENT

The family centered maternity care study could not have been completed without the tremendous effort and cooperation of many individuals who participated in the development.

They say, for not knowing him that should be left out of academic matters. But we testify to the reality of His existence. Not believing in God is also a belief in its sense. Why then should that belief superimpose on my belief? Leaving Him out of this is a contradiction to my conscience which suggests a failure. Thus, I give all the glory and honor to the Almighty God concerning the success of this study.

My profound gratitude goes to the principal of Holy Family Nursing and Midwifery Training College, Berekum, Miss Monica Nkrumah for admitting and giving me the opportunity to be train as a midwife, my supervisor Madam Martha Kyeramaa for making time to read through this write up for the necessary corrections, advice and care. And all teaching and non-teaching staff of Holy Family Nursing and Midwifery College, Berekum for their direction, support and encouragement.

My appreciation also goes to the client Madam and her family for their co-operation and information provided for me to write this care study.

My warmest appreciation also goes to the midwifery in charge Madam Susana Yeli and the entire staff of Kwatire Government Hospital [Kwatire] for their input, advice and guidance, support, supervision, encouragement and help during the development of this valuable document. Without their expertise, dedication and professionalism, this project would not have been managed in such a cohesive fashion.

Moreover, I will like to acknowledge the authors and publishers whose various books were used as references without them this script wouldn’t have been successful.

Lastly my sincere gratitude goes to my mother Mrs. Victoria, father Mr. Joseph Appiah for their massive support both spiritually, physically and financially which has brought me this far. Am also much grateful to my pastor Rev. Adwoa Takyiwaa Boateng for his prayers and advice. May the good Lord continue to bless and shower his blessings upon them whatever they have lost may the good Lord replenish it.

INTRODUCTION

The family centered maternity care study is the nursing care given to an expectant mother and family. It involves choosing a pregnant woman whose gestation is 36 weeks and rendering comprehensive care throughout late pregnancy, labor, and puerperium.

This study is a formal document of four chapters written on Madam Appiah, 23 years old G2P1 alive. Client was met on Monday, 15th November, 2021 when she was 37weeks pregnant. She went through normal pregnancy and delivered an alive male infant spontaneously on 4th December, 2021 and was discharged the same day after delivery. There was a seven-day intensive postnatal visit and properly handed over to the public health nurse on the day for continuity of care.

Chapter one narrates vividly, assessment of client and family which involves collection of client's personal, social, medical, surgical, past and present obstetrics, family history and home environment (physical and psychosocially).

Chapter two, describes when and where client was first met, the management during the antenatal care, and at what gestational age and utilization of client's data to manage her.

Chapter three, concerns admission and management of labor involving admission and management of the client throughout first stage, second stage, third stage and fourth stage of labor.

Chapter four, also elaborates on the management of puerperium which involves the examinations and subsequent care given to the baby and the mother following delivery.

LITERATURE REVIEW

This literature review gives detail information about what various authors and publishers wrote on pregnancy, labor and puerperium.

PREGNANCY

According to Fraser &Cooper (2009), although pregnancy begins with implantation; the process leading to pregnancy occurs, earlier as a result of the female gamete or occyte, merging with the male gamete, spermatozoon. There are few experiences in the life of a woman that evoke such emotions of absolute joy or profound despair than that of pregnancy. Uterine blood flow in pregnancy supplies the myometrium and placenta, with the latter receiving nearly 90 percent of the total uterine blood flow near term. Uncomplicated pregnancy is recommended that at least four ANC visits should be made according to the following schedule.

• First visit: From onset of pregnancy up to sixteen weeks (16) gestation.

• Second visit: from the 24th to 28th week of pregnancy.

• Third visit: at 32nd week of pregnancy.

• Fourth visit: at 36th week.

Konar (2011) postulates that, during pregnancy there is progressive anatomical, physiological and biochemical changes not only confined to the genital organs but also to all the systems of the body. This is principally a phenomenon of maternal adaptation to the increasing demand of growing of the foetus. Unless well understood, these physiological adaptations of normal pregnancy can be misinterpreted as physiological. The duration of pregnancy has traditionally been calculated by the

clinicians in terms of 10 lunar month or 9calender month and 7days or 280 days or 40 weeks, calculated from the first day of the last menstrual period. This is called the gestational age.

Myles (2009), as soon as pregnancy is confirmed, many physiological changes take place in the body and returned to its pre-pregnant state during puerperium due to the effect of hormones namely estrogen and progesterone. These hormones are responsible for the major changes that take place during pregnancy. Even though these hormones have their own effects by causing minor disorders that occur during pregnancy, they are one way or the other an advantage for the mother and the growing foetus since the foetus depend solely on the mother for survival in utero. Variety of care that are rendered to the expectant mothers and their entire families include history taking, physical examination [head to toe examination and abdominal examination i.e. inspection, palpation and auscultation], laboratory investigation [urine, blood and stool], administration of routine drugs [folic acid, ferrous sulphate and multivitamins]. The anatomical and physiological changes in the uterus plays an essential role in pregnancy by protecting and supporting

g the fetus, placenta and amniotic fluid. At the same time of labor, it is able to contract regularly and forcibly to expel the fetus due to its

King, (2014) asserts that, pregnancy is a time of profound anatomical and physiologic changes in a woman's body. In addition to the reproductive organs, all maternal physiologic systems make adaptations needed to support the developing foetus and at the same time, maintain maternal homeostasis. Pregnancy last approximately two hundred and sixty, six days (266days) or thirty, eight weeks(38weeks) form ovulation. The prenatal period is divided into trimesters, first trimester is considered to be week 1 to 12 (12weeks) because organogenesis is complete at the end of twelve weeks and the risk of spontaneous abortion significantly reduced at time. The second trimester was

considered to be week 13 to 28 because prior to the introduction of modern neonatal intensive care technique 28 weeks was limit of viability. The third trimester extend from weeks 28 to 40. The term post-date or post term is typically used to described a pregnancy beyond forty weeks (40).

Tiran (2008) Pregnancy occurs whereby there is conception of the foetus, normal duration is 280 days (42weeks or 9 months and 7days) counting from the last menstrual period to delivery or 265days from conception to delivery. Physiological and psychological changes occur due to the effect of estrogen and progesterone, which provide nutritive and protective environment for the developing embryo. It also prepares the breast for lactation. The anatomical and physiological adaptations occurring throughout pregnancy affect virtually every body system. The timing and intensity of the changes vary between systems but all are designed to support fetal growth and development and prepare the mother for birth and motherhood.

Ojo and Briggs (1992) Women often diagnose pregnancy even before missing their period because signs such as changes in breast, change in food and drink preference, frequency of micturation and backache confirm suspicious. Common minor disorders of pregnancy include; leg clamps, backache, heart burns, constipation, frequency of micturation, ptyalism, nausea, vomiting, leucorrhoea, and breast changes. The hormone progesterone and oestrogen are produced in large quantities which exert some action on the various system of the pregnant woman. The most outstanding of these changes is the growth which occurs in the uterus. The reproductive of a woman begins at a menarche and ends in menopause.

LABOUR

Fraser and Cooper (2009), “Labor is the process by which viable foetus, placenta and membranes are expelled through the birth canal” they described its onset as spontaneous and the presenting part being the vertex which is of normal presentation. Labor being in three stages; First stage is the onset of regular rhythmic uterine contraction and finally culminates in complete effacement of the cervix. The latent phase is prior to active first stage of labor and may last 6-8 hours in the first-time mother when the cervix dilates from 1cm to 4cm dilations. Active first stage is the time when the cervix undergoes more rapid dilatation. This begins when the cervix is 3cm to 4cm dilatation in the presence of rhythmic contraction and is complete when the cervix is fully dilated (10cm). The partograph is used during this stage to monitor the progress of labor, maternal condition and foetal condition to detect any deviation from normal for prompt action. The second stage is the expulsion of the foetus. It begins when the cervix is fully dilated. In psychological labor, the woman usually feels the urge to expel the foetus and complete when the baby is born. The first stage of labor is the period from the onset of regular uterine contractions to full dilation of the cervical OS. It lasts 12-14 hours in primigravida and 6-12 hours in multigravida. The first stage of labor comprises of; Painful uterine contractions; Progressive dilation of the cervix, Formation of the fore waters, Rupture of the membranes. The second stage of labor starts from the full dilation of the cervical OS to the complete expulsion of the baby. It lasts about one hour in a primigravida and 5-30minutes in a multigravida. Strong uterine contractions, descent of the head through the pelvis, and the birth of the child are the features of the second stage of labor. The third stage of labor entails complete expulsion of the placenta and membranes, usually within 5-15 minutes of the birth of the infant. The other feature of the 3rd stage, apart from the detachment and expulsion of the placenta, is the control of bleeding. The third stage is the separation and expulsion of

placenta and membranes. It starts from birth of the baby until the placenta and membranes have been expelled. During this stage, controlled cord traction and oxytocin drug is used to expel the placenta and control hemorrhage

Konar, (2011) asserts that, labor is called normal if it fulfills the following criteria, [1] Spontaneous in onset and at term. [2] With vertex presentation. [3] Without undue prolongation. [4] Natural termination with minimal aids. [5] Without having any complications affecting the health of the mother and or the baby. Event of labor are divided into; First stage, starts from the onset of true labor pain and ends with full dilatation of the cervix. Its average duration is 12 hours in primigravidae and 6 hours in multiparae. Second stage starts from fully dilatation of the cervix and ends with expulsion of foetus from the birth canal. Third stage begins after the expulsion of the foetus and end with expulsion of the placenta and membranes. Fourth stage is the stage of observation. Under the bladder care; the patient is encouraged to pass urine by herself as full bladder inhibits contraction and may lead to infection. If patient fail to pass urine especially in the late first stage, catheterization is to be done with strict precautions. Under rest and ambulation, if the membranes are intact, the patient is allowed to walk about. This attitude prevents venacaval compression and encourage descent of the head. Ambulation can reduce the duration of labor.

Myles (2014) labor purely in the physical sense may be described as the process by which the foetus, placenta and membranes are expelled through the birth canal. Labor has four stages. stage one comprises of the latent phase and last 6 to 8 hours in primigravida when the cervix dilates from 1cm to 4cm. The active phase within the first stage is when the cervix usually undergoes more rapid dilatation. This begins when the cervix is 4cm dilated and in the presence of rhythmic contractions, progressively dilated to 10cm or full dilatation. Second stage of labor is the explusion of the feotus. It begins when the cervix is fully dilated and the woman has the urge to expel the

baby. There is stretching of the clitoris, gasping of the anus and bulging of the perineum. Labor completes when the baby is born. In multigravida women, it last 15to 30 minutes. The stage begins after the expulsion of the foetus and ends with the expulsion of the placenta and membranes. The fourth stage is a period of carful observation of the mother made to assess excessive bleeding and the firmness of the contracting uterus immediately after the third stage of labor and it six hours after delivery of the placenta.

King (2014) also states that, the onset of labor is classically defined as the occurrence of regular painful contraction that promotes dilation of the cervix. Contractions that occur at regular intervals with increasing frequency, duration, and intensity are the hallmark of labor. The onset of spontaneous labor cannot be reliably predicted, although many pregnant women experience premonitory signs or symptoms of impending labor. Common signs and symptoms suggestive of physiologic progress towards labor include descent of the fetus, cervical changes, increase in uncoordinated uterine contractions, rupture membranes, bloody show or increased mucus discharge from the vagina, maternal perception of increased energy, gastrointestinal distress. Physiologic adaptations during labor are required to support the unique demands imposed on both the woman giving birth and her fetus. Traditionally, the processes involved in labor and birth have been conceptualized as those that affect the power (uterus), the passenger (fetus), and the passage (pelvis).

Tiran (2008), Labor is the parturition or child birth which normally occurs spontaneously between thirty- seven and forty- two weeks' gestation with a vertex presentation of a single foetus without maternal and fetal trauma. The foetus should present with the vertex and once started, the contraction should increase in strength and frequency without interruption or artificial stimulating until baby, placenta and membranes have completely expelled by the maternal effort through the

vagina. Partograph is the graphical recording of labor progress obtained by assessment of visual patterns of cervical dilation and descent of the presenting part in conjunction with records of maternal and foetal well-begin.

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

National Safe Motherhood Service Protocol (2008), normal labor begins when there are regular painful contractions lasting at least 20 seconds [timed by a trained observer], occurring at frequency of at least two contractions in every 10 minutes. There are four stages of labor described as follows; First stage; this start from the onset labor till the cervix is fully dilated and is accompanied with painful rhythmic regular uterine contractions. It last for 6 to 10 hours in multigravida and 12 to 14 hours in primigravid. Partograph is used to managed the first stage of labor [during the active stage]. Second stage, starts from full dilatation of the cervix [10cm] to the expulsion of the baby through the birth canal. It usually lasts up to 30 minutes in multiparous

woman and 60 minutes in primigravida respectively. Third stage starts after delivery of the baby and ends with the delivery of the placenta and its membranes from the birth canal as well as control bleeding after expulsion

PUEPERIUM.

Fraser & Cooper (2009), puerperium starts immediately after the delivery of the placenta and membranes and continue for six (6) weeks. After birth all the system in the woman's body will have recovered from the effect of pregnancy and returned to their non-pregnant state. The overall expectation is that by 6 weeks after the birth all the systems in the woman's body will have returned to their non-pregnant state. The concept of postpartum care is one that aims to assist the mother and her baby towards attaining an optimum health status. Where the visit from the midwife can be seen as supportive and useful to be achieved. As women centered approach to care in the postpartum period should assist physical and psychological recovery by being focus on the needs of women as individuals rather than fitting women into a routine care package. The midwife needs to be familiar with the woman's background, antenatal and labor history when assessing whether or not the woman's progress is following the expected postpartum pattern. The provision of midwifery care to women following the birth of their baby aims to encompass aspects of observing and monitoring the health of the new mother and her baby as well as offering support and guidance in breastfeeding and parenting skills. Where the time frame for attendance from the midwifery services might be viewed as an opportunity to extend the midwifes role to include the broader aspects of public and social health and more specialized areas of neonatal care.

[Kings,2014], puerperium is the time the woman begins the physiological transition to the non-pregnant state. Traditionally, puerperium has been defined as lasting for 6 weeks, because by 6 weeks most women has completed the last physiologic transitions; uterine involution is complete,

lochia has ceased, and lactation is well established. Early postnatal checks are done on general emotions and physiological well-being, infant feeding etc. Late postnatal checks are maternal hemoglobin and assessment of the baby and mother, looking particularly for tiredness and depression

According to Verrals (2010) puerperium is a period from six to eight (6-8) weeks following child birth, during this time the genital organs return to their pre-pregnant state, lactation should be established and the new infant should be accepted into the family. The uterus which developed over a forty (40) weeks period during pregnancy, has now a much shorter time in which to make regressive changes. These changes are described as involution. the secretion of prolactin from the anterior pituitary gland initiates lactation. Once lactation commences, it is maintained by the baby suckling. This provides the natural stimulus for the release of prolactin.

Ojo and Briggs (1997) states that, puerperium is a period of six (6) weeks after delivery where all organs and structures which went through some changes during pregnancy return to their pre-gravid state. This process is known as involution. The genital tract is greatly distended, bruised and perhaps lacerated. The abdominal muscles are flaccid and within a period of six weeks postpartum is called puerperium. Lactation is established during the said period. The first ten day of puerperium is term as the lying -in period where close observation of both mother and baby are considered. This process of readjustment is called involution. Lochia is the term use to describe the discharge from the uterus during the puerperium. The woman is educated on what goes on throughout the puerperal period how to cope with the changes. The puerperal woman needs a lot of rest and sleep, regular exercise, intake of adequate fluid and nutritious diet rich in, carbohydrate and vitamins. The mother is educated on how to care for the baby to prevent infections. Among

the education include cord dressing, change of napkins frequently and exclusive breastfeeding. Emphases on family planning within six weeks after childbirth.

National Safe Motherhood protocol [2008], puerperium is the period from the end of delivery to 6 weeks after delivery. The purpose of post-natal care is to maintain the physical and physiological well-being of both mother and child. The aims of puerperium include; [1] to encourage exclusive breastfeeding as well as establishment of bond between the mother and child. [2] to promote and also maintain the health of both mother and child. [3] to supervise the mother to adapt the roles of motherhood. [4] to facilitate involution of the uterus, prevention of infection as well as other complications that may arise during this period. Postnatal care includes education of the mother on the care of the baby, detection and treatment or referral of any abnormalities for further management. The major causes of death in this period are infection, hypertensive complication, hemorrhage and thromboembolism. The purpose of postnatal care to maintain physical and physiological well-being of the mother and child. The essential components of postnatal are following; comprehensive screening to detect complications in both mother and child. Treatment of complications in mother and baby, these includes, assessment and support infant in breastfeeding. Malaria and anemia prevention. Puerperium is time the woman begins the physiologic transition to the non-pregnant state. Traditionally, puerperium is defined as lasting for 6 weeks most women have completed the last of the physiologic transition; uterine involution is complete, lochia has ceased and lactation is established. There are three types of lochia namely; Lochia rubra, is seen in the first 3 days and consists of blood serum, trophoblastic, debris and may contain some small clot. Is red in color. Lochia serosa, is seen during the next 4-10 days and consist of blood serum, leucocytes and tissue debris. Is pinkish in color. Lochia alba, is seen after 10 days

and consists of leucocyte deciduas epithelial cells and cervical mucus. Is white in color and continues for 10 to 14 days.

Dutta [2013], puerperium is the period following childbirth during which the body tissues especially the pelvic organs revert back approximately to the pre-pregnant state. The period is arbitrarily divided into [a] immediate- within 24 hours; [b] early-up to 7days; and [c] remote- up to 6 weeks. The principles in management puerperium are; [1] to restore the health of the mother. [2] to prevent infections. [3] to take care of the breast, including promotion of breast feeding. [4] to motivate mother for contraception. Women experience after pains regardless of whether they have had previous pregnancies and when they are not breastfeeding. Management of after pains is by an appropriate analgesic.

WHY CLIENT WAS CHOSEN

Mad. Appiah was chosen on the 15th November,2021 at Kwatire government hospital during one of her usual antenatal visits. On arrival, she looked unwell and was offered a seat. After normal antenatal routine checkup, she complained of headache, dizziness and general body weakness, was asked to go for laboratory for investigations since she wasn't looking well. Result showed MP's positive and she was asked of her gestational age and was 37 weeks, an opportunity was taken to educate client on the effect of malaria on pregnancy, the risk involve and the preventive measures on how she can protect herself from getting it again. I kindly approached her later on and introduced myself to her that 'I'm a student from Holy Family Nursing and Midwifery Training Collage, Berekum and am here at the hospital for my practical experience. Permission was sought from her to be taken as client for the care study which she accepted. All necessary particulars were collected. Appointment for home visit was booked, direction to her house was given and contacts were exchanged.

CHAPTER ONE

1.0 CLIENT'S PARTICULARS

This chapter is about assessment of the client and family which include social history, client's lifestyle and hobbies, medical history, surgical history, menstrual history, past and present obstetrical history, environmental history as well as her family's medical history

1.1 SOCIAL HISTORY/PERSONAL HISTORY

. Madam Appiah is a twenty-three (23) year old woman and a native of Odomase Kwatire in the Sunyani sub-district. She is dark in complexion and one hundred and sixty-seven centimeters (167cm) in height and a seamstress. She is an Akan and speaks Bono Twi. She is married to Mr. Amoah, who is a Driver at Odomase. Madam Appiah and her husband are devoted Christian and worships with the Seventh Day Adventist of Ghana. She got married to Mr. Amoah at the age of 20 years, they have been together for the past three (3) years. The couple is blessed with one girl who is three years old. Madam Appiah's mother, stays with her and helps her in caring for the child as well as the household chores. Her next of kin is her husband. She likes playing indoor games like ludo and oware at her leisure time. She likes fufu and garden eggs soup. She does not smoke nor drink alcohol.

1.2 FAMILY HISTORY

Madam Appiah comes from a family of six made up of 2 males and 2 females, their mother and father. Her mother's name is Madam Kyeraa and father, Mr. Appiah. She is the fourth daughter of her parents; her elder sister is married with three children. According to Madam Appiah, there is no inherited disease such as hypertension, diabetes, sickle cell, in her family and the family of her

husband. there were no congenital abnormalities like Down's syndrome, cleft palate. According to Madam Appiah, there is history of twins in her family.

1.3 MEDICAL HISTORY

According to Madam Appiah, she was once admitted at the Kwatire Government Hospital [Kwatire] for malaria in 2020. She also admitted that, she seeks medical attention from the Kwatire Government Hospital and also when experiencing any headaches or body pains. She mentioned that, she has never had any medical conditions like hypertension, tuberculosis, epilepsy, sickle cell disease, measles, diabetes mellitus and asthma. She is not allergic to any food or drugs ever taken.

1.4 SURGICAL HISTORY

Madam Appiah said, she has never undergone any surgical procedure such as, myomectomy, laparotomy, mastectomy and salpingectomy. According to her, she has never been involved in any road traffic accident or a form of accident which might have affected her pelvis neither has she ever donated or been transfused with blood before in her life for any surgical or medical reasons.

1.5 MENSTRUAL HISTORY

Madam Appiah had her menarche at sixteen years with regular twenty-eight days' circle. Her menstrual period normally last between five to six days with moderate flow of blood, she had no pain during menstruation. She resumed her menstruation ten months after previous delivery. According to her, she uses sanitary pads whenever she is menstruating. Her last menstrual period (LMP) was 20th February, 2021 and expected date of delivery was calculated to be on the 27th Novemberr,2021.

1.6 CLIENT'S LIFESTYLE AND HOBBIES

Madam Appiah up very early around 5:00am. She visits the toilet, brushes her teeth and starts to clean her compound as she lives in a family house. She then prepares breakfast after cleaning and wakes her child up. She baths her as she will be going to school. They take breakfast together. After seeing her off to school and her husband also to work, she then leaves to her work place. She takes in gari and beans in the afternoon. According to her, she closes around 5:00pm and gets home to prepare the evening meals for the family. She baths after cooking. She does general cleaning of the house on Friday before she goes to the work place. She leaves for church service together with the family on Saturdays. After church, she frequently prepares fufu and beef with garden eggs soup in the evening. She does not smoke and has never taken any alcoholic drink before. She likes playing ludo a lot and usually engages in a conversation with her husband. She has three square meals a day. She has a good relationship with all the co-tenants in the house.

1.7 HOME ENVIRONMENT (PHYSICAL/PSYCHO-SOCIAL)

Madam Appiah lives in a family house, where she and her family occupy two rooms. The house is built with blocks and roofed with aluminum sheets and is painted. There are mango trees in front of the house. Their source of water is from a nearby borehole and a tap water. There are toilet and bath rooms in the house. According to Madam Appiah they occupy 2 rooms, she also explained that her child and her mother also occupy one of the rooms in the house while she and her husband occupies the other. She has a cupboard for storing her cooking utensils and food stuffs. She also has a barrel with a lid for storing borehole water for cooking and drinking. She verbalized the existence of a healthy relationship between her, her mother, siblings, husband's friends and neighbors. She indicated that she had being exempted from some house hold chores because of

her condition. Her husband and other neighbors are happy for her pregnancy and wish to see her deliver safely.

1.8 PAST OBSTETRICAL HISTORY

Madam Appiah G^2p1^A said she carried her previous pregnancy to term without any complications like antepartum hemorrhage, hypertension, but experienced some minor disorders like pica, nausea and vomiting at the early stages of pregnancy which stopped in her second trimester. She never had any abortion either spontaneous or induced. She said that she has received the first and second dose of tetanus diphtheria (TD) injection in her pregnancy which was given intramuscularly at the upper part of the shoulders. She added that, she completed all the course of anti-malaria prophylaxis (sulphadoxine pyrimethamine) as well as her routine drugs given to her at the hospital.

According to Madam Appiah, labor started on its own, progressed well and did not exceed eighteen hours. She said, she had spontaneous vaginal delivery without any tear or episiotomy at Kwatire Government Hospital during her previous delivery. She said her baby cried lustily soon after delivery. Her previous child recorded a birth weight of 2.8kg. According to her, placenta and membranes were completely expelled five minutes after delivery of her first baby. She said she did not bleed much after delivery even after discharge home except the normal discharge of lochia. Madam Appiah, said she never experienced any complication in puerperium like puerperal infections or postpartum hemorrhage, urinary tract infections and puerperal psychosis. The baby was immunized against all the childhood diseases before age one, Madam Appiah, said she started breastfeeding immediately after delivery, and practiced exclusive breastfeeding for seven months before introducing complementary foods. She said, she resumed her menstruation after ten months of delivery. She added that, presently the child is in good condition. Her mother and husband are the support person to her. She never practiced family planning method after delivery.

1.9 PRESENT OBSTETRICAL HISTORY

Madam Appiah G2 $P1^{A}$, attended her first antenatal clinic on the 27th May,2021 at Kwatire Government Hospital [Kwatire]. She gave her last menstrual period as 20th February,2021 and her expected date of delivery was calculated and was 27th November,2021. Madam Appiah's gestational age at booking was 12 weeks. The past history was taken and recorded. According to her ultrasound scan, the expected date of delivery was 2nd December,2021. Result of the ultrasound scan denotes the liquor to be adequate, presentation of the foetus to be cephalic and the placenta at the anterior fundal. Her vital signs as well as other investigations were taken and recorded as follows to serve as baseline data for future comparison.

Temperature	36.5 degree Celsius
Pulse	80 beat per minute
Respiration	20 cycles per minute
Blood pressure	120/80 millimeter of mercury
Weight	63 kilogram
Height	167 centimeters
Hemoglobin	11.0 g/dl
Blood group	B
Rhesus	Positive
Sickling	Negative
VDRL	Negative
Bf for malaria parasite	No MPs seen
PMTCT	Non – reactive

G6PD	No defect

Urine routine examination revealed;

Sugar	Negative
Protein (albumin)	Negative
Acetone	Negative

Head to toe examination was done and no abnormalities were detected. Abdominal examination revealed no abnormality detected; uterus was not palpable. She had no complains. Since she was not able to follow her Tetanol Diphtheria schedule in her previous pregnancy, she was given her first and second dose on the 06/07/21 and 25/10/21. She was educated on the schedule and also the important of the tetanus diphtheria.

She was educated on the following; rest and sleep, nutrition, personal and environmental hygiene and mother to child transmission of HIV/AIDS, minor disorders in pregnancy such as nausea and vomiting (morning sickness) etc. and was encouraged to come back to the clinic when it becomes severe according to her records.

The following routine drugs were given;

Tablet Folic acid	5mg daily for 30days.
Tablet Fersolate	200mg daily for 30days.
Tablet Multivitamin	1 daily for 30days.
Tablet paracetamol	1g three times a day for 3 days.

CHAPTER TWO

2.0 ANTENATAL CARE

This chapter describes the care given to a client at the first contact with the client, subsequent visit to the clinic, home visit during antenatal period and care plans written to solve problem uncounted by client during this period.

2.1 FIRST CONTACT WITH CLIENT

Madam Appiah was a regular attendant and it was through her regular visit that, she was met on 15th November,2021. Madam Appiah's gestation was 37 weeks and it was her 7th visit to the Kwatire Government Hospital. She was approached and welcomed. Enquired about her health and that of the family was made and the response was positive. Introduction was then made as a student midwife from Holy Family Nursing and Midwifery Training College, Berekum but stationed at Kwatire Government Hospital for domiciliary midwife practice. A brief information was given to her about the care study and why she was chosen and She accepted and promised to give all the needed information. She was having a problem and decided to share. The problem was that the husband is anticipating that she gives birth to male, because the couples had already given birth to female.so she was promised that sex determination would be discussed during one of the visits to her house.

Madam Appiah was asked to empty her bladder, while a specimen bottle was given to her to collect mid-stream urine to check for protein, and sugar which were all negative with the use of regent strips. Her history was taken and she was helped through her routine antenatal examination, the findings were recorded on her card as follows.:

Temperature 36.5^{o}c

Pulse	80bpm
Respiration	20cpm
Blood pressure	136/77mmHg
Weight	75 kilogram
Hemoglobin	11.0g/dl

Madam Appiah's general appearance was good. She was asked if she had any problem and she said she had no complains. Explanation was given to her that the constipation was due to hormone progesterone relaxing muscles and decreasing peristalsis. She was advised to take more fluids and food containing roughages, example; orange. She was also encouraged to take a glass of warm water in the morning before taking breakfast and do some daily exercises to improve her bowel activities. She was advised to promptly respond to the urge of defecation. She was observed closely and there was no deformity. All the procedure to be performed on her were explained. She was showed the wash room to urinate to aid accurate findings on assessment. Head to toe examination on madam Appiah under the supervision of the midwife in–charge was conducted. She was assisted her unto the couch in the dorsal position after which hands were washed.

Physical Examination; On examining the head, Madam Appiah's hair was neatly combed and there were no lice, ringworm, dandruff, and alopecia or any scalp infection. There was no oedema on face, the conjunctiva was pink and the sclera is white. Madam Appiah was engaged in a conversation just for her to open her mouth, the tongue was clean and gum was pink and no bleeding, sore or any offensive smelling. Her neck was palpated for enlarged thyroid gland and

enlarged lymph gland and distended neck veins and there were no abnormalities detected upon inspection.

On the chest, the left breasts were normally situated with prominent nipples. The left breast was a little bigger than the right as on most women. One breast was covered and the other one was exposed. She was then asked to put the hand of the part to be examine under her head. The breast was palpated systematically in a circular manner using the inner aspect of the fingers and client was taught how to do self-breast examination. The nipple was squeezed gently and a swab was used to clean after which it was observed but there were no abnormal discharges from the nipple. Client was educated on the need for self-breast examination every month. Her upper limps were of equal size and length. The palms were pink in color. Her fingernails were pink in color, neat and trimmed short. There was no oedema of the hands. The lower limb was also of equal length, the toe nails were pink in color and trimmed short. There was no oedema, tenderness and varicose vein on the legs and thighs upon inspection and palpation. Her back was inspected and palpated and there was no tenderness, oedema on the sacral region. There were no rashes on the buttock and skin. There was no deformity of the spine. She was asked to lie on her side as hand washing was done with soap under running water and dried with clean towel.

Abdominal Examination

Inspection; Madam Appiah's abdomen was inspected after helping her to lay on her back. The abdomen was examined to detect any deviation from normal while warming the palms by rubbing them together, it was observed that the abdomen corresponds with the gestational age which was 37 weeks. The abdomen was globular in shape; there were striae gravidarum and Linea nigra. There were neither rashes nor surgical scars. Foetal movement were seen.

Fundal palpation; symphysio fundal height was (35cm) thirty-five centimeters and buttocks were in the upper pole indicating cephalic presentation, the lie was longitudinal.

Lateral palpation; the fetal back was on the left side and the limb on the right side of the mother's abdomen. The position was left occipito anterior.

Pelvic palpation; the head was at the lower part of the uterus indicating a cephalic presentation. The descent of the foetal head was measured by placing the examining fingers in between the anterior shoulder and the symphysis pubis. It accommodated five fingers indicating that the descent of the foetal head is $5/5^{th}$ above the pelvic brim.

Auscultation; the foetal stethoscope was warmed by rubbing it in the palm then placed at where the back of the foetus was located. Comparing with the rate of maternal pulse, foetal heart beat was counted for one full minute (140bpm) with good volume and regular rhythm.

Vulva inspection; Hand washing was done with soap under running water and dried with clean towel. The perineum was inspected. Her vulva was neatly shaved with no oedema, scars, varicose veins, vulva warts or abnormal discharges. After the examination, the midwife in-charge also did her examination for confirmation of the findings. Madam Appiah was thanked and directed to lie on her side, sit up before getting out of the couch as this will help dizziness due to supine hypotension. She was told to do so at home to prevent backache, she was helped to redress and given a seat. Hands were washed with soap under running water and dried with clean towel, findings of the examination performed were communicated to Madam Appiah and was also congratulated for the cooperation. The findings were then recorded into her maternal record book. She was served with the following drugs and was encouraged to take them as prescribed.

Vitamins B complex one daily for 15 days

Tablet Fersolate	one daily for 15 days
Tablet multivitamin	one daily for 15 days
Tablet folic acid	one daily for 15 days

She was encouraged to have enough rest to relieve pain and stress. She was educated on preventing strenuous exercises like carrying heavy load. Madam Appiah was educated on personal hygiene and adequate diet. True signs of labor such as lower abdominal pains, contraction and 'show' were discussed with her. She was told that she will be. Upon further interaction with her, it was realized that she lacks knowledge on family planning. She was therefore educated on family planning so she could practice one after delivery. She was asked to report to the hospital for the next visit on the 22/11/21 or when she has any problem. She was assisted to take her medication from the dispensary after the discussion. Her mobile number was collected and day that she would be available at home to be visited. She was reminded once again on her next visit. She was thanked and promised to be visited and bid good bye.

2.2 FIRST ANTENATAL HOMEVISIT

On 19/11/21, Madam Appiah and her family were visited at home around 4:30pm. She was called on telephone and she gave direction. The aim of the visit was to know where she lives and meet other members of her family and also talk about birth preparedness and complication readiness plan and to assess situation rule out any serious condition such as malaria as to give continuous care after delivery. She was very glad for the visit. Seat and glass of water were offered after which interaction with her started. Introduction was made to family. But the husband was in the room, so she called him. Madam Appiah lives with her husband and their child and her mother in a single room self-contain house at Kwatire. The house is built with cement blocks and roofed with

aluminum sheets. The room is spacious with enough windows and broad door which have mosquito netting. There is one toilet and two bathrooms in the house. Their source of water is from a pipe not far from the house. They store water in large rubber barrel with cover, the source of light is electricity and they use torch light and lanterns whenever the light goes off. They dispose of their refuse in a refuse dump created for the community immediately after collecting the refuse in a rubber bucket for that purpose. The compound was not all that clean, was taken to the sitting room which was nicely decorated.

On entering the room, the trap door net was partly torn. There was adequate ventilation in there as her windows were opened. They were educated on the importance of Treated mosquito net and sleep under it to prevent malaria. The family were encouraged on the need to keep their surroundings clean, buy a trap net to replace the torn net to clean and drain the gutter off rubbish and water to prevent stagnant water that can breed mosquitoes and also, they should also cover their clean waters in the barrel to prevent mosquitoes breed which can cause malaria. They were happy and she told her mother to support her clean the environment and that they will replace the torn net. The issue of people supporting her was not a problem, since her mother was around to help with household chores. She was then asked about her birth preparedness and she brought her layette which was neatly packed in a bag for inspection. The items include baby dresses, hat, socks, cot sheets, diapers, sanitary pads, Dettol, power zone as well as bathing item. She was advised on the need to arrange with a taxi driver to convey her to the hospital when labor sets in at an odd hour. Opportunity was taken to educate them since the husband was around on the route of administration, benefits and risks, helping the child to be properly breastfed and the husband to gather resources to care for the family. She was educated on the types available, the importance and methods that help to prevent unwanted pregnancy. She was told that the National Health

Insurance Scheme (NHIS) will help reduce her cost during labor. And there is the need to save money in case of any emergency. She was once again encouraged on intake of adequate food such as green vegetables like kontomire, ayoyo, eggs and beans to boost her hemoglobin level. Madam Appiah was reminded of the next antenatal visit and also to come before the scheduled time if she encounters any problem and she responded positively. They were thanked and promised to visit again on the 22/11/21 before she delivers.

2.3 CLIENT'S SUBSEQUENT VISIT TO THE CLINIC

On the 22th November, 2021 Madam Appiah visited the antenatal clinic as scheduled. She was warmly welcomed and routine examination carried out revealed the following results:

Temperature	36.6^{o}c
Pulse	84bpm
Respiration	22cpm
Blood pressure	110/60mmHg
Weight	67kg
Hemoglobin	12.9g/dl

Urine tested negative for protein, glucose and acetone. Client was asked to empty her bladder after which she was helped unto the couch for the necessary examination. On examining the head, Madam Appiah's hair was neatly combed there were no lice, ringworm, dandruff, and alopecia and scalp infection. There was no oedema on face, the conjunctiva was pink and the sclera is white. Madam Appiah was engaged in a conversation just for her to open her mouth, the tongue was clean and gum was pink and no bleeding, sore or any offensive smelling. She was inspected and palpated

her neck for enlarged thyroid gland and enlarged lymph gland and distended neck veins and there were no abnormalities detected upon inspection. Upon inspection the chest, the breast was normally situated with prominent nipples. The left breast was a little bigger than the right breast. The breast was palpated and there were no lumps nor enlarged lymph nodes. There were no abnormal discharges from the nipple but colostrum was present when squeezed.

Client was educated on the need for self-breast examination every month after menstruation. Her upper limps were of equal size and length. The palms were pink in color, her fingernails were pink in color, neat and trimmed short. There was no oedema of the hands. The lower limps were of equal length, the toe nails were pink in color and trimmed short. There was no oedema tenderness and varicose vein on the sacral region. There were no rashes on the buttock and skin. There was no deformity at the spine. She was asked to lie on her side as handwashing was being done with soap and under running water and dried them with clean tower. Madam Appiah was informed and exposed her abdomen for inspection after helping her to lie on her back. The abdomen was examined to detect any deviation from normal while warming my palms by rubbing them together, Inspection was on the abdomen and it corresponds with the gestational age. The abdomen was globular in shape; there were striae gravidarum and linear nigra. There were neither rashes nor surgical scars. Foetal movement was seen and gestational age was assessed before palpating the level of the fundus away from the xiphisternum. On fundal palpation, fundal height was (36cm) thirty-six centimeters and gestational weeks was 37. The buttocks were in the upper pole indicating cephalic presentation, the lie was longitudinal. On lateral palpation the fetal back was on the left side and the limb on the right side of the mother’s abdomen. The position was left occipital anterior. On pelvic palpation, the head was at the lower part of the uterus indicating a cephalic presentation.

The descent of the foetal head was measured by placing the examining fingers in between the anterior shoulder and the symphysis pubis. It accommodated five fingers indicating that the descent of the foetal head is five-fifth ($5/5^{th}$) above the pelvic brim. On auscultation, Foetal stethoscope was warmed and placed at where the back of the foetus was located and the foetal heart beat was counted for one full minute (140bpm) with good volume and regular rhythm. Hand wash was performed with soap under running water and dried them with clean towel. The vulva was inspected the perineum and was neatly shaved with no oedema, scars, varicose veins, vulva warts or discharges. After my examination, the midwife in-charge also did her examination for confirmation of my findings. Madam Appiah was thanked and directed to lie on her side and sit up before getting out of the couch as this will help prevent backache and abdominal pains. She was told to do so at home to prevent backache, she was helped to redress and given a seat. The hands were washed with soap under running water and dried with clean towel, findings of the examination performed were communicated to Madam Appiah and was also congratulated for the cooperation.

2.4 SUBSEQUENT ANTENATAL HOME VISIT

Next visit to Madam Appiah house was on 26/11/21 as she was promised, at 4:00pm. A cheerful welcome was by the client. The child of Madam Appiah and her mother were happy for the home visit. They had a new net on the door and the environment was clear. She was educated on nutrition diet.

She complained of frequency of micturition. She was reassured and it was explained to her that it's as a result of the foetal head putting pressure on the urinary bladder. She was advised to take less fluid especially in the night. She was advised to urinate before going to bed or put chamber pot by the bedside at night. She was encouraged to take warm bath before bed time and clean the

perineum after emptying the bladder. She was counseled to reduce her activities and have adequate rest and sleep. When inquired about their decision on family planning, she said her husband and herself have planned on choosing the oral contraceptive method (pills) after delivery.

Her drugs were inspected for confirmation that she was taking them regularly as prescribed and found to be true her items for delivery were also inspected and it was intact. She was reassured, she will be remembered in prayers. She was asked of her donor in case she may need blood and she said she is of the same blood group as her husband and that the husband had been screened and will donate when the need arises. She was highlighted on the signs of true labor and asked for permission to leave. The family showed appreciation for the home visit once again and Madam Appiah was reminded her of the next visit if she had not delivered. As we bid each other farewell.

2.5 NURSING CARE PLAN DURING ANTENATAL PERIOD

ACTUAL PROBLEMS IDENTIFIED DURING PREGNANCY

1. On 15/11/2021 client complain of Constipation.
2. On 19/11/2021 client was educated on family planning.
3. .On 22/11/21cliene was educated on sex determination
4. On 22/11/2021 client complained of lower abdominal pain.
5. On 26/11/2021 client complained of frequency of micturition.

SHORT TERM OBJECTIVES

1.Client will gain knowledge about family planning within 24 hours.

2. Client will have adequate knowledge on sex determination within 24 hours.

3.Madam Appiah will pass stool once a day within 48 hours.

4.The woman will be able to cope with lower abdominal pain throughout pregnancy.

5. Client will understand and cope with frequent micturition within 24 hours after delivery.

LONG TERM OBJECTIVES

1. Client will go through pregnancy, labor and puerperium successful without any complication to herself and the baby.

TABLE– NURSING CARE DURING ANTENANTAL CARE

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
19/11/21 At 4:30pm	Inadequate information on family planning.	Client will acquire knowledge on family planning within 24 hours as evidenced by client verbalizing at least two importance of family planning.	1.educate client on family planning. 2. Teach client, the risks and benefits of family planning. 3.Allow client to do recap. 4. encourage client to ask questions. 5.Involve the partner	1. Samples of methods and slip charts were used to explain. 2. Client was taught that they have options that prevents pregnancy but have some mild effects like headaches. 3.Client gave some examples of family planning. 4.Client's concerns were addressed. 5. client's partner also talked about the fact that he is enjoying the discussion.	16/11/22 at 4:30pm	Goal was Fully met as Client mentioned some of the importance of family planning and showed willingness to practice after delivery	

TABLE– NURSING CARE DURING ANTENANTAL CARE

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
15/12/21 At 5:30pm	Constipation related to low intake of food rich in fibers.	Madam Appiah will pass stool once a day, within 48 hours as evidence by client verbalizing that she is able to move her bowls freely.	1.Reassured her that constipation can be managed. 2.Encourage client to take in 500ml warm water every morning before breakfast 3.Encourage client to take fruits and vegetables three times a day 4.Educate client on exercise. 5.Educate client to eat food high in fiber and roughness.	1. The causes of constipation was explained to client after reassured given. 2. Client took in warm water before breakfast. 3. Client was taking in fruits and vegetables such as e.g. Orange and carrot 4.Client was taught to do mild exercise like walking around to prevent constipation 5. Client was taking mangoes, pawpaw, whole grain meals which are high in fiber	17/12/22 At 5:30pm	Goal fully met as client verbalized that she have been able to move her bowel without any difficulty	

TABLE– NURSING CARE DURING ANTENANTAL CARE

DATE TIME	NURSING DIAGNOSIS	NURSING OBJECTIVE	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
22/11/21 At 4:30pm	lower abdominal pain related to descent of foetal head.	Client will cope with lower abdominal pain within 24 hours and throughout the pregnancy as evidenced by client behavior.	1.Explain the cause of pain to client 2.Support client emotionally. 3.Encourage client to rest. 4.Serve prescribed medication.	1. Client know it was due to pressure from the presenting part. 2.Client was supported emotionally that pain would be relieved after child birth. 3. Client was resting at least one to two hours a day rest and 8 hours' night sleep 4. Client was encouraged to take in prescribed analgesics such as paracetamol 100mg start	23/11/22 At 1:00pm	Goal fully met as client verbalized that she was able to cope with the pain.	

TABLE– NURSING CARE DURING ANTENANTAL CARE

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES	NURSING ORDERS	NURSING INTERVENTIONS	DATE/ TIME	EVALUATION	SIGN
22/11/21 5:00pm	frequent micturition related to pressure on bladder by the presenting part.	Client will understand the physiology of frequent micturition and cope with the condition within 24 hours and throughout the pregnancy as evidenced by client behavior.	1.Reassure client that it is temporal. 2.explain the physiology to client. 3.Advise client to urinate before going to bed 4. Advise client to put a chamber pot by bedside. 5. Educate client to wash and dry her pantie in the sun and use panty linear.	1. Client was reassured that it will subside after delivery. 2. Physiology was explained to her that it was as a result of gravid uterus on the bladder. 3. Client urinated before going to bed all the time 4. Client put chamber pot by bedside to urinate when she has the urged to prevent excess walk to the bathroom 5. Client washed her panties and dried them in the sun to prevent infection.	23/11/22 At 1:00pm	Goal fully met as client verbalized that she was able to cope with frequency of micturition till the end of pregnancy.	

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVE	NURING ORDERS	NURSING INTERVENTION	DATE/TIME	EVALUATION	SIGN
22/11/21	Knowledge deficit on Sex determination	Client will understand the physiology of sex determination within 24hours as evidenced by client verbalizing that it is not her fault.	1.Educate client on sex determination 2.Educate client and partner who determines the sex of a baby 3.Allow client and partner to recap on education given 4.Teach them to appreciate whatever sex they have.	1.Client was taught that males determine the sex of a baby. 2.Client and partner were taught that God has the final say in sex determination 3. Madam Appiah and partner were able to recap the education given on sex determination 4.They were thought that what men can do women can do it better.	23/11/2021 At 4:3pm	Goal fully met as client and partner verbalized that they are they will be contempt and whatever the outcome of the pregnancy will be	

CHAPTER THREE

LABOUR

3.0 MANAGEMENT DURING LABOUR

This chapter describes admission of the client and management of first, second and third stage of labor and management of fourth stage of labor, care of the baby at birth and subsequent care of baby. A general summary of the labor and nursing care plan on labor.

3.1 ADMISSION AND MANAGEMENT OF FIRST STAGE OF LABOUR.

ADMISSION

On 3/12/21. Madam Appiah reported at Kwatire Government Hospital [Kwatire] with her husband at 10:20pm with the history of labor pains. They were welcomed and offered a seat. They were supported emotionally that they were in the hands of competent midwife and so they should be calm and relaxed. Client's antenatal book was collected and glanced through to look out for client's history.

According to her, she has lower abdominal pain which that evening started with waist pain and appearance of blood stained mucous that is 'show' at 7:00pm and feels pain severely in the thighs which was on and off. She was supported emotionally, it was then explained in simple terms the physiology of labor, she was reminded and encouraged to do deep breathing exercise, and was allowed to adopt a comfortable and suitable position and sacral massage was performed on her during contraction. She said she took milo before coming. Madam Appiah was in severe pain but was still coping with it. Client was helped with her items and admitted into the first stage room and made comfortable on a well laid bed after changing into a light dress. Examination procedures to be undertaken were explained to her. Madam Appiah's consent was obtained; curtains were

drawn to ensure privacy. She was given a bed pan to empty her bladder to enhance accurate assessment and also get urine specimen for testing. Urine passed was 100mls which tested negative for protein and glucose and the result were as follows;

Urine Volume	100mls
Glucose	negative
Protein	negative
Color	amber

Her vital signs were checked and recorded as follows:

Temperature	36.7^{o}c
Pulse	80bpm
Respiration	20cpm
Blood pressure	120/70 mmHg

Physical examination

Client was asked if she feels like pushing before the examination which she said no. On examining the head, client's hair was neatly combed there were no lice, ringworm, dandruff, and alopecia and skin infection. There were no oedema on face, the conjunctiva was pink and the sclera is white. Madam Appiah was engaged in a conversation just for her to open her mouth, the tongue was clean and gum was pink and either bleeding, sore or any offensive smelling. She was inspected and her

neck was palpated for enlarged thyroid gland and enlarged lymph gland and distended neck veins and there was no abnormality detected upon inspection.

Upon inspection, the chest and the breast was normally situated with prominent nipples. The breast was normal. Her breast was palpated under the supervision of the midwife in-charge and there were neither lumps nor enlarged lymph nodes. There were no discharges from the nipple but there was breast milk when squeezed them. Client was educated on the need for self-breast examination every month. Her upper limps were of equal size and length. The palms were pink in color with creases. Her fingernails were pink in color, neat and trimmed short. There was no oedema of the hands. The lower limps were of equal length, the toe nails were pink in color and trimmed short. There was no oedema, tenderness and varicose vein on the thighs and legs upon inspection and palpation. Madam Appiah 's back was inspected and palpated and there was no tenderness, oedema on the sacral region. There were no rashes on the back and skin. There was no deformity of the spine. She was asked to lie on her side as hand wash was being perform with soap and under running water and dried them with clean towel

Abdominal examination

Abdominal examination was carried out as follows; the abdomen was examined to detect any deviation from normal. While warming the palms by rubbing them together, inspection was carried on the abdomen and the size corresponds with the gestational age. The shape of the abdomen was globular; there were presence of striae gravidarum and linea nigra. No rashes or surgical scars, foetal movement was seen. The symphysio-fundal height recorded 37cm and gestation was 39 weeks. On fundal palpation, the buttocks of the foetus was occupying the upper pole of the uterus indicating that the presentation was cephalic and the lie was longitudinal. On lateral palpation, the

back was located and a fetoscope was placed to listen to the heart rate. The foetal heart rate was 136bpm with regular and good volume. On pelvic palpation, the presentation was cephalic, position was left occipito-anterior and descent was $3/5^{th}$ above the symphysis pubis. Contractions were three in ten (3:10) lasting 20 seconds, maternal pauls of 80bpm. She was told vaginal examination was going to be conducted on her and she agreed to it. Hands were then washed and dried and a tray was set containing the following;

- A pair of sterile gloves
- A gallipot containing sterile cotton wool swabs
- A diluted antiseptic solution(savlon)
- A sanitary pad in a receiver

Vaginal examination

Vaginal examination was done under aseptic condition after seeking client's consents. She was helped to assume a supine position and she was draped from the abdomen to the thighs to ensure minimal exposure. Hand washing was performed thoroughly with soap under running water, dried with a clean dried towel. A pair of glove was worn and patient was asked to flex her knees. On inspection, there were no sore, scars, abnormal discharges, genital warts, varicose vein or oedema. The vulva was swabbed from the labia majora and to the labia minora and then to the vestibule using sterile cotton soaked in savlon solution, a swab at each time from top to down. Client's permission was sought and the middle and index finger were inserted gently into the vagina. The vagina was warm, moist, soft and distensible. The cervical dilatation was 4cm, membranes were intact and there was no molding. Client was cleaned and clean perineal pad was applied to the

vulva. Client was thanked for her cooperation and reassured that all will be well since she is in safe hands. The findings confirmed that Madam Appiah was in true labor. Gloved hands were dipped into 0.5% chlorine solution and removed by turning gloves inside out and discarded, all used items such as gallipots and receivers were immersed in 0.5% chlorine solution for 10 minutes. Hand washing was performed with soap and water and dried them with a clean towel. All finding was communicated to her using the dilatation board and recorded on the partograph and client's maternal health record book around 10:50pm

Madam Appiah was asked to lie on her left side to prevent supine hypotension and also to enhance adequate oxygen supply to the foetus and was also encouraged to void regularly to also aid in descent of the head. Client complains of anxiety due to unknown outcome of the labor and so she was supported psychologically that she was in competent hand. She was engaged in a conversation to allay her fears and also procedure to be performed on her and progress of labor were communicated to her. She was encouraged to assume a comfortable position and walk around if possible to help labor progress. Client also complained of headache and it was explained to her that it as a result of stress of labor and client was educated to take in enough fluid at frequent interval. Client complain of lower abdominal pain and she was reassured. Client was educated on the importance of changing the pad when soiled and not to touching the perineal area and to stop mishandling the pad. Her items were kept by her bedside.

Maternal condition such as blood pressure, temperature and pulse were monitored four hourly. Urine was measured and tested anytime she voids. Foetal conditions such as foetal heart rate was monitored half hourly, amniotic fluid and moulding four hourly. Progress of labor such as descent was monitored four hourly, vaginal examinations four hourly, contractions every thirty minutes. She complained of fatigue due to painful uterine contractions. She was educated not to bear down

prematurely till the cervix is fully dilated and also adopt a comfortable position. She was engaged in conversation from time to time in order to divert her attention from the pain. Client's husband was made to see client. While keeping her company, the progress of labor was being monitored. All findings were communicated to client and recorded on the partograph as well. The delivery trolley was set up and resuscitation equipment were tested and made ready. The delivery trolley contains the following.

Madam Appiah's condition and her baby remained stable until she complained of strong uterine contractions which were expulsive in nature. At11:20am, uterine contractions were 3 in 10 minutes lasting for 24 seconds maternal pulse was 80bpm and foetal heart rate 14x0bpm. At 11:50pm, maternal pulse 82bpm contraction was three in ten lasting for 30 seconds. Foetal heart rate was 140bpm. At 12:20am, foetal heart rate was 140bpm contraction was 4 in 10 minutes lasting for 32 seconds maternal pulse was 84bpm. At 12:50am foetal heart rate was 138bpm, contraction was 4 in 10minute lasting for 34 seconds and maternal pulse was 80bpm, temperature was 36.6^{o}c, urine passed was 100mls with protein, acetone and glucose negative. At 1:20am foetal heart rate was 140bpm, contractions were 4 in 10minute lasting for 35 seconds and maternal pulse was 82bpm. At 1:50pm foetal heart rate was 142bpm, contraction was 4 in 10minute lasting for 37 seconds and maternal pulse was 80bpm. At 2:20am foetal heart rate was 142bpm, contraction was 4 in 10 minutes lasting for 41 seconds and maternal pulse was 80bpm.

At 2:50am vaginal examination was done after hand wash was performed, dried and sterile gloves worn. The vagina was warm and moist the cervical Os was 8 centimeters dilated and cervix was still thin, spontaneous rupture of membrane occurred and the color of liquor was clear with no cord prolapse. Moulding was one plus (+). A clean perineal pad was placed on the vulva. Client was served 500mls of malt drink. Descent was 2/5th; maternal blood pressure was 120/70mmHg. Foetal

heart rate was 140bpm, maternal pulse was 84bpm, and contractions was 4 in 10 lasting for 45 seconds, temperature 36.4^{o}c urine passed was 80mls with protein, glucose and acetone all negative. Findings were recorded on the partograph and progress of labor was explained to the client to allay anxiety.

TOP SHELF CONTAINING

- Two pair of artery forceps
- A pair of scissors to cut the cord
- Sterile episiotomy scissors, a needle holder and disserting forceps
- Three galipot containing dry gauze and cotton wool swabs and one for diluted savlon.
- Cord ligature and kidney dish to receive the placenta.
- Sterile pair of gloves
- Sterile perineal pad

THE BOTTOM SHELF CONTAINING

- A clock to note time
- A small tray with a syringe and needle, 10 units of oxytocin for client and vitamin k injection for the baby. Resuscitation tray containing the following was set;

  Ambubag, bulb syringe, 2 face masks (small and medium) and 2 warm towels.

At 3:20am contractions became stronger and expulsive, 5 in 10 minutes lasting for 50 seconds, foetal heart rate was 138bpm, maternal pulse was 88bmp. Sterile delivery trolley was take to the

second stage room with uterotonic drugs such as oxytocin ready. Due to strong uterine contraction, client's lumbosacral region was massaged to relieve pain. At 3:50am foetal heart rate was 140bpm; maternal pulse was 84bpm and uterine contraction were 5 in 10minutes lasting for 44 seconds, contractions were 5 in 10 minutes lasting for 50 seconds and maternal pulse was 80bpm. At 4:20am, vaginal examination was to be repeated so handwashing was done dried. Then gloved were worn to confirm the second stage of labor. The cervical Os was 10cm dilated, descent was $0/5^{th}$ liquor was clear, moulding was (++) and foetal heart rate was 140bmp. The urine volume she passed was 80mls and tested for protein, acetone and glucose and they were all negative. Maternal pulse rate was 80bpm, temperature 36.5^{o}c. Findings were confirmed by the midwife in charge and were recorded on the partograph. On observation the anus has gaped and become tensed with the presenting part appearing at the vulva and bulging in the perineum. The progress of labor was explained and client was transferred to the 2^{nd} stage room. Contraction was 5 in 10 minutes lasting for 42 seconds.

3.2 MANAGEMENT OF SECOND STAGE OF LABOUR

Madam Appiah was sent to the second stage room. She was helped onto the delivery couch in a lithotomy position. She was encouraged to continue with deep breathing exercise to prevent tiredness. Privacy was provided. Procedure was explained to her and she was reminded that baby will be delivered unto her abdomen to enhance bonding between her and baby. The abdomen was washed with savlon added with lukewarm water in order to prevent infection to the baby. Quickly rubber apron, boot, hair cap and mask were put on; hands were washed and dried, sterile gloves were put on. The perineum was swabbed with weak savlon solution and vaginal examination was done to confirm full dilatation of the cervix.

The anal region was covered with a sterile pad to prevent contamination of the delivery field with feces. Client was encouraged to bear down with each contraction and rest in-between. Maternal pulse and foetal heart rate were checked by the delivery assistant to know the condition of the mother and foetus. As labor progress the anus gaped and the presenting part become visible with contractions. As the foetal head advanced, flexion was aided by placing index and middle fingers on the occiput, maintaining flexion to allow the smallest diameter of the foetal skull to distend the perineum. This was done to prevent trauma to the baby and mother. This continued until the head crowned. Madam Appiah was told not to push again but to pant so as to prevent rapid expulsion of the head which can lead to tear. The sinciput, face and chin swept the perineum. The baby's head was delivered by extension. The face was cleaned with sterile gauze and eyes were cleaned with dry sterile cotton wool swab from the inner canthus to the outward using one swab for each eye. Fingers were used to check for cord around the neck and there was none. The mother was reminded that the baby will be delivered unto her abdomen while waiting for restitution followed by external rotation of the head indicating that the shoulders were lying in the anterior-posterior diameter of the pelvic outlet. Both hands were placed at each side of the head and the anterior shoulder was delivered by downward traction and the posterior shoulder by upward. An alive male infant was delivered at 4 :30am and cried lustily immediately after birth.

3.3. IMMEDIATE CARE OF TIIE BABY

Immediate care of baby started as soon as the head was delivered. The eyes were cleaned with a dry sterile cotton wool swab from inner canthus outward. The face was cleaned with dry sterile gauze, the cord was clamped two centimeters (2cm) from baby's abdomen using umbilical cord clamp and 3cm from the first clamp. Then covered with gauze and cut between to prevent blood from splashing. The baby was shown to the mother to identify sex and baby was dried with a clean

towel and soiled linen was changed and baby was kept in skin to skin contact with the mother during the first hour after birth to prevent hypothermia and promote breastfeeding. Baby weighed 3.3kg. An identification band with mother's name, baby's sex, date and time of birth was applied to the baby's wrist. Apgar score for the first one minute was 9/10. Apgar score in the fifth minute was 10/10. Baby was put to breast to aid in bonding and also help to release natural oxytocin from the posterior pituitary gland. Baby's condition was satisfactory and mother was congratulated for her cooperative.

3.4 MANAGEMENT OF THIRD STAGE OF LABOUR

Still with client in the supine, Procedure was explained to Madam Appiah. After cutting the cord, a sterile receiver was placed near the vulva in-between the woman thigh to receive the cut end of the cord. The abdomen was palpated to rule out any second foetus in utero and there was none. Oxytocin injection, ten units (10IU) was given intramuscularly on mother's thigh. Madam Appiah was informed that, it was time to deliver the placenta and that she should not push. Cord was clamped close to the perineum using artery forceps. The cut end of the cord was held with an artery forceps and left hand was placed above the symphysis pubis with the palm facing the umbilicus to embrace the uterine contractions. Controlled cord traction and counter traction of the uterus was applied to deliver the placenta by firmly grasping the cord and applying in an outward and downward direction till the placenta become visible at the vulva. It was received into cupped hands and membranes expelled out gently, placenta and membranes were completely delivered at 4:45am, It was quickly examined, to ensure its completeness, all the lobes were complete and there was no abnormality such as infarcts detected, the membranes were also intact. The cord was centrally situated with the blood vessels radiating just to the edge of placenta with three vessels, two arteries and one vein in the cord. The uterus was gently rubbed and blood clot expelled and

the vulva cleaned with a sterile pad. The cervix, vagina wall and perineum were examined under a bright light and there was no tear or lacerations detected. Client was cleaned up and a new sterile perineal pad a**p**plied over the vulva. She was transferred into the fourth stage room and baby was given to her to breastfeed to initiate breastfeeding. She was congratulated for her effort and cooperation. Placenta was decontaminated within 0.5% chlorine solution and discarded into the placenta container. Uterus was firmly rubbed up from the fundus through her abdomen until the uterus contracted. Client was thought how to massage her own uterus to keep it contracted. She was encouraged to empty her bladder frequently to help prevent bleeding and aid involution of the uterus. The delivery instruments were immersed in 0.5% chlorine solution for ten minutes (10mins) and washed with soapy water cleaned and packed for sterilization, the delivery bed and trolley were decontaminated and cleaned for re-use. The floor was mopped off blood and liquor and decontaminated too.

3.5 MANAGEMENT OF THE FOURTH STAGE OF LABOUR

Mother was served with porridge and bread to replace last energy. Her perineal pad was inspected and was soaked with lochia and was changed for her. She was encouraged to urinate whenever she feels like to help in the contraction of the uterus and also help prevent postpartum hemorrhage. Madam Appiah was once again encouraged to change perineal pad frequently when soiled to prevent infection. She was advised to wash her hands before and after changing her perineal pad, taught how to massage the uterus from time to time. Madam Appiah was encouraged to continue breastfeeding the baby on demand and always wash her hands before handling the baby, symphysio-fundal height measured 18cm as uterus was examined and it was firmly contracted. Lochia was inspected and found to be bright red in color and flow moderately. Vitamin A capsule 200,000 international units orally was served to mother and repeat in twenty-four hours. Post-

delivery vital signs were checked and recorded between the following results on the mother and baby

MOTHER

Temperature	36.5^{o}C
Pulse	82 bpm
Respiration	20cpm
Blood pressure	110/70mmHg

BABY

Apex heart beat	140bpm
Respiration	40cpm
Temperature	36.6
Weight	3.3kg

Vital signs of both mother and baby were checked every fifteen minutes (15min) for the first one hour, half hourly for the next two hours, one hourly for the next three hours and then four hourly till mother and baby were discharged. All findings were recorded on the fourth stage chart. Refer to appendix.

Baby's skin color was pink, breathing pattern was normal and umbilical cord was not bleeding. Breastfeeding was initiated within the first thirty minutes (30mins) after delivery and baby passed meconium and urine.

3.6 SUBSEQUENT CARE OF THE BABY

Vitamin K 1mIs was given intramuscularly and also gentamycin eye drop was instilled into his eyes. He was also given Bacillus Calmette Guerine (BCG) 0.5mls and Polio 0.2 drops on the right upper aim and tongue respectively. The mother was advised not to rub or apply anything on the site of injection. Madam Appiah was informed of the possible rise in temperature as a result of the injection.

Baby was examined from head to toe in the presence of the mother to identify any congenital abnormalities or birth injuries. First, procedure was explained to the mother, hands were washed with soap and water and dried with a cleaned dried towel, a tray was set and sent to the examination table, windows and doors were and also closed switched off all nearby fans. Then wore a pair of disposable gloves.

Examination of the new born

The head was examined for the, shape, size and caput succedaneum. Hair was silky and black, there was no sunken or bulging fontanelles, the face was round, smooth and without any rashes, the eyes were clear and clean without any discharge, the ears were also patent without any polyps, growth nor any discharge was possible. There was no swelling on the neck and rotation and flexion of the head and the upper notch of the pinna of the ear were in the same level with the canthus of the eyes. The nose was pointed and patent without any discharge or polyps. The mouth was easily opened by pressing against the angles of the jaw to visualize the tongue for any tongue-tie, the palate for cleft palate, the lip for cleft lip and if there were any false teeth but none of these was observed.

The chest and abdomen: Observation of the respiratory movement revealed that the chest and the abdominal movement were synchronous. The nipple was well spaced, the shape of the abdomen was round, the cord vessels revealed two arteries and one vein without any bleeding from the cord.

The genitalia and anus were examined for patency, the anus was also examined, and it was patent as the tip of the baby's sterile rectal thermometer was inserted in the baby's rectum. Upon palpating the scrotal suck tooth testicles have descanted and the urethral meatus is at the tip of the penis.

The limbs and digits: In addition to noting length and movement of the limbs, the digits were counted and separated and webbing was not present. The feet were examined for deformity such as talipes, and extra digits and none was observed. The elbows, groins, and popliteal spaces were examined but no abnormality was detected and there was normal flexion and rotation of the wrist and ankle joints too.

The back: baby was turned to the other side to inspect and palpate the back for any swellings, spinal bifida, occult bifida, dimples or hairy patches but no abnormality detected.

The baby was weighed and it recorded 3.3 kilogram (kg). Head, chest circumferences and length of baby measured 33centimeters (cm), 32 centimeters (cm) and 54 centimeters (cm) respectively.

BABY'S FIRST BATH

The following morning, the mother was informed that baby was going to be bath and she agreed. So all items were gathered including the following baby's towel, soap, sponge etc. Hot and cold water were mixed and temperature tested using the elbow. Plastic apron was worn, hands were washed with soap under running water and dried. Since it was the baby's first bath, gloves were worn. The baby was placed on a flat protected surface and was undressed. He was covered in a

clean cot sheet, baby's eyes were clean with wet cotton wool swab from the inner cantus to the outer cantus, the face was cleaned with damp face towel and dry it. The nape of the baby's neck was supported with one hand and his ears were plugged with two fingers of the other hand. Supporting baby's head. The baby's head was wash with soap and sponge. The soap was rinsed by lifting baby off the flat surface. The baby was then placed on flat surface again and exposed baby's arms and front, trunk was washed, paying attention to the skin folds. Back of baby was washed down to the feet, paying attention to the skin folds. Baby was supported firmly and immersed in the bath of warm water, with head above water and rinsed thoroughly. Baby was placed on a flat surface covered with a clean towel. small towel was used to dry baby paying attention to skin folds. Baby oil was smeared on the head and body including buttocks; baby was dressed up and his hair was combed nicely. The baby's cord was then exposed to be dressed. Gloved hand was immersed into 0.5% chlorine solution and discarded them.

Cord dressing

A tray containing sterile cotton wool swab in a gallipot and methylated spirit in another gallipot, sterile gloves and a receiver was set. Hand were washed and dried with a clean towel. With a pair of sterile gloves put on, the umbilical cord was observed for loosen clamp to re-clamp if necessary and also for bleeding but there was no bleeding. The tip of the cord was held with a swab soaked in a methylated spirit. The skin stem away from the base of the cord was cleaned. The base of the cord was swabbed with another swab. The stem was swabbed from the base upward using a swab in each stroke until the cord was well cleaned. The tip of the cord was cleaned with another swab and pressed to check if it is bleeding. The cord was left exposed to dry and heal by dry gangrene. The baby was dressed, up covered and given to his mother to breastfeed to aid contractions of the uterus. All findings were communicated to madam Appiah by telling her that, her baby was healthy

and had no problem. The mother was thanked for her cooperation. All used instruments were decontaminated in 0.5 % chlorine solution for ten minute (10mins) and washed with soap and sponge, rinsed under running water and were packed for sterilization. Hands were washed and dried. Finding were recorded into the delivery book and client's maternal record book. Hands were immersed in the chlorine solution before discarding it. Madam Appiah was advised to feed baby on demand. Maternal vital signs were checked and recorded frequently thus every one hour to detect any deviation from the of the mother and baby was satisfactory. All findings were recorded into the delivery book and client's maternal record book.

SUMMARY OF LABOUR NOTE

CONDITION ON MOTHER

Date and time of delivery	04/12/2021 at 4:30pm
Type of delivery	spontaneous vaginal delivery (SVD)
Time placenta and membranes delivered	4:35am
Time injection oxytocin 10units was given	4:31pm
Blood loss	100mls

DURATION OF LABOUR

First Stage	-	7 hours twenty minutes (7hrs:20mins)
Second Stage	-	Five minutes (5min)
Third Stage	-	Six minutes (6min)

Total Duration - Seven hours thirty- one minutes (7hrs:31mins)

CONDITION OF PLACENTA MEMBRANES AND CORD

Placenta - Healthy

Lobes and Membranes - complete and healthy

Foetal surface - grayish blue

Maternal surface - Dark red

Cord Insertion - Centrally Situated

Cord Vessels - Two arteries and one vein)

PROBLEMS IDENTIFIED DURING LABOUR AND DELIVERY

ACTUAL PROBLEMS

1. On 3/12/2021client was seen to be anxious related to unknown outcome of labour

2. 0n 3/12/2021client complained of fatigue related to painful uterine contraction and stress of labour

3. On 3/12/2021 client complained of lower abdominal pain related to uterine contractions and descent of foetus

4. On 3/12/2021 client complained of headache related to stress of labour.

SHORT TERM OBECTIVES

1.Client will be relieved of anxiety within one (1) hour.

2.Client will be relieved of fatigue.

3.Client will be able to cope with lower abdominal pain within 2 hours.

4.Client's headache will be relieved within 4 hours.

LONG TERM OBJECTIVE

Madam Appiah will have a normal progress of labor and puerperium without any complication to both mother and baby.

NURSING CARE PLAN DURING LABOUR

DATE / TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES	NURSING ORDERS	NURSING INTERVENTION	DATE / TIME	EVALUATION	SIGN
3/12/21 At 10;25pm	Anxiety related to unknown outcome of labor	Madam Appiah, will be relieved from anxiety within 1 hour evidenced by; 1. Client verbalizing that she is no more anxious. 2. Midwife visualizing that there is no tense.	1. Reassure client 2. Explain the physiology of labor to client. 3. Explain every procedure to the client. 4. Allow client to ask questions and give correct answers to it. 5. Communicate all findings to client.	1 Client was reassured that she is in the hands of a competent midwife. 2. Physiology of labor was explained to my client. 3. Every procedure was explained to my client. 4. Client was allowed to asked question and correct answers were given to her. 5. Findings of all procedures carried out on client were communicated to her.	03/01/21 At 11:25pm	Goal fully met as evidenced by; 1. Client verbalized that she is no more anxious. 2. Midwife observing that client looks cheerful.	

NURSING CARE PLAN DURING LABOUR

DATE / TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES	NURSING ORDERS	INTERVENTION	DATE/ TIME	EVALUATION	SIGN
03/12 /21 At 11:15am	Fatigue related to painful uterine contraction and stress of labor.	Madam Appiah, will be relieved of fatigue within 4 hours evidenced by; 1. Client verbalizing that she is relieved of fatigue. 2.Midwife observing that client looks refreshed.	1.Support client emotionally. 2.Encourage client to remain calm to prevent exhaustion. 3.Encourage her to continue with deep breathing exercise. 4.Allow client to adopt a comfortable position but harmless. 5.Educate client to breathe through her mouth during contractions.	1. Client was reassured that very soon she will be relieved 2. Client remained calm and was not shouting 3. Client did the deep breathing exercise where necessary. 4. Client adopt a comfortable but harmless position 5. Client through her mouth with contractions until the cervical Os is fully dilated.	04/01/21 At 3:15 am	Goal fully met as 1. Client verbalized that she is relieved of fatigue. 2 Midwife observing that client was made comfortable after labor.	

NURSING CARE PLAN DURING LABOUR

DATE / TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES	NURSING ORDERS	NURSING INTERVENTION	DATE / TIME	EVALUATION	SIGN
03/01/21 At 12:40am	Lower abdominal pain related to uterine contraction and descent of foetus	Client will understand and cope with the lower abdominal pain within 1 hour as evidenced by; 1. She is copping. 2. midwife visualizing a mark change in client's reaction to contractions.	1.Support client emotionally. 2.Explain in simple terms physiology of labor to client. 3.Remind and encourage client to do deep breathing exercise. 4.Allow client to adopt a comfortable and suitable position. 5.Perform sacral massage during contractions	1. Client was reassured that. 2. Client was enlightened on the series of process during labor 3. Client was doing the deep breathing exercises. 4. Client adopted a comfortable and suitable position that aid progress of labor 5. Client was given sacral massage during contractions	03/02/21 At 1:00am	Goal fully met as evidenced by 1. Client verbalized that there is no more pain. 2. Nurse observing that client has remained calm in bed after delivery.	

NURSING CARE PLAN DURING LABOUR

DATE / TIME	NURSING DIAGNOSIS	NURSES OBJECTIVES	NURSING ORDERS	NURSING INTERVENTION	DATE / TIME	EVALUATION	SIGN
02/01/21 At 1:10am	Headache related to stress of labor.	Client will be relieved of headache within 4 hours as evidence by; 1. client verbalizing that she is relieved.	1.Reassure the client that it is temporal. 2.Encourage client rest in between contractions. 3. Ensure adequate fluid intake. 4. check blood pressure 2 hourly. 5. Serve prescribed medication.	1. Client was reassured she will be managed. 2. Client was resting in between contractions. 3. Client took six glasses of water during labor. 4. Blood pressure was checked 2 hourly. 5. Tablets paracetamol 1g was served as prescribe.	03/01/21 At 5:10am	Goals fully met as evidenced by; 1.Client verbalized that the headache has reduced. 2.Midwife visualized that client has a cheerful look.	

CHAPTER FOUR

4.0 MANAGEMENT OF PUERPERIUM

Chapter four of the care study entails management during puerperium care of the mother and baby, post-delivery home visits, postnatal care reviews, termination of care and nursing care plan on puerperium.

4.1 DAY OF DELIVERY

Madam Appiah and her baby were received in to a warm comfortable bed in the lying-in ward at 5;35am on the 04/12/21. She was encouraged to void whenever she has the urge to prevent postpartum hemorrhage. They were monitored for the first one hour after delivery in the labor ward before transferring them to the lying-in-ward for continuous monitoring. Madam Appiah's vital signs were monitored every fifteen minutes for the first two hours and half hourly for the next one hours followed by one hourly for the next 3 hours and then four hourly until condition was stable. Immediate vital signs after delivery recorded as;

Temperature	36.5°C
Pulse	82bpm
Respiration	20cpm
Blood pressure	110/70 mmHg

Madam Appiah’s breasts were somehow lactating, fundal height measured 18 cm above the symphysis pubis. Uterus was well contracted and lochia was red in color with moderate flow. She was also encouraged to wash hands with soap under running water before and after changing perineal pad to prevent infection. She was encouraged on early ambulation to promote effective

blood circulation and drainage of lochia and also clean her perineum from the anterior to posterior. Hand washing before breastfeeding baby was also encouraged to breastfeed exclusively to help in the contractions the uterus.

The baby was closely observed for any change in condition. He was all pink, suckled well and passed meconium which was dark green in color and also passed urine which color was straw confirming patency of the urethra and anal orifice. Baby and mother were healthy. She was encouraged to feed the baby on demand till lactation is well established. Vital signs of the baby were checked and recorded as follows:

Temperature - 36.6°C

Apex beat - 140bpm

Respiratory - 40cpm

Weight - 3.3kg

The baby weighed 3.3kg. and it was later examined from head to toe to exclude any congenital abnormality and birth injuries that might have been sustained during birth. Client was visited by her husband, co-tenants and nephew. They were so excited and expressed their gratitude to the staff. They were later informed about their possible discharge the next day and advised to assist her in the care of the baby so that mother can have enough rest.

4.2 FIRST DAY POST DISCHARGE

The first day post-delivery was on 04/12/21. She was visited in the morning looking healthy. According to her she and the baby had a good night sleep. At 10;40am, procedure to be carried out was explained to her, and privacy ensured. Her breast has started lactating but not in much, abdomen was soft uterus was well contracted and lochia was inspected and it was red color

without odor and moderate flow. She took a warm bath and applied a new perineal pad. She was served with porridge and ‘’koose’’. Head to toe examination was done on Madam Appiah after procedure has been explained to her but nothing abnormal was detected. Her uterus was well contracted and fundal height measured and it was 16 centimeters. Her vital signs were checked and recorded as follows:

Temperature	36.4 degree Celsius
Blood pressure	110/60 mmHg
Pulse	84bpm
Respiration	20cpm

Baby

The baby was topped and tailed in the morning and cord dressed with methylated spirit and let opened to dry after permission sought from Madam Appiah. The baby was active and passed meconium during topping and tailing. Baby was examined from head to toe in the presence of his mother. Nothing abnormal was detected during examination of the baby. The baby’s vital signs were checked and recorded as follows;

Temperature	36.6 degree Celsius
Respiration	32 cycles per minute
Apex beat	140 beat per minute
Weight	3.3kg

The baby was then handed over to her mother to breastfeed after being nicely wrapped in a warm sheet. Madam Appiah second dose of Vitamins A 200000 unit was served.

Preparation for discharge

Client's husband and mother were formally told that they would be discharged if after examination their condition remains stable around 11:00am on the 04/12/21 and preparation were made towards their discharge. Client's mother was educated to top and tail the baby until cord falls off since bathing the baby can cause infection to the cord when wet. They were also educated on the need to keep the baby's cord dry and clean and avoid applying any cream or local herbs except dressing with methylated spirit and sterile cotton wool swabs. Mother was also encouraged to expose the cord after dressing the baby. Mother was encouraged to breastfeed baby exclusively. She was also encouraged to feed the baby especially during the night which will serve as family planning. She was encouraged to also observe baby's cry and sleeping pattern and report any adverse change. She was also encouraged to frequently change baby's soiled diapers to prevent sore buttocks and keep baby warm as well. She was educated on nutritious diet and also takes fruits to improve her immunity as well as aid in involution of the uterus. She was educated on postnatal exercise, personal hygiene and family planning. Madam Appiah was served with the following drugs on discharge after review by the midwife in-charger.

Tablet folic acid	5mg daily for 30 days
Tablet ferrous sulphate	200mg 12 hourly for 14 days
Tablet multivite	5mg 8 hourly for 14 days
Tablet paracetamol	100mg 8 hourly for 5 days

Tablet vitamin B complex	1 tablet for 30 days

She was helped to pack her belongings after being served with the drugs she was discharged to go home. Her hospital bills were settled by the health insurance scheme. She was informed of the postnatal home visit which she agreed. She was congratulated and bid farewell

4.3 FIRST DAY POSTNATAL HOME VISIT

First day postnatal home visit was made on the 05/12/21 around 8:00am and 5:30pm. Madam Appiah and her family were in good health. Procedures to be carried out were explained to her and we requested to void if she has the urge. Head to toe examination revealed that breasts were lactating, abdomen was soft, uterus well contracted, and SFH measured 14cm, the lochia was red (rubra) with no odor and a moderate flow when her perineal pad was inspected. She then went and took her bath and no abnormality was detected. Her vital signs were checked and recorded as follows:

	Morning	**evening**
Temperature	36.6	36.5
Blood pressure	110/70mmHg	120/70mmHg
Pulse	82bpm	84bpm
Respiration	22cpm	20cpm

She complained of after pain and breast engorgement which was explained that the pain was as a result of the uterus trying to resume its non- pregnant state (contraction). Head to toe examination was also done on the baby and nothing abnormal was detected. The baby was top and tail and her mother and client were told to observe the procedure. The baby's cord was dressed after top and

tail. Baby was not sucking well. She was completely pink and cord was dried and it passed meconium and voided when it was being top and tailed. The baby vital signs were checked and recorded as;

Morning		**evening**
Temperature	36.8 degree Celsius	37. degrees Celsius
Respiration	36cycles per minute	40 cycles per minute
Apex beat	138 beat per minute	133 beat per minute
Weight	3.2kg	

The baby was wrapped in a warm sheet. he was handed over to the mother to breastfeed. She thanked her for their cooperation and permission was sought after some few minutes into action with the family.

4.4 SECOND DAY POSTNATAL HOME VISIT

Madam Appiah and her family were visited on the 6/12/21 at 8:30am and 5;30pm. All the family members were in good health. Every procedure to be carried out was explained to Madam, Appiah. Her breasts were very full and warm to touch. Her perineal pad was inspected for lochia and it was red (rubra) in color with no odor and the flow was moderate. Head to toe examination was done and no abnormality was detected. Fundal height was measured to be 12cm on the second day and the uterus was well contracted morning vital signs checked and recorded as temperature -36.7^{o}c, blood pressure- 110/70mmHg, pulse- 72bpm, respiration- 24cpm and evening vitals were checked

and recorded as; Temperature- 36.8^{o}c, Blood pressure- 110/70mmHg, Pulse 74bpm, Respiration - 22cpm.

On the 5/01/21 Madam Appiah complained of inadequate sleep at night, loss of appetite and anxiety due to weight loss of the baby. client was educated to sleep in the day time when baby is sleeping, take warm baths before going to sleep and client's family was educated to help in the care so that client can rest. She was thought that, baby's weight loss is as a result of baby passing meconium and was reassured that baby will gain weight with time. She was therefore educated on how to fix baby properly to the breast. Baby was top and tail, she passed meconium and urine in the process, cord was somehow dry and it was dressed with dry cotton and methylated spirit. Head to toe examination was done on the baby and no abnormality was detected, Baby was pink all over, could suckle and has passed meconium and urine. Morning vital signs were checked on the baby and recorded as follows: temperature-36.5^{o}c, respiration 34cpm, apex heart beat –140 bpm, and Evening vital was checked and recorded as; Temperature - 36.7^{o}c, Respiration - 36cpm, Apex beat - 142bpm, Weight-3.1kg

THIRD DAY POSNATAL VISIST

Madam Appiah and her family were visited on 7/12/21 at 8:30am and 5;30pm . All the family members were in good health. Every procedure to be carried out was explained to Madam, her perineal pad was inspected for lochia and it was red (rubra) in color with no odor and the flow was moderate. Head to toe examination was done and no abnormality was detected. Fundal height was measured to be 10cm on the third day and the uterus was well contracted vital signs was checked and were as follows: Morning temperature - 36.7^{o}c, blood pressure -110/70mmHg, pulse – 80bpm and Evening, temperature – 36.8^{o}c, blood pressure – 110/70mmHg, pulse – 84bpm.

Baby was top and tail. Cord was dressed dry with cotton and methylated spirit. Head to toe examination was done for the baby and no abnormality was detected. Vital signs were checked on the baby and recorded as; Morning, temperature – 36.7^{o}c, respiration – 34cpm, apex heart beat – 138bpm, Weight-3.0kg. Evening, temperature – 36.8^{o}c, respiration – 34cpm, apex heart beat – 140bpm.

4.5 THE FOURTH DAY OF POSTNATAL HOME VISIT

On 8/12/21, Madam Appiah and family were visited to assess their general well-being and continue with the care, once again greetings were exchanged and enquired about their welfare. Procedure was explained to her, head to toe examination was done and nothing abnormal detected. Lochia was checked and it was red (rubra) on the fourth day with no offensive odor. Fundal height was measured to be 8cm. She had no complains. She was educated to on pelvic floor exercises and also the need to maintain good personal hygiene. Proper hand washing with soap and water after visiting the toilet, changing baby's soiled napkins and before breastfeeding the baby was encouraged.

Head to toe examination was done on the baby and no abnormality was detected. Vitals signs checked and recorded as

Morning; temperature - 36.5^{o}c, blood pressure -110/60mmHg, pulse – 86bpm and Evening, temperature – 36.7^{o}c, blood pressure – 110/60mmHg, pulse – 84bpm, respiration-22.

The baby was examined from head to toe on a flat surface and no abnormality was found. Cord dressing was done. After the bath, baby was wrapped in a warm cloth and handed over to the mother to breastfeed, after vital signs have been checked and recorded as follows; Morning;

temperature – 36.5^{o}c, respiration – 32cpm, apex heart beat – 142bpm, Weight-3.0kg. Evening; temperature – 36.8^{o}c, respiration – 38cpm, apex heart beat – 140bpm

FIFTH DAY POSTNATAL HOME VISIST

On 9/12/21, Madam Appiah and family were visited daily between the hours of 8 to 9 am in the morning to assess their general well- being and continue with the care. Madam Appiah has hair to toe examination was done and no abnormality was detected. Lochia was checked for it flow and it was serosa with no odor. Breast were soft and well lactating, indicating that engorgement has subsided as well as sore nipple when observed. Symphysio fundal height was 6cm.Vital signs were checked and recorded as;

Morning, temperature – 36. 7^{o}c, blood pressure – 110/60mmHg, pulse – 84bpm, respiration – 22cpm when she has already done bathing.

Baby's head to toe examination was done on flat surface and no abnormality was detected. The cord was dry and almost off. Baby was top and tail, and cord dressing was done. Head to toe examination was checked and recorded as; Morning, temperature – 36.8^{o}c, respiration – 34cpm, apex heart beat – 138bpm, Weight-3.1kg.

SIXTH DAY POSTNATAL HOME VISIT

Madam Appiah and the family were visited on 10/12/21, 9;00am to assess their general well-being and continue with the care. Madam Appiah had already taken her bath and procedure was explained to her, Lochia was checked for flow and it was serosa with no offensive odor. Symphysio fundal height was 4cm. Vital signs were checked and recorded as;

Temperature - 36.5^{o}c,

Blood pressure - 110/70mmHg,

Pulse - 82bpm,

Respiration - 20cpm

Baby was also examined after bathing and nothing abnormal was detected. Baby's cord has fell off. Vital signs were checked and recorded as;

Temperature - 37.0^{o}c,

Apex heart beat - 142bpm,

Respiration - 36cpm.

Weight-3.2kg

4.6 SEVENTH DAY POSTNATAL HOME VISIT

Last visit to Madam Appiah 's house was on the 11th December,2021 on 8;00am. The purpose of the visit was to ensure that there had been improvement in her condition with the explanation and the medication given. The entire family was in good h ealth. Every procedure to be carried out on her as well as her baby was explained to her and she agreed to continue. Head to toe examination was done but nothing abnormal was detected. Her perineal pad was inspected for the color and flow of lochia. The color was white (alba) and had a moderate flow with no odor. Fundal height was measured to be 2cm. Her vital signs were checked and recorded as; Temperature - 36.8 degree Celsius, Respiration - 22 cycles per minute, Blood pressure - 110/60 mmHg, Pulse - 84 beats per minute.

The baby was also examined after bathing and nothing abnormal was detected. His vital signs were checked and recorded as; Temperature - 36.5 degree Celsius, Respiration - 32 cycles per minute, Apex heart beat - 140 beats per minute, weight-3.3kg. Baby was handed over to the mother to breastfeed. Education was done on the intake of nutritious diet. She was also reminded of the 1st postnatal visit to the clinic and the need to send the baby to child welfare clinic and the importance of immunizing the baby against the childhood vaccine preventable diseases. She was told that before the first postnatal clinic, if she encounters any problem she should report to the hospital. Madam Appiah and family were told that, that day was the last visit and they were thanked for their co-operation and left.

4.7 POSTNATAL (REVIEW) VISIT TO THE CLINIC

Madam Appiah and the baby reported to the clinic for her first postnatal visit on the 13th of, 2021. December. She came to the clinic with her baby. Baby and mother were looking healthy. Every procedure to be carried on her and the baby was explained to her. Mother's vital signs were;

Temperature - 36.4 degree Celsius,

Respiration - 20 cycles per minute,

Blood pressure -110/70 mmHg,

Pulse - 84 beats per minute.

She was given a specimen bottle and taught how to collect midstream urine for urine examination but nothing abnormal was detected. Her hemoglobin level was 12.2 grams per deciliter (g/dl). She emptied her bladder and was assisted to lie on the examination bed. Privacy

was ensured and a head-to-toe examination was done, after hand was wash with soap and water and clean them with a clean towel. The head was inspected and there was no abnormality. The face was inspected for oedema, chloasma but no abnormality was detected. The eyes were inspected too for jaundice, pallor of conjunctivitis and lips but nothing was detected. The ears too were inspected and there was no discharge. Madam Appiahs neck was also palpated and there was no enlargement of the thyroid gland, lymph gland and no distended neck vein. Examination of the breast was performed and there were no masses, lump, crack nipple and she was lactating well. She was educated on the need to wear well-fitting brassieres and how to perform self-breast examination. Madam Appiah's upper extremities were inspected for equality, cleanliness of finger nails, oedema of the finger and pallor of the palms but nothing was detected. According to her, she had no numbness and tingling sensation of the fingers. Abdominally, the uterus was not palpable, the perineum was intact and lochia pale in color (alba). The lower limbs were also inspected for tenderness of the calf muscle and feet palpated for oedema but they were normal. All findings were communicated to her and information was also recorded in the postnatal record book. She was still practicing the exclusive breastfeeding and was encouraged to continue with it. She was educated on the intake of adequate nutritious diet. Emphasizes on family planning was made again to help her make a right choice during six weeks' postnatal visit. The need to attend child welfare clinic and the need to complete baby's immunization schedule was also stressed on. It was explained to Madam Appiah that there is the need to introduce her to the public health nurse of Kwatire Government Hospital [Kwatire], for continuity of care. It was also explained to her that, care was ending that day but was reassured that communication will continue and that the public health nurse is competent in the discharge of her duties and thus will give her the needed care. She was encouraged to report to

the facility anytime she encountered any health-related problem. She was also advised on the importance of the child welfare clinic again. All procedures needed to be carried out on the baby were explained to the mother and she agreed. The baby was taken from the mother and undressed on a warm flat surface after hand was washed with soap and water and dried with a clean towel. The part of the baby that needs to be examined at a particular time was exposed. Baby was alert when the examination was going on. General appearance of the baby was good and the skin color was pink. The head was normal. the anterior fontanelle was palpated and it was pulsating. It admitted two fingers. The posterior fontanelle also admitted a tip of finger. The eyes were examined for the signs of jaundice, discharge and the conjunctiva for pallor but no abnormality was detected. The nose was small in shape. The nostrils were patent. The neck was also examined for the presence of lymph node, but was normal. Upper extremities were also inspected for the length, reflexes and many more but were normal. The chest was also inspected for the shape, size, position of the nipple and the chest movement was normal. The abdomen was also normal in shape, size and with no distension of the abdomen. The genitalia were inspected and nothing abnormal detected. The baby's back was also examined but there was no abnormality. Lower extremities were also examined and no abnormality detected. Baby cloth was removed and weighed, he weighed 3.4kg. baby was dressed up. Hands were washed with soap and water and dried with clean towel; findings were communicated to the mother. Vital signs were checked and recorded as; Temperature-36.9 degree Celsius, Respiration - 32 cpm, Apex beat - 138 beats per minute. After examination of the baby, Madam was informed that the circumcision is about to be done and asked if she wanted to observe but replied in the negative. The baby was prepared and circumcised by the midwife in-charge. Gel was applied to the circumcised area wrapped with gauze after which baby was clothed and given to mother

to breastfeed. Education was then given to wash hand with soap and water before handling baby and to always keep the wound dry to prevent infection and report any signs of bleeding, swelling or discharge.

Mother was advised to register the baby at the birth and death registry and also for weighing regularly, family planning and exclusive breastfeeding was also stress on again.

She was thanked for her co-operation throughout the care after she was introduced to the public health nurse for continuity of care.

4.8 CARE PLAN DURING PUERPERIUM

PROBLEMS IDENTIFIED

1. On 5/12/2021 client complained of after pain related to physiological activities of the uterus (involution)

2. On 5/12/2021 client complained of breast engorgement related to inadequate emptying of the breast.

3.On 5/12/2021 client complained of inadequate sleep at night related to frequent night breastfeeding.

4. On 6/12/2021 client complained of loss of appetite related to hormonal changes during puerperium.

SHORT TERM OBJECTIVES

1. Madam Appiah will be relieved of after pains within 72hours.

2. Madam Appiah will be relieved of breast engorgement within 72 hours.

3. Client will be able to sleep for 1 hour in the day and 3 hours during the night within 24 hours.

4. Madam Appiah will eat half of her food served within 48 hours.

LONG TERM OBJECTIVES

Madam Appiah and her baby will go through normal puerperium without any complication to them and the family.

NURSING CARE PLAN FOR PUERPERIUM

DATE / TIME	NURSING DIAGNOSIS	NURSING OBJECTIVE	NURSING ORDERS	NURSING INTERVENTION	DATE / TIME	EVALUATION	SIGN
05/12/21 At 9:00am	After pains related to physiological activity of the uterus (involution)	Madam Appiah will be relieved of after pains within seventy-two hours (72hours) after delivery as evidenced by: client verbalizing that.	1. Reassure client. 2. Explain the physiology of pain to client. 3.Encourage client to void frequently to aid n involution 4.Encourage client to breastfeed baby frequently 5.Serve prescribed medication.	1. Client was reassured to allay anxiety 2. Physiology of pain was explained to client that pain was due to uterine involution. 3. client was Encouraged to avoid frequently to aid in involution 4. client was encouraged to breastfeed baby frequently 5. prescribed Analgesics were served	06/12/21 At 9:00am	Goal fully met as evidenced by; Client verbalizing that she was relieved of after pain.	

NURSING CARE PLAN FOR PUERPERIUM

DATE / TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES	NURSING ORDERS	NURSING INTERVENTION	DATE / TIME	EVALUATION	SIGN
05/12/21 At 10:00am	breast engorgement related to inadequate emptying of the breast.	Madam Appiah will be relieved of breast engorgement within 72 hours evidenced by 1.Client verbalizing that she is relieved. 2. Midwife observing the engorgement has subsided.	1.Reassure client to allay anxiety. 2.Educate client on how to position the baby well when breastfeeding 3.Educate client to breastfeed baby frequently 4.Apply warm and cold compress alternatively. 5.Serve analgesics when necessary 6.Encourage client to empty breast manually	1. Client was reassured to allay anxiety 2. Client positioned the baby well when breastfeeding 3. Client breastfeed baby frequently on demand 4. Client applied warm and clod compress on the breast. 5.Paracetamol tablet 1g+ was served to relieved pain 6. Client did manual expression to relieve heaviness.	08/01/21 At 10:00am	Goal fully met as 1. Client verbalized that she was relieved of fullness of breast. 2. Midwife observed there was improvement in the condition on examination.	

NURSING CARE PLAN FOR PUERPERIUM

DATE / TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
05/12/21 At 5:00pm	Interrupted sleep related to frequent night breastfeeding	Client will be able to sleep for 1hours in the day and 3hours at night within 48hours as verbalized by client verbalizing, she is able to sleep and midwife visualizing that client look refreshed.	1.Reassure client that it can be managed. 2.Encourage client to feed baby on demand. 3.Educate mother to sleep in the day time while baby is asleep 4.Explain the importance of night breastfeeding her. 5.Encourage husband to support mother with the care of the baby.	1. Client was reassured that she will able to sleep within hours. 2. Client was encouraged on the essence of feeding on demand. 3. client was educated to sleep in the day time while baby is asleep 4. Importance of night breastfeeding was explained to her. 5. Husband was encouraged to take care of baby if not crying to allow mother to sleep	06/01/21 At 5:30pm	Goal fully met as client verbalized that she was able to sleep during the night for at least 4hours and during the day for 2 hours.	

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVE	NURSING ORDERS	NURSING INTERVENTION	DATE / TIME	EVALUATION	SIGN
06/12/21 At 5:30 pm	Loss of appetite related to hormonal changes during puerperium.	Client will eat half of her food served within 48hours as evidenced by client verbalizing that, she is able to eat half of her food.	1.Reassure client. 2.Do mouth care twice a day. 3.Serve client's favorite food. 4.Serve clients food Attractively. 5.Administer vitamin supplements.	1. Client was reassured 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 a ball of fufu and garden eggs soup with. 4.Client's food was served attractively by garnishing the food. 5. Vitamin supplements such as folic acid, multivitamin were administered to client.	04/01/21 At 5:00 pm	Goal achieved. Client said, she ate half of meal served. Support person reported that client ate more than half of meal served.	

SUMMARY AND CONCLUSION

This family centered maternity care study was performed on Madam Appiah who was 23years of age, G2P1^{A}. Madam Appiah started her antenatal clinic on the 27th May, 2020 when she was 16 weeks pregnant at Kwatire Government Hospital. She was met at the said hospital for the first time on 15th November, 2021 when she was 37 weeks pregnant on one of her usual antenatal visits to the clinic. She was given comprehensive nursing care throughout pregnancy, labor and puerperium. She encountered minor disorders during pregnancy, labor and puerperium but they were well taken care of. She had a spontaneous vagina delivery of a live male child without any complications, since she was well managed during pregnancy and at the time of labor. Madam Appiah had a normal puerperium and all examinations were carried on her as required.

The care study has helped me to understand that, midwives should treat pregnant woman as an individual and unique person with special needs and problems. Base on the assessment, planning, intervention and evaluation. The family centered maternity care study has exposed me to situations where knowledge received in the classroom has practically been demonstrated on a client and family from pregnancy through to puerperium.

Moreover, the study has also helped me to gain more knowledge and insight about client's needs as well as interaction with people. It is very interesting but need a lot of hard work, commitment, encouragement and advised before one can achieve her aim. However, the midwife needs to be smart, bold sociable and intelligent.

Again, it has also broadened my knowledge on issue concerning pregnancy, labor, and puerperium. With the experience gained, hope to give the best of standard of care to all my clients that will

come under my care irrespective of their social status and the environment I find myself, in order to reduce maternal and infant morbidity and mortality.

The study should therefore be maintained in the Diploma in Registered Midwifery Program by the Nursing and Midwifery Council-Ghana. If this method of care is continued, maternal and infant mortality rate will be reduced in the developing countries.

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APPENDIX I

COMPLETED DIAGNOSTIC INVESTIGATION

DATE	SPECIMEN	INVESTIGATION	NORMAL VALUES	FINDINGS	REMARKS
15/06/21	Blood	Hemoglobin level	11 –16 gldl	11.5gldl	Normal
		Sickling test	Negative	Negative	Normal
	Urine	Protein	Negative	Negative	Normal
		Sugar	Negative	Negative	Normal
24/06/21	Blood	VDRL	Non-reactive	Non-reactive	Normal
		HBs Ag	Negative	Negative	Normal
	Urine	Protein	Negative	Negative	Normal
		Sugar	Negative	Negative	Normal
29/08/21	Blood	Hemoglobin level	11 – 16gldl	11.6g/dl	Normal
		Sickling test	Negative	Negative	Normal
		Grouping and rhesus factor	A, B, AB, O	positive	Normal
		Sickling test	Negative	Negative	Normal
	Urine	Protein	Negative	Negative	Normal
		Sugar	Negative	Negative	Normal
16/10/21	Blood	H emoglobin level	11 – 16gldl	10.9 g/dl	Normal
		Sickling test	Negative	Negative	Normal

	Urine	Protein	Negative	Negative	Normal
		Sugar	Negative	Negative	Normal
27/10/21	Blood	VDRL	Non-reactive	Non-reactive	Normal
		Hemoglobin level	11- 16	11.9gldl	Normal
	Urine	Protein	Negative	Negative	Normal
		Sugar	Negative	Negative	Normal
14/11/21	Blood	Hemoglobin level	11-16gldl	12.4g/dl	Normal
		Sickling test	Negative	Negative	Normal
	Urine	Protein	Negative	Positive	Normal
		Sugar	Negative	Negative	Normal
22/11/21	Blood	Hemoglobin	11-16gldl	12.8g/dl	Normal
		VDRL	Non-reactive	Non-reactive	Normal
	Urine	Protein	Negative	Negative	Normal
		Sugar	Negative	Negative	Normal

ANTENATAL CHART RECORD

Date	Weight (kg)	Blood Pressure (mmHg)	Urine (protein and sugar)	Haemo-globin level (g/dl)	Gestational age (weeks)	Fundal height cm)	Presentation	Descent (th)	Foetal heart rate (bpm)	Complains	Treatment and advice	Remarks
27/05/21	64	113/72	Negative Negative	11.6	12	-	-	-	-	No complain	Tablet folic acid, multivitamin, ferrous sulphate, tablet paracetamol 1000mg,1st dose of tetanus injection	Well

16/06/21	65	122/61	Negative	12.0	16	palpable	-	-	-	Waist pain	Tablet folic acid, multivitamin, ferrous sulphate, tablet fluids,2nd dose of tetanus injection	Well

Date	Weight (kg)	Blood Pressure (mmHg)	Urine (protein and sugar	Haemo-globin level (g/dl	Gestational age (weeks)	Fundal height cm)	Presentation	Descent (th)	Foetal heart rate (bpm)	Complains	Treatment and advice	Remarks
24/07/21	67	120/80	Negative	12.5	20	20	-	-	FM+	Feels well	Folic Acid, Multivitamin, Ferrous sulphate,1st dose of SP.	Healthy
24/08/21	70	130/67	Negative	-	24	23	-	-	138	Feels well	Folic Acid, Multivitamins, Ferrous sulphate.	Well
15/09/21	72	126/65	Negative	-	28	28	-	-	140	No Complain	Folic Acid, Multivitamins, Ferrous sulphate	Healthy
15/10/21	75	136/77	Negative	-	32	31	Ceph	-	142	No Complain	Folic Acid, Multivitamins, Ferrous sulphate	Healthy

Date	Weight (kg)	Blood Pressure (mmHg)	Urine (protein and sugar	Haemo-globin level (g/dl	Gestational age (weeks)	Fundal height cm)	Presentation	Descent (th)	Foetal heart rate (bpm)	Complains	Treatment and advice	Remarks
30/10/21	75	120/80	Negative	12.5	34	34	-	-	FM+	Feels well	Folic Acid, Multivitamin, Ferrous sulphate,1st dose of SP.	Healthy
15/11/21	77	123/71	Negative	-	36	36	-	-	138	Feels well	Folic Acid, Multivitamins, Ferrous sulphate.	Well
25/11/21	76	130/86	Negative	-	38	37	-	-	140	No Complain	Folic Acid, Multivitamins, Ferrous sulphate	Healthy

APPENDIX II

PHARMACOLOGY OF DRUGS USED (MOTHER)

NAME OF DRUGS	CLASSIFICATION	DOSAGE	ROUTE OF ADMINISTRATION	ACTION & USE	ACTUAL EFFECTS	SIDE EFFECT OF DRUGS	SIDE EFFECT EXPERIENCED
Tablet folic acid	Haematinics	5 milligrams once daily	Orally	Proper formation and functioning of red blood cell.	Hemoglobin level increase	Nausea and vomiting	None
Tablet multivitamin	Vitamin preparation	200 milligrams twice daily	Orally	Increased appetite. Helps in the formation of red blood cell	Increase appetite.	Gastro intestinal disturbances	None
Tablet ferrous sulphate	Iron supplement	200 milligrams 2 twice	Orally	Help in formation of hemoglobin and red blood	Hemoglobin level increased	Gastrointestinal disturbance	Dark stool

PHARMACOLOGY OF DRUGS USED CONTINUED (MOTHER)

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

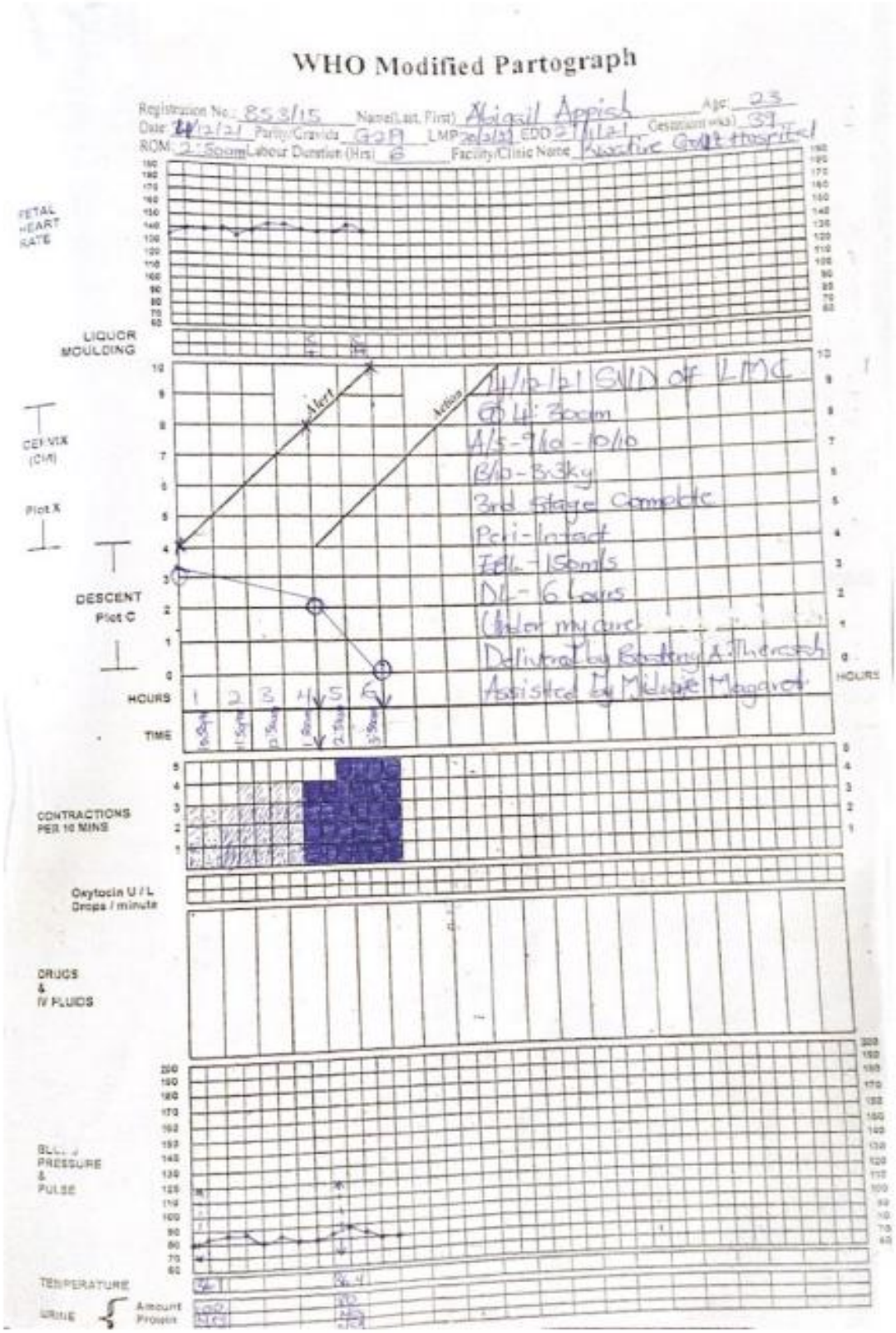
PHARMACOLOGY OF DRUGS USED CONTINUED (MOTHER)

NAME OF DRUGS	CLASSIFICATION	DOSAGE	ROUTE OF ADMINISTRATION	ACTION & USE	ACTUAL EFFECTS	SIDE EFFECT OF DRUGS	SIDE EFFECT EXPERIENCED
Injection oxytocin	Oxytocic drug	10 units	Intramuscularly	Stimulate uterine contractions	Client had good uterine contractions and bleeding was controlled	Nausea and vomiting	None

APPENDIX III

PHARMACOLOGY OF DRUGS USED (BABY)

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


WHO Modified Partograph
Registration No.: 853/15
Name(Last, First): Abigail Appiah
Age: 23
Date: 24/12/21
Parity/Gravida: G2P1
LMP: 26/3/21
EDD: 2/1/22
Gestation (wks): 39
ROM: 2:50pm
Labour Duration (Hrs): 6
Facility/Clinic Name: Bawaleshie Govt Hospital
FETAL HEART RATE
LIQUOR MOULDING
CERVIX (CM)
Plot X
DESCENT
Plot O
Alert
Action
24/12/21 SVD of LMC
@ 4: 30cm
A/S - 9/d - 10/10
B/b - 3.3kg
3rd Stage Complete
Peri-Intact
EBL - 150mls
DL - 6 hours
Under my care
Delivered by Bentum A. Theresah
Assisted by Midwife Margaret
HOURS
TIME
CONTRACTIONS PER 10 MINS
Oxytocin U / L
Drops / minute
DRUGS & IV FLUIDS
BLOOD PRESSURE & PULSE
TEMPERATURE
URINE
Amount
Protein

LABOR NOTES

Client G2P1 reported to the Facility with the complaint of labour pains, client labour progressed well with second stage and client had SVD of live male infant with A/S of 9/10 - 10/10. Im Oxytocin 10 Unit was given to client within one minute after birth, third stage of labour was conducted successfully by active management of third stage (AMTSL) at 11:35am. Client and baby were comfortable in bed. Skin to skin contact was observed.

Please circle or write responses.

DELIVERY

DATE 4/12/21 TIME: 4:30am METHOD: Spontaneous / Vacuum Extraction / C/S / Other

PERINEUM: Intact / Episiotomy / Laceration

ANESTHESIA: None / Local / General

THIRD STAGE

Active Management: Yes / No Medication: Time 11:35am Type/Dose Oxytocin 10 Units

PLACENTA: TIME: 11:30am Complete / Incomplete

BLOOD LOSS AMOUNT: (150ml) Small (Less than 250 cc)
Moderate (250-499 cc)
Large (more than 500 cc)
Significant for mother

BABY

Weight: 8.3kg

Sex: Male / Female

Baby Position: Vertex / Breech / Other

APGAR

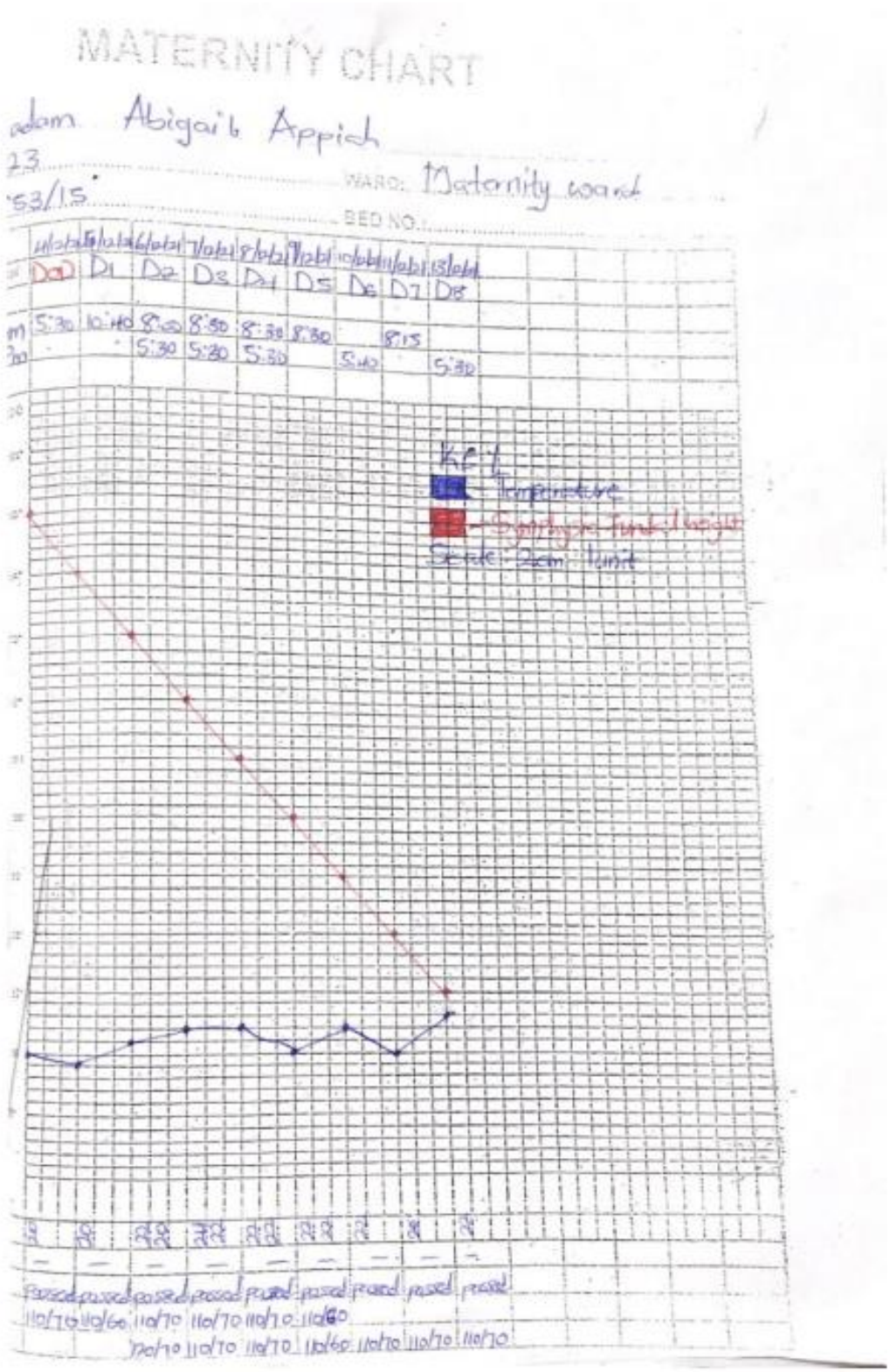
Time	Color	Breath	Heart	Tone	Reflex	TOTAL
1min	2	2	2	1	2	9/10
5min	2	2	2	2	2	10/10

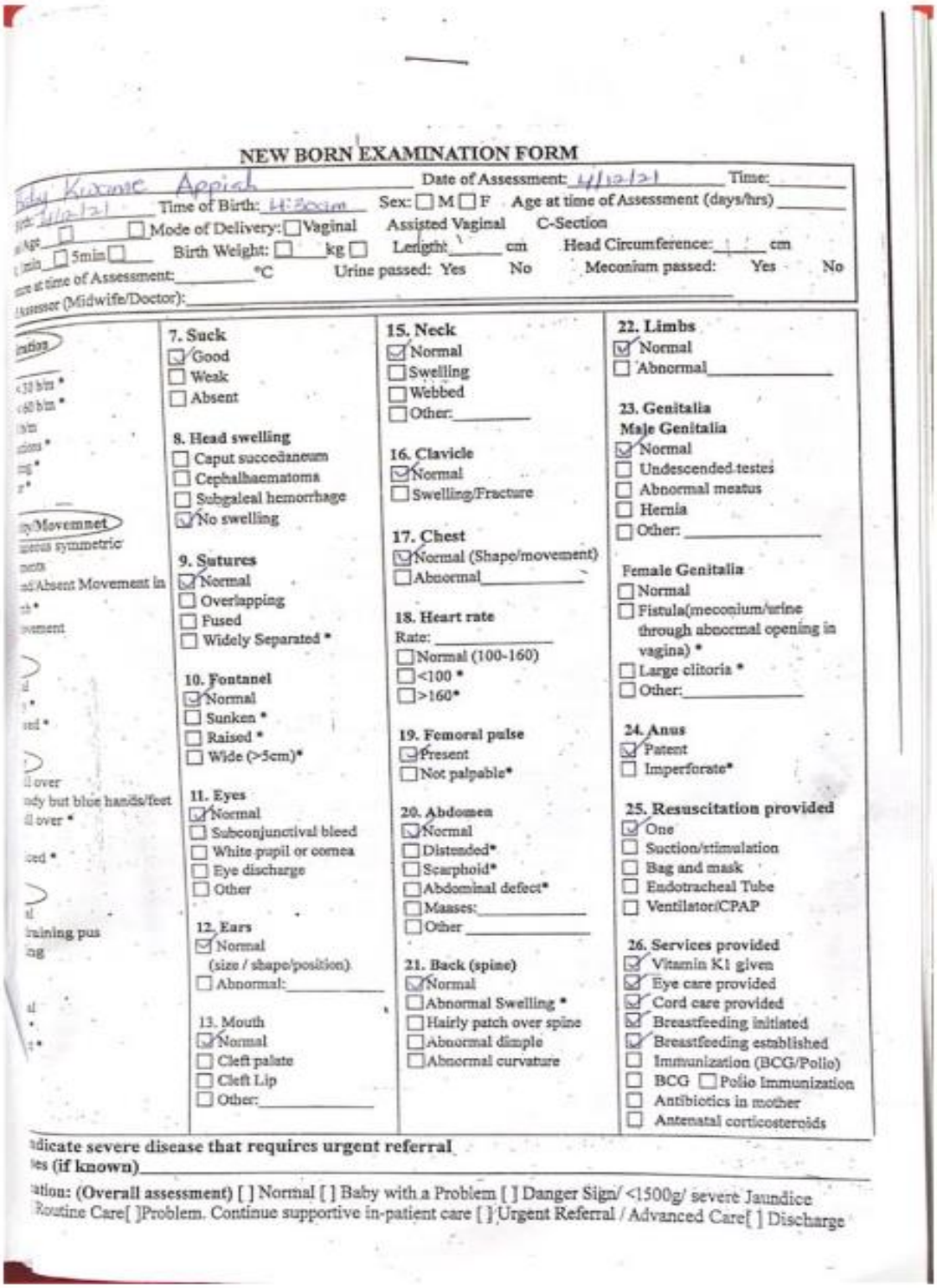
COMPLICATIONS OF MOTHER / BABY: None / Other:

FOURTH STAGE MONITORING

Frequency	Time	B/P.	Pulse	Fundus	Bleeding	Bladder
Every 15 minutes first 2 hours	5:15am	116/80	84			
	5:30am	120/68	82		15	
	5:45am	116/80	80		5	
	6:00am	110/80	81		50	
	6:15am	111/64	79		5	
	6:30am	120/70	85		3	
	6:45am	110/80	88		4	
	7:00am	100/60	89		4	
Every 30 minutes For 1 hour	7:30am	120/70	88		0	
	8:00am	118/80	85		2	

Birth Attendant Theresa A. Boateng & Midwife Margaret Date 4/12/21


MATERNITY CHART
adam Abigail Appiah
23
53/15
WARD: Maternity ward
BED NO.:
D1 D2 D3 D4 D5 D6 D7 D8
5:30 10:40 8:30 8:30 8:30 8:30 8:15
5:30 5:30 5:30 5:40 5:30
Key
Temperature
Symphysio-fundal height
Scale: 2cm: 1unit
Passed passed passed passed passed passed passed passed
110/70 110/60 110/70 110/70 110/70 110/60
120/70 110/70 110/70 110/60 110/70 110/70 110/70



NEW BORN EXAMINATION FORM

Baby Kwame Appiah Date of Assessment: 4/12/21 Time:
Date: 4/12/21 Time of Birth: 11:30am Sex: ☐ M ☐ F Age at time of Assessment (days/hrs)
Age ☐ Mode of Delivery: ☐ Vaginal Assisted Vaginal C-Section
min ☐ 5min ☐ Birth Weight: ☐ kg ☐ Length: cm Head Circumference: cm
ure at time of Assessment: °C Urine passed: Yes No Meconium passed: Yes No
Assessor (Midwife/Doctor):

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:
☐ Normal (100-160)
☐ <100 *
☐ >160*

19. Femoral pulse
☑ Present
☐ Not palpable*

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

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

22. Limbs
☑ Normal
☐ Abnormal

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

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

24. Anus
☑ Patent
☐ Imperforate*

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

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

dicate severe disease that requires urgent referral
es (if known)

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

NEW BORN EXAMINATION FORM

Name: Baby Kwame Appiah Date of Assessment: 4/12/21 Time:
Date of Birth: 4/12/21 Time of Birth: 2:30am Sex: ☑M ☐F Age at time of Assessment (days/hrs)
Astational Age ☐ ☐ Mode of Delivery: ☐Vaginal Assisted Vaginal C-Section
APGAR: 1min ☐ 5min ☐ Birth Weight: ☐3.5kg ☑ Length: 54 cm Head Circumference: cm
Temperature at time of Assessment: °C Urine passed: Yes No Meconium passed: Yes N
Name of Assessor (Midwife/Doctor):

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

2. Activity/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

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- ☑ Patent
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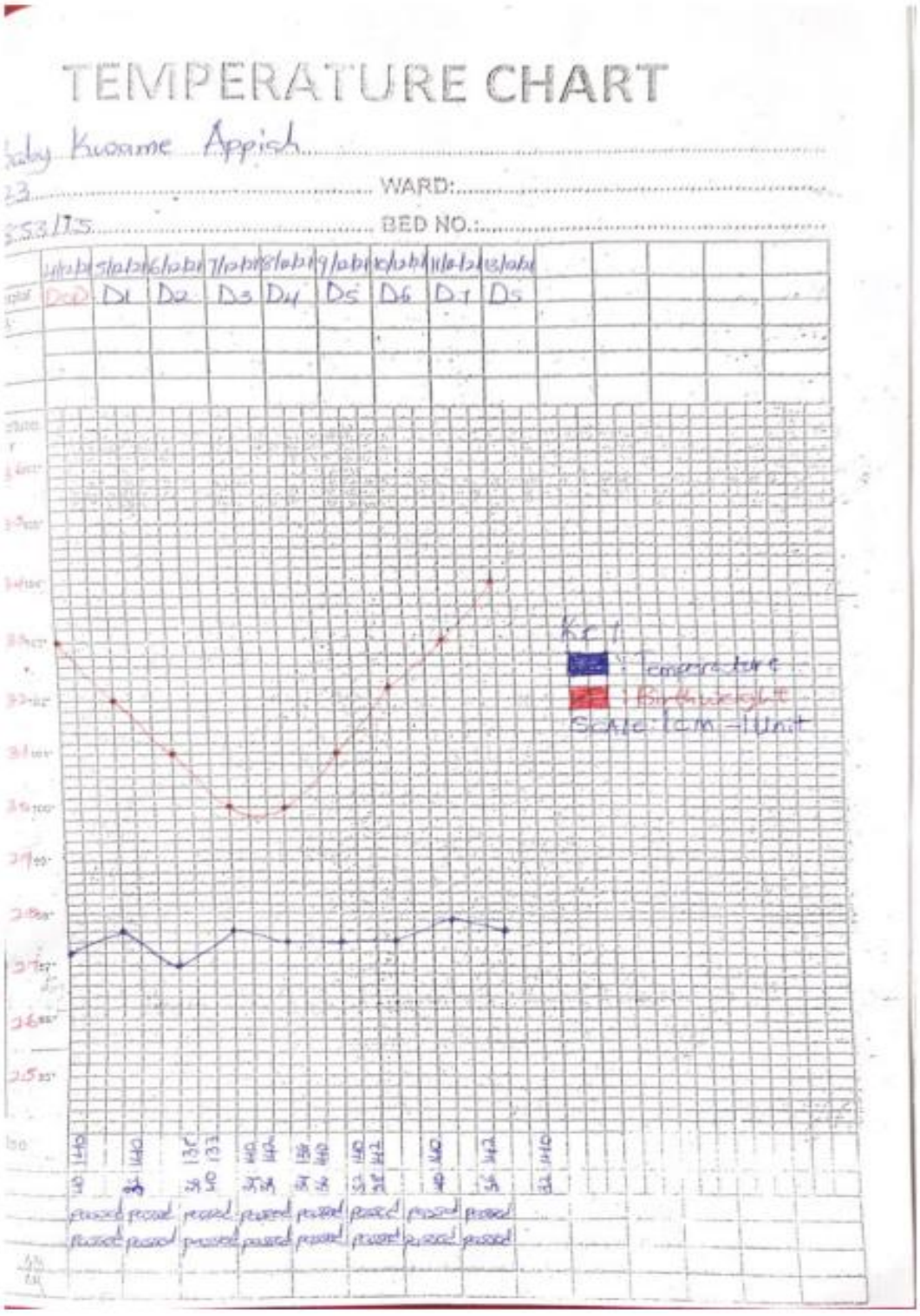
- ☐ Breastfeeding established
- ☑ Immunization (BCG/Poli
- ☑ BCG ☐ Polio Immuniza
- ☐ Antibiotics in mother
- ☐ Antenatal corticosteroids

*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[ ] Dischar


TEMPERATURE CHART
Baby Kwame Appiah
WARD:
BED NO.:
D1
D2
D3
D4
D5
D6
D7
D8
Key
Temperature
Birthweight
Scale: 1cm = 1Unit

NEW BORN CHART

Name: Baby Kwame Appiah ..... No: ..... Birth Weight: 3.3 kg .....

Sex: Male ..... Mother's No: 8.53/15 ..... Length: 54 cm .....

Nature of Delivery: Spontaneous Vaginal Delivery ..... Diagnosis: Term Baby .....

Date of Birth: 4/12/21 ..... Time: ..... Date of Discharge: 4/12/21 .....

Date	4/12/21		5/12/21		6/12/21		7/12/21		8/12/21		9/12/21		10/12/21		11/12/21		13/12/21					
No. of Days	D0		D1		D2		D3		D4		D5		D6		D7		D8					
Weight	3.3 kg		3.2 kg		3.1 kg		3.0 kg		3.0 kg		3.1 kg		3.2 kg		3.3 kg		3.4 kg					
	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM
Temperature	36.6°C		36.8°C	37.0°C	36.5°C	36.7°C	36.8°C	36.5°C	36.7°C	36.5°C		36.7°C		36.7°C		36.7°C		36.9°C				
Stools	passed		passed	passed	passed	passed	passed	passed	passed	passed		passed		passed		passed		passed				
Urine	passed		passed	passed	passed	passed	passed	passed	passed	passed		passed		passed		passed		passed				
Remarks	Head Neck Trunk Limbs: No Abnormalities Detected.																					

SIGNATORIES

CANDIDATE NAME

NAME: AYIWA-BOATENG THERESAH

SIGNATURE: .....

DATE: 5/10/2022

THE MIDWIFE IN- CHARGE

NAME: MS SUSANA YELI

SIGNATURE: ..... (Sick)

DATE: 5/10/2022

SUPERVISOR

NAME: MS. ERNESTINA MENSAH

SIGNATURE: .....

DATE: 7/10/2022

THE PRINCIPAL

MONICA NKRUMAH

SIGNATURE: .....

DATE: 10/10/22

STAMP.....