HOLY FAMILY NURSING AND MIDWIFERY TRAINING COLLEGE

BEREKUM

A CLIENT/FAMILY CENTERED MATERNITY CARE STUDY ON MADAM MONICA ANINIWAA

BY

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

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PREFACE

The Client/Family Centered Maternity care study is a systematic and a holistic obstetric nursing care rendered to a pregnant woman and her family throughout pregnancy, labour and puerperium so as to enhance quality health services and client satisfaction. The Client/Family Centered Maternity care study enables the student midwife to put into practice her acquired Knowledge in the classroom and to identify client's problem and also use partograph which is tested and recommended by the World Health Organization (WHO) in order to manage a labouring woman and to detect deviation early. The Client/Family Centered Maternity care study enables the student midwife to put into practice the Safe Motherhood initiative which has been adopted by the Ghana Health Service in order to help reduce the maternal morbidity and mortality among pregnant women to render quality health care through antenatal, labour and puerperium. Last but not the least, it helps the student midwife to gain knowledge in the changes that has brought about new management ideas and quality assurance in the various hospitals, clinics and maternity homes. Lastly, The Client/Family Centered Maternity care study is a required study that every final year student of Registered Midwifery program is supposed to undertake to satisfy the Nursing and Midwifery Council to help contribute to the award of Registered Midwifery License to Practice. Index Number: 4122180070

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INTRODUCTION

The Client/family Centered Maternity care study is a tool that enables the student midwife to put into practice the knowledge and skills acquired in the course of her study or training. This Client/family Centered Maternity care study was carried out on Madam Aniniwaa, a 32years old woman, gravida3 para 2^{AA} during the period of pregnancy, labor and puerperium. The interaction with her started on the 26 October,2021 when she came for routine antenatal visit at the Chiraa health center, which is in the Bono Region. She was in her 36^{th} week gestation. After an interaction for about 15 minutes, she was told about the intention to use her for a study which she gladly accepted. She was visited at home to know her family, assess her environment and the community in which she lives. She was given the required education, support and management throughout the study. Problems identified during pregnancy, labour and puerperium were managed by the use of the nursing process. This care study also helped in identifying and giving treatment as well as provision of psychological and emotional support to Madam Aniniwaa. She was also taught how to initiate breastfeeding and how to subsequently care for the baby. She went through pregnancy successfully and delivered a healthy baby girl on 20^{th} November, 2021 without any complications to both mother and baby. This study is grouped in to four (4) chapters. Chapter one talks about client's particulars and various histories. Chapter two is about antenatal care and home visits made to client's house. Chapter three talks about the care given to client during labour, delivery and immediate care of the baby. Chapter four entails the care given to client during puerperium and finally a care plan to chapter two, three and four drawn to identified problems and their management, it also includes summery and conclusions. At the tail end are the following appendix in order; bibliography, maternal antenatal chart, the partograph, maternity sheet, and the ANC records of the woman.

LITERATURE REVIEW

PREGNANCY

Tiran (2008) defines pregnancy as a condition of having a developing embryo or fetus within the body. It is the state from conception to the delivery of the fetus. The normal duration is about 280 days, 40 weeks or 9 months and 7 days counted from the first day of the last menstrual period to delivery.

Henderson and Macdonald (2009) states that pregnancy is the carrying of one or more offspring/fetus in the uterus of a woman. Pregnancy can be single, multiple or triplet. It usually last 38 weeks after conception in a woman who have a menstrual cycle length of four weeks and this is approximately 40 weeks from the last menstrual period. This is established by a detailed history and relevant clinical examination based on the signs and symptoms of pregnancy. The signs and symptoms of pregnancy are; waist pain, abdominal pain, loss of appetite, amenorrhea, breast changes, nausea and vomiting, increased frequency of micturition, enlargement of the uterus, skin changes and quickening. These signs will become obvious to the woman in sequential stages. The signs and symptoms of pregnancy may be considered as presumptive, probable and positive.

Jayne Marshall and Maureen Raynor (2009) defines pregnancy as the state of carrying a developing fetus within the body. When pregnancy occurs, menstruation ceases and returns some weeks after delivery during the postnatal period. It further states that all the changes in the mother's body during pregnancy are due to the effects of specific hormones. During pregnancy, progesterone and estrogen levels rise. The raised progesterone and estrogen levels also causes some changes in the muscle layer and the epithelium of the vagina such as thicker and viscous mucous helping to prevent ascending infection as well as enlargement of the breast and other organs in order to support fetal development and growth. Changes

experienced in a woman emotional state are due to hormonal factors examples of these hormones are progesterone, estrogen, and human chorionic gonadotrophin.

Ghana Health Service (2008) states that antenatal care is the health care and education given during pregnancy and is important since they help prevent complications and promote health care. It further states that the objectives of antenatal care include;

1) To promote and maintain the physical, mental and social health of mother and baby by providing education to the pregnant mother on nutrition, rest, sleep, personal hygiene, family planning, immunization, danger signs, STIs, HIV/AIDS, birth preparedness and complication readiness.
2) To detect and treat high risk conditions arising during pregnancy, whether medical, surgical or obstetric.
3) To ensure the delivery of a full term healthy baby with minimal stress or injury to mother and baby.
4) To help prepare the mother to breastfeed successfully, experience normal puerperium and take good care of the child physically, psychologically and socially.
5) To ensure safe delivery and postpartum health.
6) To promote quality care, antenatal care services must be organised in such a manner as to provide comprehensive and individualised care. As much as possible all care activities should be provided by the same care provider to the pregnant woman (Focused Antenatal Care).

The protocol further states that, the number of times a client needs to be seen during pregnancy may vary, but for an uncomplicated pregnancy, it is recommended that at least four antenatal visits should be made. Some cares rendered at Antenatal Clinic include: antenatal exercises, physical examination. The aim of antenatal care is to monitor the progress of pregnancy to optimize maternal and fetal health. It is essential that, the midwife critically evaluates the physical, psychological and sociological effects of pregnancy on the woman and her family.

LABOUR

According to Ghana Health Service (2008), normal labour begins when there are regular, painful, rhythmic uterine contractions lasting at least 20 seconds (timed by a trained observer), occurring at a frequency of at least two contractions in every 10 minutes and with a cervical dilatation of at least 3cm. It further explained that there are four stages of labour described as follows, first stage: This starts from the onset of labour till the cervix is fully dilated and it is accompanied with painful rhythmic regular uterine contractions. It lasts for 6 to 10 hours in multigravidas and 12 to 14 hours in primigravidas. Partograph is used to manage the first stage of labour (during the active phase). Second stage: This 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 multipara and 60 minutes in nullipara respectively. Third stage: This stage starts after delivery of the baby and ends with delivery of the placenta. It marks the separation and complete expulsion of the placenta and its membranes from the birth canal as well as control of bleeding after the expulsion. Fourth stage: It is the first six hours following the birth of the placenta and control of hemorrhage. It deals with vigilant observation of both mother and baby immediately after the third stage of labour till the first six hours after deliver. Also mentioned specific objectives during labour and delivery and these include;

1. Proper management of the four stages of labour.
2. Early identification and proper management of complications.

Jayne Marshall and Maureen Roynor (2009) described labour as the process by which the fetus, placenta and membranes are expelled through the birth canal. She also stated that, labour is divided into four (4) stages, these are: first stage which deals with the onset of painful rhythmic uterine contractions and dilatation of the cervix, second stage deals with full dilation of the cervix and expulsion of the fetus, third stage is the delivery of the placenta, membranes and the control of hemorrhage, last but not the least, fourth stage of labour is the

closed monitoring of mother and baby for the first one hour following the delivery of placenta to the next six hours post-delivery. Labour begins with the first uterine contraction, continues with hours of hard work during cervical dilatation, birth of the baby and ends as the woman and her significant others begin the attachment process with the new born. He stated that five factors affect the process of labour and birth. These are the passenger which include the fetus and placenta, passenger way which is the birth canal, powers which is the contractions, position of the mother and physiological responds. He further identifies the stages of labour as follows; the first stage of labour begins with the onset of regular uterine contractions, effacement, dilatation of the cervix and progress in descent of the presenting part. Again the first stage of labour has been divided into three phases namely; the latent phase where there is more progress in effacement of the cervix and little increase in descent. Active phase and transitional phase where there is more rapid dilation of the cervix and increase rate of the descent of the presenting part. The second stage of labour is the stage in which the infant is born. This stage begins with full cervical dilation (10cm) and complete effacement (100%) and ends with the baby's birth. He further explained that, the second stage takes an average of 20minutes for a multiparous women and 50 minutes for nulliparous women but labor of up to 2hours has been considered within the normal range for second stage. The third stage of labour last from the birth of fetus until the placenta is delivered. He stated that, the placenta normally separates with the third or fourth strong uterine contractions after the infant has been born. The duration of third stage may be as short as 3 to 5 minutes although up to 1 hour is considered within normal limits. Lastly, the fourth stage of labor last for 2 hours after delivery of placenta. It is the period of immediate recovery when homeostasis is re-established. It is an important period of observation for complications such as bleeding.

Henderson (2009) states that normal labour naturally follows a sequential pattern that involves painful regular uterine contractions stimulating progressive effacement and dilatation of the cervix and descent of the fetus through the pelvis, culminating in the spontaneous vaginal birth of the baby, followed by the expulsion of the placenta and membranes. It's also states the following under vaginal examination; this procedure is one of the options to help confirm the onset of labour. However, it is invasive and often very uncomfortable for the women and also poses a potential infection risk. Women may request it in seeking reassurance about the status of labour. The aims of midwifery care in labour are to achieve a safe labour and birth for mother and baby, and a pleasurable, fulfilling experience of child birth for the mother and her partner in order to give woman-centered care, the midwife should: Assess the needs and expectations of each individual woman regarding labour and birth. Plan care with each woman in labour that is tailored to meet her specific needs and expectations Put the care plan into practice, and evaluate the care given to measure its effective. Also states the following under vaginal examination; this procedure is one of the options to help confirm the onset of labour. However, it is invasive and often very uncomfortable for the women and also poses a potential infection risk. Women may request it in seeking reassurance about the status of labour.

Ojo (2006) defines labour as the process by which the uterus empties its content after the 38th week of pregnancy. It entails the contraction and retraction of the uterine muscle fibers, the dilation of the cervical os and the expulsion of the baby liquor amini, placenta and its membranes.

Tiran (2008), stated that, normal labour occurs spontaneously between 37 and 43-weeks' gestation with a vertex presentation of a single fetus and is completed within 24 hours without maternal or fetal trauma.

PUERPERIUM

According to Jayne Marshall and Maureen Raynor (2009) puerperium starts immediately after delivery of the placenta and membranes and continues for six weeks. The overall expectation is that by 6 weeks after the birth, all the systems in the woman's body will recover from the effects of pregnancy and return to their non-pregnant state, lactation is established and a new infant accepted into the family. She also said 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. Further explained that after delivery the uterus is palpated at the level of the umbilicus. If the uterus is then palpated on each successive day, it is found to be fingerbreadth lower in the abdomen at each examination. By the 10^{th} day it can no longer be palpated abdominally because anteversion and antiflexed are almost complete. She also explained that during puerperium that breastfeeding is initiated and established. Proper fixation of the baby to breast and complete emptying of the breast are needed to maintain lactation during puerperium. There are three types of lochia namely; **Lochia rubra**: which consist of blood shreds of fetal membranes and decidua, vernix caseosa, lanugo and meconium. It is red in colour and it last for the first 1-4 days.

Lochia serosa: which consist of less red blood cells but more leukocytes, wound exudates, mucous from the cervix. It lasts for 5-9 days and it is yellowish or pink or pale brownish.

Lochia alba: contains plenty decidua cells, leukocyte, mucous, cholesterol crystals fatty and granular epithelial cells. It last for 10-15 days and it is pale white in colour.

According to Henderson (2009), puerperium is traditionally defined as the time from immediately after the end of labour until the reproductive organs have returned as nearly as possible to their pregravida condition, a period estimated to be around 6 weeks. The

following are some of the aims of postnatal care, the successful achievement of which will result from the contribution to care made by the midwife and other members of the multidisciplinary healthcare team.

- To assist the woman with the successful establishment of her infant breast feeding.
- To help the woman adapt to and successfully fulfill the role and responsibilities of motherhood. Also promote and monitor the woman and the infant's physical well-being and to promote and monitor the woman's psychological well-being. Again, it fosters good family relationships.
- To educate the woman and her family in the needs and development of the infant.
- It also enhances the woman's confidence in her ability to fulfill her role as a mother to promote health education.

During the puerperium the following physiological changes take place in all women as the body returns to its pre-pregnant state: Involution of the uterus and other soft parts of the genital tract. Commencement of lactation and Physiological changes in other systems of the body. It is important that the midwife is familiar with these to ensure that appropriate care and advice are given. 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. Its further states that, the falling progesterone levels affect the alimentary tract. The smooth muscle tone gradually improves throughout the body, and symptoms of heartburn the woman may have experienced should resolve. Constipation may however remain a common problem during the postnatal period.

Ojo and Briggs (2006) confirm this definition and added that, puerperium last for six weeks after delivery of the placenta and membranes, and arresting hemorrhage. The first seven days of puerperium is referred to as the lying-in-period where close observation and care of the

mother and baby is done. During this time involution of the uterus takes place where frequent breastfeeding is done to cause the release of oxytocin which enables the uterus to contract causing it return to the pre-gravid state. During puerperium the bruises heal and the genital organs and any other organ which underwent changes during pregnancy return to the gravid state. Lactation is also established during this period. It further stated some aims of postnatal care as;

- ❖ To promote and monitor the woman's and the infant's physical wellbeing.
- ❖ To assist the woman with the successful establishment of her infant feeding
- ❖ To educate the woman and her family in the needs and development of the infant
- ❖ To foster good family relationships
- ❖ To enhance the woman's confidence in her ability to fulfill her role as a mother.

Ghana Health Service (2008) states that Puerperium is the period from the end of delivery to 6 weeks after delivery and goes on to further states that the purpose of postnatal care is to maintain the physical and psychological well-being of both mother and child.

The aims of puerperium include:

1. To encourage exclusive breastfeeding as well as the establishment of a bond between mother and child.
2. To promote and also maintain the health of both mother and child.
3. To supervise the mother to successfully adopt 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.

Also enumerates that there are 3 types of lochia namely; **Lochia rubra:** it is seen in the first 3 days and consists of blood serum, trophoblastic debris and may contain some small clots. It is bright red in colour **Lochia serosa**: it is seen during the next 4-9 days and consists of blood serum, leucocytes and tissue debris. It is pinkish in colour.

Lochia alba: it is seen after10 days and consists of leucocytes, decidua's epithelial cells and cervical mucus. It is pale white and continues for 10-15 days. The average amount of discharge of the first 5-6 days is estimated to be 250m

According to Tiran, (2008) puerperium is defined as a period following childbirth, which the uterus and it organs and structures are returning to the non-pregnant state, spans 6weeks post-delivery.

WHY CLIENT WAS CHOSEN

Madam Aniniwaa, Gravida3 Para 2^{AA} with 36+2 weeks' gestation was chosen as a client for the client/family centered maternity care study on the 26/10/2021 at Chiraa health center, which happened to be her seventh visit to the antenatal clinic in the morning. When her antenatal record was glanced through, she had a very good obstetrical history. During the antenatal sessions, Madam Aniniwaa, approached me with her anxiety level relating to lower abdominal pain and persistent waist pains. Madam Aniniwaa was encouraged and reassured that, her condition would be managed. Madam Aniniwaa was also a regular antenatal attendant and presumably, her labour will be uneventful. An opportunity was then taken for introduction as a student midwife from the Holy Family Nursing and Midwifery Training College, Berekum on district midwifery practice and she was informed that she would be taken as a client for the study and that she would be monitored for the rest of her pregnancy, through labour and puerperium and she agreed. She was thanked for her understanding and cooperation. The Midwife In-Charge was informed and permission was granted. She gave the direction to her house after home visits was discussed, phone numbers were also exchanged and client was seen off.

CHAPTER ONE

ASSESSMENT OF CLIENT AND FAMILY

1.0 INTRODUCTION

This chapter gives detailed information about the client's personal history, social history, family history, menstrual history, surgical history, past and presents obstetric histories and her habit of daily living.

1.1 PERSONAL AND SOCIAL HISTORY

Madam Aniniwaa is the name of the client chosen. She is G3 $P2^{AA}$ and 32 years of age. Client comes from Chiraa, a town in the Sunyani West in the Bono Region of Ghana. She stays with her partner and 2 daughters. She is dark in complexion, weighed 90 kilograms and 160 centimeters tall at booking. She is a Christian by religion and worships at the church of Pentecost Ghana at Chiraa. Madam Aniniwaa had her formal education up to junior high level and she has a partner by name Mr. Obeng Isaac, who is a driver and also a Christian. Madam Aniniwaa is a farmer. She speaks Twi. Madam Aniniwaa mentioned Mr.Obeng Isaac her husband, as her next of kin and she is supported by her family. Madam Aniniwaa, her partner and 2 children live together.

1.2 FAMILY HISTORY

According to Madam Aniniwaa, she said God blessed her parents with four children and she is the first born among the four. She said three are females and the remaining one is a male. Her father's name is Opanin Yaw Nsia and her mother's name is Madam Abena Grace who are both farmers and natives of Chiraa. According to Madam Aniniwaa, her family has no history of diseases like; hypertension, leprosy, epilepsy, sickle cell disease, diabetes, heart or liver diseases and mental illness. She said there is no history of any congenital abnormalities like cleft palate or cleft lip, hydrocephalus, spinal bifida and imperforate anus in her family

but has a history of multiple pregnancies. She also added that, both parents and all her siblings are alive.

1.3 MEDICAL HISTORY

According to Madam Aniniwaa, she has no known medical disease such as Hypertension, Heart disease, Sickle Cell Disease, Diabetes, Epilepsy, HIV infection, Respiratory disease, Tuberculosis, Mental illness, Asthma and others. She said she has no known allergies to any drug or food and she visits the antenatal clinic with the use of the National Health Insurance Scheme (NHIS)

1.4 SURGICAL HISTORY

According to Madam Aniniwaa, she has never undergone any surgical operation and has never sustained any injury in the pelvic before. She has no history of any road traffic accident neither has she donated blood nor has been transfused before. She said she was not given any episiotomy during her previous deliveries too.

1.5 MENSTRUAL HISTORY

Madam Aniniwaa had her menarche at the age of 12. Her regular menstrual cycle is 28 days which flows moderately for five days. She uses sanitary pad during the flow and changes it two times daily. She has no history of dysmenorrhea and uses only the natural method of family planning. Her last menstrual period was on 10th February 2021 and her expected date of delivery was 17th November 2021, when calculated.

1.6 CLIENT LIFESTYLES AND HOBBIES

Madam Aniniwaa wakes up around 5:30am every day. When she wakes up, washes her face and brush her teeth with tooth paste and tooth brush. She then sweeps her compound and empties her dustbin. She also empties her bowel two times a day when she feels the urge to. She mostly washes her utensils in the evening after supper. She prepares breakfast, bath her children and prepared them for classes since school has being close due to COVID-19.

Madam Aniniwaa takes her bath twice daily. She eats three times a day with her favorite food being fufu with palm nut soup. She does her washing on Saturdays but do wash on weekdays sometimes when the need arises. On Sundays, she goes to church with her children together with her husband adhering to all the COVID 19 protocols. She is sociable and neither smokes nor takes in alcohol. She also scrubs her bathroom and toilet every Saturday. Madam Aniniwaa has a good cordial relationship with her relatives as well as the people in her neighborhood. According to her, her partner usually goes for work around 7:30am and returns home around 5:00pm.

1.7 PAST OBSTETRIC HISTORY

PREGNANCY

Madam Aniniwaa is Gravida 3 Para 2^{AA} and carried her previous pregnancies up to term without any complications. Madam Aniniwaa said she had two years intervals between her previous pregnancies and that her third pregnancy is one year interval and experienced minor disorders such as frequent micturition, nausea, vomiting and backache during her past pregnancies. She had her first and second dose of tetanus diphtheria vaccination during her first pregnancy, then the third dose during the second pregnancy and all the five doses of anti-malaria prophylaxis (Sulphadoxine Pyrimethamine) during her previous pregnancies. She has no history of abortion, no history of any pregnancy induced diseases (e.g. hypertension, diabetes, and anemia).

LABOUR

Madam Aniniwaa said her children were delivered per vaginum (spontaneous vaginal delivery) at the Municipal Hospital Sunyani with no tears or episiotomy. Client said that, the duration of her labour was less than 24 hours in both cases. She said the placenta was delivered few minutes after the delivery of the babies without any complications such as post-partum hemorrhage.

PUERPERIUM

Madam Aniniwaa said the babies were in good condition after delivery. She said she breastfed few minutes after delivery in the labour ward. Madam Aniniwaa said that her children cried immediately after they were born and they had no congenital abnormalities like, cleft palate, cleft lips, imperforate anus, extra digits and had no ill health such as puerperal psychosis, anaemia, malaria, puerperal pyrexia, puerperal sepsis, mastitis after delivery. Madam Aniniwaa said her children were fully immunized against the childhood preventable diseases as she attended weighing and also practiced exclusive breastfeeding in both cases. She also said her family supported in the care of her children. and she did not experience any puerperal psychosis.

1.8 PRESENT OBSTETRIC HISTORY

Madam Aniniwaa, $G3P2^{AA}$ began her antenatal clinic attendance on 13/04/2021 at the Chiraa Health Center with early cyesis, history was taken by the midwife in charge. She gave her last menstrual period as 10/02/2021 and her expected date of delivery was calculated to be 17/11/2021. She was then given an antenatal record book to go for a National Health Insurance Card. The results of the laboratory investigations that were carried out on her were documented as follows;

Hemoglobin	13.4 grams per deciliters
Sickling test	Negative
Blood group	O
Rhesus factor	Positive
Urine for protein and sugar	Negative
PMTCT	Non-reactive
VDRL	Non-reactive
Hepatitis B	Negative

HIV status	Negative
G6PD	Negative
Stool test	No abnormality detected

Vital signs were checked and recorded as follows:

Temperature	36.0 degree Celcius
Pulse	78 beat per minute
Respiration	20 cycle per minute
Blood Pressure	120/80 millimeter per mercury
Height	160 centimeters
Weight	90 kilogram

Head to toe examination was carried out and no abnormality was detected. On palpation, the uterus was palpable and she was 18 weeks of gestation, there was no descent and fetal heart rate was positive. She gave no complaint and the following routine drugs were given;

Tablet Folic Acid	5 milligrams daily for 30 days
Tablet Ferrous Sulphate	200 milligrams daily for 30 days
Tablet Multivite	daily for 30 days
Tablet Vitamin C	daily for 30 days

Client was encouraged to take her drugs as ordered. She was given her 4th dose of tetanus vaccination and took the first dose of Sulphadoxine Pyrimethamine on Direct Observation Therapy (DOT). She was educated on danger signs of pregnancy such as severe headaches, excessive vomiting, bleeding, oedema, paleness, and the need to prevent herself from getting malaria by sleeping under a treated insecticide mosquito net at night, and the application of mosquito repellent whilst outside her room especially in the evenings. Since then she has been regular for antenatal care and all findings from the various examination have been within normal ranges as of the day she was met.

CHAPTER TWO

ANTENATAL CARE

2.0 INTRODUCTION

This chapter is about the antenatal care given to the client. This includes the first contact with the client, subsequent visit to the clinic, home visits during antenatal period and a care plans drawn to solve all problems faced by the client.

2.1 FIRST CONTACT WITH THE CLIENT

The first contact with Madam Aniniwaa was on the 26/10/2021 when she was coming for her routine antenatal follow up at Chiraa Health Center with 36 weeks' gestation. Clients were educated on prevention of malaria and birth preparedness and complication readiness during pregnancy and she contributed so much during the discussion. During the antenatal sessions, Madam Aniniwaa complained of lower abdominal pain and persistent waist pain. Madam Aniniwaa was encouraged and reassured that, her condition would be managed. When it got to her turn, she came into the consulting room with her antenatal card which was collected and glanced through. An opportunity was taken and an introduction was made to her as a student midwife from Holy Family Nursing and Midwifery Training College Berekum, and an interest was expressed for client to be used for care study which she accepted. She was encouraged not to hesitate in giving out any needed information about her problems and also ask questions. Her vital signs were checked and recorded as;

Temperature	36 .5 degrees Celcius
Pulse	80 beats per minute
Respiration rate	24 counts per minute
Blood Pressure	120/70 millimeters per mercury
Weight	100 kilograms
Urine	protein/sugar) Negative/Negative

The results of the various laboratory investigations done were as follows

Hemoglobin	11.6grams per deciliters
Malaria Parasite	Not present

Head to toe examination was explained to her which she consented. She was later sent to the palpation room for various examinations to be conducted on her. All the necessary requirements needed for the examination were gathered and sent to the examination room. Privacy was provided by closing the windows and door and client was assisted to undress and asked to empty her bladder. She sat on the couch and lied laterally. Client then assumed a supine position. Hands were washed under running water with soap and dried with clean towel.

HEAD TO TOE EXAMINATION

On the head, the hair was inspected for the presence of dandruff, lice, and infections of the scalp and none of these ware seen. Client was encouraged to continue to keep her hair clean and neat always. There was no edema, or rashes on the face during examination. The conjunctiva was not pale neither were there discharges and redness of the eyes. The ears were examined for discharges and checked if is in alignment with the contour of the eyes. The nose was checked for discharges and congestion but there was none. The lips were checked for cracks, pallor, dryness, sore and lesions but none was detected. The mouth was also inspected for inflammation of the gum, sore of the mouth and teeth for tooth decay but none was seen. The neck was inspected and palpated for enlarged lymph nodes, thyroid gland and distended vein, rigidity or pain but none was detected. Breast examination was done and her breast was exposed and inspected for the size, shape and state of the skin. The nipples for retraction, inversion or dirt but no abnormality was detected. The left breast was examined whiles her left hand was placed under the head and the right hand was also placed under the head during examination of the right breast. The breasts were palpated systematically in a circular manner

using the inner aspect of the fingers for any lumps and swollen axillary lymph nodes but no abnormalities detected. She was taught how to perform self-breast examination. The areolar were squeezed gently and cleaned with swabs to see if there is any abnormal discharges but no abnormality was detected. The nipples were prominent and centrally situated. She was encouraged to examine her breasts regularly and report any abnormalities earlier to the clinic. The upper extremities were in alignment with the body on inspection. There is no extra or missing digit on the fingers on inspection. The lower extremities were also inspected for edema, varicose veins, cuff muscle tenderness but none was identified and they were of equal length and size. Client was asked to turn and the back inspected but no abnormality such as costovertebral angle tenderness was not detected.

Abdominal Examination

Abdominal examination was preceded by abdominal inspection**.** The abdomen was ovoid in shape, medium in size and fetal movement ware also visible and there were no scar indicating previous operation. There was however the presence of linear nigra and striae gravidarum on her abdomen.

On fundal palpation, client was faced and the fundus was palpated with both palms on either side of the fundus. The fingers curved around the top of the fundus to determine what lies in the fundus. A soft mass was felt and that indicated the buttocks.

During the measurement of symphysiofundal height, the zero end of the measuring tape was placed on the fundus and the tape was extended along the midline from the fundus of the uterus to the symphysis pubis and the symphysiofundal height measured 36 centimeters with gestational age of 36 weeks.

Lateral palpation, on palpation, the right hand was used to stabilize one side of the maternal uterus, and the left hand was moved gently in a rotatory manner on the other side of the

uterus where the fetal limbs (rough part) were palpated at the right side. This was repeated at the other side and the fetal back (smooth part) was felt at the left side.

On auscultation, the fetal stethoscope was warmed and placed at the area where the back was felt bold and closer to the chest to listen to the fetal heart rate, then with one hand at the maternal radial pulse to ensure that it is not the maternal pulse being listened to, the fetal heart rate was checked for one minute which was 136 beats per minute.

Pelvic examination, this examination was done facing madam Aniniwaa's feet. She was asked to flex the knee slightly and breathe in and out slowly. The palms were placed just below the level of the umbilicus with the fingers directed towards the symphysis pubis and thumb almost meeting, a hard mass was felt at the lower pole which indicates the fetal head.

To assess descent, Location of the anterior shoulder was made and two fingers were placed on it. The symphysis pubis was also located with the right ulna border, just above the symphysis pubis and the anterior shoulder. Five fingers were admitted between the upper boarder of the symphysis pubis and the anterior shoulder, the space indicating descent of 5/5.

Before vulva examination, permission was sought to inspect the vulva of the client and she agreed. The procedure was explained to the client and privacy was provided. Client was helped to assume supine position with the knees flexed and legs apart. Mons pubis was nicely shaved. There were no warts, ulcer of the vulva, abnormal discharges, varicose veins, oedema or rashes on examination. She was encouraged to continue practicing good vulva hygiene. Client was asked to assume lateral position and sit up before getting out of bed. Hand washing with soap and water was done under running water and dried with a clean dry towel. All findings were recorded in her antenatal record book and communicated to her as well. She was asked if she had any complain and she complained of waist pains and lower abdominal pains. It was explained to her that the waist pains and the lower abdominal pains were as a result of the fetal head descending into the pelvis during the latter end of

pregnancy. She was educated not to stand for longer periods but should have moments of relaxation in between activities and should avoid lifting heavy loads. Permission was sought from her for home visits which she accepted and gave directions to her house as well as telephone number. She took her 3th dose of Sulphadoxine Pyrimethamine under Direct Observation Therapy (DOT).

Her routine drugs were given as;

Tablet Folic Acid	5 milligrams daily for10days
Tablet paracetamol	1milligram daily for 10 days
Tablet Ferrous Sulphute	200milligram once daily for 10days.

2.2 FIRST ANTENATAL HOME VISIT

On 29/10/2021 at 4:35pm, Madam Aniniwaa was visited in her house as arranged. The main purpose was to check on how she was doing and to observe her surrounding,condition of the house,relationship with family and neighbours and psychosocial environment. Client stays at Chiraa, near motor fittering shop. The distance to Madam Aniniwaa's house is about 1 hour walk. On arrival, greetings were exchanged, seat and water were offered and a brief introduction was made since she was already aware of the visit. Client's partner was around and everything was explained to him. Madam Aniniwaa, her partner and children were happily living in a compound house, single room. The compound was neat, no stagnant water or choked gutters and the refuse were kept in a dust bin, neatly covered and she empties it whenever it's full at the community refuse dump. There is electricity and water supply in the house, so she fetch water from the pipe and stores it in a clean plastic container with a lid. Madam Aniniwaa said, she stays in the house with her partner and daughters. It was realized that Madam Aninwaa has a trap door in addition to her main door and her windows are made up of louver blades. Both the trap door and windows are covered with wire mesh to prevent mosquitoes as well as other flying insects from entering the room. The bathroom and toilet

were very neat which she said they scrubbed every Saturday. The bathroom and toilet were built within the house. Client does her cooking at her corridor. The rooms were very spacious and well ventilated. She has a good cordial relationship with her relatives as well as the people in her neighborhood. Client's layette was inspected and everything was intact. The items were neatly arranged in a medium-sized travelling bag and they included items such as; cot sheets, baby's clothing including socks and cap, perineal pads, toilet rolls, rubber (mackintosh) for delivery, cloths, and many more. She complained of constipation and heartburns after meals when her condition of health was inquired and she was educated not to take much oily food especially in the evenings and should always eat in bits and early for digestion to take place before she goes to bed. She was encouraged to avoid taking spicy foods and she was educated on constipation. She was also educated on true labour signs such as "show" and painful rhythmic regular contractions. Madam Aniniwaa was then appreciated for the warm reception and permission was sought to leave and next visit scheduled to be on the 02/11/2021 and was then seen off by client.

PSYCHOSOCIAL ENVIRONMENT

Madam Aniniwaa,her husband and family members have a good relationship with each other.she has friendly relationship with her neighbours and other relatives and people who stay around her area.Client said she do not have alot of friends but usually visits few friends when she has her leisure time and they also visit them sometimes.Madam Aniniwaa's mother also added that she likes attending social gatherings like wedding,funerals and naming ceremony in her area.she is very well approachable,free and fun to be with.she also believes that respect is reciprocal so you should respect one another.

2.3 SECOND ANTENATAL HOME VISIT

Madam Aniniwaa was visited the second time on the 02/11/2021 around 3:00pm. A seat and water were offered upon arrival after the exchange of greetings. The environment was tidy and well kept. She was asked to mention the true labour signs and she was able to recall all of them. She was also assured of the competency of the midwives and therefore need not to be anxious. Enquiries were made about the support person who would take her to the hospital when labour sets in and she said her mother. She was also encouraged to make an arrangement with a taxi driver who would take her to the Health Center when the need arises. The arrangement in the room was still the same and ventilation was perfect, just like the previous visit. Permission was sought to leave and she was reminded of the next visit to the facility which will be on the 08/11/2021.

2.4 SUBSEQUENT VISIT TO ANTENATAL CLINIC

Madam Aniniwaa came for Antenatal visit on 8th November 2021 round 8:00am she was humbly welcomed and offered a seat. Her vital signs were checked after some rest and recorded as follows:

Blood Pressure	120/80 millimeters per mercury
Temperature	36.1 degree Celsius
Pulse	79 beat per minute
Respiration	23 cycles per minute
Weight	75kilograms

Client was asked to empty her bladder and urine testing was done and it was negative. She was sent to the examination room and privacy was provided. Client was assisted to undress, sit and lie on her side on the bed. Client was covered with piece of cloth. Hand washing was done and dried with a clean dry towel. Client was asked to assume a supine position for head to toe examination. The head, eyes, ears, nose and mouth were inspected and no

abnormalities were seen. The neck, breasts, upper and lower extremities were examined for abnormalities but none was seen. Client foot was examined for oedema and spine for any abnormality but no abnormality detected. Abdominal palpation was done and recorded as:

Gestational age	38+2weeks
Symphysiofundal height	38centimeters
Presentation	cephalic
Lie	longitudinal
Position	right occipito anterior
Foetal Heart Rate	138 beats per minute
Descent	4/5th

All findings were explained to her and questions were asked. Client had no complains. She was encouraged to come to the hospital if she experienced any of the true signs of labour made known to her during the second home visit. She was encouraged to continue taking the routine drugs that were given to her during her previous ANC visit. She was thanked and accompanied to the entrance

PROBLEMS IDENTIFIED DURING ANTENATAL CARE

On the 8th of November, 2021 at 9:30am, patient complained of;

1.Waist pain

2. Lower abdominal pains

On the 10th of November, 2021 at 4:35pm, patient complained of;

3. Constipation

4. Heart burns

On the 13th of November, 2021 at 3:00pm, patient complained of;

5. Interrupted sleep at night.

SHORT TERM OBJECTIVES

1. Client will be able to cope with waist pains within 48 hours.
2. Client will be able to cope with lower abdominal within 48 hours.
3. Client will be relieved of constipation within 24 hours.
4. Client will be relieved of heart burns within 72 hours.
5. Client will be able to sleep for at least 2 hours during the day and 6 hours at night within 48 hours.

LONG TERM OBJECTIVES

Madam Aniniwaa will go through pregnancy, labor and puerperium successfully without any complications to both mother and fetus

ANTENATAL NURSING CARE PLAN

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES/ OUTCOME CRITERIA	NURSING ORDER	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
08/11/2021 9:30am	waist pain related to relaxing of pelvic ligament	Client will cope with the waist pains within 48 hours as evidenced by; 1. Client verbalizing that she is coping with waist pains. 2.Midwife noticing that client no longer complain.	1. Reassure client that the condition is temporal 2. Educate client on the physiology of waist pains in pregnancy. 3.Educate client to rest in between activities. 4.Educate client to bend on knee when picking object. 5. Served prescribed analgesic.	1. Client was assured that she will be relieved after delivery. 2. Client was informed that waist pains is due to descent of the fetal head. 3. Client rested in between activities. 4. Client was inform that she should bend on knee when picking object. 5. Client was served 1g paracetamol tablet tdsx3.	10/11/21 10:00am	Goal fully met as 1.Client verbalized that she is able to cope with waist pains. 2.Midwife visualized that client no longer complains.	K.H.A. D

CONTINUATION OF ANTENATAL CARE PLAN

DATE/TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES/OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTIONS	DATE/ TIME	EVALUATION	SIGN
10/11/21 At 9:30am	Lower abdominal pain related to the descend of the fetal head	Client will be able to cope with lower abdominal pain within 48 hours the end of pregnancy as evidenced by; 1. Client verbalizing that she can cope with lower abdominal pain. 2.Midwife noticing that client no longer complain.	1. Reassure client that her condition is temporal. 2. Explain the physiology of lower abdominal pain to client. 3. Educate client to apply warm compress to the lower abdomen. 4. Educate client to do mild exercise. 5. Serve client with prescribed analgesic[paracetamol]	1. Client was assured that she will be relieved after delivery. 2. Client was informed that lower abdominal pains is due to contraction. 3.Client applied warm compress to the lower abdomen. 4. Client was informed to do mild exercise such as sweeping. 5.Client was served 1g paracetamol tablet tdsx3	10/11/21 At 10:00am	Goal fully met as 1. She is able to cope with the lower abdominal pain. 1. Midwife visualized that client no longer complains.	K.H. A.D

ANTENATAL NURSING CARE PLAN CONTINUED

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
10/11/21 4:35pm	Constipation related to the activity of progesterone causing decreased peristalsis and relaxation of the smooth muscle of the bowel during pregnancy	Client will be able to empty her bowel once daily within 24 hours as evidenced by; 1.Client verbalizing that she has no difficulty in emptying her bowel. 2.Midwife noticing that client no longer complains	1. Reassure client that the condition is temporal. 2.Explain the physiology of constipation to client that there was decreased peristalsis movement and relaxation of smooth muscle of the bowel. 3.Educate client to take in 6 to 7 glasses of water a day. 4.Educate client on the intake of roughages like orange, whole grain rice, millet etc. 5. Encourage client to engage in minimal exercise like walking.	1. Client was assured that she will be relief after delivery. 2.Client was informed that constipation is due to inadequate intake of fluid. 3. Client took 6 to 7 glasses of water a day. 4. Client took roughages like orange, whole grain rice, millet. pregnancy. 5. Client performed minimal exercise like walking.	12/11/21 3:25pm	Goal fully met as; 1.Client verbalized that she emptied her bowel once daily within 24 hours. 2.Midwife visualizing that client no longer complains.	K.H. A.D

ANTENATAL NURSING CARE PLAN CONTINUED

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVE/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
10/11/21 4:35pm	Heart burns related to effect of progesterone causing relaxation of the cardiac sphincter during pregnancy.	Client heart burns will be relieved within 72 hours as evidenced by; 1.Client verbalizing that heart burns has been reduced. 2.Midwife noticing that client no longer complain	1. Reassure client that her condition is due the pregnancy and is temporal. 2. Educate client on the physiology of heart burns. 3. Educate client to reduce the intake of spicy and oily foods. 4.Educate client to sit after eating before going to bed to allow proper digestion 5. Educate client to use more pillows when sleeping to raise the head and shoulders.	1. Client was assured that she will be relieved after delivery. 2. Client was informed that heart burns is due to the reflux of gastric content into the esophagus. 3.Client reduces the intake of oily and spicy food. 4.Client relaxes by sitting after eating before going to bed. 5. Client use more pillows when sleeping to raise the head and shoulders.	12/11/21 3:25pm	Goals fully met as; 1.Client verbalized that she is relieved. 2.Midwife visualizing that client no longer complains.	K.H.A .D

ANTENATAL NURSING CARE PLAN

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES/OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/TIME	EVALUATION	SIGN
13/11/21 3:00pm	Inadequate sleep at night related to frequent of micturition.	Client will be able to sleep at least 3 hours within a day and 6 hours at night within 48 hours as evidenced by; 1.Client verbalizing that she was able to sleep. 2.Midwife noticing that client no longer complain.	1. Reassure client that her condition is temporal. 2. Educate client to take in less fluid at night. 3. Educate client to empty her bladder whenever she has the urge to and practice personal hygiene. 4. Educate client to reduce intake of fluids containing natural diuretics such as tea at night. 5. Explain the physiology of frequent micturition client.	1. Client was assured that she will be able to have enough sleep after delivery. 2. Client took one glass of water after eating and before going to bed. 3. Client have her bladder emptied whenever she has the urge to and clean her genitals with dry tissue. 4.Client took fluid containing natural diuretics once a week at night. 5.Client was informed that frequent micturition is due the descent of the fetal heard.	15/11/21 9:00am	Goals fully met as 1.Client verbalized that she was able to sleep 3 hours during the day and 6 hours during the night. 2.Midwife visualizing that client no longer complains.	K.H.A .D

CHAPTER THREE

LABOUR

3.0 INTRODUCTION

This chapter gives information about labour, admission and management of the various stages of labour, immediate care of the newborn, subsequent care of the newborn, examination of the newborn and care plans drawn for the management of the problems encountered during this period.

3.1 ADMISSION AND MANAGEMENT OF FIRST STAGE OF LABOUR.

ADMISSION

On 19/11/21 at 5:45 pm, Madam Aniniwaa arrived at the Chiraa Health Center with her mother. They were warmly welcome and seats were offered to them. She complained of severe lower abdominal pains and thirst which started around 3:00pm. Madam Aniniwaa said she had noticed some mucoid blood stain vaginal discharge (show) around 4:00 pm before coming.Her ANC card was collected and Expected date of delivery(EDD),haemoglobin level was rechecked and recorded as 13.5g/dl.She really looked anxious,so she was therefore reassured to allay anxiety and was asked to do deep breathing exercise.Her items for delivery were nicely and neatly packed in a bag and it contained all the needed items of which it was collected and labelled.She was asked about the last meal,bowel action and any drug taken.She was taken to the labour room and at the delivery room, she was offered a bed. Procedures to be done were explained to her and consent was gained. Her vital signs were checked and recorded as follows;

Temperature	36.5degree Celcius
Pulse rate	70beats per minute
Respiration rate	18cycles per minute
Blood Pressure	110/70 millimeters per mercury

On head to toe examination, nothing abnormal was detected then on abdominal examination; the abdomen was ovoid in shape and medium in size. Striae gravida and linear nigra were seen on the abdomen. The symphysiofundal height was 38 centimeters. The foetal buttocks were felt occupying the upper pole of the uterus. The foetal limbs were palpated at the right side whilst the foetal back was felt on the left side and with a gestational age of 38+2 weeks. On pelvic palpation, the lie was longitudinal and the presentation was cephalic. Examination for decent indicated a descent of $4/5^{th}$. On auscultation, the foetal heart rate was 130 beats per minute then contractions were timed for 10 full minutes by placing the palm on the fundus and it was three in ten (10) minutes lasting for twenty (20) seconds. A tray already set which has two sterile gallipots with one containing sterile cotton while the other contained savlon and a sterile gloves, a receiver for the used swabs and a clean perineal pad. Client was assisted to assume a dorsal position with the knees flexed and a mackintosh and towel placed under client. Hands were washed with soap under running water and dried with a clean dry towel. A pair of sterile gloves were worn and client was draped afterwards. She was asked to expose vulva. The Mons pubis was neatly shaved; there were no sores, rashes, varicose veins, and oedema of the vulva, vulva warts and no perineal scars from previous episiotomy or tears. Five sterile cotton wool swabs were used for the examination. The dominant hand was used to pick the cotton wool and dipped into the savlon, swab was dropped from the right hand into the left hand and swabbed per stroke from downwards starting with the labia majora, swabbed downwards and the used swab was disposed of. The labia minora was swabbed also from downwards and the used swab was disposed into a receiver. The labia minora was patted to exposed the vestibule using the non-dominant hand. A swab was used to wipe the vestibule downward and the used swab was disposed into the receiver. Using the right hand, the middle and index fingers were inserted gently into the vagina pressing firmly downwards. The vagina was warm and moist, ischial spines were blunt, the sacrum was well

curved, and the sacral promontory was not reached. The cervix was soft and thin and four (4) centimeters dilated at 6:00pm with membranes intact and there was no moulding. The presentation was cephalic and well applied to the cervix. Hands were removed and observed but nothing abnormal was seen. The Midwife in charge was asked to confirm the dilatation.

A clean perineal pad was applied on the vulva and client was asked to lie on her left side to prevent supine hypotension syndrome. Client was tidied up neatly and placed in a comfortable position. Gloves were dipped in 0.5% chlorine solution and removed inside out. Hands were washed with soap under running water and dried with a dry clean towel. She was informed of the progress of labour and educated on cervical dilation which was done with the help of a dilatation board. She complained of fatigue. All findings and the progress of labour were explained to client. She was encouraged to change perineal pad if it fell on the floor or when soaked, empty her bladder frequently and walk around to facilitate descent and cervical dilatation. Client was made comfortable in bed and all information gathered was recorded on a partograph sheet at 6:30pm. At 10:30pm, she was assisted to assume a lithotomy position for vaginal examination. On vaginal examination, the vagina was warm and moist, membranes are still intact cervix was 9cm dilated with a well applied presenting part, moulding was (+), and descent was $1/5^{th}$. On auscultation foetal heart rate was 132 beats per minute contractions timed were 4 in 10 lasting 40 seconds. These findings were confirmed by the midwife in charge.

Vital signs were checked and recorded as:

Temperature	37.2 ^{0}C
Pulse	84 beats per minutes
Respiration	23 cycles per minutes
Blood pressure	120/60mmHg

The following investigation were also done and recorded as follows:

Urine for albumin	Negative
Urine for acetone	Negative
Urine for glucose	Negative

Urine passed was 150mls. Client was cleaned up, a new pad was applied to the perineum. She was made comfortable in bed for further monitoring and observation. All findings were communicated to client and recorded on a partograph. Delivery trolley was set with items on the top shelf including; two artery forceps, one cord scissors, four sterile towels, two gallipots with cotton wool swab and gauze, one receiver, episiotomy scissors. Items on the bottom shelf also includes; a jug for measuring the amount of blood loss, receiver for placenta, container with syringes and needles, fethoscope, and oxytocin drug, antiseptic lotion [savlon], sterile gloves, extra perineal pad, small bowel of water and a sucker (penguin), cod clamp, urethral catheter and drainage bag, identification band, examination gloves, mackintosh, cot sheet, drum containing gauze and cotton wool, cheatle forceps in its container.

PREPARATION FOR BIRTH

During the preparation for birth, 2 helpers were identified, that is skilled and unskilled helpers. The skilled helper was the Midwife-In-Charge who would supervise labour and delivery as well as the care of the baby. The unskilled helper who was the client's mother will run errands and assist in times of need. The emergency plan was reviewed by calling a taxi driver, who was informed that he would be called in case of any emergency and his number was kept. The contact numbers of the referral hospital were active when checked. Client was informed that after delivery of the baby, it will be placed on her chest for skin to skin contact for one hour for which she responded positively. Mother's hands were washed with soap under running water and her abdomen and chest were washed with savlon in preparation for skin-to-skin care prior to the second stage of labour. The area for delivery was also prepared.

Madam Aniniwa was told that, the windows and doors would be closed and fan put off when delivery is eminent to provide warmth for the baby. There was adequate lighting and a portable light was available. Hands were washed thoroughly with soap under running water. A dry, flat resuscitation area was prepared and equipment's were tested in case the baby will need any ventilation. Equipment assembled to prepare for birth included the following; sterile gloves, cot sheets, scissors, cord clamps, suction device, ventilation bag and mask, stethoscope, timer (second hand), head covering. The delivery set and emergency drugs were all checked and they were available and ready for use when needed.

3.2 MANAGEMENT OF FIRST STAGE OF LABOUR

When the preparation for birth was done, contractions, pulse and fetal heart rate were monitored every 30 minutes whiles dilatation, descent, temperature and blood pressure were monitored every 4 hours and recorded on the partograph to detect any deviation from normal. Client was seen anxious. Client further added that she is thinking about the outcome of the labour. Client was reassured of normal labour and delivery of a healthy baby without any complications after delivery. She was educated not to use her perinea pad when it falls. She was encouraged to breathe through her mouth when there was contraction and also to avoid pushing during contractions since the cervix was not fully dilated and to prevent edematous cervix. Bedpan was provided for her to empty the bladder frequently to enhance effective contraction and descent of the fetal head since full bladder slows down the progress of labour. At 11:30pm, there was spontaneous rupture of membranes, vaginal examination was done to exclude cord prolapse and to see if client is fully dilated. Liquor was clear and the parietal bones were in apposition indicating that moulding was (+ +). Client's vital signs were checked and recorded as follows:

Temperature	37.0 degrees Celcius
Pulse	82 beats per minute

Blood Pressure 110/70 millimeters per mercury

Respiration rate 20 cycles per minute

Descent was 0/5th above the pelvic brim, fetal heart rate was 138 beats per minute with good volume. Contractions were 4:10 lasting 44 seconds. She passed 120mls of urine and sample was tested for protein and glucose, which was negative. On vaginal examination, the vagina was warm and moist, the cervix was 10centimeters (cm) dilated and well applied to the presenting part. Hands were washed with soap under running water and dried with a clean dry towel. All findings were plotted on the partograph. Client complained of the urge

bear down at 11:30 pm. The Midwife in- charge was informed about the progress of labour and also asked to confirm the findings and she said Madam Aniniwaa's cervix was fully dilated after assessing her. Findings were recorded on the partograph sheet and client was informed of full dilatation of the cervix. She was reminded again that the baby would be delivered onto her abdomen for skin to skin contact. Client was encouraged to push with contractions and rest in between contractions.

3.3 MANAGEMENT OF THE SECOND STAGE OF LABOUR

Client was assisted to assume the lithotomy position. Rubber apron, boots, goggles, mask and head scarf were worn. Hands were washed with soap under running water and dried with clean dry towel. Privacy was provided. The already prepared delivery trolley containing the needed items was pulled nearer to the delivery bedside and the sterile towel covering the top shelf of the trolley removed. Delivery pack was opened and a pair of sterile gloves was worn. The vulva and inner thighs were swabbed with sterile cotton balls soaked in savlon solution. Client's abdomen and thighs were draped with a sterile dry towel. Client was informed again that the baby would be delivered on her abdomen. She was again encouraged to push with contractions, rest in between contractions and adhere to instructions at this stage. A clean perinea pad was applied to the perineum to prevent fecal matter from contaminating the

baby's face. The index and middle fingers were placed on the foetal head as it advances to aid flexion to allow the smallest diameter to distend the vulva. This was done to prevent perinea lacerations and intracranial injury to the baby. When foetal head crowned, client was asked to pant with contraction. The occiput escaped the pubic arc and with extension of the head, the sinciput, face and chin swept the perineum and the head was born. Two fingers were passed around the neck to feel for cord around neck but there was none. The baby's face was cleaned and eyes were wiped inside out with sterile gauze. Restitution took place, thus there was external rotation of the head which is simultaneous with internal rotation of the shoulders. The head of the foetus was held in both palms on each side of the parietal bones and a downward traction was applied to allow the anterior shoulder to slip under the symphysis pubis. The posterior shoulder was delivered by an upward traction towards the mother's abdomen. The rest of the baby's body was delivered by lateral flexion onto the mother's abdomen to provide warmth and to create bonding. Time of delivery was 12:00am as noted. The baby was dry thoroughly and it cried lastly.The sex of the baby was female.

3.4 IMMEDIATE CARE OF THE BABY AT BIRTH

It starts right at the time the head is delivered by cleaning the face and eyes with clean gauze. As soon as the head of the baby was born, its eyes were cleaned with sterile gauze starting from the inner canthus to the outer canthus of the eye and the face. The liquor was cleaned from the baby's body thoroughly. The baby was placed skin to skin and covered with a warm dry cloth. The first minute APGAR score was assessed to be 8/10. A healthy baby girl was delivered and sex confirmed by mother. The umbilical cord was clamped with a cord clamp 2centimeters from baby's abdomen, it was again clamped 3 centimeters away from 1centimeter with artery forceps. The cord was covered with a sterile gauze and cut in between the two clamps to separate the baby from the mother. The fifth minute APGAR score was 9/10. An identification band bearing mother's name, sex of baby, time and date of

delivery was placed on baby's hand**.** Skin to skin care was continued to provide warmth and bonding. Breastfeeding was then initiated to promote bonding between mother and baby and also help to release natural oxytocin which would help in the contraction of the uterus. During the skin to skin care, baby's temperature and breathing were observed. Madam Aniniwaa was congratulated for her effort and cooperation.

3.5 MANAGEMENT OF THIRD STAGE OF LABOUR

The procedure for the third stage management was explained to Madam Aniniwaa. Within a minute after the baby was born,10 units of oxytocin was given intramuscularly to aid in the contraction of the uterus after confirming that there was no second twin in the uterus. The cord was reclumped closer to the vulva and the hanging end was placed in the receiver in between her thighs to receive the placenta and membranes. The bladder was checked and it was empty. Controlled cord traction was used in the delivery of the placenta in order to prevent retained placenta or membranes and inversion of the uterus. The left hand was placed on the fundus to feel for contractions. When the uterus contracted, the left hand was removed and placed above the symphysis pubis with the palm facing the abdomen of the mother to stabilize the uterus to prevent inversion of the uterus. Steady traction on the cord and counter traction of the uterus was maintained until the placenta appeared at the vulva. Both hands were used to hold the placenta and twisted gently to prevent the membranes from tearing. The placenta and its membranes were delivered at 12:05 am. The uterus was massaged to maintain contraction and expel clots. Sterile gauze was wrapped around the first and second fingers of the two hands to inspect the cervix. The cervix the vaginal walls and perineum were inspected, there were no tears found in the cervix, the vaginal wall, and the perineum. Blood loss per vaginum was approximately 100mls. She was cleaned up nicely and a clean perinea pad was applied. She was covered with a new sheet and made comfortable in bed. Madam Aniniwaa was encouraged to empty her bladder whenever she had the urge in order

for the uterus to contract well and she was also taught how to massage the uterus herself and report any changes quickly. Madam Aniniwaa was congratulated for the effort made.

EXAMINATION OF THE PLACENTA AND MEMBRANES

The placenta was placed in 0.5% chlorine solution before thorough examination. The placenta was placed on a flat surface. On inspection, a sterile gauze was used to wipe the tip of the cord and checked. There was one big vein and two arteries in the cord with no abnormality detected. The cord was situated at the center of the placenta. No knots were found in the cord. On examination of the maternal surface, it was dark-red in color. There was no missing lobe nor infarts. The placenta was held by the cord, allowing the membranes to hang down. A hand was inserted into the hanging membranes to spread it out and to aid in inspection of the membranes, and there was only one whole through which baby came. The amnion was peeled from the chorion and examined. They were both intact. The foetal surface was smooth, shiny and bluish-grey in color and with no abnormality, such as vessels, velamenteous cord insertion. Both placenta and membranes were complete and was therefore discarded. After this, the items used for delivery were decontaminated in 0.5% chlorine solution for 10 minutes. Items were then washed, rinsed, dried and packed for sterilization. Hands were then washed with soap under running water and dried with clean dry towel. Estimated blood loss was 150 milliliters, when retro placenta clot was added. Findings were discussed to client and the necessary documentations were made. Madam Aniniwaa was thanked once again for her effort and cooperation.

3.6 MANAGEMENT OF FOURTH STAGE OF LABOUR

Madam Aniniwaa and her baby were assisted and taken into the lying-in ward where they were closely observed for six hours after a successful completion of the third stage of labour. During this stage, the mother and the baby were assessed every 15 minutes for 2 hours, 30

minutes for an hour and hourly for three hours which was recorded behind the partograph to detect any deviation from normal. Client's vital signs were checked and recorded as follows:

Temperature	36.7 degrees Celcius
Pulse	80 beats per minute
Respiration	22 cycles per minute
Blood pressure	110/70 millimeters of mercury

Madam Aniniwaa was encouraged to empty her bladder frequently to ensure effective uterine contraction and also to change soiled pads frequently to prevent infections. Mother was then assisted to put baby to breast for natural release of oxytocin to aid in involution and bonding between her and the baby. Client's mother was also encouraged to support her.

PREVENTION OF DISEASE

This was done within the first 90 minutes after delivery since the baby can contract infection during birth. Hand washing was performed and dried with a clean dry towel. Tetracycline eye ointment was smeared onto the lower eyelids of the baby. The umbilical cord was dressed with cotton wool swabs and methylated spirit to prevent cord infection. Vitamin K 1 milligram was administered intramuscularly to prevent bleeding in the new born. Mother was educated not to put any herbs on the cord. Mother was also encouraged to wash hands before and after touching her baby, perineal pad and also visiting the wash room. Hands were then washed with soap under running water and dried with a clean dry towel.

EXAMINATION OF THE NEWBORN

Procedure was explained and permission was sought from mother to examine the baby for which she agreed. Hands were washed with soap under running water, cleaned and dried and examination gloves were worn. The baby was examined from head to toe to detect any deviations from normal if any. Baby was positioned on a warm safe flat surface within the view of the mother. Baby was unwrapped and general observation was done. Baby's skin was

pink in colour on observation then wrapped and exposed systematically. The head was examined for shape, size, widened sutures, bulging and sunken fontanels, lacerations, any edematous swelling caput succedaneum but no abnormality was detected. The ears were examined for size, shape, and patency, alignment and for discharges. There was no abnormality detected and it was aligned with the contours of the eyes. The sclera was examined for jaundice and blood stains, conjunctiva for pallor, presence of clear lens and discharges but there was no abnormality. The nose was examined for shape, size, patency, deviated septum congestion and discharges but there were none. The mouth was inspected for false teeth, tongue tie, color of tongue and gum, cleft lip and palate by using the little finger to feel for palate, sub mucus cleft but everything was normal. The neck was also palpated for enlarged lymph nodes, rigidity and congenital goiter but none was present. The chest and abdomen was observed and respiratory movement were regular, nipples were in alignment without engorgement and breast had no mass the abdomen was examined for shape and size, with no bleeding from the umbilical cord and abnormalities such as omphalocele and gastroschisis were absent. Examination of the upper extremities was done and hands were inspected for symmetry, clubbing, extra or missing digits and webbing. Hands and arms were inspected for movement, paralysis, palms for the number of palmer creases, nail beds were checked for color, webbed digit, missing or extra digit and reflexes (Moro, grasping reflexes) and everything was normal. The lower extremities were examined for equality, extra or missing digits, clubbed feet and talipes but no abnormality was detected. Congenital hips dislocation was checked using the Ortolani's test and there was no dislocation since a 'clunk' sound was not heard. The back of the baby was examined and no abnormalities such as spinal bifida, meningocele of the spine detected. The genitalia and anus were well developed. The urethral and anal orifices were patent as she passed urine and meconium respectively. The baby was weighed and the weight was 3.5kg, head circumference was 33cm, length 45cm

and temperature was 37.2. The baby was classified as normal. Gloves were removed and disposed aseptically before washing hands with soap under running water and dried with clean dry towel. Findings were documented and communicated to client.

SUMMARY OF LABOUR AND DELIVERY

DURATION OF LABOUR

1st stage	4 hours 53minutes
2nd stage	25 minutes
3rd stage	9 minutes
Total	5 hours 27 minutes

Baby's vital signs and weight were checked and recorded as follows;

Temperature	37.2 degrees Celcius
Apex heart beat	138 beats per minute
Respiration	42 cycles per minute
Weight	3.5 kilograms

The baby's skin was smeared with baby oil, dressed warmly wrapped with a clean dry sheet and placed beside her mother.

MANAGEMENT OF THE MOTHER

Madam Aniniwaa was informed that her vital signs will be checked every 15 minutes for 2 hours and every 30 minutes for an hour. Having sought permission from client, her vital signs were checked and recorded as follows;

Temperature	36.7 degree Celcius
Pulse	80 beats per minute
Respiration	21 cycles per minute
Blood Pressure	110/70 millimeters per mercury

The uterus was massaged to feel for contractions. Blood clots were expelled and blood loss was 100 milliliters. The Symphysiofundal height was 16 centimeters. At the end of the 3 hours monitoring, all findings were recorded on the partograph. Lochia was red in color (rubra), moderate in quantity and had no foul smell. Madam Aniniwaa was educated on the need to urinate frequently and change perinea pad when soaked, how to fix baby to the breast, the importance of exclusive breastfeeding for the first 6 months and to feed the baby on demand was stressed. She was also encouraged to wash hands thoroughly with soap and water before and after breastfeeding of the baby and after changing perinea pad. General condition of client was good and all labour notes were recorded behind the partograph sheet.

CONDITION OF BABY AT BIRTH

The baby's general examination was done and nothing abnormal was detected.

Temperature	37.2 degrees Celcius
Respiration	42 cycles per minute
Apex beat	138 beats per minute
Weight	3.5 kilograms
Length	45 centimeters
Head circumference	33 centimeters
Sex	Female

CONDITION OF MOTHER AT BIRTH

The condition of the mother was good. Client's initial vital signs were checked and recorded as;

Temperature	36.7 degree Celcius
Pulse	80 beats per minute
Respiration	21 cycles per minute
Blood pressure	110/60 milliliters per mercury

PROBLEMS IDENTIFIED DURING LABOUR

On the 20th of November, 2021 at 12:00am, patient complains of;

1. Lower abdominal pains

2. Risk of dehydration

3. Anxiety

4 Fatigue

SHORT TERM OBJECTIVES

1. Client will cope with lower abdominal pains till end of labour
2. Client will cope with waist pains till end of labour
3. Client will be relieved of anxiety within 20 minutes.
4. Client will be relieved from fatigue.

LONG TERM OBJECTIVE

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

LABOUR CARE PLAN

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
20/11/21 12:00am	Lower abdominal pains related to strong uterine contractions.	Client will cope with the lower abdominal pains till end of labour as evidenced by; 1.Client verbalizing that she is coping with the pain. 2.Midwife noticing that client no longer complain.	1.Reassure and explain physiology to client. 2. Engage client in a diversional therapy by conversing with her. 3.Encourage ambulation. 4. Teach client to practice deep breathing exercise. 5. Explain the physiology of lower abdominal pain to client.	1. Client was reassured and physiology was explained to her. 2.Client was engaged in a conversation during labour. 3.Client was walking around her bed and on the ward. 4. Deep breathing exercise were performed by client under conducive environment. 5. Client was taught that lower abdominal pains was due the descent of the presenting part as well as contraction of the uterus.	20/11/21 01:35am	Goal fully met as; 1. client verbalized that she coped well with the lower abdominal pains. 2.Midwife visualizing that client no longer complains	K.H. A.D

LABOUR CARE PLAN CONTINUED

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES/ OUTCOME CRITERIA	NURSING ORDER	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
20/11/21 12:30am	Risk of dehydration related to the excessive sweating.	Client will remain hydrated throughout the labour and delivery as evidence by; 1.Client making conscious effort to sip water every 30 minutes. 2.Midwife observing client sip water and record vital signs	1. Assess for signs and symptoms of dehydration 2.Encourage copious fluid intake. 3.Educate patient on fluid needs during labour 4.Serve fluid nourishing diet. 5. Assess vital signs regularly.	1. Features of dehydration was absent, client had good skin turgor, moist skin and mucus membrane and reported no thirst. 2. Client took in 300mls of orange juice and water every hour. 3.Client was taught that fluid aid in pushing during labour. 4.Client took 250mls of light soup during the process of labour. 5.Client BP, pulse and respiration were monitored.	20/11/21 1:30am	Goal fully met as client verbalizing that; 1.She is able to sip water every 30 minute. 2.Midwife observing client has normal BP, pulse and respiration.	K.H.A. D

LABOUR CARE PLAN CONTINUED

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
20/11/21 12:00am	Anxiety related to unknown outcome of labour.	Client will be relieved of anxiety within 20 minute as evidenced by; 1. Client verbalizing that she is no more anxious and midwife observing that client is no longer tends.	1. Reassure client that she is in comfortable hands. 2. Explain every procedure to be carried out on client to her to allay anxiety. 3. Educate client on positive outcome of labour. 4. Encourage deep breathing exercise. 5.Encourage client to ask questions and answer appropriately.	1. Client was assured of safe delivery. 2. Every procedure to be carried out on client was explained to her to allay anxiety. 3. Client reassured that though it may end in C/S but we are sure of SVD. 4. Client was doing the deep breathing exercise. 5. Client's questions were answered appropriately.	20/11/21 12:20am	Goal fully met as 1.Client verbalized that she was no more anxious. 2. Midwife visualizing that client no longer complains.	K.H.A.D

LABOUR CARE PLAN CONTINUED

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES	NURSING ORDERS	NURSING INTERVENTION	DATE /TIME	EVALUATION	SIGN
20/11/21 12:00am	Fatigue related to physical stress of labour.	Client will be relieve of fatigue within 1hour as evidenced by: 1.Client been active during labour. 2.Midwife visualizing active client.	1.Reassure client on the condition to allay fear and anxiety. 2.Encourage client to continue with the relaxation techniques. 3.Support client to do deep breathing exercise during contraction. 4.Encourage client to take sips of milo and drink. 5.Encourage client to assume a comfortable position	1.Client was reassured on condition to allay fear and anxiety. 2.Client was comfortable with relaxation technique. 3.Client performed deep breathing exercise during contraction. 4.Client took sips of mashed kenkey with milk throughout the labour process. 5.Client assumed left lateral position.	20/11/21 01:00am	Goal fully met as: 1.Client was actively involved in the labour process. 2.Midwife observed an active client.	K.H.A.D

CHAPTER FOUR

PUERPERIUM

4.0 INTRODUCTION

This chapter talks about the management of both mother and baby from delivery to six weeks' post-partum and care plans drawn for the management of problems identified during puerperium.

4.1. DAY OF DELIVERY

Madam Aniniwaa had a spontaneous vagina delivery to a live female child at 12:00am on the 20th November 2021. Client and the baby were cleaned neatly and transferred to the lying-in ward after one-hour observation. Where her baby was wrapped nicely to prevent heat loss and put beside her mother after the third stage of labour. She was encouraged to empty her bladder whenever she feels the urge in order to prevent the occurrence of any postpartum hemorrhage; early ambulation was emphasized to promote effective circulation and drainage of lochia. She was encouraged to change perinea pad when soaked to prevent ascending infection. She was educated on the need for exclusive breastfeeding for six months and how to fix baby to the breast. Emphasis was also made on proper hand washing before breastfeeding or handling of the baby, after visiting the toilet, changing her perinea pad and changing of baby's soiled napkins or diapers. Madam Aniniwaa took fufu and Light soup for supper. The following were her vital signs:

Temperature	36.7 degree Celcius
Pulse	80 beats per minute
Respiration	22 cycles per minute
Blood Pressure	110/70 millimeters per mercury

BABYS VITAL SIGNS

Temperature	37.2 degrees Celcius
Pulse	138beats per minute
Respiration	42cycles per minute
Weight	3.5 kilogram

The symphysiofundal height was 16 centimeters. Lochia was red, odourless and moderate. Throughout the six hours spent, client's vital signs were checked 15 minutes for 2 hours,30 minutes for 1 hour and hourly for 3 hours to help assess the health of the client and all were recorded on the partograph.

SUBSEQUENT CARE OF THE BABY

At 12:00am,(7hours 1minute)after birth, Madam Aninwaa was informed about the need for baby bath, general examination of the baby and immunization and she responded positively. Head to toe examination was done and no abnormality detected and all findings were communicated to her.

4.2 FIRST BABY BATH

Madam Aniniwaa was informed to seek her consent to bath the baby of which she accepted. She was also told on the need for the baby bath, Baby was then picked to be bathed, mother was told to watch closer. Education was given during the procedure. The requirements needed for the procedure were gathered as follows on the top shelf includes ; Methylated spirit, Sterile cotton wool swabs and gauze in a gallipot, baby's sponge, baby's diapers, baby's dress, baby's soap in a soap dish, baby's towel and cot sheet to wrap the baby. Items on the bottom shelf includes; jug of hot water, disposable gloves, jug of cold water, a bowl of mixing water, pomade, surgical gloves and mackintosh. Plastic apron was then worn, hands were washed with soap under running water and then dried with a clean dry towel. Cold and hot water were mixed and the elbow was used test for its temperature. Gloves were worn and

the baby was placed on a protected warm flat surface, undressed and covered with the towel leaving the face. The eyes were cleaned with a sterile cotton, dipped in sterile water from the inner contours outwards and disposed them into a receiver. The face was cleaned with a wet face towel. The nape of the neck was supported with the left palm and the ears were plugged with the thumb and index finger to prevent water from entering the ears. The baby's head was washed in a circular motion with a soapy sponge after which it was rinsed and dried with a towel. Baby was bathed, paying particular attention to the skin folds. The whole body was gently immersed in the water with the head supported above the water level. Baby's body was dried with towel paying attention to the skin folds. Vaseline was smeared all over the baby's body to provide warmth. The baby was then dressed up exposing the cord. Gloves were removed, hands washed and dried with a clean towel.

CORD DRESSING:

This procedure was explained to the mother to gain her consent. Hands were washed with soap under running water and dried with clean towel after baby was bathed. Sterile gloves were worn, and the clamp of cord was observed for looseness. Cord was inspected for bleeding but cord was not bleeding. Baby was wrapped in a sheet to keep her warm but cord was exposed and the mother was asked to protect her whiles on the table. A cotton wool swab was used to hold the tip of the cord with one swab soaked in methylated spirit. The skin around the cord was swab 5cm away from the base of the cord. The stem of the cord was swab from base upwards using a swab for each stroke finally the tip of the cord was swab with cotton wool swab soaked in methylated spirit. The cord was left exposed to dry. Gloved hands were immersed in 0.5% chlorine solution and removed inside out. Hands were washed with soap under running water and dried with a clean towel.

Madam Aniniwaa was educated not to put anything on the cord but she should only dress cord with methylated spirit. The baby's head was covered to prevent heat loss and the baby

was given to the mother to breastfeed. Madam Aniniwaa was educated on the needs of exclusive breastfeeding for the first six months and she was encouraged to practice it. She was educated and encouraged to allow the baby to completely empty one breast before giving the other breast to the baby. She was also educated to report early to the health facility when she observes any danger signs such as irregular breathing rate, fever, poor feeding and jaundice. Client was told not to apply any hot water to the baby's fontanels since they will close by themselves when the time is due. Client was educated on breastfeeding problems such as cracked or sore nipples, breast engorgement and mastitis. Mother was also educated and encouraged to eat a well-balanced diet and also to take her routine medications given.

4.3. FIRST DAY POST DELIVERY (DAY OF DISCHARGE)

On the 21th November, 2021, which was the first day post-delivery, Madam Aniniwaa woke up around 7:30am, emptied her bowel, and cleaned her teeth after which she was given warm water to bath. She complained of backache and after pains. She was told that the pain was as a result of contraction of the uterus and also she was educated and taught how to adapt a proper position during breastfeeding. She made herself comfortable in a white dress and all procedures to be carried out on her and the baby was explained to her to seek for consent which she agreed. Her vital signs were checked and recorded as;

Temperature	36.6 degrees Celcius
Blood pressure	110/65 millimeters of mercury
Pulse	80 beats per minute
Respiration	20 cycles per minute

After the vital signs, head to examination was carried out and no abnormality was detected. The breast was not lactating well but she was reassured and encouraged to continue breastfeeding. The symphysiofundal height was 18 centimeters, uterus was well contracted on palpation. Lochia was red (rubra) in colour and amount was small and not offensive. She

was reminded on changing of the perinea pad when soiled to prevent ascending infection to the uterus. She was also reminded on how to perform self-breast examination and exclusive breastfeeding was also encouraged. Permission was sought from the mother to re-examine the baby and the procedure was explained to her. Hand washing was done and the baby was examined. On examination, there was no abnormality detected. The baby was top and tailed and the cord dressed with sterile cotton wool swab soaked in methylated spirit. Opportunity was taken to teach the mother and the family about cord dressing of the baby. She was reminded not to put anything on the cord except what was given to her and also encouraged not to apply hot compress on the head, with the intention of closing the fontanels. The baby passed meconium and urine during top and tail. Her vital signs and weight were checked and recorded as follows;

Morning

Temperature	36.6 degrees Celcius
Pulse	134 beat per minute
Respiration	42 cycles per minute
Weight	3.4 kilograms

Baby was re-dressed and wrapped in a warm sheet and was given to her mother for breast feeding. All findings were communicated to the mother. Madam Aniniwaa took porridge and bread as her breakfast. She was reminded on the need for proper personal hygiene, good nutrition, and exclusive breastfeeding for six months. She was encouraged to start and complete the immunization schedules at the child welfare clinic and its importance was stressed. She was also told to come for the first post-natal visit on 28/11/21. Posture and method of breastfeeding was demonstrated to Madam Aniniwaa after which she was asked to do same and she did it perfectly. She was also educated on breastfeeding the baby on demand (not less than 8 times a day), and adequate feeding at night. Madam Aniniwaa was educated

on the importance of birth registration and was asked to register the baby. Client was informed that she would be visited at home for seven days and was helped to pack her belongings. Client was given the following drugs;

1. Tablet Folic Acid 5mg one tablet daily for 30 days
2. Tablet Vitamin B complex 200mg three times for 14 days
3. Tablet Ferrous Sulphate 200mg twice for 14days
4. Tablet Paracetamol 1g three times daily for 3 days
5. Cap- Amoxicillin 500mg three times for 7 days

Client's bills were settled with her National Health Insurance Card. A taxi was hired so client was seen off.

4.4 FIRST POSTNATAL HOME VISIT

Madam Aniniwaa and her family were visited in their home on the 21st 0f November, 2021, at 4:30pm. Greeting were exchanged on arrival and was asked how she and her baby were feeling and she said they were doing well. Permission was asked to perform head to toe examination on both mother and baby which she agreed after a brief observation of the environment and the room in which they sleep. After giving her consent, she was asked to empty her bladder and made comfortable in her bed. No abnormality was identified on head to toe examination. The breast was somehow lactating. The abdomen was soft, uterus was well contracted and the symphysiofundal height measured 17centimeters. Perinea pad was inspected and a small amount of lochia rubra which was not offensive was seen. Her vital signs were checked and recorded as;

Evening

Temperature	36.2 degree Celcius
Pulse	80 beat per minute
Respiration	20 cycles per minute
Blood pressure	110/65 millimeters per mercury

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

Evening

Temperature	36.6 degree Celsius
Pulse	135 beat per minute
Respiration	44 cycle per minute
Weight	3.4 kilograms

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

4.5 SECOND POSTNATAL HOME VISIT

The second visit was made to client's house at 9: 30am in the morning and 5:00pm in the evening on the 22nd of November, 2021. Having been received warmly, the family responded of good health when enquired. Every procedure to be performed on both client and baby were explained and she agreed. Head to toe examination was done on the mother and everything was normal. Her fundal height was 16centimeters. Perinea pad was inspected and an odorless red(rubra) lochia was seen on perinea examination including a clean vulva and perineum. Client's vital signs were checked and recorded as follows;

Morning

Temperature	36.8 degree Celcius
Pulse	79 beat per minute
Respiration	20 cycle per minute
Blood pressure	100/60 millimeter per mercury

Evening

Temperature	37. 0 degree Celcius
Pulse	80 beat per minute
Respiration	21 cycles per minute
Blood pressure	100/60 millimeters per mercury

The baby was top and tailed and cord dressed with sterile cotton wool swabs and methylated spirit in the presence of the mother. The baby was dressed, wrapped and given to mother to breastfeed. Baby's vital signs and weight were checked and recorded as follows;

	Morning	**Evening**
Temperature	36.3 degrees Celcius	36.8 degrees Celcius
Apex heart beat	137 beat per minute	137 beat per minute
Respiration	46 cycles per minute	44 cycle per minute
Weight	3.3 kilograms	3.3 kilograms

Client complained of breast engorgement. She was reassured and helped to position and fix baby well to the breast while breastfeeding. She was also encouraged to make sure one breast is fully emptied before given the other breast. She was also encouraged to apply warm compress for relieve from pain. Permission was sought to leave.

4.6 THIRD DAY POSTNATAL HOME VISIT

The third home visit was made to Madam Aniniwaa's house on the 23rd of November, 2021 around 8:30am in the morning and 4:30pm in the evening. Greetings were exchanged. Mother and baby were in a healthy condition. Enquiry was made about the breast engorgement of which she said the engorgement and pain has been reduced. Client was encouraged to breastfeed baby on demand and also to apply warm compress on the breast. All procedures to be carried out were explained to client and she agreed. Head to toe examination was done on the mother but no abnormality was found. She was enquired about her complains of which she said there was none. Her symphysiofundal height was measured and recorded as 15centimeters. Client's perinea pad was inspected and it was pink (red) with scanty flow without any offensive odour. Vital signs of mother were checked and recorded as;

Morning

Temperature 36.0 degree Celcius

Pulse 83 beat per minute

Respiration 22 cycle per minute

Blood pressure 100/65 millimeter per mercury

Evening

Temperature 36.2 degree Celcius

Pulse 81 beat per minute

Respiration 20 cycles per minute

Blood pressure 100/60 millimeters per mercury

The baby was top and tailed and general examination was carried out on her. No abnormality was identified on examination. Baby passed stools and urine during bath. The cord was

dressed with sterile cotton wool swabs and methylated spirit. Baby was dressed up nicely. Baby's vital signs and weight was taken and recorded as follows;

Morning

Temperature	36.8 degrees celcius
Apex heart beat	138 beat per minute
Respiration	46 cycles per minute
Weight	3.2 kilograms

Evening

Temperature	37.0 degrees celcius
Apex heart beat	138 beat per minute
Respiration	45 cycle per minute
Weight	3.2 kilogram

All findings were communicated to Madam Aniniwaa and permission was sought to leave and was seen off by client.

4.7 FOURTH POSTNATAL HOME VISIT

Madam Aniniwaa was visited on the 24th November, 2021 at 8:45am and 4:30pm. Client, her baby and the entire household were all in good health. Head to toe examination was done on the mother and everything was normal. Breasts were soft and lactating well. Symphysiofundal height was measured to be 14centimeters. Lochia was pink in color(serosa), small and without odour. Client's vital signs was checked and recorded as follows;

Morning

Temperature	36.4 degree Celcius
Pulse	77 beat per minute
Respiration	20 cycle per minute
Blood pressure	100/ 65 millimeter per mercury

Evening

Temperature	37.0 degree Celcius
Pulse	80 beats per minute
Respiration	20 cycles per minutes,
Blood pressure	100/70 millimeters of mercury

Baby was top and tailed after general examination was carried out but nothing abnormal was identified. Baby passed stools and urine during top and tail. Cord was dressed with sterile cotton wool swabs and spirit. The cord was dry and shrinking. Baby's vital signs and weight was taken and recorded as follows;

Morning		**Evening**
Temperature	36.8 degrees Celcius	36.8 degree Celcius
Apex beat	138 beat per minute	137 beat per minute
Respiration	42 cycles per minute	42 cycles per minute
Weight	3.2 kilograms	3.2 kilogram

All findings were communicated to client and documented. Client complains of frequency in micturition and she was reassured that such problem does occur but would be managed and also she was educated and taught how to adapt a proper position during breastfeeding, Permission was sought to leave which was granted.

4.8 FIFTH DAY POSTNATAL HOME VISIT

On the 25th of November, 2021 at 8:00am, Madam Aniniwaa and her family were visited. Mother and baby were in a healthy condition. Client was waiting to be examined before she takes her bath so permission was sought for head to toe examination to be performed and no abnormality was detected. Her breasts were soft and lactating well. Her symphysiofundal height measured 13centimeters. lochia was pink (serosa), small flow and had no odour. Client's vital signs was checked and recorded as follows:

Temperature	36.0degrees Celcius
Pulse	81 beats per minute
Respiration	20 cycles per minute
Blood pressure	100/65 millimeters of mercury

Head to toe examination was done and no abnormalities were found. Baby passed stool and urine. The cord was dressed with sterile cotton wool swabs and methylated spirit but it was shrinking and detaching. Client gave no complains on this day. Vital signs and weight of baby were checked and recorded as;

Temperature	36.2 degrees Celcius
Apex beat	130 beat per minute
Respiration	41 cycles per minute
Weight	3.3kilogram.

Opportunity was taken to educate client on protocols on COVID-19 and permission was sought to leave.

4.9 SIXTH DAY POSTNATAL HOME VISIT

Client was visited again the 26th of November, 2021 around 9:00am. Madam Aniniwaa was met with her mother who was washing some clothes. Greetings were exchanged. The condition of mother and baby was very good. Head to toe examination was done after explaining the procedure to client and nothing abnormal was detected. Her symphysiofundal height was 12centimeters. Lochia was pink in color(serosa), small and without odour. Client vital signs were checked and recorded as;

Temperature	36. 5 degrees Celcius
Pulse	81 beat per minute
Respiration	22 cycles per minute
Blood pressure	100/70 millimeters per mercury

Head to toe examination was done on baby and her grandmother was coached, nothing abnormal was detected. Warm water was ready so baby was bathed. The stump of the cord was clean and dry was almost healed . Baby's vital signs and weight were checked and recorded as follows;

Temperature	37.0 degrees celcius
Apex beat	129 beat per minute
Respiration	42 cycles per minute
Weight	3.4 kilograms

Madam Aniniwaa was reminded of the first postnatal visit to the clinic and also reminded of the termination of care on the next day which would be the last day of visit. She was congratulated for her efforts and cooperation. All the findings were communicated to client and permission was sought to leave.

4.10 SEVENTH POSTNATAL HOME VISIT

The seventh day postnatal home visit was made to client's house on the 27th of November, 2021 around 8:30am. Client and baby were in a good condition. On head to toe examination, no abnormalities were seen on the mother. Her breast was lactating well, symphysiofundal height was 11centimeters. Lochia was pink (serosa) with no odour Her vital signs were checked and recorded as;

Temperature	36.1 degree Celcius
Pulse	80beats per minute
Respiration	22ycles per minute
Blood pressure	110/60 millimeters of mercury

Baby was already bathed and head to toe examination was done and no abnormality was found on the baby. Vital signs and weight of baby was checked and recorded as;

Temperature 37.1 degrees Celcius

Pulse 130 beat per minute

Respiration 44 cycles per minute

Weight 3.5 kilograms.

Client complains of inadequate sleep at night and she was reassured of getting enough sleep and encourage to breastfeed baby to the fullest before going to bed. Client was thanked for her cooperation throughout the postnatal home visits Madam Aniniwaa was reminded to visit the clinic on 28th November 2021 for one week postnatal clinic.

4.11 FIRST POSTNATAL VISIT TO THE CLINIC

Madam Aniniwaa visited the clinic with her baby accompanied by her elder sister on the 28th of November 2021 around 9:30am. They were warmly welcomed and offered seats. Client was asked about how she and her baby as well as her family were doing well and she said they were all doing well. Every procedure to be done was explained to her and permission was granted to begin the procedure. A specimen container was given to her for mid-stream urine collection for routine examination and urine protein and glucose, were both negative when tested. Hemoglobin level was 11.5 grams per deciliter after blood sample was taken and tested.Hands were washed under running water with soap and dried hands Client's vital signs were checked and recorded as;

Temperature 37.0 degree Celcius

Pulse 78 beat per minute

Respiration 20 cycles per minute

Blood pressure 100/60 milliliters per mercury

Privacy was provided and Madam Aniniwaa was helped to lie on the examination couch for head to toe examination while the elder sister carried the baby for that period. Her hair was neatly and nicely braided. The eyes and ears had no discharges, conjunctiva had no pallor and

the sclera had no jaundice. The nose has no discharge neither did the neck have any nodule nor enlarged lymph node. The breast as well had no lump, engorgement, mastitis or nipple crack but was lactating well. The upper and lower extremities had no edema. On abdominal examination, there was no enlarged and tenderness of both spleen and liver. There were no warts, varicose veins or edema on the vulva. Lochia drainage was mild, serosa and not offensive and on palpation,the uterus was well contracted and not palpable. Madam Aniniwaa was congratulated for keeping herself clean and was helped to get off the couch to redress. Findings were then communicated to Madam Aniniwaa and recorded. Hands were then washed and dried with a clean dry towel. Permission was sought to perform head to toe examination on the baby which was granted. Baby's hair looked neat and nicely combed, with no abnormalities of the fontanels and sutures present on palpation. The conjunctiva and sclera were inspected for pallor and jaundice respectively but none was present. The ears and nose were inspected as well as the lips and mouth, but no abnormality was found. There were no palpable lymph nodes on the neck. The chest was inspected and there was no indrawing. The abdomen was firm with a well healed umbilical stump and the skin had no rashes. The upper and lower extremities had no abnormality as well as the baby's back. The genitalia were also examined with no abnormality detected. The baby's vital signs and weight were checked and recorded as follows;

Temperature	36.5 degree Celcius
Apex heart beat	130 beat per minute
Respiration	40 cycle per minute
Weight	3.7 kilograms

Findings were communicated to mother and recorded. Madam Aniniwaa was educated on the importance of family planning and the husband to space their birth and was also reminded to continue breastfeeding the baby exclusively. Client was also reminded on the need to attend

child welfare clinic to complete the child's immunization schedules and also attend six weeks postnatal review. She was again reminded about the registration of her baby with the birth and death registry. Care was terminated and client was handed over to the Midwife in-Charge for the continuity of care. Madam Aniniwaa was thanked for her cooperation and effort throughout the care.

4.12 SECOND POSTNATAL VISIT TO THE CLINIC

According to the Midwife in-Charge, Madam Aniniwaa visited the clinic with the baby for her sixth week postnatal review on the 2nd January, 2022 and was warmly welcomed by the midwife-in-charge. Mother and baby were in healthy condition and had no complains. Her hemoglobin level was 13.5 gram per deciliter and urine tests for protein and glucose were negative. Her vital signs and weight were checked and recorded as;

Temperature	36.2 degree Celcius
Pulse	77 beat per minutes
Respiration	21 count per minutes
Blood Pressure	106/65 milliliters per mercury
Weight	5.1kilogram

Head to toe examination was carried out on client but no abnormality was detected. Baby's vital signs and weight was also checked and recorded as;

Temperature	36.0 degree Celcius
Respiration	40 cycles per minute
Pulse	135 beats per minute
Weight	4.6 Kilograms

Baby's general condition was good on head to toe examination and baby's posterior fontanels had closed and the anterior fontanels was palpated for pulsation and it was normal. All

findings were communicated to client and documented. Baby was given the due immunizations which included the following;

Vaccine	Dosage	Route of Administration
Polio 1	2drops	Oral
Rotavirus	1.0millimeters	Oral
Penta	0.5millimeters	intramuscularly on right thigh

These were recorded in the child record booklet. They were then handed over to the child welfare clinic and family planning unit to ensure continuity of care. Client was encouraged to visit the facility in case of any health-related problem. All findings were communicated to Madam Aniniwaa and was thanked for her cooperation and support throughout the care.

4.13 PUERPERIUM CARE PLAN

PROBLEMS IDENTIFIED

On 21/11/21 at 7:30am client complained of;

1. Backache
2. After pain

On the 22/11/21 at 9:30am, client complained of;

3. Engorgement breast

On 23/11/21 at 8:45am, client complained of;

4. Frequent micturition

On 26/11/21 at 4:30pm client complained of;

5. Inadequate sleep at night.

SHORT TERM OBJECTIVES

1. Client will be relieved of backache within 48 hours.
2. Client will be relieved of after pains within 72 hours.
3. Client will be relieved of frequency of micturition at least four times a day within 2 hours.
4. Client will be relieved of breast engorgement within 48 hours.
5. Client will be able to sleep 2 hours within a day and 6 hours at night within 24 hours.

LONG TERM OBJECTIVE

Madam Aniniwaa and her baby will go through puerperium successfully without any complication.

PUERPERIUM NURSNG CARE PLAN

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
21/11/21 7:30am	Backache related to poor position during breastfeeding.	Client will be relieved of backache within 48 hours as evidenced by; 1.Client verbalizing she has been relieved from backache. 2. Midwife noticing client no longer complain.	1. Reassure client that pain will be relieved. 2. Educate client on proper position during breastfeeding 3.Encourage client to rest in between activities. 4.Encourage client to do mild exercise. 5. Serve client with the prescribed analgesic to relieve pain. (Paracetamol)	1. Client was assured that she will be relieved of backache by assuming right position when breastfeeding 2. Client was educated on assumed proper position when breastfeeding that is lying her back against a wall. 3. Client rest in between activities. 4. Client is to do mild exercise such as sweeping. 5.Client was served 1g paracetamol tablets tdsx3 .	23/11/21 9:30am	Goal fully met as 1.Client verbalized that her backache has been relieved. 2. Midwife notice that client no longer complains.	K.H.A.D

PUERPERIUM CARE PLAN CONTINUE

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
21/11/21 7:30am	After pains related to involution of the uterus	Client will cope with pains within 24 hours as evidenced by; 1.Client verbalizing that she is coping. 2.Midwife noticing client no longer complains	1.Reassure client that her condition is temporal. 2. Explain the physiology of after pains to client. 3.Encourage client to continue breastfeeding on demand. 4.Encourage client to apply warm compress to the lower abdomen. 5. Serve client with the prescribed analgesic (paracetamol).	1.Client was assured that pain will be relief after the uterus return to its normal state 2.Client was informed that after pain is due to the uterus returning back to its normal position. 3.Client continue to breastfeeding on demand. 4. Client applied warm compress to the lower abdomen. 5. 1g paracetamol tablet tdsx3 was served to client.	23/11/21 9:30am	Goal fully met as 1.Client verbalized that she was able to cope with pain. 2.Midwife visualized that client no longer complains.	K.H.A. D

PUERPERIUM CARE PLAN CONTINUE

DATE/ TIME	NURSING DIAGNOSIS	OBJECTIVE/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
23/11/21 7:30am	Frequency of micturition related to physiological changes that occur during puerperium that is reversal of hemodilation .	Client will be able to cope with frequency of micturition within 2 hours as evidenced by; 1.Client verbalizing that her normal bladder function has resumed. 2.Midwife noticing that client no longer complains.	1. Reassure client that her condition is temporal. 2. Explain the Physiology of frequency micturition to client. 3. Encourage client to put a pale closer to her bed at night. 4. Encourage client to bend forward when urinating so that the bladder will be empty. 5. Educate client to minimize the intake of water at night.	1. Client was assured that she will be relief after the blood becomes thicker. 2. Client was informed that frequency of micturition is due the thinning of the bladder during pregnancy. 3.Client was informed to put a pale closer to her bed at night. 4. Client bend forward anytime she urinates. 5. Client takes in less water at night.	26/11/21 8:30am	Goal fully met as 1. Client verbalized that she is able to cope with frequency of micturition. 2. Midwife noticing that client no longer complains.	**K.H.A.D**

PUERPERIUM CARE PLAN CONTINUE

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES/ OUTCOME CRITERIA	NURSING ORDER	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
22/11/21 9:30am	Breast engorgement related to slow emptying of the breast.	Client will be relieved of breast engorgement within 48hours as evidenced by; 1.Client verbalizing that her breast is no longer heavy. 2.Midwife noticing that client breast is not engorged.	1.Reassure client that breast engorgement will be relief after frequent breastfeeding her baby. 2.Encourage client to breastfeed baby on demand to reduce fullness. 3. Teach client manual expression of breast milk. 4.Assist client to apply warm compress on the breast after feeding to relieve pain. 5. Encourage client to put on well-fitting brassiere.	1. Client was assured that frequent breastfeeding will help relief breast engorgement. 2. Client was informed to breastfeed baby on demand. 3.Client express breast milk frequently. 4. Client applies warm compress on the breast morning and evening 5. Client supported her breast with a well-fitting brassiere.	26/11/21 4:00pm	Goal fully met as; 1. Client verbalized that she has been relieved. 2.Midwife visualized that client breast looks normal.	K.H.A.D

PUERPERIUM CARE PLAN CONTINUE

DATE/ TIME	NURSING DIAGNOSIS	OBJECTIVE/OUT COME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
26/11/21 4:30pm	Insomnia related to night breastfeeding baby and baby crying at night.	Client will be able to sleep 1 hour uninterrupted at night within 24hours as evidenced by; 1. Client verbalizing that she can now sleep. 2.Midwife noticing that client no longer complains.	1.Reassure client that the condition is temporal. 2. Educate client to feed baby on demand. 3. Encourage client to change baby's wet nappy. 4. Educate client on how to fix baby to the breast. 5. Educate client on how to breastfeed while lying.	1. Client was assured on the condition. 2.Client was informed to breastfeed baby on demand. 3.Client was told to change baby's wet nappy frequently 4.Client fix baby correctly to the breast. 5. Client was taught how to breastfeed while lying.	27/11/21 7:30am	Goal fully met as; 1.Client verbalized that she can now have enough sleep. 2.Midwife visualized that client no longer complains.	K.H.A. D

SUMMARY AND CONCLUSION

This family and client centered maternity care study was conducted on Madam Aniniwaa, a 32years old woman, who is gravida 3 para 2 alive. She was met at the Chiraa Health Center in the Bono Region. The client was 36 weeks' gestation when she was met on 26th October 2021. Client hails from Chiraa which is in the Bono Region. Care was given during pregnancy, labour and puerperium. Madam Aniniwaa and her baby went through these processes safely without any complications. She went through some minor disorders during pregnancy and puerperium which were managed successfully. The care study is an important and managerial tool which gives opportunity to student midwives to put into practice the theoretical knowledge and the ability to deal with obstetric problems as midwifery professionals. Various observations and examination including laboratory investigations were carried out to aid in the progress of normal pregnancy, labour and puerperium. Madam Aniniwaa delivered a live female child on 20th November, 2021 through spontaneous vaginal delivery without any complications and went through a normal and safe puerperium. Madam Aniniwaa and her family were cooperative, supportive and adhered to any form of education given to them. Through home visits, a close monitoring was made throughout pregnancy and puerperium. The baby was immunized on the day of delivery. Mother and her baby were in a healthy condition. Mother and baby were handed over to the Midwife- In-Charge for continuity of care. The care rendered to Madam Aniniwaa and her family has given the opportunity to recognize the various needs of individual women during pregnancy, labour and puerperium. Hope the experienced of this care study will enable render quality nursing and maternity care to all expectant mothers and their families throughout the career as a midwife.

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APPENDIX I

COMPLETE DIAGNOSTIC INVESTIGATIONS

DATE	SPECIMEN	INVESTIGATION	NORMAL RANGE	FINDINGS	REMARKS
13/04/21	Blood	Hemoglobin level	13-4g/dl	13.0g/dl	Normal
		Sickling status	Negative	Negative	Normal
		HIV/PMTCT	Negative	Negative	Normal
		G6PD	Negative	Negative	Normal
		HBsAg	Negative	Negative	Normal
		Blood Group	A, B, AB, O	O	Normal
		Rhesus factor	Positive/Negative	Positive	Normal
		Urine	Negative	Negative	Normal
28/05/21	Urine	Protein	Negative	Negative	Normal
		Sugar	Negative	Negative	Normal

DATE	SPECIMEN	INVESTIGATION	NORMAL RANGE	FINDINGS	REMARKS
31/06/21	Urine	Protein	Negative	Negative	Normal
		Sugar	Negative	Negative	Normal
26/07/21	Urine	Protein	Negative	Negative	Normal
		Sugar	Negative	Negative	Normal
24/08/21	Urine	Protein	Negative	Negative	Normal
		Sugar	Negative	Negative	Normal
20/09/21	Blood	Protein	Negative	Negative	Normal
	Urine	Sugar	Negative	Negative	Normal
19/10/21	Urine	Protein	Negative	Negative	Normal
		Sugar	Negative	Negative	Normal
19/11/21	Blood	Hemoglobin level	11-16g/dl	12.7g/dl	Normal
	Urine	Protein	Negative	Negative	Normal
		Sugar	Negative	Negative	Normal

APPENDIX 1I

PHARMACOLOGY OF DRUGS FOR MOTHER

NAME OF DRUG	CLASSIFICATION	DOSAGE	ROUTE	ACTION AND USES	ACTUAL EFFECT	SIDE EFFECTS	SIDE EFFECT EXPERIENCED
Tetanus diphtheria	Anti-tetanus vaccine	0.5milligram	Subcutaneous	Help prevents tetanus	Client was protected against tetanus infection	Slight fever and chills	None observed
Tablet Multi vitamin	Vitamin Preparation	200 milligrams twice daily	Oral	Increase Appetite, helps in the formation of red blood cells	Increased appetite.	Gastrointestinal disturbance	None observed
Tablet Ferrous Sulphate	Hematinic	200 milligrams once daily	Oral	Helps in red blood cell formation.	Increase in hemoglobin level.	Gastrointestinal disturbance and blood stool	None observed

NAME OF DRUG	CLASSIFICATION	DOSAGE	ROUTE	ACTION AND USES	ACTUAL EFFECT	SIDE EFFECTS	SIDE EFFECT EXPERIENCED
Tablet Folic Acid	Vitamin Preparation	5 milligrams Once daily	Oral	Proper formation and function of red blood cell	Hemoglobin level increased	Nausea and vomiting	None observed
Tablet Paracetamol	Analgesics	1 gram 3 times daily for 3 days	Oral	Helps to relieve pain	Pain was relieved	Prolong use causes damage to the liver.	None observed

PHARMACOLOGY OF DRUGS FOR BABY

NAME OF DRUG	CLASSIFICATION	DOSAGE	ROUTE	ACTION AND USES	ACTUAL EFFECT	SIDE EFFECT	SIDE EFFECT EXPERIENCED
Vitamin K	Coagulant	1milligram	Intramuscular	Production of prothrombin	No bleeding	None	None observed
Tetracycline eye ointment	Prophylaxis antibiotic	2 drops	Instillation	To prevent eye infections	Infection of the eye prevented	Nephroxicity	None observed
Oral Polio Vaccine	Antigen	2 drops	Oral	Production of antibodies against poliomyelitis	Baby is under observation	There may be diarrhea	None observed
Bacillus Chalmette Guerin injection	Antigen	0.05mg	Intradermal	Immunity against Tuberculosis	Baby is under observation	Mild fever, swelling at injected site and blister formation	Blister noticed
Pneumococcal 1	Antigen	0.5 ml	Intramuscular (right thigh)	Immunity against pneumonia	Baby is under observation	Fever and redness at the site of injection	None observed
Pentavalent 1	Antigen	0.5 ml	Intramuscular (left thigh)	Immunity against Diphtheria, Pertussis, Tetanus, Haemophilus influenza B and Hepatitis B	Baby is under observation	Low grade Fever	None observed
Rotavirus 1	Antigen	1.5ml (2 drops)	Oral	Immunity against rotavirus(diarrhea)	Baby is under observation	Vomiting	None observed

APPENDIX III

ANTENATAL CHART RECORD

Date	BP (mmHg)	Weight (kg)	Urine Protein/ Sugar	Gestation (weeks)	Fundal Height (cm)	Presentation	Descent	Fetal Heart Rate(FH)	Complains	Treatment	SIGN
13/04/21	110/60	69	Negative/ Negative	17	NP	_	_	+	Feels well	Tablet folic acid, tablet ferrous and tablet multivite. Education on danger signs in pregnancy.	S.T
11/05/21	120/70	69	Negative/ Negative	21+2	21	_	_	+	Feels well	Tabs folic acid Tab Multivite Spa and education on immunizations.	M.B
08/06/21	90/60	67	Negative/ Negative	25+2	26	Cephalic	_	130	Feels well	Routine drugs were given and Encouraged to avoid stressful exercises.	M.B
06/07/21	100/50	70	Negative/ Negative	29+2	29	Cephalic	$5/5^{th}$	140	Headache	Routine drugs and tablet Paracetamol and education on sleeping under treated net.	S.T

ANTENATAL CHART RECORD CONTINUED

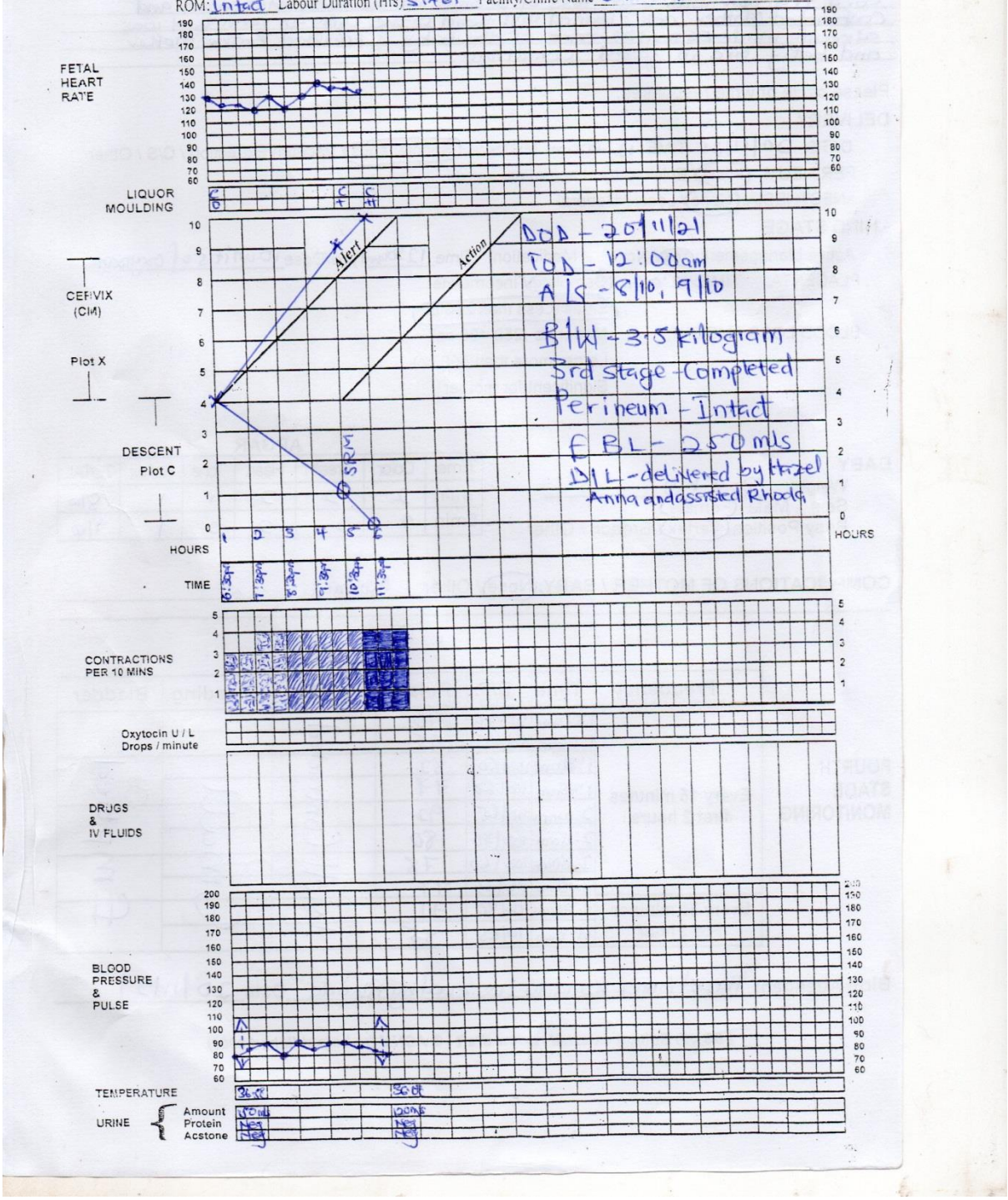
Date	BP (mmHg)	Weight (kg)	Urine Protein/ Sugar	Gestation (weeks)	Fundal Height (cm)	Presentation	Descent	Fetal Heart Rate(FH)	Complains	Treatment	SIGN
3/08/21	110/50	70	Trace/ positive	33+2	32	Cephalic	$5/5^{th}$	134	Feels well	Tablet folic acid tablet ferrous and Tablet Multivite and education on dander signs in pregnancy, Voluntary counselling and testing.	P.D
31/08/21	110/70	72	Trace/ Negative	35	35	Cephalic	$5/5^{th}$	136	No complains	Tabs folic acid, Tab Multivite Spa and education on immunizations.	Asana

ANTENATAL CHART RECORD CONTINUED

Date	BP (mm Hg)	Weight (kg)	Urine Protein/ Sugar	Gestation (weeks)	Fundal Height (cm)	Presentation	Descent	Fetal Heart Rate(FH)	Complains	Treatment	SIGN
26/10/21	100/ 60	73	Negative/ Negative	36+2	36	Cephalic	5/5th	138	Lower abdominal pains and waist pains	Routine drugs. Client served with Paracetamol 1gm and educated on birth preparedness and complications readiness.	K.H.A.D
02/11/20	100/ 60	74	Negative/ Negative	37+2	38	Cephalic	4/5th	140	Feeling well	Routine drugs. Education on signs of labour.	K.H.A.D
09/11/20	120/ 80	75	Trace/Negative	38+2	38	Cephalic	4/5th	138	No complains	Routine drugs Encouraged to avoid stressful exercises.	K.H.A.D

WHO Modified Partograph

Registration No.: 178/21 Name(Last, First) Aminaaa Moniq Age: 32 years
Date: 19/11/21 Parity/Gravida G5P2^{2nd} LMP 10/02/21 EDD 17/11/21 Gestation(wks) 38+2
ROM: Intact Labour Duration (Hrs) 5:40 Facility/Clinic Name Chiraa Health center



LABOR NOTES

At 12:00am, client had an SVD to alive female infant with APGAR Score of 8/10. in first 1 minute within 5 minutes cord was clamped and cut 10units of Oxytocin given IM to mother right at 12:01am, placenta and membrane delivered completely by controlled cord traction with blood loss of 250mls, uterus well massaged and contracted. Mother well cleaned and Send to the lying-in room bed was already made. Essential care of the baby is provided. Both mother and baby are in good condition.

Please circle or write responses.

DELIVERY

DATE: 20/11/21 TIME: 12:00am METHOD: (Spontaneous) / Vacuum Extraction / C/S / Other

PERINEUM: (Intact) / Episiotomy / Laceration

ANESTHESIA: (None) / Local / General

THIRD STAGE

Active Management: (Yes) / No ·Medication: Time 12:01am Type/Dose 10 units of oxytocin

PLACENTA: TIME: 12:05am (Complete) / Incomplete

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

BABY

Weight: 3.5kg

Sex: Male / (Female)

Baby Position: (Vertex) / Breech / Other

APGAR

Time	Color	Breath	Heart	Tone	Reflex	TOTAL
1min	2	2	2	1	1	8/10
5min	2	2	2	2	1	9/10

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

FOURTH STAGE MONITORING

Frequency	Time	B/P.	Pulse	Fundus	Bleeding	Bladder
Every 15 minutes first 2 hours	1:00am	110/70	90	Contracted		
	1:15am	110/65	95			
	1:30am	100/60	82			Emptied
	1:45am	100/60	77			
	2:00am	110/65	92			
	2:15am	100/70	80			Emptied
	1:30am	100/60	78			
	3:15am	106/65	77			
Every 30 minutes For 1 hour	3:45am	120/80	71			
	4:15am	110/65	85			

Birth Attendant Hazel Anna Konadu assisted by Rhoda Date 20/11/21

MATERNITY CHART

NAME: MONICA ANINIWAA

AGE: 32 years WARD: LYING - IN

IP NO.: 178/21 BED NO.:

Date	20/11/21	21/11/21	22/11/21	23/11/21	24/11/21	25/11/21	26/11/21	27/11/21
Days in Hospital	DOD	D1	D2	D3	D4	D5	D6	D7
Days P. O.								
Hour AM	12:00	7:30	9:30	8:30	8:45	8:00	9:00	8:30
PM		4:30	5:00	4:30	4:30			
Temperature C / F								
Pulse								
Resp.								
B.M.								
Urine	Passed	Passed	Passed	Passed	Passed	Passed	Passed	Passed
B. P. AM	110/70	110/65	100/60	100/65	100/65	100/65	100/70	110/60
PM		110/65	100/60	100/60	100/70			

SFH

KEY

- S. FUNDAL HEIGHT
- TEMPERATURE

NEW BORN EXAMINATION FORM

Name: Baby Ama Aniwaa Date of Assessment: 20/11/21 Time: 1st day
Date of Birth: 30/11/21 Time of Birth: 12:00am Sex: ☐ M ☑ F Age at time of Assessment (days/hrs) _____
Astational Age 38 ☐ +2 ☐ Mode of Delivery: ☑ Vaginal Assisted Vaginal C-Section
APGAR: 1min 8 5min 9 Birth Weight: 3 kg 5 Length: _____ cm Head Circumference: 33 cm
Temperature at time of Assessment: 37.2 °C Urine passed: Yes No Meconium passed: ☑ Yes No
Name of Assessor (Midwife/Doctor): Konadu Hazel Anna Danquah

1. Respiration
Rate 42 cpm
☐ Rate < 30 b/m *
☑ Rate < 60 b/m *
☐ 30-60 b/m
☐ Retractions *
☐ Grunting *
☐ Stridor *

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

3. Tone
☑ Normal
☐ Floppy *
☐ Increased *

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

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

6. Cry
☑ Normal
☐ Shrill *
☐ Absent *

7. Suck
☑ Good
☐ Weak
☐ Absent

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

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

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

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

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

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

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

16. Clavicle
☑ Normal
☐ Swelling/Fracture

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

18. Heart rate
Rate: 138 bpm
☑ Normal (100-160)
☐ <100 *
☐ >160*

19. Femoral pulse
☑ Present
☐ Not palpable*

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

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

22. Limbs
☑ Normal
☐ Abnormal _____

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

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

24. Anus
☑ Patent
☐ Imperforate*

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

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

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

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

NEW BORN EXAMINATION FORM

Name: Baby Ama Aniniwaa Date of Assessment: 21/11/21 Time: 2nday
Date of Birth: 20/11/21 Time of Birth: 12:00am Sex: ☐ M ☑ F Age at time of Assessment (days/hrs) _____
Astational Age 38 ☐ + 2 ☐ Mode of Delivery: ☑ Vaginal Assisted Vaginal C-Section
APGAR: 1min 8 5min 9 Birth Weight: 3 . kg 4 Length 45 cm Head Circumference: 33 cm
Temperature at time of Assessment: 37.2 °C Urine passed: Yes ✓ No Meconium passed: ✓ Yes No
Name of Assessor (Midwife/Doctor): _____

1. Respiration
Rate 42cpm
☐ Rate < 30 b/m *
☑ Rate < 60 b/m *
☐ 30-60 b/m
☐ Retractions *
☐ Grunting *
☐ Stridor *

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

3. Tone
☑ Normal
☐ Floppy *
☐ Increased *

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

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

6. Cry
☑ Normal
☐ Shrill *
☐ Absent *

7. Suck
☑ Good
☐ Weak
☐ Absent

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

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

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

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

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

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

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

16. Clavicle
☑ Normal
☐ Swelling/Fracture

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

18. Heart rate
Rate: 138bpm
☑ Normal (100-160)
☐ <100 *
☐ >160*

19. Femoral pulse
☑ Present
☐ Not palpable*

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

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

22. Limbs
☑ Normal
☐ Abnormal _____

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

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

24. Anus
☑ Patent
☐ Imperforate*

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

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

*May indicate severe disease that requires urgent referral
Diagnoses (if known) _____
Classification: (Overall assessment) [ ] Normal [ ] Baby with a Problem [ ] Danger Sign/ <1500g/ severe Jaundice
Plan: [✓] Routine Care [ ] Problem. Continue supportive in-patient care [ ] Urgent Referral / Advanced Care [ ] Discharge

TEMPERATURE CHART

NAME: Baby Ama Aniniwaa

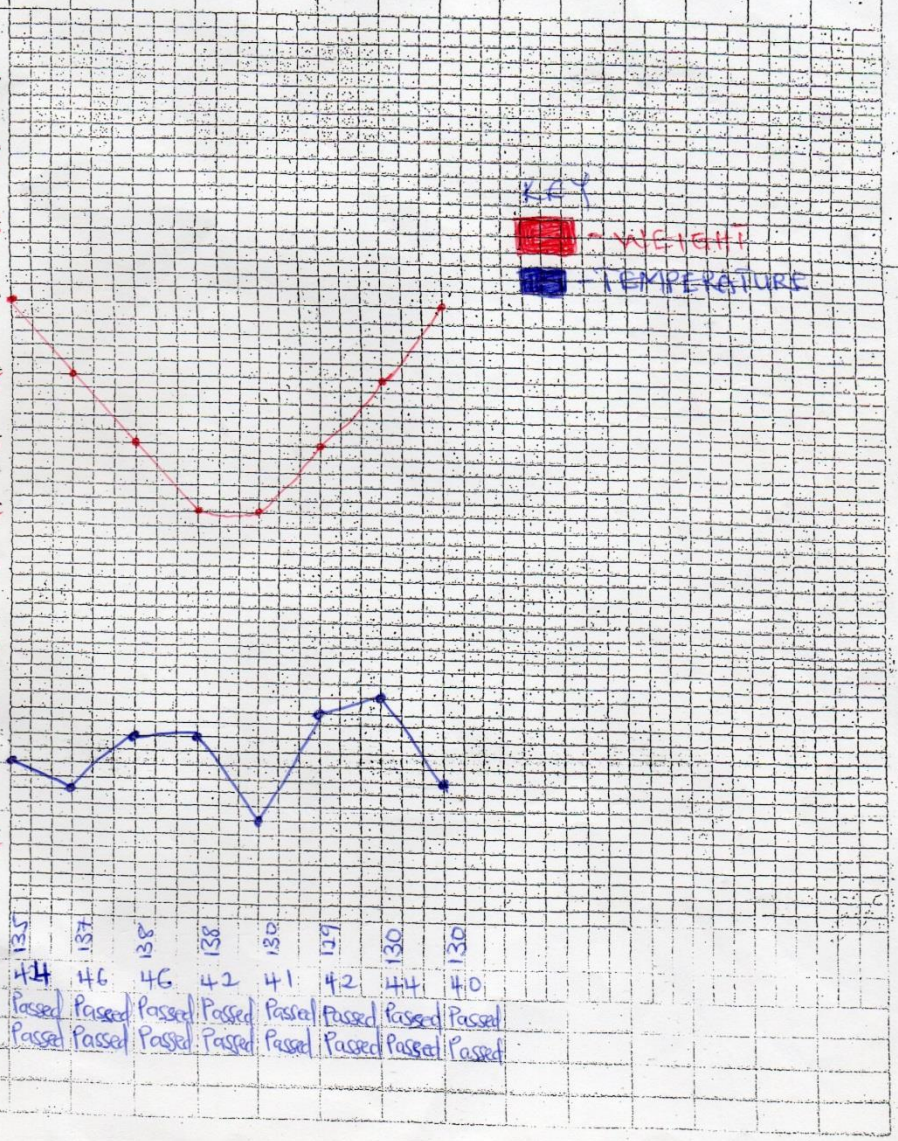
AGE: ..... WARD: Maternity

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

Date	20/4/21	21/4/21	22/4/21	23/4/21	24/4/21	25/4/21	26/4/21	27/4/21	28/4/21
Days in Hospital	DD	D1	D2	D3	D4	D5	D6	D7	D8
Days P. O.									
Hour AM		7:30	9:30	8:30	8:45	8:00	9:00	8:30	
Hour PM				4:30	4:30				
Pulse	135	137	138	138	130	129	130	130	
R.B.S.	44	46	46	42	41	42	44	40	
B.M.	Passed	Passed	Passed	Passed	Passed	Passed	Passed	Passed	
Urine	Passed	Passed	Passed	Passed	Passed	Passed	Passed	Passed	
B. P. AM / PM									

Temperature

C	F
41.1	38
40.5	37
40	36
39.5	35
39	34
38.5	33
38	32
37.5	31
37	30
36.5	29
36	28
35.5	27



NEW BORN CHART

Name: Baby Ama Aniniwaa No: Birth Weight: 3.5 kilogram

Sex: Female Mother's No: 178/21 Length: 45 centimeters

Nature of Delivery: Spontaneous Vaging Diagnosis: Term Baby

Date of Birth: 20/11/21 Time: 12:00am Date of Discharge: 21/11/21

Date	20/11/21		21/11/21		22/11/21		23/11/21		24/11/21		25/11/21		26/11/21		27/11/21							
No. of Days	DOL		D1		D2		D3		D4		D5		D6		D7							
Weight	3.5		3.4		3.3		3.2		3.2		3.3		3.4		3.5							
	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM
Temperature	37.2		36.6	36.6	36.3	36.8	36.8	37.0	36.8	36.8	36.2		37.0		37.1							
Stools	Passed		Passed	Passed	Passed	Passed	Passed	Passed	Passed	Passed	Passed		Passed		Passed							
Urine	Passed		Passed	Passed	Passed	Passed	Passed	Passed	Passed	Passed	Passed		Passed		Passed							
Remarks	Head Neck Trunk Genitalia Limb		No abnormality detected																			

SIGNATORIES

CANDIDATE NAME

NAME: HAZEL ANNA DANQUAH KONADU

SIGNATURE:.....

DATE: 10/10/2022

THE MIDWIFE IN-CHARGE

NAME: MS GLADYS MAHAMA

SIGNATURE: ..... (Sgd)

DATE: 10/09/2021

SUPERVISORS

NAME: MS ERNESTINA MENSAH

SIGNATURE:.....

DATE: 10/10/2022

THE PRINCIPAL

NAME: MONICA NKRUMAH

SIGNATURE: ..... (Sgd)

DATE: 12/10/2022

ACADEMIC CO-ORDINATOR - NURSING
HOLY FAMILY NURSING & MIDWIFERY
TRAINING COLLEGE, BERekum