HOLY FAMILY NURSING AND MIDWIFERY TRAINING COLLEGE

BEREKUM

A CLIENT/FAMILY CENTERED MATERNITY CARE STUDY ON

MADAM BOAHEMAA HELINA

BY

ADOMA JULIET OFORIWAA

4122210027

SUBMITTED TO THE NURSING AND MIDWIFERY COUNCIL OF GHANA IN PARTIAL FULFILMENT TOWARDS THE AWARD OF LICENSE TO PRACTICE AS A PROFESSIONAL REGISTERED MIDWIFE (DIPLOMA)

AUGUST, 2023

TABLE OF CONTENT

PREFACE

Family centered maternity care study is a systematic approach of rendering holistic midwifery care to gravid woman and her family throughout pregnancy, labour and puerperium base on a thoughtful understanding of the client as a unique individual with special problems and needs. The family centered maternity care is mainly based on total nursing care in which the physical, psychological, spiritual, social, and rehabilitative aspect of the client is considered. It includes the expectant mother, her family and the community in preparing towards the impending arrival of a new family member.

The client and family centered maternity care study also helps students midwives to make good use of the new trends in midwifery like the use of partograph to monitor client in the first stage of labour and the continuity of care to the client after delivery. With this it also enables the student to practice the aspect of midwifery that deals with the client needs, the right of the clients in rendering quality and proper care to her satisfaction. It also helps the student to gain knowledge in the changes and management, ideals and practices in the clinics and maternity homes.

The care study offers the student midwife the opportunity to put the knowledge and skills acquired during training into practice. It also enables her to detect problems and needs of the mother and her family. Also the family centered maternity care study helps to reduce maternal and neonatal morbidity and mortality. The client and family centered maternity care study is compiled into a document in partial fulfillment for the award of registered midwifery certificate by the Nursing and Midwifery Council of Ghana.

ACKNOWLEDGEMENT

My profound goes to the Lord Almighty for the grace and understanding granted in the courseof study.

My sincere thanks go to the principal Ms. Monica Nkrumah of Nursing and Midwifery Training College, Berekum who helped and guided in diverse ways to make this work a success. My heartfelt thanks go to my supervisor Mrs. Ernestina Mensah for her dedication and immense contribution which has made this work a success, and also all Tutorial and non-teaching staff who helped in diverse ways in making this exercise a fruitful one.

I am grateful to all the staff especially the head of Ampenkrom St. Matthew Hospital and the in-charge of the Maternity Mrs. Irene Akoto.

Special thanks to the client, Madam Helina his husband, and entire family for their maximum co-peration and necessary information given during the writing of this care study. Furthermore, sincere thanks to all beloved family members more especially my

Brother Adomah Clifford and my father Adomah Abraham and my siblings for their financial, spiritual and moral support.

Finally, sincere gratitude goes to the publishers of various books used as reference for this care study.

.

INTRODUCTION

The family centered maternity care is an academic work which gives the student midwife the opportunity to nurse a client throughout pregnancy, labour and puerperium using the knowledge and skill acquired during the 3-year training programme.

The study is based on the use of nursing process as guidelines to identify and help thepregnant woman in solving every problem identified during the period of care.

The study was conducted on Madam Helina, a 22year old gravida 2 Para 1 alive. She hails from Tamale in the Northern Region of Ghana but stays at Papa Adu House, Apenkrom , Dormaa inthe Bono region. We had an encounter on 22nd November, 2022 at Apenkrom Hospital. 37 weeks gestation and had come for her seventh antenatal care visit.

Introduction was made as a student midwife who wishes to take care of her throughout the rest of her pregnancy, through delivery and pueperium. She had no health issues when we had the encounter.

The interaction ended after client had delivered spontaneously to an alive female child withoutany complication. Mother and baby had a successful puerperal period and they were handed over to the public health nurse for continuity of care in a healthy state. There are four chaptersoutlined in this script.

Chapter One: Is the collection of the client's social, medical, menstrual, lifestyle and hobbies,past and present obstetrical histories.

Chapter Two: Involves antenatal care which begins from the time of conception till theninth month when the woman was due for delivery.

Chapter Three: Is about the care given to the client during labour and delivery.Chapter Four: Talks about the puerperium.

At the end of each chapter is a care plan drawn to solve problems encountered by client, summary, conclusion, bibliography and appendix. The client will be called Madam Helinathroughout this project.

LITERATURE REVIEW

PREGNANCY

According to Tiran, D. (2012) pregnancy is from conception to delivery of the fetus; normal duration is 280 days (40 weeks or 9 months and 7 days), counting from the first day of the last to delivery or 265 days from conception to delivery.

According to Marshall and Raynor (2014) pregnancy is divided into three trimesters. The first trimester is from conception until 12 weeks of gestation. The phase is associated with changes such as breast tenderness and feeling nauseated. The second trimester starts from 13 weeks to 25 weeks where pregnancy is noticed physically as the woman's body make-up changes to adjust to the pregnancy. The third trimester is from 26 weeks to 40 weeks, a period when the fetus continuous to grow and become matured for delivery. Care must therefore be taken once pregnancy has been confirmed so that the woman carries the pregnancy to term successfully.

According to Weller (2014), pregnancy is being with a child, the condition from conception to expulsion of the foetus. The normal period is 280 days or 40 weeks counted from the first day of the last menstrual period.

Myles (2014) describes pregnancy as a unique experience for every woman and each pregnancy the woman experiences will be new and uniquely different, nausea and vomiting, constipation, heartburns, headache, leg cram are minor disorders of pregnancy. Changes in the urinary system during pregnancy occur as a result of enlarging uterus affecting all the parts of the urinary tract at various times with the hormones of pregnancy having an even greater influence than mechanical effects. Progesterone relaxes the walls of the ureters, and allows dilatation and kinking. In some women this can result in stasis of urine resulting in marked infection

King (2014) states that, the prenatal period covers the time from the first day of the last menstrual period to the start of true labour, which marks the beginning of the intrapartum period. Prenatal period is divided into trimesters, the first trimester is 1to 12 weeks because organogenesis is completed at the end of twelve weeks (12) and the risk for spontaneous abortion is significantly reduced at this time. Second trimester is 13 to 28 weeks, third trimester extends from weeks 28 to 40. The term 'post- date' is typically used to describe a pregnancy beyond forty weeks (40)

According to Oduro-Kwarteng (2015), pregnancy is the condition of having a developing embryo or foetus in the uterus as a result of the union of an ovum and spermatozoa. Pregnancy can occur any time after a female begins to menstruate (menarche) in conjunction with ovulation until she reaches menopause where ovulation ceases.

LABOUR

According to Jacob (2013), labour is the process that involves a series of integrated uterine contractions that occur over time, and work to propel the product of conception (foetus, placenta and amniotic fluid) out of the uterus through the birth canal.

Konar (2013) states that, labour is the process by which the fetus, placenta and membranes are expelled through the birth canal. The events of labour are divided into four stages: First stage starts from the onset of true labour pains and ends with full dilation of the cervix. It is in other words the 'cervical stage' of labour. Its average duration is twelve hours (12) in prim gravida and (6) in multipara. Second stage starts from dilation of the cervix (not from the rupture of membranes) and ends with expulsion of the fetus from the birth canal. It mostly last up to 30 minutes in multiparous and 60 minutes in nulliparous women. Third stage begins after delivery after delivery of the fetus and ends with the expulsion of the placenta and membranes. Its average duration is about 15 minutes

in both primigravida and multipara. Fourth is the stage of observation for at least one (1) hour after expulsion of product of conception. During this period, general condition of the patient and the behavior of the uterus are to be carefully monitored.

Marshall& Raynor (2014) stated that labour in the physical sense as the process by which the fetus, placenta and membranes are expelled through the birth canal. Normal labour occurs between 37 to 40 weeks of gestation. Labour begins when there are regular, painful contractions and with cervical dilatation. Signs and symptoms of labour are painful regular contractions, show, progressive dilation of the cervix, and sometimes ruptured membranes. First stage of labour begins with cervical dilatation which begins with rhythmic contractions until the cervix is fully dilated. This stage is in two phases, the latent phase is 0 - 3cm and the active phase starting from 4cm – 10cm when the cervix is fully dilated with both phases lasting from 8- 12hours. Second stage of labour begins with the expulsion of the foetus from the birth canal. It begins when the cervix is fully dilated and the woman feels the urge to expel the foetus. It is however complete when the baby is born. This last from 30 minutes to 1 hour. The third stage is the separation and the expulsion of the placenta and its membranes as well as arrest of haemorrhage. From the above, it can be deduced that labour is a physiological phenomenon which can be managed by the midwife with the use of partograph, aseptic delivery process and active management of third stage of labour (control cord traction).

Myles (2014) describes labour as the process by which the fetus, placenta and membranes are expelled through the birth canal. It also explained that the first stage of labour can be divide into 3 stages namely;

- The latent phase which is prior to the active phase of first stage of labour and may last for 6-8hours in primigravida when the cervix dilates from 1cm to 3cm and to cervical canal shortens from 3cm long to less than 0.5cm long.

- The active phase which is the time the cervix undergoes more rapid dilation. This begins when the cervix is 4cm dilated and the presence of rhythmic contractions, is completed when the cervix is fully dilated (10cm).
- The transitional phase which is the stage of labour when the cervix is from around 8cm dilated until it is fully dilated or the until the expulsive contractions of second stage are felt by the woman. There is often a brief lull in the intensity of uterine activity at this time.

According to Tiran (2015), normal labour occurs spontaneously after 37 weeks' gestation with vertex presentation of single foetus, completed within 24 hours without maternal and foetal trauma; physiology depends on interaction between uterus, maternal pelvis and foetus.

PUERPERIUM

According to Jacob (2013), puerperium is a period following childbirth during which the body tissues especially the pelvic organs reverse back approximately to the pre-pregnant state both anatomically and physiologically, he further explained that, the post-partum period is divided in immediate puerperium that is the first 24 hours early puerperium from the end of all 24 hours up to 7 days. Remove 8 from the end of 7 days up to 6 weeks.

Konar (2013) states that, lochia is the vaginal discharge for the first fortnight during puerperium. The discharge originates from the uterine body, cervix and vagina. Depending upon the variation of the colour of discharge, it is named as;

- ❖ Lochia rubra; red, 1-4 days
- ❖ Lochia serosa; pink or pale brownish, 5-6 days
- ❖ Lochia alba; pale white, 10-15 days

Konar (2013) also added that, the average amount of discharge for the first 5-6 days is estimated to

be 250ml, normal duration extends up to 3 weeks.

American Academy of paediatrics (2014) cited in their provider guide: Essential Care for Every Baby that all babies must be given eye care by instillation of tetracycline/chloramphenicol eye drop/ointment to prevent eye infection and also administering of vitamin K injection to prevent haemorrhage disease of the new born as well as cord dressing.

Marshall and Raynor (2014) stated that puerperium starts immediately after the delivery of the placenta membrane and continues for six weeks. In many cultures around the world, 40 days for recuperation is a time-honoured practice. The general expectation is that by six weeks after birth all the systems in a woman's body will have recovered sufficiently from the efforts of the pregnancy and recovered to their non-pregnant state.

Oduro-kwarteng (2015), defines puerperium as a period that start immediately after delivery of the placenta to 6-8 weeks. This period is characterized by a lot of physiological changes, some of which include the following; lactation is well established, the productive organs return to the non-pregnant state.

According to Tiran (2015) puerperium is a period of six to eight weeks following childbirth during which the uterus and other organ structures return to their non-pregnant state.

Myles (2014) stated that puerperium starts immediately after delivery of the placenta and membranes and continues for six weeks after which all the systems in the woman's body will recover from the effects of pregnancy and return to their non -pregnant state. Myles strikes the difference between exercise and healthy activity verses rest, relaxation and sleep. Exploring each person's level activity will encourage advice in relation to appropriate exercise and by association, nutritional intake and rest or relaxation and sleep. Undertaking regular pelvic floor exercise is of benefit to the woman's

long-term health. Myles mentioned that, regardless of whether women are breastfeeding, they may experience tightening, and enlargement of their breast towards the 3rd or 4th day. Hormonal influences encourage the breast to produce milk. For women who are breastfeeding the general advice is to feed the baby and avoid excessive handling of the breast. Simple analgesics may be required to reduce the discomfort.

WHY CLIENT WAS CHOSEN

Madam Helina G2 P1 reported to the antenatal clinic on the 22nd November, 2022 and she complained of loss of appetite. She explained that her previous pregnancy was not like that. Client was advised that every pregnancy different and that she should not worry. She was advised to perform proper oral hygiene, also she should eat in bit and at frequency intervals. Opportunity was taken for introduction as a student midwife from Holy Family Nursing and Midwifery Training College, Berekum on community midwifery practical experience for a period eight weeks. Permission was sought from her to be taken as a client for the care studywhich she accepted. All the necessary particulars were collected. Appointment for home visitwas booked, direction to her house was given and phone numbers were exchanged.

CHAPTER ONE

CLIENT PARTICULARS

1.0 INTRODUCTION

This chapter gives a preview on the various histories and information about the client, her family and the community in which she lives.

1.1 SOCIAL AND PERSONAL HISTORY

Madam Helina, a 22-year-old gravida 2 para 1 alive comes from Tamale in the Northern region of Ghana, but stays at Apenkrom in the Bono Region. She is fair in complexion and weighs 65kg and 160cm in height. Her native language is Hausa. She is a Christian. She owns a provision shop which she runs at her house. Madam Helina is married to Mr. Owusu a 34 years old man who is afarmer. They have been married for almost 4 years. She had her basic education at Northern Region, the husband also had his education up to the PrimarySchool. Her source of support is the husband and the family. Her beloved husband is the next of kin.

1.2 FAMILY HISTORY

Mr and Mrs Boateng happen to be her parents and they are all alive. She is the fifth born of her parent's among six siblings. Both parents speak Twi and Hausa. Both hail from Tamale and now reside at Apenkrom. According to Madam Helina, there is no history ofHypertension, Diabetes Mellitus, Sickle cell disease, Asthma and mental illness in her family. They do not have any history of congenital abnormalities such as cleft lip or palate or heart diseasein the family. She admitted that multiple pregnancies run through her mother's family. Deaths in her family occur naturally.

1.3 MEDICAL HISTORY

According to Madam Helina, she has no history of medical condition such as hypertension, diabetes, hepatic disorders, kidney problems, pulmonary disorders among others. She has never been admitted to the hospital. Even though she sometimes suffers from certain illnesses, she is treated as an outpatientclient whenever she reports to the hospital for treatment. Throughout her life, she has never reacted toany drug or a type of food taken She is not on any lifelong medication.

1.4 SURGICAL HISTORY

According to Madam Helina, she has never received or donated blood. She has not been involved in any road traffic accident or accident or any sort which could affect the adequacy ofher pelvis or spine. She has never undergone any surgical operation since infancy. None of herfamily members has even undergone any surgical procedure.

1.5 MENSTRUAL HISTORY

Madam Helina was 14 years when she had her menarche. Her regular menstrual cycle is 28 days amount of blood loss is moderate each month and last for 5 days. She uses sanitary pad during the flow and changes it two times daily. Her last menstrual cycle was on 4th March, 2022. She has no history of dysmenorrhea. Her expected date of delivery was calculated to be 11th December, 2022.

1.6 CLIENT'S HOBBIES AND LIFESTYLE

Madam Helina usually goes to bed at 9:30 pm and wakes up at 5: 30 am. Routinely, morning devotion is the first line of action she takes to give glory to God for his kind gesture and benevolence towards her life and family. She does few house chores like sweeping, dusting and baths her child. She then starts to prepare breakfast. She serves it for her child to eat after which she prepares her

for school. Since Madam Helina is a shopkeeper, she also prepares for work after taking her bath and making sure everything is in order in the house. She goes to the market and come home at 3:30pm to prepare supper for the family. All these are done from Monday to Friday. On weekends, she does certain chores such as washing dirty cloths and scrubbing the house. She prefers playing ludo and watching local movies. She uses pepsodent and pepsodent brush every morning to clean her teeth. Tuo zaafi with green leafy soup and meat is her favorite meal. She eats three times daily and takes in enough water and empties her bowel twice a day. Together with her family, they watch movies and have some fun until the day fades away. She neither smokes nor drinks alcohol**.**

1.7 PAST OBSTETRICAL HISTORY

PREGNANCY

Madam Helina is Gravida 2 Para 1 alive with no history of spontaneous or induced abortions. The interval between the first pregnancy and the current one is three years. According to the Antenatal records, she never had problem during her pregnancies such as pre-eclampsia, antepartum haemorrhage, anaemia and gestational diabetes. She experienced some minor disorders like leucorrhoea, ptyalism, of which she was managed, but was a regular attendant at Antenatal session and took two Tetanus shots and four doses of Sulphadoxine Pyremethamine.

Labour

According to client, labour started spontaneously and mode of delivery was vaginal delivery when she was term, it was neither induced nor augmented, no laceration at the perineum at Tamale Teaching Hospital. The outcome of labour was a live healthy female child (first child) with birth weight of 3.4kg and length of 50cm. Postpartum complications such as postpartum haemorrhage, retained placenta, breast engorgement was not recorded and client confirmed not experiencing any complications. According to client blood loss was minimal and the duration of labour did not exceed

18 hours.

Puerperium

According to client, she did not suffer any complications after delivery and baby too was healthy. Madam Helina exclusively breastfed the child for the first six (6) months and continued with complementary feeds. And weaned her at 2 years. The child was also fully immunized against the childhood preventable diseases. According to client, much attention was given to her from her beloved husband and family during this puerperal period so she did not want.

According to client, she has never used any artificial family planning method but uses the natural family planning (cycle beads). She attended the postnatal clinic as scheduled.

1.8 PRESENT OBSTETRICAL HISTORY

Madam Helina reported to the antenatal clinic on 27/07/22 with the last menstrual period on 4/03/2022. Upon this the expected date of delivery was calculated to be 11/12/2022. Serving as baseline for the comparison with the subsequent antenatal recording, the following laboratory investigation and vital signs were recorded on her booking visit; Temperature 36.5 degree Celsius, Pulse 92 beats per minute, Respiration 23 cycles per minutes, Blood Pressure 90/60 millimeters of mercury, Weight 72 kilograms, Height 170 centimeters

The results of the various laboratory investigations done were as follows; Haemoglobin 9.7 grams perdeciliters, sickling test Negative, Blood group O, Rhesus Negative, Hepatitis B Non-Reactive, VDRLNegative, G6PD Normal, HIV status Non-Reactive, Urine for protein and sugar Negative, Gestationalweeks 20weeks, Symphysio fundal height palpable No abnormality was detected on

Madam Helina after carefully conducting head to toe examination. Her complains were headache and her inability to sleep especially at night. Client was regular at antenatal clinic, and her complaints were addressed and scheduled for the next visit. Client attended subsequent visit at the antenatal clinic and the routine care and drugs were given to her until she was met.

She was served with the following routine drugs.

Tablet ferrous one daily x 30 days Tablet

Folic Acid one daily x 30 days Tablet

Multivitamin one daily x 30 days

CHAPETR TWO

ANTENATAL CARE

2.0 INTRODUCTION

This chapter describes the care given to the client during antenatal period. It also gives information about first contact with client, home visits made and nursing care plan on problems identified.

2.1 FIRST CONTACT WITH THE CLIENT

Madam Helina was a regular attendant to the antenatal clinic and it was through one of these visits that she was met on the 22nd of November, 2022 at 37weeks gestation and her 6th visit to the clinic. She was warmly welcomed and a seat was offered to her and inquiry about her health and that of her family was made. She said they were all fine and that she was coming for antenatal care. Her antenatal book was collected and glanced through and then introduction was made to her as a student midwife from Holy Family Nursing and Midwifery Training College, Berekum who came to have clinical experience and then wish to use her for a care study. All details of information and procedures involved in the study were explained to her and she gladly agreed and promised to give all the information needed and the maximum cooperation.

She was asked to empty her bladder and a specimen bottle was given to her and it was explained to her the need to obtain midstream urine, to check for ketone, protein and sugar.

Urine Testing

Procedure was explained to the woman and her consent was gained. Protective clothing such as mackintosh and gloves were worn. Quantity of the urine was noted, the colour observed, the odour andsediments were noted for. Instructions on the reagent bottle were read, expiry date was checked for and a strip was picked from it and dipped into the urine. The strip was removed immediately

and the edge of the strip was tapped against side of the reagent container. The strip was compared closely with the corresponding colour chart on the bottle. Urine specific gravity and Ph was measured immediately. The findings were communicated to the woman. Items used were discarded according to infection prevention guidelines. Hands were washed and dried. Findings were also recorded and reported to the midwife in-charge. Vital signs and other observation was checked and recorded in her antenatal book as follows; Haemoglobin level 9.8g/dl, Weight 72kg, Temperature 36.6degree Celsius, Pulse 95bpm, Respiration 22cpm, Blood Pressure 120/60mmhg.Head to toe examination was explained to her. The necessary equipment for the procedure were gathered and taken to the examination room. Privacy was provided. She was asked to sit on the bed, lie lateral and then assume a supine position. Hands were washed and dried. Under the supervision of the midwife-in-charge, the following examinations were carried out on Madam Helina.

Physical examination

The examination was started on the client from the head and was supervised by the midwife-in-charge. On inspection, the hair was observed to be neatly braided and appeared clean.

Her face was also clean and no abnormality was detected. Her eyes were normal in colour and in good condition. The ears were also in proper alignment with the eyes, the nose had patent nares. The mouth was very clean with teeth very clean and in good condition, the lips were nicely kept with a lip balm applied to it, the tongue was kept clean. No abnormality was detected. As the procedure was on going, client was congratulated for having taken good care ofherself. The neck was free from lymph nodes and goiter.

The **breast** was exposed to check for size, shape, dimpling and nipple retraction and condition of the skin. One breast was covered and she was asked to put the hand of the part to be examined under her head. The breast was palpated systematically in a circular manner using the inner aspect of the fingers and client was taught self - breast examination. Nipples were squeezed gently and a

cotton wool swab used to clean and examined for odour, and any abnormal discharge. The same was done for the other breast and no abnormality was noted. Breastfeeding history was asked and her desire to breastfeed was positive as her child was breastfed.

The **Extremities,** she was asked for tingling and tightness of the finger on making a fist, the hands and fingers were inspected for edema, pallor of palms and nail bed for capillary refil and no abnormality was noted. The legs were inspected for size and equality and palpated for edema, tenderness in the calf muscles varicose veins, and no abnormality was noted.

The **back** was examined for deformity of the spine (scoliosis), edema of the sacral region, pain at the costovetebral angle and no abnormality was detected. The condition of the skin was also noted to be normal.

Abdominal examination

Inspection; the abdomen was inspected for scars, size, shape, striae-gravidarium, linear nigra and foetal movement. Linear nigra was present, the shape was ovoid with no scars, the size was average and there was fetal movement.

Measurement of the Symphysio-fundal height; the upper border of the symphysis pubis was located.For measuring the symphysio-fundal height, the zero mark of the measuring tape was placed on the fundus and to the upper boader of the symphysis pubis. The symphysio-fundal height measured 36cm and the gestational age was 37 weeks.

Fundal palpation; the hands were rubbed together to make them warm in order not to induce contractions. The palms were placed on either side of the fundus while facing the woman's head. Fingers were curved around the top of the fundus and a soft mass was felt, indicating thatthe buttocks were occupying the upper pole of the uterus.

Lateral palpation; the palms were placed on both sides of the uterus, midway between the symphysis pubis and the fundus. The uterus was stabilized with one hand and examined by the

other hand. The palpation was started from the abdominal midline to the lateral side of the abdomen and from the symphysis pubis to the fundus in a rotatory manner. The foetus back (the smooth part) was located at the right side of the woman's abdomen, and the limbs (the rough part) were at the left side.

Pelvic palpation; facing the woman's feet**,** she was asked to flex her knees slightly and breath in and out slowly to aid in the relaxation of the abdominal muscle. The palms were placed on either side of the uterus just below the level of the umbilicus and fingers directed toward the symphysis pubis, thumbs almost meeting. Presentation was determined to be cephalic as a hard mass was palpated, the lie being longitudinal.

Decent; the anterior shoulder was located to determine descent of the head. Two fingers were kept over the anterior shoulder and the symphysis pubis was located. The right ulna border was placed just above the symphysis pubis and the anterior shoulder. Four fingers were accommodated and the descent was recorded as 4/5th.

Auscultation; Foetus stethoscope was warmed by rubbing it in the palm. The foetus heart was auscultated by placing foetus stethoscope on the area where the back was located. The ear was placed against the stethoscope, making sure hands were not touching the stethoscope when the foetus heart beat was being counted. Comparing the rate with the maternal pulse and counting how many beats were heard for one minute, it was 140bpm with regular rhythm.

Vulva examination

Permission was sought from Madam Helina to examine her vulva, which was granted. Hands were washed using aseptic techniques before the procedure. The woman was helped to relax on the examination bed. She was made to bend her knees and was told to separate her legs gently. With the aid of a direct light, her inner thighs were touched gently before touching her genitals in order not to startle her. The labia, clitoris and perineum were inspected. The skin was very smooth and

clean and the pubic hair was free of nits and lice. The labia tissue felt soft and consistent on palpation. There wasno swelling, redness, marks, rashes, pimples or sores. There were no abnormal discharges. No signs offistulae were also observed. She was asked to bear down while holding the labia open to watch for anybulging of the anterior or posterior vaginal wall and it was normal. Madam Helina was helped to dressup after the examination and all findings were explained to her. She was thanked for her understanding and cooperation. Hands were washed and dried and all findings were recorded in her antenatal book. She complained of backache and interrupted sleep she was educated to support her back with pillow when sitting. Permission was sought from Madam Helina for home visit and it was granted and then directions to her house as well as her contact numbers were asked for. Routine drugs were served as follows;

Tablet Folic Acid 5 milligrams daily for 7days

Tablet Ferrous Sulphate 200 milligrams daily for 7daysTablet Multivitamins 200milligrams daily for 7daysTablet sulphadoxine pyrimethamine fourth dose

She was again reminded on the home visit and said goodbye to her.

2.2 FIRST ANTENATAL HOME VISIT

The first home visit to Madam Helina house was on the 24th November 2022 at exactly 3:00pm by motor bike. The aim of the visit was to assess her home environment and to know how she is preparedtoward birth. Greetings were exchanged and seat offered on arrival. She was asked about her health and that of her family and responded that they are all well. She then gave a positive feedback on the complains she made the last time that she is been relieved of inability to sleep and backache. She complained of loss of appetite when asked whether she has a complain and she was educated to eat in bit but frequently and ensure oral hygiene. She was asked to continue with her

routine drugs as prescribed. She promised to do as educated. She was encouraged to maintain the neatness in her compound. Before leaving, her layette was inspected, she had already packed her Bag with items like; sanitary pads, toiletries etc. In this bag included purse with money, insurancecard and antenatal book. She was also educated on birth preparedness and complication readinessplan because when asked of the person who would accompany her to the hospital to deliver it wasrealized that she has not taught it. The permission to leave was sought and she was promised of another visit.

PHYSICAL ENVIROMENT

She was in the house with her child who had closed from school. The husband was not yet back from work. Madam Helina lives in a; one -bed room house which is a semi-detached one with a bath room, toilet and kitchen built on the compound of the house.

The house is built with blocks and painted green, roofed with aluminum sheet but does not have a fence wall and a gate. She lives with her husband, child and her sister in-law. Inside her room wasa neatly laid bed with a treated mosquito net hanged over it. Things were arranged nicely in her room and a curtain at her entrance. The room was well ventilated. She has a ceiling fan. She usedcoal pot for cooking. There is a pipe in the house where client fetches water for domestic activitiesand store. Electricity is the source of power used in the house. She has a kitchen which is built with blocks which was very clean and in a good condition. She gathers rubbish or waste in a container with a cover which she finally disposes every day into the public refuse dump. She wasadvised to always cover her dustbin to prevent flies from settling on uncovered food which couldbring about diseases. The compound was very nice because it looked very neat and the surroundingwas neatly weeded. There was no stagnant water and no choked gutters.

PSYCHOSOCIAL ENVIROMENT

Client whole family was ready to accept the new born into the family which was observed through their discussion. Observation was done that her relationship with the family member is very cordial and has never had a fight among them.All the members see themselves as one team. Therefore, in terms of any difficulties theyencounter, they all come into unity to find possible solutions to that. Client said their religion teaches them to live peace with one another. Madam Helina attends occasions like marriage, funeral and other festivals with husband.

2.3 SECOND ANTENATAL HOME VISIT

The second home visit was made on 27th November,2022 at 4:00pm. The visit was made purposely to check on the health status and educate Madam Helina on birth preparedness and complication readiness plan. Client was asked of the previous complaint and she gave a positive feedback. Client was doing well except that she complained of not being able to empty her bowels for the past two days. She was therefore encouraged to take in more fluids, fruits and vegetables such as pineapple, oranges, water melon and pawpaw, lettuce, carrot etc. which will aid in peristaltic movement. She was educated on the true signs of labour such as rhythmic regular uterine contractions and show, and was told to give a call or report immediately to the clinic as soon as she sees any danger signs of pregnancy such as severe frontal headache, severe lower abdominal pains, bleeding per vaginum and excessive vomiting. She was thanked for her cooperation and reminded of her next visit to antenatal clinic on 29th December, 2022.

Permission was sought to leave of which she escorted me.

2.4 SUBSEQUENT VISIT TO THE FACILITY

On 29th November,2022 client came for antenatal care. She was given a seat to sit. The vital signs and weight were checked and recorded as: Weight 73kg, Temperature 36.5degrees Celsius, Pulse 90bpm, Respiration 24cpm, Blood pressure 110/60mm/Hg. Head to toe examination was conducted which was supervised by the midwife-in-charge. She emptied her bladder and midstream specimen of urine taken and tested negative for protein and sugar. Hands were washed with soap and water and dried with clean towel. Fetal movement was observed, and the abdomen was of medium size and ovoid in shape. On palpation and measurement, the symphysio-fundal height was 38cm and the gestational age was 38weeks. The descent was 5/5, fetal heart beat was 142bpm. She was assisted to dress up after which hands were washed and dried. All findings were communicated to her and recorded in her antenatal booklet. She was asked about her food intake and bowel movement and she said she could now empty her bowels once daily as before, but has frequency in micturation and waist pains so she was told that it was due to the fact that the fetal head was descending into her pelvis. She was advised to avoid prolonged standing and strenuous activities which could aggravate the problem of waist pans. She was served with routine drugs and paracetamol, 1g tid x 3days. She was informed of the next visit to the facility which was 6th December 2022 if she has not delivered and to report before the scheduled date if she encounters any challenge or experience any of the signs of labour taugh

2.5 CARE PLAN DURING ANTENATAL PERIOD

PROBLEMS IDENTIFIED DURING ANTENATAL

Madam Helina complained of the following;

1. Backache
2. Loss of appetite
3. Constipation
4. Waist pains
5. Frequent micturation

SHORT TERM OBJCTIVES

1. Client will cope with backache till the end of pregnancy.
2. Client will regain appetite and take 1/3 of meal served within 72hours.
3. Client will be relieved of constipation and pass stool once 24hours.
4. Client will cope with waist pain within 24 hours till the end of pregnancy.
5. Client will cope with frequency of micturition within 24 hours until delivery.

LONG TERM OBJECTIVES

Madam Helina will go through pregnancy, labour and puerperium successfully without any complication to herself and her fetus.

ANTENATALCARE PLAN

DATE /TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTIONS	DATE/ TIME	EVALUATIONS	SIGN
22/11/22 3:00pm	Backache Related to Pressure on sacral nerves by the Presenting part of the fetus.	Client will cope with backache within 24 hourstill the end of pregnancy as evidenced by client not complaining an ymore.	1. Reassure client. 2. Encourage client to siton a chair with back rest. 3. Encourage client to resther back on a pillow whensitting. 4. Encourage client's family to help her with household chores. 5. Encourage client to sleep on a firm mattress.	1. Client was reassured. 2. Client was sitting on a chair with back rest or learning against a wall 3. Client supported her back with pillow when sitting. 4. Client's family were to helping with the household chores. 5. Client slept on the floor and avoided the sagging bed till she delivered.	6/12/22 7:20 am	Goal fully met as evidenced tha client is coping with backache	**A.J**

ANTENATALCARE PLAN CONT'D

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTIONS	DATE/ TIME	EVALUATIONS	SIGN
24/11/22 4:00pm	Loss of appetite related to Hormonal changes during late pregnancy	Madam Helina will regain her appetite and take 1/3 of meal within 72 hours as evidenced by 1. client verbalizing that there is improvement in appetite. 2. Midwife observed client of her meal served.	1. Reassure Madam Helina. 2. Educate Madam Helina to take food in bits and at frequent interval. 3. Served vitamins supplement as prescribed. 4. Serve food attractively. 5. Plan meals with Madrone	1. Madam Helina was reassured. 2. Madam Helina took food in bits and at frequent interval. 3. Client was served vitamins supplement 4. Client food was always ganished with attractive colours. 5. Madam was always involved in the meal planning.	27/11/22 4:00pm	Goal fully met as client informed the midwife that she ate well as discussed.	A.J

ANTENATAL CARE PLAN CONT'D

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVE	NURSING ORDERS	NURSING INTERVENTIONS	DATE/ TIME	EVALUATION	SIGN
27/11/22 4:00pm	Constipation related to inadequate Fibre intake.	Client will be relieved of constipation and pass stool once 24 hours as evidenced by client verbalizing that she is able to move her bowels freely each morning and midwife nothing no complaints from client.	1. Reassure client. 2. Advice client to engage in tolerable exercises.	1. Client was reassured. 2. Fiber diet was served. 3. She was encouraged to take 1000mls of fluids per day, at least. 4. She was advised to Engageintolerable exercises.	29/11/22 4:00pm	Goal fully met as client reported she had resumed normal bowel movement once daily.	A.J

ANTENATAL CARE PLAN CONT'D

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTIONS	DATE/ TIME	EVALUATION	SIGN
29/11/22 4:00pm	Waist pain related to decent of foetus head putting pressure on sacral nerves	Madam Helina will cope with waist pains within 24 hours till the end pregnancy as evidenced by client action.	1.Reassure Helina 2.Encourage Madam Helina to have rest in between activities. 3.Teach client on good body mechanics 4. Educate Madam Helina on minimal workand exercise. 5. Give prescribed analgesics	1. Madam Helina was reassured pain was temporal. 2. Madam Helina took rest in between activities. 3.Madam Helina was taught to bend down from the knees when picking objects from the floor. 4.Madam Helina was educated on minimalwork exercise 5. Madam Helina was served (tab paracetamol1g tid) 3 days	06/12/22 7:20am	Goal fully met as client said her waist pain has subsided	A.J

ANTENATL CARE PLAN CONT'D

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVE	NURSING ORDERS	NURSING INTERVENTIONS	DATE/ TIME	EVALUATION	SIGN
29/11/22 4:00pm	Frequent micturation related to foetus exerting pressure on bladder in late pregnancy.	Madam Helina will cope with frequency of micturition within 24 hours after delivery as evidenced byclient verbalizing	1. Reassure client. 2. Educate client on the physiology behind the micturition. 3. Educate client to put chamber on her bed side. 4. Educate Madam Helina on the use of panty liner 5. Educate client on urinating in the night before going to bed.	1. Client was reassured. 2. Client was educatedthat it is due to the descent of the fetal head into the pelvis reducing bladder capacity. 3. Madam Helina kept chamber on her bed side. 4. Madam Helina was educated on the use ofpanty liner 5. Client was educated on the need to pass urinein the night before goingto bed.	06/12/22 7:20am	Goal fully met as client understood the physiology behind frequency of micturition.	A.J

CHAPTER THREE

LABOUR

3.0 INTRODUCTION

This chapter describes the management of all the four stages of labour of the client and the care plan drawn for problems identified in labour.

3.1 ADMISSION AND MANAGEMENT OF THE FIRST STAGE OF LABOUR ADMISSION

Madam Helina reported to the facility on the 6th day of December, 2022 at 2:00am accompanied by her sister-in-law. They were offered seats at the labour ward after which greetings were exchanged. Her items were collected and general condition was also observed to be good. She was orientated to the ward environment, where the washroom is and where she was going to keep her items. She complained of lower abdominal pain and waist pains. The woman was in an anxious state and she was educated on the various stages of labour and was reassured. Her vital signs were checked and recorded as follows; BP 110/70 millimeters, Respiration 22 cycles per minute, Temperature 36.4 degrees Celsius, Pulse 90 beats per minute. A general examination was conducted under the supervision of a senior midwife. According to Madam Helina she had seen 'show' prior to her coming. She was accompanied to the labour room and helped onto the delivery bed after emptying her bladder. The volume of her urine was 150mls with protein negative and glucose negative.

Pillows were put under her head and upper shoulder. Privacy was provided and her consent was sought. Hand washing was performed. Head to toe examination was carried out. She was not pale, the conjunctiva was pink, sclera, palms, tongue, and soles of the feet and no signs of

anaemia were present. The feet were also not oedematous and were in a good condition. No enlarged veins at the neck. An abdominal examination wasdone as follows; The size, shape and present of scars were inspected and were no scares. Symphysio-fundal height was 37centimeters when measured. Palpation was done to detect for position and presentation of the foetus ,which was occipito-posterior and cephalic respectively. Descent of the fetal head was 4/5th.

On auscultation, fetal heart rate was 145 beat per minutes. The contractions were 3 in 10 lasting less than 20 seconds. There was no abdominal tenderness excluding enlargement of the liver and spleen.

Vaginal examination

The procedure was explained to the client and privacy was provided. The woman was encouraged toempty her bladder. The client was helped to be in the lithotomy position. She was draped. Hand washing was done with soap and running water and were dried with a hand towel. Sterile gloves were worn. Her soiled pad was removed and discarded using the left hand. The woman was asked tobend her knees and separate her legs. The vulva was inspected and there were no scars from previousbirth. There was no inflammation, varicosities, discoloration and oedema. A swab was picked using the right hand and was dipped in disinfectant in an individual gallipot. The swab was dropped from right into left hand and the labia majora and minora was swabbed, then the vestibule was swabbed with the right hand using one swabper stroke; and wiping from anterior to posterior. The swabs were disposed of with the labia minora still parted, the right middle finger was gently inserted into the vagina and was firmly pressed downwards causing the relaxation of the vaginal wall. The index finger was gently inserted, vagina was warm and moist, the cervix was soft. There was a cervical effacement,

no cord prolapse, membranes were still intact and no moulding was felt. The cervical dilatation was 4cm at 1:00am when vaginal examination was performed. The woman was dried and aclean pad

was applied.

Sterile gloves were removed and hands were washed using soap and running water. Hands were dried using a hand towel. The woman was helped to turn over to her side. She was made comfortable in bed. Findings were reported to the woman and she was encouraged to ask questions and express her concerns. The relatives were informed about the progress of labour. All findings were documented on the partograph.

Preparation for birth

In preparing for birth, two skilled helpers were identified. The first skilled helper was the Midwife-in-charge who will be consulted in case of anything and the second skilled helper was astaff nurse who always helps the Midwife-in-charge whenever there was a labour case. The unskilled helper was the client's sister- in law. The physician Assistant was informed that there isa client in labour so in case of any emergency, he will be consulted. Client's sister- in law was also asked to contact the taxi driver to be alert in case there is the need for a referral (advanced care), he would be called.

The area for delivery was prepared by assisting client to wash her hands and abdomen to prepare for skin-to-skin care prior to the second stage of labour. Windows and doors were closed, and curtains were drawn when delivery was imminent to provide privacy and also to provide warmth. A portable lamp was made available to assess the baby in case of light off. Hands were washed thoroughly with soap and clean water to prevent the spread of infection. The area for ventilation was also prepared and the equipments were checked. A dry, flat and safe space was prepared to receive ventilation if needed. The equipment to help babies breathe were assembled at the area for ventilation. The functions of the equipment were tested especially the ventilation bag and mask. Equipment assembled to prepare for birth included the following; sterile gloves, cot

sheets, head covering, scissors, cord clamp, suction device, ventilation bag and mask, stethoscope and clock. Delivery set and emergency drugs were made ready for use**.**

Management of first stage of labour

Having finished with birth preparation, Madam Helina was seen anxious since she did not know the outcome of the labour and was seen pushing each time there was contractions. Client was reassured of normal labour and healthy baby without any complications after delivery. Client was encouraged to do deep breathing excersise when there was contraction and also avoid pushing during contractions since the cervix was not fully dilated to prevent the cervix from becoming oedematous and possible tearing. Client was also encouraged to empty her bladder frequently toenhance effective contraction and descent of the foetal head since full bladder could slow downprogress of labour. Client was educated not to use her perineal pad when it falls on the floor andthe importance of changing the pad when soiled and not to be touching the perineal area. The foetal heart rate, contractions and maternal pulse were monitored every thirty (30) minutes but temperature, blood pressure, dilation of the cervix and descent of the foetal head were checked every four (4) hours.

SETTING OF TROLLEY

The trolley was set with the following instruments and items on top and button shelf;

The top shelf which contain the sterile instrument contain the delivery pack and is made up of

- Two sterile artery forceps
- One sterile cord scissors
- Membrane pierce
- Sterile receiver for placenta
- Sterile Episiotomy Pack containing scissors and suturing forceps

Bottom shelf also contains;

- Drum containing gauze and cotton wool
- Chisel forceps in its container
- Bulb syringe in a bowl of water
- Sterile gloves
- Perineal pads
- Cord clamps
- Savlon
- Measuring jug
- An injection tray containing 10unit of oxytocin.
- Identification band
- Examination gloves
- Cot sheet

At 5:00 am, Madam Helina complained of the urge to bear down. Vagina examination was done again and cervical dilatation was 8cm, contractions were present descent was $1/5^{th}$, membranes were intact with moulding (+) which indicated that the parietal bones were in apposition. Contractions were 4 in 10 minutes lasting for 55 seconds, fetal heart rate was 138bpm, maternal pulse was 84bpm, blood pressure 130/70mmHg and temperature.36.3^{o}c whilst urine measured 100mls and protein and acetone were tested negative. She was hence made to rest comfortably in bed.

Madam Helina complained of severe bearing down sensations with the uterine contraction becoming more expulsive and frequent, at 7:00 am vaginal examination was performed again due to her complains and cervical os was fully dilated; 10cm., membranes ruptured spontaneously with clear liquor. Descent was $0/5^{th}$, moulding was two plus (++) which Indicated that the bones were overlapping each other but could not slip off, contractions were 5 in10 minutes lasting 45 seconds. Fetal heart rate was 140 beat per minutes, maternal pulse was 96 beats per minutes. And liquor was clear. The abdomen was also cleaned with savlon to prepare for skin to skin care. The midwife in charge confirmed full dilatation. Findings were recorded on the partograph sheet and client was informed of full cervix dilation. During this time, she complained of exhaustion and was reassured and encouraged to rest in between contraction and 300mls of milo drink was also served. The delivery trolley was set. The already set delivery trolley was pushed to the delivery bed.

3.2 MANAGEMENT OF THE SECOND STAGE OF LABOUR

Madam Helina had successfully passed through the first stage. Her cervix was fully dilated at 7:00am.The set trolley was pushed to the delivery bed side. Protective clothing such as head gear, goggle, facemask, plastic apron and boots were worn. After hand washing, surgical gloves were put on to completethe sterility of the entire procedure. She was encouraged to assume dorsal position with the knee flexedas agreed earlier. The vulva was swabbed with the sterile cotton and savlon lotion. She was draped with 4 sterile towels; one each on the abdomen, under the buttocks as well as both thighs. Full dilationof the cervix was confirmed by the midwife on duty. A pad was applied to the perineum to prevent faecal content from entering the baby's face. She was reassured and encouraged to bear down with contractions and to rest in between contraction. After crowning, the birth of the head was controlled with the index and middle fingers placed on the fetal head to aid

flexion to prevent perineal laceration. With extension, the sinciput, the face, and chin swept the perineum for the head to be born. After the delivery of the head, sterile gauze was used to wipe the eyes from the inner canthus outwards. The face, mouth and nose were also wiped. There was restitution followed by external rotation of the head (internal rotation of the shoulders occurred spontaneously). With both hands on each side of the baby's head, over the ears, a downward gentle pressure was applied towards the mother's perineum to deliver the anterior shoulder. The posterior shoulder was also delivered by upward movement towards the mother's abdomen. The trunk and the rest of the body were also delivered by lateral flexion onto the mother's abdomen at 7:20am.

3.3 IMMEDIATE CARE OF THE BABY

The immediate care of the baby starts from the delivery of the baby's head. The baby's eyes were cleaned from inside out with sterile gauze. The liquor was cleaned from the baby's body and the baby was covered with a warm dry cloth. The baby cried immediately. The first minute Apgar score was assessed to be 8/10; baby was shown to the mother to identify the sex of the baby. The cord was clamped tightly with a cord clamp 2 centimeters away from the baby's abdomen and second amp 3cm from the first clamp a gauze was placed over the cord in between and cut to separate baby from mother. An identification tag was put on the baby's hand. This tag bears the mother's name, sex, date and time of delivery. The fifth minute Apgar score was assessed to be 10/10. The baby was put skin to skin with mother, respiration monitored and breastfeeding initiated

3.4 MANAGEMENT OF THE THIRD STAGE OF LABOUR

Procedure involve in this stage was explained to client's understanding.Permission was sought before continuing with the third stage management. Using the active management of the third stage, Madam Helina's uterus was palpated through the abdomen to exclude the presence of second twin. Oxytocin 10 unit was injected intramuscularly on the upper outer thigh of the client. The cord was re-clamped with an artery forceps closer to the perineum. The lefthand was put on the fundus to feel for contraction. As soon as contraction was felt, left hand was repositioned and placed on the suprapubic area with the palm facing the mother's abdomen. The uterus was pushed upward to prevent inversion of the uterus. The right hand held the forceps and the cord. Gentle downward traction was put on the cord and maintained until the placental tissueswere visible at the vulva. The placenta was cupped in both hands and gently turned in a twisting motion to deliver the membranes. The act of twisting is to prevent the tearing of the membrane.

The placenta was delivered completely at 7:26am. A quick inspection was made to ensure that the membranes and lobes were intact and it was placed in the receiver. Immediately, the fundus of the uterus was massaged through the abdomen until it was well contracted. Client was taught to be massaging her uterus from time to time. Blood clot was expelled from the uterus and the blood expelledmeasured 150mls. She was reassured and permission was asked to conduct examination to exclude anyform of trauma to the cervix, vagina and the perineum. There were no cervical, vaginal, or perineal tears. All soiled materials were removed and she was properly cleaned with Dettol solution and made comfortable in a well laid bed. She was encouraged to empty her bladder regularly to ensure good contraction and to report any bleeding. The instruments were placed in a 0.5%chlorine solution for decontamination. She gave thanks to the glorification of God. Other family members and her husband were also allowed to see Madam Helina and her baby

3.5 EXAMINATION OF THE PLACENTA

The placenta was immersed in 0.5% chlorine solution and it was examined. The placenta was held by the cord with the membranes hanging and the membranes were examined for completeness and it was intact. The placenta was then laid on a flat surface for further examination. The amnion was peeled from the chorion up to the umbilical cord and was fully viewed, the lobes fit together without any gap and edges also forming uniform circle at the maternal surface this meant that there was no missing lobe, there was no white patches on the maternal surface, there was also no blood vessels radiating into the membranes which meantno succenturiate lobe. The cord was situated at the centre of the placenta with one vein and two arteries seen in the cord. There was no abnormality detected. The placenta was discarded after decontaminating it according to the protocol of the facility. The instruments and equipment used were soaked in 0.5% chlorine solution for ten minutes and washed, rinsed, dried and repacked for sterilization. Hands were dipped in chlorine solution before discarding the gloves.

3.6 MANAGEMENT OF THE FOURTH STAGE OF LABOUR

The fourth stage of labour begins right after delivery of the placenta, membranes as well as the arrest of bleeding until six hours after the delivery. During the fourth stage, the client and the baby were under close observation for early detection of postpartum complication that arose.

Mother

Madam Helina and baby were transferred to the lying-in ward after an hour observation. She was encouraged to continue breast feeding. Mother's vital signs were closely monitored every 15 minutes for 2 hours, every 30 minutes for an hour and every hour for three hours. The uterus was felt for contraction every 15 minutes to make sure it was well contracted. Her vital signs were recorded as follows**;** Temperature 36.2 degrees Celsius, Pulse 80bpm, Respiration 20cpm, Blood Pressure 120/60mmhg Madam Helina was also educated on how to feel for contraction and also

massage her uterus. The symphysio fundal height was measured and recorded as 18cm**.** Mother was advised to report any severe bleeding observed. The lochia was red in colour, moderate flow and had no odour. The client complained of lower abdominal pain which worsened with suckling. The physiology of this was also explained to the client. She took Milo and Bread. Family members were also encouraged to visit Madam Helina and the new born baby.

Baby

The baby was observed for colour, breathing, bleeding from the cord and warmth but no abnormality was found. The baby was able to suckle the mother's breast.

Prevention of disease (prophylaxis for the baby)

This was done within the first 90 minute to prevent infections such as ophthalmia neonanatorium and hemorrhagic disease of the new born therefore the following treatments were given. The baby's eyes were cleaned with sterile cotton wool swab with normal saline from the inner to outer canthus and gentamycin eye drop was instilled. The umbilical cord was dressed with six cotton wool swabs and methylated spirit. Because Vitamin K is painful it was given after the examination. Hand washing was performed before and after handling of baby.

Examination of the new born

After washing hands and drying them, the procedure was explained to Madam Helina. Disposable gloves were worn and the baby was examined in the presence of the mother in a clean, warm environment, with nearby windows closed and light switched on to produce heat. Baby was placed on a covered flat surface with only the part being examined exposed systematically. Baby's general condition was stable. A detailed head to toe examination was carried out to determine if there is any abnormality.

The hand and face: The head were examined for softness/tension of fontanelles, size and shape, lacerations, caput succedaneum as well as intracranial haemorrhage but no

abnormality was detected. Head circumference was measured by encircling the head with a tape measure from theoccipital protuberance to the supra-orbital ridges and it measured 33cm. The eyes opened spontaneously when the baby was held in an upright position and the conjunctiva was clear. Eyeswere also examined for colour, redness, discharge, placement and conjunctiva for haemorrhage but no abnormality was found. The nose was inspected for size and shape and examined for deviated septum but the septum was normal. The nostrils were inspected for patency and discharges and the mucosa for colour and polyps which were all normal.

The mouth was examined by pressing the angle of the jaw which opened the mouth and the tongue, gum and palate were inspected and there was no false tooth noticed. The palate was high arched, intact and the uvula centrally placed. There was no cleft palate or cleft lip, tight frenulum or tongue tie. Suckling, rooting and swallowing reflexes were checked and was present. The ears were inspected; the upper notch of the pinnae was at the same level with the canthus of the eye. External auditory meatus was patent and the cartilage in the pinnae was checked for it softness. The shape and size was also noted and no abnormality was detected.

Neck: The neck was inspected and palpated with no swelling such as congenital goiter, enlarged lymph node, rotation and flexion were good.

Chest and abdomen: The chest were examined, the respiratory movement was regular and the respiratory rate was 40cpm. Breasts were palpated for consistency, masses, and the nipples for position and breast for engorgement. The space between the nipples was noted and the nipples werein alignment. The abdomen was round with no bleeding from the umbilical cord and no signs of infection. The cord was examined and there was one vein and two arteries. The liver, spleen and bladder were palpated for size, tenderness and masses but no abnormality was detected. Apex beat was present and was recorded as 132bpm.

Limbs and digits: The length, movement and paralysis of the upper limbs were also noted. The digits were counted to be normal and separated to exclude webbing and the palm for the number of palmer creases. The shape and colour of the nail bed were inspected and reflexes (grasping, Moro) checked. Everything was normal. With the lower limbs, the leg and feet were inspected for symmetry, extra digits, webbing, movement, fare foot adduction, clubbed feet, knock-knees, bowed leg, tibia torsion and paralysis but no abnormality was found. The hip had no dislocation and the reflexes (knee jerk/ patella, plantar) were present. The feet were examined for any disability such as talips equinovarus. The axillae, elbow groin and popliteal spaces were examined without any abnormality detected.

Back: The spine was also examined with baby turned to one side. The back was palpated for swelling, dimpling, hairy patches to exclude spinal bifida and for missing vertebrae but no abnormality detected

Genitalia and anus: The urethra meatus was inspected for patency, foreign bodies and kind of discharge. The anus was examined for patency and it was patent. The anus was also palpated for sphincter tone, masses, tenderness but it was normal. The baby passed meconium and urine Baby's length was measured to be 50centimetres, weight was 3.5kg and temperature was 36.4◦C. In all, there was no abnormality detected. The baby was classified as normal and routine care of the baby continued. Gloves were removed and disposed aseptically before washing hands with soap under running water and dried with clean dry towel. The baby's skin was smearedwith baby oil and wrapped. All findings were recorded.

CONDITION OF BABY AT BIRTH

Temperature	36.4^{o} C
Apex beat	132 bpm
Respiration	40 cpm

Other assessments were recorded as follows;

Sex	Female
Head circumference	33cm
Length	50cm
Weight	3.5kg

Within few minutes after birth, baby passed urine and meconium.

First Minute APGAR score

Appearance	2
Pulse	2
Grimace	1
Activity	1
Respiration	2
Total	8/10

Fifth Minute Apgar score

Appearance	2
Pulse	2

Grimace	2
Activity	2
Respiration	2
Total	10/10

The general condition of the baby was satisfactory.

3.7 CARE PLAN DURING LABOUR

PROBLEMS IDENTIFIED DURING LABOUR

06/12/2022

Lower abdominal painFatigue

Waist pains

Anxiety

SHORT TERM OBJECTIVE

1. Client will understand and cope lower abdominal pains with 1 hour
2. Client will be relieved of fatigue within 2 hours after labour.
3. Client will be relieved of waist pain till the end of labour.
4. Client will be relieved of anxiety with 1 hour.

LONG TERM OBJECTIVES

Madam Helina will go through labour and delivery successfully without any complication to her and the baby.

LABOUR CARE PLAN CONT'D

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
06/12/22 2:00am	Lower Abdominal pain related to Painful Uterine Contractions	Client will cope and relieved with lower abdominal pains till the end of labour as evidenced by client verbalizing that the lower abdominal pain has relieved	1. Reassure client. 2.Explain the physiology of the pain to her. 3.Encourage client to practice deep breathing exercise. 4. Provide diversional therapy. 5.Encourage ambulation	1. Client was reassured of competent nursing care. 2. The physiology of the pain was explained to the client. 3. Client was encouraged to practice deep breathing exercise. 4. Client was engaged in a conversation 5. Client was encouraged to walk around the bed.	07/12/22 7:20am	Goal fully met as client verbalized that she was able to cope with the pain.	A.J

LABOUR CARE PLAN CONT'D

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATIONS	SIGN
06/12/22 2:00am	Waist pains related to Pressure exerted by the presenting part at the sacral region.	Client will be relieved of waist pain by the end of labour as evidenced by client verbalizing that the waist pain has relieved.	1. Reassure client. 2. Educate her on the physiology of the pain. 3. Massage client's sacral region. 4. Educate her to assume a comfortable position but harmless.	1. Client was reassured. 2. She was educated on the physiology of the pain. 3. Client's sacral region was massaged. 4. She was educated to assume the all fours position.	07/12/22 7:20am	Goal fully met as the midwife observed a relaxed client.	A.J

LABOUR CARE PLAN

DATE/ TIME	NURSING DIGNOSIS	NURSING OBJECTIVES	NURSING ORDERS	NURSING INTEVENTION	DATE/ TIME	EVALUATION	SIGN
06/12/22 2:00am	Maternal Exhaustion related to physiology of labour.	Client will be relieved of fatigue 2 hours after labour as evidenced by Client verbalizing it.	1. Reassure client. 2. Encourage client to rest in between contractions. 3. Encourage client on relaxation techniques. 4. Encourage client to stop screaming and conserve energy. 5. Give client nutritious diet.	1. Client was reassured. 2. Client was encouraged to rest in between contractions. 3. Client was taught deep breathing exercise. 4. Client stopped screaming to conserve energy. 5. Client was served with nutritious diet.	06/12/22 7:20am	Goal fully met as Midwife observing client go through normal labour successfully.	A.J

LABOUR CARE PLAN CONT'D

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVE	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
06/12/22 2:0am	Anxiety related to Unknown outcome of labour.	Client anxiety will be relieved at the end of labour as evidenced by Client verbalizing that she is no more anxious.	1.Reassure client. 2. Explain every procedure to her. 3.Educate her on possible outcome of labour. 4.Encourage client to ask questions. 5.Introduce client to competent midwives	1. Client was reassured. 2. Procedure was explained to client. 3. Client was educated on possible outcome of labour. 4. Client was encouraged to ask questions. 5. Client was introduced to competent midwives.	06/12/22 7:20am	Goal fully met as client was seen relaxed in her bed.	A.J

CHAPTER FOUR

PUERPERIUM

4.0 INTRODUCTION

This chapter provides information about the subsequent care given to the mother and her baby after delivery till six weeks.

4.1 DAY OF DELIVERY

Both mother and baby were monitored every 15 minutes for 2 hours, 30 minutes for 1 hour and hourlyfor 3 hours. Madam Helina and her baby were transferred to the lying-in ward for vigilant observationand they were made comfortable in bed with all observations recorded. Her health was inquiired and the pains she complained during her labour had subsided. Madam Helina was examined from head to toe before she took her bath and no abnormality was found. The lochia was red in colour, moderate inquantity with no bad odour. Findings from assessment of Madam Helina were recorded as follows; Temperature 36.6degree Celsius, Pulse 80bpm, Respiration 20cpm, Blood pressure 120/70mmHg, Symphysio fundal height 18cm, Lochia Rubra. Madam Helina was asked to change her perineal pad when soiled to prevent ascending infection to the uterus and also empty her bladder to help involutionof the uterus. She was advised to wash her hands before and after changing pad. She had her bath andkept warm with her baby in bed and encouraged on exclusive breastfeeding on demand. She was alsoadvised to report any abnormal bleeding for prompt action to be taken. Madam Helina was also educated on simple hand washing before and after touching and feeding the baby and after visiting thetoilet. She was encouraged to take enough rest and sleep especially after breast feeding and put the baby to sleep to restore her energy.

Madam Helina complained of after pains and was reassured it is temporal and that it will subside with management. She was served with two tablets of paracetamol to relieve the after pains and was encourage to rest

Six hours after the delivery of the baby, placenta and membranes, the baby was given a warm bath and she passed meconium and urine during her bath. After that the baby was wrapped nicely in a warm towel and her findings from assessment was recorded as follows; Temperature 36.6degrees Celsius, Apex beat 132bpm, Respiration 38cpm, Weight 3.5kg, Length 50cm, Head circumference 35cm.

BABY BATHING

The baby was bathed after six hours observation with warm water and cord dressed.

REQUIREMENTS

1. Soap
2. Sponge
3. Cream/ powder
4. Sterile cotton in a gallipot or wrapped
5. Methylated spirit
6. Basin
7. Towels: 1 big towel and 3 small ones
8. Cot sheets 2
9. Apron
10. Gloves
11. A clean baby dress, cap and socks
12. Mackintosh

13. 2 jugs containing hot and cold water each
14. Two receptacles for used water and dirty linen
15. A receiver for used swab

PROCEDURE

The procedure was explained to mother and a tray was set. The mother and the support person were made to observe the procedure. A plastic apron was worn and hands were washed with soap, water anddried with a clean towel. The water was mixed and the temperature was tested using the elbow. Sterilegloves were worn and baby was placed on a flat surface. She was undressed and wrapped in a big towel. The eyes were cleaned with cotton wool swabs soaked in clean water from inner canthus outwards. She faces was cleaned with damp face towel and dried. The nape of baby's neck was supported with one hand. Her ears were then plugged using two fingers of the hand and the head was washed with soapy sponge. With the body resting on the elbow and still supporting the nape, the babywas place at the edge of the bowl to rinse the soap off the head and dried. The baby was exposed; armsand front of trunk were washed paying attention to skin folds. The baby's back was turned with one hand supporting the chest and washed back down to feet paying attention to the skin folds. She was immersed in a bath of warm water with the head above the water and rinsed thoroughly. The baby wasplaced on a flat surface covered with clean sheet. The baby was dried by using a clean small towel paying attention to the skin folds. The cord was dressed by using sterile cotton wool swabs soaked in methylated spirit. The tip of the cord clamp was held with one sterile cotton wool swab and another was used to clean the base of the cord. The whole cord anteriorly and posteriorly each with a separate swab from the base upwards. The tip of the cord was cleaned with another swab and the cord was left exposed and the swab which was used to hold the cord clamp was used to clean it. The baby was dressed, wrapped and, given to mother to breastfeed. The waste materials were discarded according to infection prevention protocol. Mother

was told that the baby will be topped and tailed till cord falls off.

Gloves were removed and disposed of. Hands were washed with soap and water before handling the baby. Client was in a good condition after the procedure was carried out.

4.2 FIRST DAY POST DELIVERY AND DISCHARGE

The first day post-partum for Madam Helina was 7th December, 2022. She took a warm bath in the morning at 7am and 5pm after her perineal pad was inspected for the presence of lochia which was small, no odour and red in colour. The after pain was asked and she said the pain was better now. Herconsent was sought for head to toe examination. Everything was normal, breast was lactating well anduterus measured 18cm. Her vital signs were recorded as follows; Temperature 36.4degrees Celsius, Respiration 20cpm, Pulse 74bpm, Blood 110/60mmHg**.** Madam Helina complained of inadequate sleepduring the night as a result of feeding her baby at night. She was encouraged to continue breastfeedingat night since it is important for the growth of her child and also sleep when the baby was asleep especially during the day time. Baby was cleaned with warm water and cord was dressed with cotton wool swab soaked in methylated spirit. Baby was examined from head to toe in the presence of the mother and no abnormality was detected. Baby was reassessed and dressed up neatly and the findingsrecorded as follows: Temperature 36.4degree Celsius, Respiration 40cpm, Apex beat 138bpm, Weight 3.5kg, Skin colour pink, Cord bleeding No,Suckling Yes**.** All findings were communicated to Madam Helina. The baby was handed over to her tobreast feed. This proved that what was taught during antenatal period was well understood. Madam Helina took millet porridge with bread as breakfast. She was educated on healthy adequate nutritious diet to help in the production of more breast milk and improve her immunity, and help repair worn outtissues. Madam Helina was again educated on good personal hygiene, post natal exercise and the various family planning methods. The essence of the exercise was to help the

pelvic organs to return to their original position. She was informed of her discharge. Furthermore, Madam Helina was encouraged to feed her baby on demand. She was also advised to register the baby at the birth and death registry. Baby was given BCG and polio "O" vaccine and mother was advised not to apply anything to the site in order to ensure effectiveness of the drugs. She was then asked to come with thebaby to take the rest of the immunization at the time scheduled in order to prevent the baby from any of the childhood preventable diseases. Madam Helina took rice and stew with egg after birth. She washelped to pack her items and also served her routine drugs. She was informed of a visit to her house fora period of one week starting from the next day and she agreed. After settling her bill with national insurance, she was discharged.

POSTNATAL HOME

4.3 VISITS FIRST POSTNATAL HOME VISIT

Madam Helina was visited in the house after delivery for the first time around 7:30am and 4pm on8th December, 2022. Greetings were exchanged and a seat was offered. The whole family was in good health and her previous complaints had improved, her after pain was better. Both mother andbaby looked healthy on arrival to their house. Client was informed of the procedures to be carried out. Hands were washed and dried with a clean towel. Baby passed meconium and urine. Baby was examined from head to toe. No abnormality detected. Vital signs checked and recorded. The baby was cleaned. The cord was also dressed with cotton wool swabs and methylated spirit using aseptic technique; it was clean, dry and not offensive. The baby was then dressed properly and handed over to the client's sister. Madam Helina emptied her bladder and head to toe examination was done. The conjunctiva was examined and there was no pallor. The breasts were soft and lactating well. The uterus was well contracted with symphysio fundal height of 16cm. The perineum was clean, dry and intact, lochia was small red (rubra) and not offensive. Her vital signs checked and recorded as follows: Temperature 36.2degree Celsius,

Pulse 82beat per minute, Respiration 22cycles per minute, Blood pressure 110/60millimeters of mercury. Baby was given to mother to breast feed. Baby was able to suck well. The baby was assessed and findings were recorded as follows; Temperature 36.2degree Celsius, Pulse130bpm, Respiration 40cpm, Weight 3.4kg, Skin colour Pink, Cord no bleeding, Suckling Yes, Stool Colour Dark yellowish. In the evening client was visited again findings were not different from the morning visit. Madam Helina was educated on family planning, danger signs in the newborn such as breathing difficulties, cyanosis, persistent vomiting and fever. Client and family were congratulated and permission was sought to leave.

4.4 SECOND POSTNATAL HOME VISIT

Madam Helina was visited on the 9th December, 2022 around 7:34am and 4pm. She and her baby were in good health. All procedures to be carried out on them were explained to her. Her perineal pad was inspected and lochia flow was small and red in colour without bad odour before she took her bath. Madam Helina was examined from head to toe and everything was normal, breast was lactating well. The symphysio fundal height was 14cm when measured and findings from assessment were recorded as follows: Temperature 36.4degree Celsius, Respiration 20cpm, Pulse 72bpm, Blood pressure 110/60mmHg. Baby was then cleaned, she passed urine and meconium stool and was also examined from head to toe and nothing was detected. Her cord was dressed and was quite dry, no signs of infection were found. The baby was dressed up and findings were record as follows: Temperature 36.4degree Celsius, Respiration 40cpm, Pulse138bpm, Weight 3.4kg, Skin colour pink, Cord bleeding No, Cord Shrinking, Suckling Yes, Stool color Dark yellowish. In the evening client was visited again and findings were not different from the morning visit. The mother was advised not to apply anything on the cord and encouraged to continue with post-natal exercise and exclusive breast feeding. She was reminded of another visit

the following day.

4.5 THIRD POSTNATAL HOME VISIT

Madam Helina was visited in the house for the third time at 7am and 5pm on the 10th December, 2022to check up on how they were faring. She said she slept well when the baby was well as fed but howevercomplained of having headache. Perineal pad was inspected. Lochia was small with red colour. She took her bath after everything in the evening. Nothing abnormal was detected during head to toe examination. Symphysio fundal height was 12cm and findings from assessment were recorded as; Temperature 36.0degree Celsius, Pulse 80cpm,Respiration 19bpm, Blood pressure 110/60mmHg. No abnormality was found during head to toe examination.

Baby was top and tailed. The cord was dressed with cotton wool with methylated spirit. She was dressed up and findings after assessment were; Temperature 36.0degree Celsius, Apex beat 136bpm, Respiration 42cpm, Weight 3.5kg, Skin colour pink, Cord bleeding No, Cord Shrinking, Suckling Yes, Stool colour Dark yellowish. In the evening client was visited again and findings were not different from the morning visit.

All findings were explained to her understanding. She was once again reminded of next visit and was thanked for her cooperation.

4.6 FOURTH POSTNATAL HOME VISIT

On 11th December, 2022 around 8:00am and 4pm, client and family were visited as usual, greetings were exchanged and seat was offered and all family members were in good condition according to the mother. Client was asking of the previous complaint made and she gave a positive feedback. Head to toe examination was carried out and no abnormality was detected. Baby's cord was dressed with cotton wool swabs and methylated spirit, it was dry, not offensive and almost off. Head to toe examination was carried out on mother and no abnormality was

detected. The Symphysio fundal height was 10 centimeters, perineum was clean and intact. Lochia was small, brownish, contains blood, mucus and leucocytes and not offensive. The breast was lactating well. She also complained of backache and she was reassured and educated on other positions used in breastfeeding such as lying on her side to breastfeed and was also educated to support her back when sitting. Her vital signs were checked and recorded as follows: Temperature 36.3degree Celsius, Pulse 82beat per minute, Respiration 22count per minute, Blood pressure 110/60mmHg. The baby's vital signs and weight were checked and recorded as follows: Temperature 36.3degree Celsius, Apex 128 beats per minute, Respiration 41 cycles per minute, Weight 3.6kilogram Mother was encouraged to ask questions. All findings were communicated to her and the necessary documentation was done. She was thanked and permission was sought to leave. She was reminded of another visit the next day.

4.7 FIFTH POSTNATAL HOME VISIT

The 5th day postnatal visit was on 12th December, 2022 around 8:30am. Everybody in the family was fine and the environment was very clean. Client was asking of the previous complaint made and she gave a positive feedback. Madam Helina permission was sought for head to toe examination after taken her bath, everything was normal and her vital signs were; Temperature 36.2 degree Celsius, Respiration 20cpm, Pulse 70bpm, Blood pressure 100/60mmHg. On the fifth day, the symphysio fundal height was 8cm. The breast was lactating well. Examinations were done and everything was normal. Baby's vital signs were: Temperature 36.2degree Celsius, Respiration 40cpm, Apex 136bpm, Weight 3.7kg Mother was encouraged to continue good personal hygiene as well as that of the baby.

4.8 SIXTH POSTNATAL HOME VISIT

On 13th December, 2022 was the sixth home visit to Madam Helina house at 10:00am. Client was doing well as well as baby and the entire family**.** Procedures to be done were explained to her. Head totoe examination was done on the baby and there was no abnormality detected. For the mother, Symphysio fundal height was 6cm. The perineal pad was inspected and the flow was scanty and pink in colour and not offensive. Her vital signs were also checked and recorded as follows; Temperature

36.4 degree Celsius, Pulse 81bpm, Respiration 20cpm, Blood pressure 110/60mmHg. Head to toe examination was done and no abnormality was detected. The cord stump was clean, dry and not offensive. The baby was looking active and fine. Madam Helina was asked to bath baby and clean theumbilical stump with cotton wool swab and methylated spirit under supervision and it was done well.The baby's vital signs were checked and recorded as

follows Temperature 36.4 degree Celsius, Apex136 beats per minute, Respiration 42cycles per minute ,Weight 3.8kilogram, Client was encouraged to continue with the exclusive breast feeding, exercise and the intake of nutritious diet for strong immunity and promotion of lactation. Client and her family were thanked for their time and cooperation and were informed of the last home visit being the next day.

4.9 SEVENTH POSTNATAL HOME VISIT

On 14th December, 2022 around 8:00am, client and family were visited as usual, greetings were exchanged and seat was offered and all family members were in good condition according to the mother. Head to toe examination was carried out and no abnormality was detected. Head to toe examination was carried out on mother and no abnormality was detected. The cord stump was clean. The Symphysio fundal height was 4 centimeters, perineum was clean and intact. Lochia

was small, alba the breast was lactating well. Her vital signs were checked and recorded as follows: Temperature 36.3degree Celsius, Pulse 82beat per minute, Respiration 22count per minute, Blood pressure 110/60mmHg. The baby's vital signs and weight were checked and recorded as follows: Temperature 36.3degree Celsius, Apex 128 beats per minute, Respiration 41 cycles per minute, Weight 3.9kilogram Mother was encouraged to ask questions. All findings were communicated to her and the necessary documentation was done. She was thanked and permission was sought to leave. She was reminded of another visit the next day.

4.10 FIRST POSTNATAL VISIT TO THE CLINIC

Madam Helina arrived at the clinic with her baby accompanied by her sister on the 14th December, 2022. They were offered a seat and then asked about their health and they were fine including thebaby. All procedures to be carried out were explained to Madam Helina. Her vital signs were checked and recorded as follows: Temperature 36.3degree Celsius, Pulse 78bpm, Respiration 20cpm,Blood pressure 100/60mmHg. Her midstream urine specimen was collected and tested for protein andsugar but all were absent. Her haemoglobin level measured 12.0g/dl. Madam Helina weight was 70kg.She was helped to lie on the couch for a head to toe examination having emptied her bladder. On inspection the hair was well kept, there were no discharges from eye, nose, the conjunctiva was not pale, the sclera had no yellow discoloration and the mouth was clean. The ears were not discharging, neck was palpated for swollen lymph nodes but no abnormality was detected. The breast was examined and no abnormality was found and was lactating well with no engorgement. On abdominal examination, the uterus was 4cm and no enlargement of any abdominal organ. The vulva was inspectedand there was no varicose vein, edema and bad odour. The Lochia was pale in colour with scanty flowand odourless. The extremities were free from any edema. All findings were communicated to her. Thebaby was also examined from head to toe and everything

was normal and her vital signs and weight checked were as follows: Temperature 36.6degree Celsius, Respiration 42cpm, Apex beat 138bpm, Weight 3.6kgAll the information was recorded in the post-natal records. The mother was educated ongood intake of well-balanced diet since this would improve her health status and also to produce morebreast milk. She was also educated on family planning for her to have an informed choice so that during the six weeks post-natal visit she could make a right choice. She was also advised to visit the child welfare clinic for the baby to complete all the immunization scheduled. She was thanked for hercooperation and also all the time spent together. She was very happy and was handed over to the midwife in-charge for continuity of care.

4.11 SECOND POST NATAL VISIT TO CLINIC (SIX WEEKS)

According to the midwife in-charge, Madam Helina reported to the facility at 9:00am on the 17th January, 2022. She came alone with her baby and they both looked nice and active. Every procedure to be carried out was explained to her. She was asked to empty her bladder and midstream urine was taken and tested for sugar and protein and the result was negative. Her heamoglobin level was 12.2gldl. Her vital signs were taken which recorded as follows: Temperature 36.5 degree Celsius, Pulse 74bpm, Respiration 19cpm, Blood pressure 110/60. Baby's vital signs were checked and recorded: Temperature 36.6 degree Celsius, Respiration 38cpm, Apex beat 134bpm, Weight 3.8kg. Madam Helina and her baby were sent to the child welfare clinic for immunization as well as family planning unit after which they were handed over to the public health nurse for community of care.

4.12 CARE PLAN DURING PUERPERIUM

PROBLEMS IDENTIFIED DURING PUERPERIUM;

1. After pain
2. Inadequate sleep
3. Backache
4. Headache

SHORT TERM OBJECTIVES

1. Madam Helina after pains will be relieved in 72 hours
2. Madam Helina will sleep 1 hour at day time and 3 hours at night within 24 hours
3. Client will be relived of backache within 72 hours
4. Client headche will be reduced within 24 hours

LONG TERM OBJECTIVES

Madam Helina will go through puerperium successfully without any complication to her and the baby.

PUERPERIUM CARE PLAN

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
06/12/22 9:00 am	After pains related to Uterine Involution	Client after pains will be relieved in 72 hours as evidenced by client action.	1. Reassure the client. 2. Encourage client to empty her bladder frequently. 3. Educate client on relieve measures 4. Encourage client to continue breastfeeding the baby. 5. Serve prescribed analgesic.	1. Client was reassured. 2. Client was encouraged to empty her bladder frequently. 3. Client was educated on relieve measures. 4. Client was encouraged to continuously feed the baby on demand. 5. Prescribed analgesic was served. {tab paracetamol 1gram tidx3}	08/12/22 9:00 am	Goal met as client verbalized that her pain was reduced.	A.J

PUERPERIUM CARE PLAN CONT'D

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES /OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTIONS	DATE/ TIME	EVALUATION	SIGN
08/12/22 6:30 am	Insomnia related to night breast feeding.	Madam Helina will sleep 1 hour at day time and 3 hours at night within 24 hours as evidenced by Client verbalizing.	1. Explain the importance of night breast feeding to her. 2. Encourage her to feed the baby on demand. 3. Encourage her to sleep when baby is asleep. 4. Encourage her support person to help her in the household chores. 5. Encourage client to rest enough during the day.	1. Importance of night breast feeding was explained to her. 2. Client was encouraged on the essence of feeding on demand. 3. She was encouraged to sleep when baby was asleep. 4. Her relatives were encouraged to help her in her household chores like washing to enable her to sleep during the day. 5. Client was encouraged to rest enough during the day.	09/12/22 6:30 am	Goal met as Madam Helina said that she slept for 3 hours during the night and 1 hours during the day	A.J

PUERPERIUM CARE PLAN CONT'D

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVE/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
11/12/22 8:00am	Backache related to Exaggerated posture during Pregnancy	Client will be relieved of backache within 72 hours as evidenced by; Client verbalizing.	1. Reassure client 2. Explain physiology of backache to client. 3. Apply gently massage over the back. 4. Encourage client to sleep on firm mattress. 5. Serve prescribed analgesics. (Paracetamol).	1. Client was reassured 2. Client was educating on physiology of backache. 3. Gentle massage was applying to client 4.Client was encouraged to sleep on warm firm mattress 5. Paracetamol was served as prescribed.	14/12/22 8:00am	Goal met as client said her pain stopped.	A.J

PUERPERIUM CARE PLAN CON'T

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES /OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTIONS	DATE / TIME	EVALUATION	SIGN
10/12/22	Headache related to stress during labour.	Client will be Relieved of headache within 24 hours as Evidenced by Client verbalizing that the Pain has subsided.	1.Give emotional support to client 2. Encourage client to sleep anytime baby is asleep. 3. Encourage client to take in copious fluid. 4.Encourageclient's mother and husband to assist in the care of the baby 5.serve prescribed analgesic such as paracetamol 1 gram twice a day	1. client was given emotional support. 2. Client was encouraged to sleep anytime baby is asleep. 3. Client was encouraged to take in copious fliud. 4. Client's mother and father were encouraged to assist in caring for the baby 5.Client was served with 1gram paracetamol twice daily.	11/12/22	Goal fully met as client verbalized that she has been relieved of the headache.	A.J

TERMINATION OF CARE

Madam Helina and her family were made aware on the first time of interaction that the care would be terminated during the postnatal review visit where she and her baby would be handed over to the public health nurse in –charge for continuity of care.

Madam Helina and her family were able to go through pregnancy, labour and puerperium successfully through all the education and care given to them. After examination both client and baby were handed over to the public health nurse for continuity of care. Profound gratitude was expressed to the client and family for their total cooperation. They were also grateful for the care and support.

SUMMARY AND CONCLUSION

The client family centered maternity care study was conducted on Madam Helina a 22 years old gravida 2 para 1 and her entire family through pregnancy, labour and puerperium and she went through these processes safety without any complication. Madam Helina became a regular attendant to clinic 27th March, 2022. She was managed through pregnancy, labour and puerperium safely through which all minor disorders were taken care of using the nursing care plan and goals were met when evaluated. She had a spontaneous vaginal delivery to a life femalebaby on 6th December, 2022 and discharged the next day. Client and family were visited for the first seven days after delivery.

She visited the clinic on her first week and six weeks postnatal. Madam Helina was given a focused and comprehensive care throughout her pregnancy, labour and puerperium. Madam Helina and her baby were in a healthy condition and they were handed over to the midwife in-charge for continuity of care.

Client and her family were much grateful at the end of the study.

The care rendered to Madam Helina has helped in equipping me with skills necessary to meet the needs of pregnant, laboring and puerperal women. It has also established between us a good interpersonal relationship.

The care study is an important and managerial tool which gives opportunity to student midwives to put into practice theoretical knowledge and to be able to deal with obstetric problems as midwifery professional.

BIBLIOGRAPHY

American Academy of Paediatrics (2014)

Jacob, A., (2013). midwifery case book; A practical record of maternal & new born nursing. (2nd ed.). India; Jaypee brothers medical publishers.

King LTMC (2014) varneys Midwifery (5th ed) New Delhi: Jones and Bartleft India pot, Ltd

Konar, H., (2013). D. C. Dutta's textbooks of obstetric. Kolkata: New Delhi: Jones and Bartleft India pot, Ltd

Marshall, J, & Raynor, M. (2014), Textbook for midwives (6th ed). London; Churchchill. Livingston Ltd.

Myles. (2014). Myles Textbook for midwives. Edition 15. Edinburgh London; Churchchill Livingston Elsevier limited.

Oduro-kwarteng, V., (2015) Obstetric for nurses and midwives, (2nd ed) Kumasi; Robee printing press.

Tiran, D., (2012). Ballieres Midwives Dictionary. (11th ed). London: Bailliere Tindal. World Health Organization (WHO 2014), Managing prolonged and obstructed Labour. (http:/whqlidoc.who.int/publications/2008/97892415466694 eng.pdf)p.

Tiran, D., (2015). Bailliere's midwives dictionary, (12th ed). London; Bailliere's Tindal.

Weller.B.F.,(2014). Bailliere's Nursing Dictionary,(25th ed) London: Bailliere Tindal Edinburgh.

APPENDIX I

COMPLETE DIAGNOTIC INVESTIGATION

Date	Specimen	Investigation	Normal values	findings	Remarks
26/07/22	Blood	Haemoglobin level	11.4g/dl-16g/dl	15.3g/dl	Normal
		Sickling status	Negative	Negative	Normal
		Grouping and	A, B, AB, O	O	Normal
		Rhesus factor	Positive/Negative	Positive	Normal
		HIV status	Negative/Positive	Negative	Normal
		Syphilis (VDRL)	None reactive	Negative	Normal
		Hepatitis status	Negative	Negative	Normal
		G6PD	No defect/ Full defect/ Partial defect	No defect	Normal
	Urine	Glucose	Negative	Negative	Normal
		Protein	Negative	Negative	Normal

COMPLETE DIAGNOSTIC INVESTIGATION CONTINUE

Date	Specimen	Investigation	Normal Values	Findings	Remarks
26/07/22	Urine	Sugar	Negative	Negative	Normal
		Protein	Negative	Negative	Normal
23/08/22	Urine	Sugar	Negative	Negative	Normal
		Protein	Negative	Negative	Normal
22/09/22	Urine	Sugar	Negative	Negative	Normal
		Protein	Negative	Negative	Normal
18/10/22	Urine	Sugar	Negative	Negative	Normal
		Protein	Negative	Negative	Normal
	Haemoglobin Level	12g/dl.16g/dl	12.5g/dl	Normal	Normal

Date	Specimen	Investigation	Normal values	Findings	Remarks
15/11/22	Urine	Sugar Protein	Negative Negative	Negative Negative	Normal Normal
22/11/22	Urine	Sugar Protein	Negative Negative	Negative Negative	Normal Normal
29/11/22	Urine	Protein Sugar	Negative Negative	Negative Negative	Normal Normal

APPENDIX II (PHARMACOLOGY OF DRUGS USED (MOTHER)

Name of Drugs	**Classification**	**Dosage**	**Route of Administration**	**Action & Use**	**Actual Effects**	**Side effects of drugs**	**Side effect experienced**
Tablet folic acid	Heamatinics	5 milligrams once daily	Orally	Proper formation and functioning of red blood cell.	Haemoglobin	Nausea and vomiting	None
Tablet multivitamin	Vitamin Preparation	200 milligrams twice daily	Orally	Increased appetite. Helps in formation of red blood cells.	Increase appetite.	Gastrointestinal disturbance	None
Tablet ferrous sulphate	Iron Supplement	200 milligrams twice daily	Orally	Helps in formation of haemoglobin and red blood cells	Haemoglobin level increased	Gastrointestinal disturbance	Dark stool

PHARMACOLOGY OF DRUGS USED CONTINUE

Name of Drugs	**Classification**	**Dosage**	**Route of Administration**	**Action & Use**	**Actual effects**	**Side Effects of Drugs**	**Side Effects experienced**
Tablet sulphurdoxine pyimethamine	Anti-malaria And Prophylaxis	3 dosage stats from 16 or after quickening and remaining doses within 4weeks interval until she delivers.	Orally	Treatment and prevention of malaria.	Malaria prevention	Itching, nausea, dizziness, headache	None
Injection oxytocin	Oxytocin Drugs	10 units	Intramuscular	Stimulate uterine contraction	Client had good contractions and bleeding was controlled	Nausea and vomiting	None
Capsule vitamin A	Group A Vitamin Supplement	200,000 units for two days	Orally	Growth development immaturity and proper sight	Normal vision and healthy skin	Vomiting	None

PHARMACOLOGY OF DRUGS FOR THE BABY

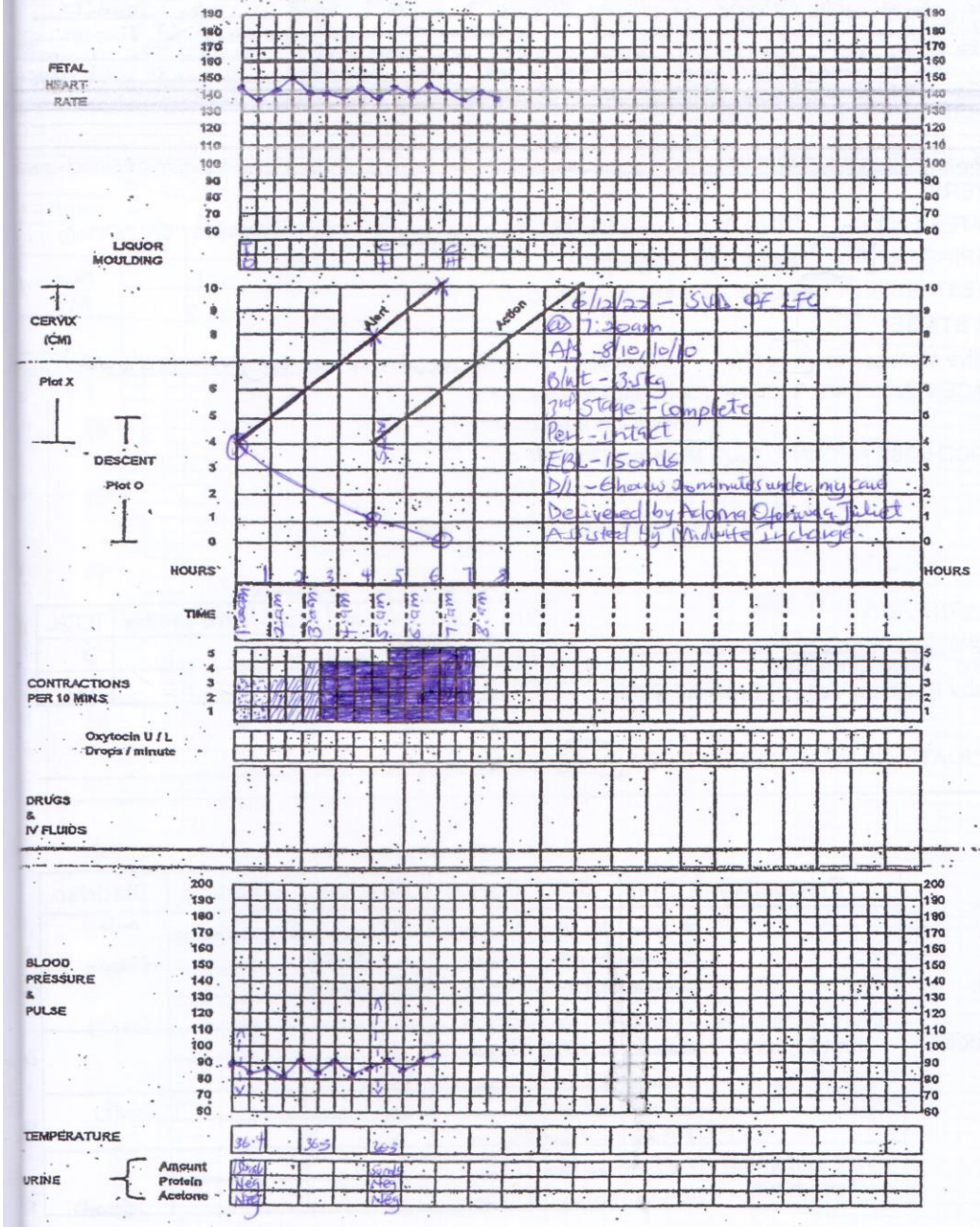
Name of drugs	**classification**	**Dosage**	**Route of Administration**	**Action & use**	**Actual effects**	**Side effects of drugs**	**Side effects experienced**
Vitamin K	Group K Vitamins (coagulant)	1.0mg	Intramuscular	Production of prothrombin which aids clotting	No bleeding	None	None
Gentamycin eye drop	Antibiotics	2 drops	Instillation	To prevent infection	Infection of the eye was prevented	None	None
Poliomyelitis	Antigen Vaccine	2 drops	Orally	Production of antibodies	Baby is under observation	There may be diarrhoea	None
Injection Baccilus calmette Guerin	Antigen Vaccine	0.5 mg	Intradermal	Production of antibodies for prevention of tuberculosis	Baby is under observation	Blister formation	None

APPENDIX III

Date	Weight	Blood Pressure	Urine for Protein/ Sugar	Gestational Age in Weeks	Fundal Height (CM)	Presentation	Descent of Foetal Head	Foetal Heart Rate (FH)	Treatment Given	Complain	sign
26/07/22	73kg	100/60	Negative/Negative	20	18	-	-	-	Routine drugs	Well	M.C
23/08/22	76kg	110/70	Negative/Negative	24	20	-	-	-	Routine drugs	No complains	A. P
22/09/22	77kg	110/70	Negative/Negative	28	26	cephalic	$5/5^{th}$	-	Routine drugs	Healthy	L.P
18/10/22	80kg	120/70	Negative/Negative	32	32	cephalic	$5/5^{th}$	138bpm	Routine drugs	Healthy	G. T
15/11/22	82kg	110/60	Negative/Negative	36	36	cephalic	$5/5^{th}$	144bpm	Routine drugs	No complains	M. C
22/11/22	83kg	110/70	Negative/Negative	37	37	cephalic	$5/5^{th}$	148bpm	Routine drugs	No complains	A.J
29/11/22	84kg	110/60	Negative/Negative	38	38	cephalic	$5/5^{th}$	146bpm	Routine drugs	No complains	A.J

WHO Modified Partograph

Registration No. AAA102 Name (Last, First) Boahemaa Helina Age 21years
Date 6/12/22 Parity/Gravida G2P1A LMP 4/3/22 EDD 11/12/22 Gestation (wks) 36weeks
ROM (Time, Date) SPM Labour Duration (Hrs) 6hrs 2mins Facility/Clinic Name ST. MARTIN HOSPITAL AMPENKI



LABOR NOTES

On 6/12/22 at 7:20am Client had Spontaneous Vaginal delivery to a live female child with APGAR SCORE of 8/10, 10/10. Birth weight was 3.5kg, 10units of oxytocin was given. Placenta and its membranes were delivered at 7:26am. Skin to skin was initiated. Breastfeeding was initiated. Head to toe examination was given to baby. Cord care and eye care was provided. Vitamin K was given to baby. Mother and baby vitals was checked and recorded.

Please circle or write responses.

DELIVERY

DATE: 6/12/22 TIME: 7:20am METHOD: (Spontaneous) / Vacuum Extraction / C/S / Other

PERINEUM: (Intact) / Episiotomy / Laceration

ANESTHESIA: (None) / Local / General

THIRD STAGE

Active Management: (Yes) / No ·Medication: Time 7:21am Type/Dose oxytocin (10 units)

PLACENTA: TIME: 7:26am (Complete) / Incomplete

BLOOD LOSS AMOUNT: 150mls (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
5min	2	2	2	2	2	10

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

FOURTH STAGE MONITORING

Frequency	Time	B/P.	Pulse	Fundus	Bleeding	Bladder
Every 15 minutes first 2 hours	7:30am	120/70	90bpm	18cm	Normal Lochia	Nill
	7:45am	110/60	86bpm	Well contracted	"	100mls
	8:00am	110/70	79bpm	Well contracted	"	
	8:15am	100/70	78bpm	✓	"	Empty
	8:30am	100/70	77bpm	✓	"	
	8:45am	110/70	80bpm	✓	"	
	9:00am	110/70	74bpm	✓	"	Empty
	9:15am	100/60	86bpm	✓	"	
Every 30 minutes For 1 hour	9:45am	100/60	78bpm	✓	"	
	10:15am	110/60	87bpm	✓	"	350mls

Birth Attendant ADOMA OFORIWAA JULIET Date 6/12/22

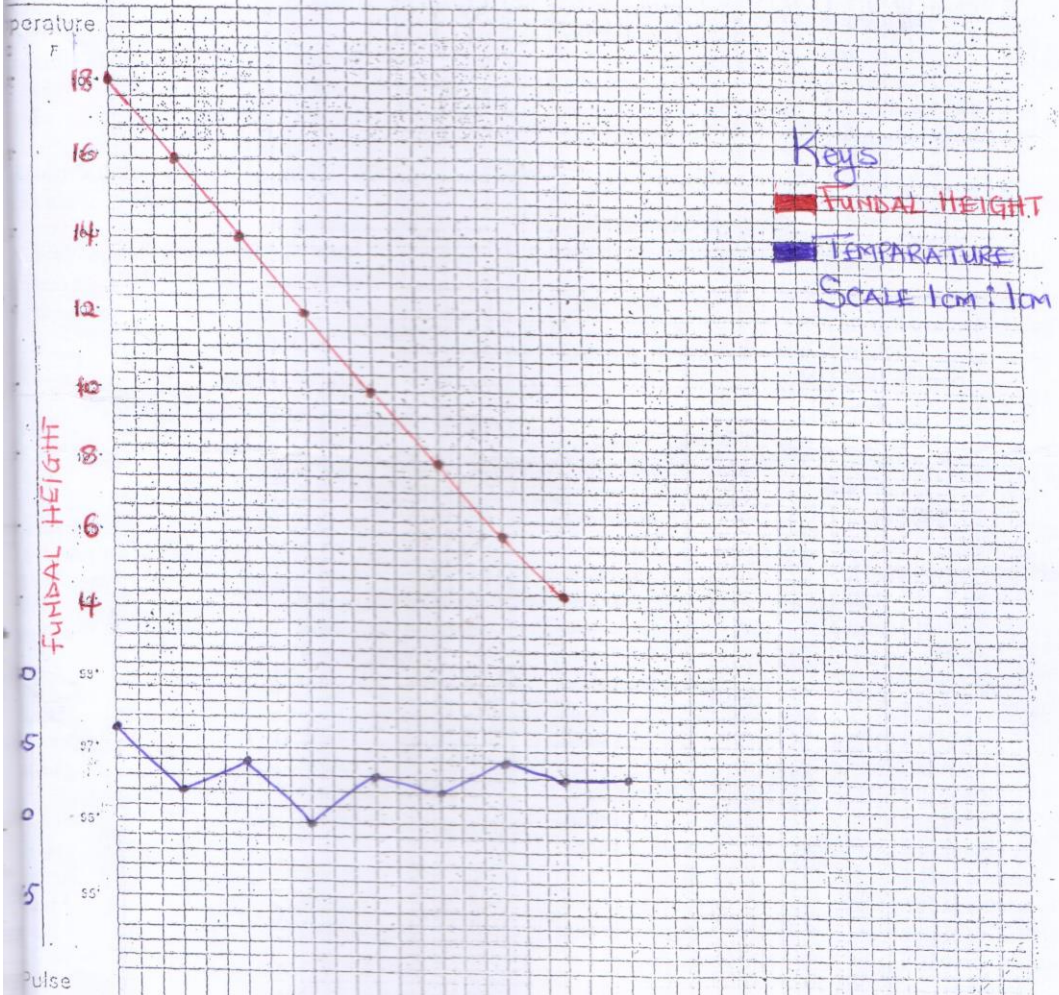
MATERNITY CHART

E: Madam Boahemaa Helina

21 years WARD: Maternity

BED NO.: Two

	6/12/22	7/12/22							
In Hospital	DD	D1	D2	D3	D4	D5	D6	D7	D8
P. O.	AM								
AM		7:00	7:50	7:34	7:00	8:00	8:30	10:00	8:00
PM		5:00	4:00	4:00	5:00	4:00			



Pulse

	22cpm	20cpm	19cpm	22cpm	20cpm	20cpm	22cpm
	Passed	Passed	Passed	Passed	Passed	Passed	Passed
	Passed	Passed	Passed	Passed	Passed	Passed	Passed
AM	110/60	110/60	110/60	100/60	100/60	110/60	110/60
PM	110/60	110/60	110/60	100/60			

NEW BORN EXAMINATION FORM

Name: Baby Boghemaa Helina Date of Assessment: 7/12/2022 Time: 6:00am

Date of Birth: 6/12/2022 Time of Birth: 7:30 Sex: ☐ M ☑ F Age at time of Assessment (days/hrs) one

Astational Age 38 wkets ☐ Mode of Delivery: ☑ Vaginal Assisted Vaginal C-Section

APGAR: 1min 8/10 5min 10/10 Birth Weight: 3.5 kg ☐ Length: 50 cm Head Circumference: 35 cm

Temperature at time of Assessment: 36.2 °C Urine passed: Yes No Meconium passed: Yes No

Name of Assessor (Midwife/Doctor): _____

1. Respiration

Rate 40

- ☐ 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: 130

- ☑ 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 Boahemaa Helina Date of Assessment: 6/12/2022 Time: 7:3[illegible]

Date of Birth: 6/12/2022 Time of Birth: 7:20am Sex: ☐ M ☑ F Age at time of Assessment (days/hrs) 1[illegible]

Astational Age 38 ☐ Mode of Delivery: ☑ Vaginal Assisted Vaginal C-Section

APGAR: 1min 8/10 5min 10/10 Birth Weight: 3.6 kg ☐ Length: 50 cm Head Circumference: 33 cm

Temperature at time of Assessment: 36.6 °C Urine passed: Yes No Meconium passed: Yes

Name of Assessor (Midwife/Doctor): _____

1. Respiration
Rate 38
- ☐ Rate < 30 b/m *
- ☐ Rate < 60 b/m *
- ☐ 30-60 b/m
- ☐ Retractions *
- ☐ Grunting *
- ☐ Stridor *

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

3. Tone
- ☑ Normal
- ☐ Floppy *
- ☐ Increased *

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

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

6. Cry
- ☑ Normal
- ☐ Shrill *
- ☐ Absent *

7. Suck
- ☑ Good
- ☐ Weak
- ☐ Absent

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

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

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

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

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

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

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

16. Clavicle
- ☑ Normal
- ☐ Swelling/Fracture

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

18. Heart rate
Rate: 132
- ☐ 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 [illegible]

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

NEW BORN CHART

Name: Baby Boahemaa ..... No: ~~AAA102~~ ..... Birth Weight: 3.5kg .....

Sex: Female ..... Mother's No: ~~AAA102~~ ..... Length: 50cm .....

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

Date of Birth: 6th December 2022 ..... Time: 7:20am ..... Date of Discharge: 7th December 2022

Date	6/12/2022		7/12/22		8/12/22		9/12/22		10/12/22		11/12/22		12/12/22		13/12/22		14/12/22					
No. of Days	DOD		D1		D2		D3		D4		D5		D6		D7		D8					
Weight	3.5kg		3.5kg		3.4kg		3.4kg		3.5kg		3.6kg		3.7kg		3.8kg		3.9kg					
	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM
Temperature	36.6°C	36.6°C	36.4°C	36.4°C	36.2°C	36.2°C	36.4°C	36.4°C	36.0°C		36.3°C		36.2°C		36.4°C		36.3°C					
Stools	Passed	Passed	Passed	Passed	Passed	Passed	Passed	Passed	Passed		Passed		Passed		Passed		Passed					
Urine	Passed	Passed	Passed	Passed	Passed	Passed	Passed	Passed	Passed		Passed		Passed		Passed		Passed					
Remarks	Head Neck Trunk Genitalia Limbs		NAD																			

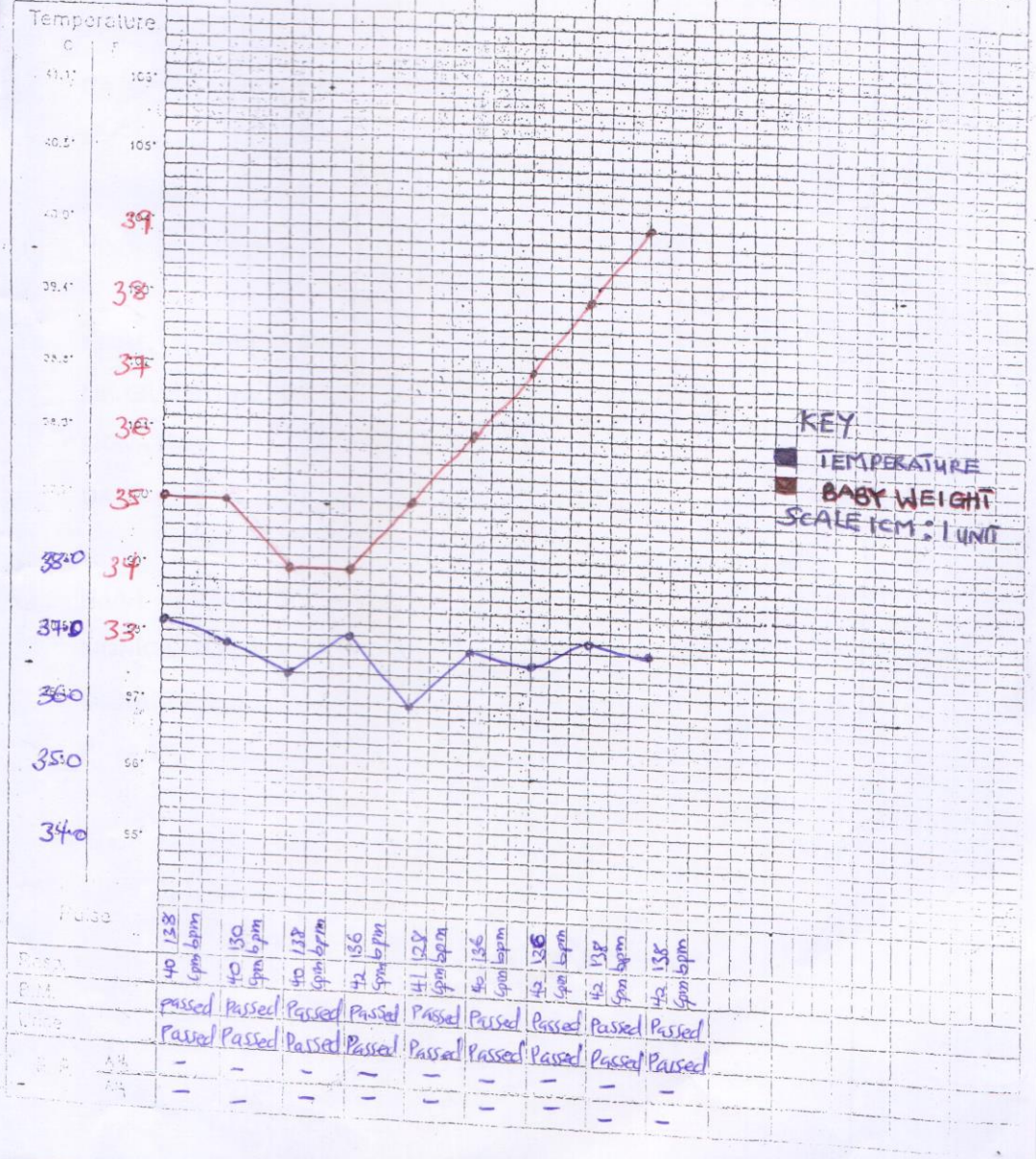
TEMPERATURE CHART

NAME: Baby Boahemaa

AGE: 21 YEARS WARD: LYING IN

IP NO.: BED NO.: TWO

Date	6/12/22	7/12/22	8/12/22	9/12/22	10/12/22	11/12/22	12/12/22	13/12/22	14/12/22
Days in Hospital	DD	D1	D2	D3	D4	D5	D6	D7	D8
Days P. O.	AM								
Hour AM	7:20	7:00	7:30	7:34	7:00	8:00	8:30	10:00	8:00
PM	-	5:00	4:00	4:00	5:00	4:00			
Temperature C									
F									
Pulse	138 bpm	130 bpm	128 bpm	136 bpm	128 bpm	136 bpm	126 bpm	138 bpm	138 bpm
Urine A.M.	40 gms	40 gms	40 gms	42 gms	41 gms	40 gms	42 gms	42 gms	42 gms
P.M.	passed	Passed	Passed	Passed	Passed	Passed	Passed	Passed	Passed
Urine	Passed	Passed	Passed	Passed	Passed	Passed	Passed	Passed	Passed
B. P. A.M.	—	—	—	—	—	—	—	—	—
P.M.	—	—	—	—	—	—	—	—	—



SIGNATORIES

NAME OF STUDENT MIDWIFE;

MISS JULIET OFORIWAA ADOMA

SIGNATURE:.....

DATE:...28-06-2023.....

NAME OF MIDWIFE-INCHARGE;

MRS. IRENE AKOTO

SIGNATURE:..... (for)

DATE:.....7/07/2023

NAME OF SUPERVISOR;

MS. ERNESTINA MENSAH

SIGNATURE:.....

DATE:..28 - 06 - 2023.....

NAME OF PRINCIPAL;

MONICA NKRUMAH

SIGNATURE:..... ACADEMIC COORDINATOR-NURSING HOLY FAMILY HOSPITAL MIDWIFERY TRAINING COLLEGE-BERekum

DATE:.....17/07/2023.....