HOLY FAMILY NURSING AND MIDWIFERY TRAINING COLLEGE

BEREKUM

A CLIENT/FAMILY CENTERED MATERNITY CARE STUDY

ON

MADAM SUSSANA

BY

APPIAH-KUBI ANITA

4122190037

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PREFACE

The client/family centered maternity care is systematic approach used in giving holistic obstetrical care to a pregnant woman and her family from the period of antenatal, labour and puerperium. It helps the student midwife to acquire the right kind of approaches to care for the pregnant woman. Some of these approaches are, explaining procedure to the client to gain the client's consent, providing privacy and getting the family involved in the care.

The maternity care study helps the student midwife to acquire knowledge which can be used to solve any problem associated with pregnancy, labour and puerperium. The competence of the student midwife is also tested in the practical aspect through the maternity care study which the student uses to identify both short and long-term problems, set objectives for these problems and give intervention that will help her solve them. The main reason for carrying out this care study is to reduce maternal and infant mortality rate and to promote the health of the baby and mother, including the family. It is in this view that the World Health Organization (WHO) develops the partograph in managing the first stage of labour. Using this tool assists the midwife to identify any complication of labour for prompt intervention. The student midwife during this care study gets the chance to use the partograph to enable her to become competent in using it.

Finally, the client/family centered maternity care is an obligation for every final year student midwife as a requirement by the nursing and midwifery council of Ghana in partial fulfillment towards the award of registered midwifery certificate.

ACKNOWLEDGEMENTS

My supreme gratitude goes to our Lord God for his mercy, grace, blessing and gift of life granted me to write this script.

My special thanks go to the principal of Holy family Nursing and Midwifery training college, Berekum HFNMTC, Ms. Monica Nkrumah and also to my supervisor teaching and non-teaching staff of (HFNMTC) especially the midwifery tutors, I say a very big thanks for your guidance. May God richly bless you.

To my client Madam Susana and her husband Mr. Amos and the entire family, I express my endless appreciation. Without them, this study would have never been successful. I thank them for the acceptance, cooperation, love and commitment they showed towards this piece of work. I am very indebted to them. May God bless them abundantly.

Also many thanks go to the Administrator in charge of Derma Community Health Center and her staff for their guidance and support during my domicilary midwifery practice. Furthermore, I thank my Mother Madam Georgina, my brother Emmunel for supporting and making my completion a success. To all my friends and relatives, thank you a lot and God bless you.

Finally, my sincere thanks go to the authors and publisher whose books I extracted valuable information to enhance the writing of this script.

To all examiners who are going to mark this script and to everyone who helped in one way or the other, I am very thankful.

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 the pregnant woman in solving every problem identified during the period of care. The study was conducted on Madam Sussana, a 26year old gravida 3 Para 2 alive. She hails from Offinso in the Ashanti Region of Ghana but stays Derma in the Bono region. We had an encounter on Tuesday 26th Otocber, 2021 at Derma Health Center, Derma. 36 weeks gestation and had come for her eight antenatal care visits. Introduction was made as a student midwife who wishes to take care of her throughout the rest of her pregnancy, through delivery and puerperium. She had no health issues when we had the encounter. The interaction ended after client had delivered spontaneously to an alive female child without any 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 after six weeks of care.

There are four chapters outlined in this script.

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

Chapter Two: Involves antenatal care which begins from the time of conception till the ninth 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 Sussana throughout this project.

LITERATURE REVIEW

Pregnancy

Myles(2009) Pregnancy is confirmed when many physiological changes take place in the body and return to its pre-pregnant state during puerperium due to the effect of hormones namely estrogen and progesterone. These hormones are responsible for the major changes that take place during

pregnancy. Even though these hormones have their own effects by causing this minor disorders that occur during pregnancy, they are one way or the other an advantage for the mother and the growing foetus since the foetus depends solely on the mother for survival in utero. . Prenatal visit begins soon after the first missed menstrual period to ensure good health of the expectant mother and the fetus. Normal pregnancy last for about 40weeks or 280 days and health care providers refer to early, middle or late pregnancy trimesters. The first trimester last from week 1 through to 13, the second from week 14 through to 26, and the third from week 27 through to 40. A pregnancy is considered to be at term if advances to 38 to 40 weeks. The average duration of pregnancy is 280 days or 40 weeks and this is countered from the last menstrual period. Every pregnancy is a unique experience for that woman and each pregnancy that the woman experiences will be uniquely different.

Perry, (2014) Pregnancy is a period of physical and psychological preparation for birth and parenthood. Prenatal visit begins soon after the first missed menstrual period to ensure good health of the expectant mother and the fetus. Normal pregnancy last for about 40weeks or 280 days and health care providers refer to early, middle or late pregnancy trimesters. The first trimester last from week 1 through to 13, the second from week 14 through to 26, and the third from week 27 through to 40. A pregnancy is considered to be at term if advances to 38 to 40 weeks. Every pregnancy is a unique experience for that woman and each pregnancy that the woman experiences will be uniquely different. This is why it is so important that, the midwife has a knowledge and understanding of the common disorders of pregnancy which include; constipation, fatigue, headache, lower abdominal pain, waist pains, leg cramp, backache, increase vaginal discharge among others in order to advice the woman on strategies that will help her cope with the condition and minimize the effects she experience

Ojo and Briggs, (2011), pregnancy occurs when menstruation ceases for some weeks or months before delivery. Most women experience some minor disorders such as morning sickness, nausea, frequency of micturition, heart burns among others. These conditions may not be life threatening but can be harmful: the women therefore need to be educated on these conditions so that they can understand and cope with their occurrence. In pregnancy progesterone and estrogen increases. These hormones are responsible for the major changes that take place during pregnancy. Even though these hormones have their own effects by causing this minor disorders that occur during pregnancy, they are one way or the other an advantage for the mother and the growing foetus since the foetus depends solely on the mother for survival in utero

Fraser and Cooper (2009),pregnancy is a time of enormous physical and psychological change and adaptation as the woman and her family prepared or expected a new member of the family. For most women, this is an exciting and happy period of time but may be over shadowed by fear and expectations. Pregnancy is the growth of the uterus and the foetus. The average duration of pregnancy is 280 days or 40 weeks and this is countered from the last menstrual period. Every pregnancy is a unique experience for that woman and each pregnancy that the woman experiences will be uniquely different. This is why it is so important that, the midwife has a knowledge and understanding of the common disorders of pregnancy which include; constipation, fatigue, headache, lower abdominal pain, waist pains, leg cramp, backache, increase vaginal discharge among others in order to advice the woman on strategies that will help her cope with the condition and minimize the effects she experience.

Verrals (1993), pregnancy is the period in which a foetus develops inside a woman's womb or uterus. In the late trimester the uterus pushes on the bladder causing frequent micturition. The hormones progesterone and estrogen are produced in large quantities which exert some action on the various systems of the pregnant woman such as frequency of micturition. During this period,

physiological and psychological changes occur due to the effect of estrogen and progesterone which provide nutritive and protective environment for the developing embryo and also prepares the breast for lactation.

Labour

Myles (2009), labour is described as the process by which the fetus, placenta and membranes are expelled through the birth canal. First stage of labour begins with regular rhythmic uterine contractions to the full dilatation of the cervix (10cm) and is managed by the use of a partograph. Partograph is a graphical representation of the progress of labour and salient features of the mother. This helps to improve maternal and neonatal outcome, increases the regularity and quality of observation done on the foetus and mother, serves as early warning system and also helps in decision on augmentation or termination of labour. The first stage lasts for about six to twelve hours and this stage is shorter in multiparous women than in primigravid women.The stage one has active and latent phase and within the latent phase has the transitional phase. The second stage starts from full dilatation of cervical os which is 10cm up to the expulsion of the foetus. The third stage of labour starts from the expulsion of foetus to the separation and expulsion of its membrane and subsequent control of hemorrhage. It usually last within 5-15 minutes after the birth of the baby. The fourth stage of labour is the first six hours vigilant observation of the mother and baby

Fraser and Cooper (2009), Labour is the process by which the foetus, placenta and the membranes are expelled through the birth canal. Normal labour occurs between thirty seven to forty two weeks of gestation. The World Health Organization (1997) defines normal labour to as low risk throughout, spontaneous in onset and presenting with vertex culminating in the mother and infant in good condition after birth. The four stages of labour are described as; stage one is the period of

onset of regular uterine contraction to when the cervix is full dilatation of the cervical os and it last 12-14 hours in the primigravida and 6-12 hours in a multiparous woman.

The stage one has active and latent phase and within the latent phase has the transitional phase. The second stage starts from full dilatation of cervical os which is 10cm up to the expulsion of the foetus. The third stage of labour starts from the expulsion of foetus to the separation and expulsion of its membrane and subsequent control of hemorrhage. It usually last within 5-15 minutes after the birth of the baby. The fourth stage of labour is the first six hours vigilant observation 0f the mother and baby. It also deals with the establishment of lactation and detection of abnormalities and complications in both mother and baby

Safe Motherhood Service Protocol (2008), labour begins when there are regular, painful contraction The National lasting at least 20 seconds (timed by a trained observer), occurring at a frequency of at least two contraction in every 10 minutes and with a cervical dilatation of at least 3 centimeters. The 4 four stages of labour are; first stage, it begins from onset of contraction to full dilatation. In the first stage after 4 cm dilatation a partograph is issued for the monitoring of the labour. The second stage starts from full dilatation to expulsion of foetus. The third stage starts from expulsion of foetus to expulsion of membranes. The fourth stage of labour starts from the expulsion of membranes to the end of puerperium. The WHO partograph has been modified to make it simpler and easier to use .the partograph is issued after 4cm dilatation of cervix to monitor the progress of labour and manage the labour.

Konar (2013), Labour as series 0f event that takes place in the genital organs in an effect to expel the whole product of conception out of the womb through the vagina into the outside world. The four stages of labour are first second third and fourth .The labour pain has two component; visceral

pain which occurs during the early first stage and the second stage of child birth and somatic which occurs during the late first and second stage. The pain in the first stage is mediated by the T10 to L1 spinal segment and in the second stage is carried by T12 to L1 and S2 and S4spinal segments

Ojo (2011), Labour is the process by which the uterus empties its contents after 28 weeks of pregnancy. It entails the contraction and retraction of uterine muscle fibers, the dilatation of the cervical os and complete expulsion of the fetus, liquor amnii, placenta and membranes.The first stage is the period of onset of regular uterine contraction to when the cervix is full dilatation of the cervical os and it last 12-14 hours in the primigravida and 6-12 hours in a multiparous woman. The first stage has active and latent phase and within the latent phase has the transitional phase. The second stage starts from full dilatation of cervical os which is 10cm up to the expulsion of the foetus the stage last for an hour in primigravida and 5-40 minutes in a multigravida. The third stage of labour entails the expulsion of foetus to the separation and expulsion of its membrane and subsequent control of hemorrhage. It usually last within 5-15 minutes after the birth of the baby. The fourth stage of labour is the six hours after the delivery of the placenta and membranes and close monitoring of the client and baby.

Henderson (2004), states that labour is the period from dilation to expulsion of foetus and it's membranes the aims of midwifery care in labour are to achieve a safe labour and birth for mother and baby, and a pleasurable fulfilling experience of child birth for the mother and her partner .labour is called normal if it fulfils the following criteria; spontaneous from onset, painful uterine contraction at regular interval

Puerperium

Myles (2008), states that, following the birth of the baby and the expulsion of the placenta, the mother enters a period of physical and physiological recuperation .Puerperium starts immediately after the delivery of the placenta and membranes and continues for six weeks. Differences between exercise and healthy activist verses rest , relaxation and sleep was strike .Exploring each person's level of 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 benefit to the women's long –term health. After birth the uterus involute and there is a heavy discharge called the lochia which originates from the uterine body, cervix and vagina. Depending upon the variation of the colour of the discharge is named as;

Lochia rubra (red) 1-4

Lochia serosa (yellowish or pink or pale brownish) 5-9

Lochia Alba (pale white) 10-15

Fraser and Cooper (2009), puerperium is the period of six weeks after birth which begins as soon as the placenta is expelled. During this period, the reproductive organs return to their non- pregnant state .Puerperium is divided into 3 phases that is; immediate phase – the first 24 hours after delivery of the placenta, early phase- 24hours after delivery of placenta up to 7 days, remote phase 7 days to 6 weeks to 6 months.. The general expectation is that by six weeks after birth all the systems in a woman's body will have recovered sufficiently from the effects of the pregnancy and recovered to their non – pregnancy state .immediately after delivery the uterus is firmer and weight about 1000g. There is involution that is the uterus returning to its nonpregnant state, there is discharge from the uterine body, cervix and vagina called the lochia..

Depending upon the variation of the colour of the discharge is named as; Lochia rubra (red) 1-4days Lochia serosa (pink or pale brownish) 5-9 days, Lochia Alba (pale white) 10-15 days

The National Safe Motherhood Service Protocol (2008), the postpartum period is the time from the end of delivery to six weeks after delivery. The post natal, care includes education of the mother on the care of the baby, detection and treatment or referral of any abnormalities for further management. The major causes of death in this period are infection, hypertensive complications, hemorrhage and thromboembolism. The period is arbitrarily divided into; immediate -within 24 hours, early – up to 7 Days and remote – up to 6 weeks. Uterus involute and there is a heavy discharge called the lochia which originates from the uterine body, cervix and vagina. Depending upon the variation of the colour of the discharge is named as; Lochia rubra (red) 1-4days Lochia serosa (pink or pale brownish) 5-9 days

Lochia Alba (pale white) 10-15 days

Ojo and Briggs (2011), states that puerperium lasts for about six weeks after the delivery of the placenta and arrest of haemorrhage. The first ten day of puerperium is term as the lying-in period where close observation of both mother and baby are considered. During this period the abdominal muscles are flaccid and the bruises in the vaginal heals and the genital organs and any other organs which underwent changes during pregnancy return to their pregravid state. Lactation is also established bonding is fostered through the establishment of breastfeeding. The process of readjustment is called involution

Marshall and Raynor (2014), states that puerperium starts immediately after the delivery of the placenta membranes and continues for six weeks. In many culture around the world, 40 days for recuperation is a time- honored 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 effects of the

pregnancy and recovered to their non – pregnancy state. The pelvic organ revert approximately to the pre pregnant state both anatomically and physiologically. The period is divided into; immediate- within 24 hours, early- up to 7 days, remote- up to 6 weeks uterus involute and there is a heavy discharge called the lochia which originates from the uterine body, cervix and vagina.

Depending upon the variation of the colour of the discharge is named as; Lochia rubra (red) 14days

Lochia serosa (pink or pale brownish) 5-9 days

Lochia Alba (pale white) 10-15 days

WHY CLIENT WAS CHOSEN

Madam Susana was chosen as a client on 29th October, 2021 at Derma Community Health Clinic during one of her usual antenatal visit. During education that morning. the topic “personal

hygiene”, she made some contributions which indicated that Madam Susana had little knowledge on the topic. The needed information on the topic she required was provided. Introduction was made as a student from Holy Family Nursing and Midwifery Training College Berekum, and was at the hospital for practical experience. Permission was sought from her to be taken as a client for the care study which she accepted. All the necessary particulars were collected. Appointment for home visit was booked, direction to her house was given and phone numbers were exchanged

CHAPTER ONE

CLIENT'S PARTICULARS

1.0 INTRODUCTION

This chapter talks about the client and family. It comprises social, family, medical, surgical, menstrual, lifestyle, past obstetrical and present obstetrical histories.

1.1 PERSONAL AND SOCIAL HISTORY

Madam Sussana G3P2 is 25 year old and stays in at Derma, a suburb of Tano South. She is dark in complexion and her height is 158cm. Madam Sussana is married to Mr. Amos. She owns a provision store and also farms. She speaks Twi and Ga. She attained her education up to Junior High School. Madam Sussana is a Christian who worship at Methodist. Miss Mensah her mother is her next of kin and she neither smokes nor drinks alcohol.

1.2 FAMILY HISTORY

Madam Sussana is the third born of four siblings (two females, two males). According to Madam Sussana, her family has no history of diseases like epilepsy, asthma, hypertension, sickle cell, diabetes, jaundice, heart diseases and mental illness likewise the husband's family. They also have no history of multiple pregnancy.

1.3 MEDICAL HISTORY

Madam Sussana has never experienced any serious illness like heart disease, hypertension, sickle-cell disease, diabetes mellitus, jaundice, respiratory disease or any psychiatric disorder such as

epilepsy that could lead her to admission to the hospital but always reported to the outpatient department whenever she has a minor illness She explained she has no known allergy to any food and has never reacted to any medication given or environmental hazards like dust, scent of perfume, spices among others. She has never received any blood transfusion or donated blood.

1.4 SURGICAL HISTORY

Madam Sussana said she has not encountered any fracture or injury on any part of her body or any severe cut which has been sutured as a result of road traffic accident or domestic accident. She has never undergone any surgical operation especially on her pelvis that could affect her labour.

1.5 MENSTURAL HISTORY

Madam Sussana said she had her menarche when she was 15 years old and her menstrual flow has been regular. Client said she normally bleeds for 6 days and indicated that she has a regular cycles of 28 days and the amount of blood loss is moderate with no dysmenorrhea and her last menstrual period was on the 19/02/21

1.6 CLIENT'S LIFESTYLE AND HOBBIES

Madam Sussana usually goes to bed around 10:30pm and usually wakes up around 5:00am. She brushes her teeth onces daily and bath twice in the day. She said she normally takes porridge with bread for breakfast, yam and garden eggs stew for lunch and fufu with light soup for supper.

After breakfast she bathes her children and prepares them for school. She visits the toilet in the morning and voids when necessary. She prefers chatting with the people around her then sleeps in

the afternoon or sometimes rest for two hours in the afternoon to reduce stress and strains of pregnancy. After supper she chats with the family before going to bed. According to the client she does not take in alcohol.

1.8 PAST OBSTETRIC HISTORY

PREGNANCY

Madam SussanaG3P2said she has never had either spontaneous or induced abortion. According to her, she carried her previous pregnancies to term without any complications like antepartum haemorrhage, pregnancy induced hypertension or any other complications except minor disorders like abdominal pains, and backache that occurred in the latter stages of the pregnancy and was managed. According to her, she took five doses of Sulphadoxine Pyrimethamine (SP) as prophylaxis which was given to her ,to prevent malaria and receive the first, second, and third doses of tetanus diphtheria in her first pregnancy and third dose of tetanus diphtheria (TD) injection in her second antenatal records book.

LABOUR AND DELIVERY

According to client labour was not induced and she did not also had preterm delivery.

She had spontaneous vaginal delivery in her previous deliveries at the hospital. Her babies were active and cried immediately after birth and their condition was stable. Even though she could not tell the weight of her children, however, she said her children were of moderate size. Madam

Sussana said, the placenta was delivered few minutes after delivery of the babies. She was not given episiotomy neither did she have tears or bled after birth.

PUEPERIUM

When inquired, Madam Sussana went through puerperium, practiced exclusive breastfeeding for six months before adding other foods such as porridge with soya beans, groundnut paste, egg yolk and fish powder, (complementary feeds) which she was taught at child welfare clinic at six months and completely stopped breastfeeding when the child was two years old. Her children were immunized against the childhood preventable diseases such as tuberculosis, measles, poliomyelitis and others. According to client her children did not also suffer any serious ill health as they grow. She had a successful puerperium with her mother and husband's support without any complication such as puerperal infection or postpartum psychosis. According to her, she has interest in family planning and hence does practice it to space-out her children and also prevent them from facing financial difficulties.

1.9 PRESENT OBSTETRIC HISTORY

According to her antenatal records, Madam Sussana reported at the antenatal clinic on 13th August, 2021 and her gestational age was 24 weeks. Client said her last normal menstrual period

(LMP) was 19th February, 2021 so her expected day of delivery (EDD) was calculated as 27th October, 2021. Her antenatal card revealed that on her first visit, histories were taken examination and investigations were carried out with her consent and the following investigations were requested and carried out it revealed the following;

Urine R/E: No abnormality detected.

Stool R/E:	No abnormalities detected.
Hemoglobin:	11.0 g/dl
VDRL:	Non-reactive.
MPs	No MPs seen
Blood group:	O Rhesus
factor:	Positive
HIV/AIDS:	Negative.
HBsAg:	Nonreactive.
G6PD:	No defect.
Temperature:	36.2^{o} C
Pulse:	88bpm
Respiration:	22cpm
Blood pressure:	107/59 mmHg.
Weight:	64 kg
Height:	165cm

Head to toe examination was done and no abnormality was detected. She complained of abdominal pains. She was managed and was kept on the following drugs,

Tablet folic acid	5 milligrams daily for 30days
Tablet fersolate	200 milligrams daily 30 days

Tablet multivitamin	200 milligrams daily 30 days

CHAPTER TWO

ANTENATAL CARE

2.0 INTRODUCTION

Chapter two is about the antenatal care given to the client. This includes the first contact with client, subsequent visits to the clinic, home visits during the antenatal period and care plans drawn to solve problems encountered by the client.

2.1FIRST CONTACT WITH CLIENT

The first contact with Madam Sussana was on 29/10/2021 during her fourth antenatal visit to the clinic with 36 weeks' gestation. She was greeted and offered a seat. The staff around and the workers were introduced to Madam Sussana. Her antenatal book was checked and it was realized that she fell within the criteria of client selection for care study. An introduction was made and she was informed that she would be taken as a client for the study and she would be monitored from pregnancy, through labour to puerperium. She agreed and she was thanked for her understanding and co-operation. She was also assured of confidentiality. The in-charge was informed about the selection which she agreed. The result of data recorded on the first contact with client are as follows:

Temperature	36.4 degrees Celsius
Pulse	85 beatss per minute
Respiration	21 cycless per minute
Blood Pressure	120 / 80 millimeter in mercury
Weight	64 kilogram

Urine for protein and sugar Negative

Examination to be done on her was explained to her and she gave her approval for the procedures to be carried out. She was reassured that all findings will be communicated to her afterward. She was asked to empty her bladder if the urge is there and was assisted to lie on the bed afterwards. Soap and was used in washing of the hands under running water after which they were dried with a clean towel and privacy was ensured. Head to toe examination was performed.

PHYSICAL EXAMINATION

The hair was inspected for cleanliness, there were no lice, dandruff, ringworm, loss of hair orany other scalp infection and no abnormality was detected. Client was congratulated for keeping the hair clean so was encouraged to keep it up. The ears were inspected and there were no discharges or pain. The eyes were inspected for jaundice of the sclera, pallor of the conjunctiva, alignment with the ears and discharges but nothing abnormal was detected. Her lips were inspected for pallor, dryness, sores, lesions and mouth for tooth decay, loss of teeth and halitosis but no abnormality was detected.

Madam Sussana's neck was also inspected and palpated and there was no enlarged thyroid gland, lymph gland and no distended neck vein or masses.

Examination of the breasts was performed. The left breast was examined while the left hand was placed under the head and the right hand was also placed under the head during examination of the right breast.

The breast was palpated systematically in a circular manner using the inner aspect of the fingers. No abnormality was found in terms of shape and size. There were no masses, lumps, cracked or sore nipple and enlarged axillary lymph nodes. The condition of the skin was also good. She

was educated on the need to wear well-fitting brassieres and how to perform self-breast examination.

The upper extremities were examined for equality and alignment with the body but both were equal. The hands and fingers were also examined for dirt and grown nails, pallor of palms and all these were absent. Capillary refill of the finger nails was checked by pressing the tip and releasing it and the result was good. Client was therefore congratulated and encouraged to continue with her cleanliness.

The lower extremities were examined for size and equality, varicose veins and oedema as well as leg cramps, tenderness in the calf muscle but no abnormality was detected. Capillary refill of the toe nails was also checked and the result was also good.

Client was assisted to turn her back for inspection and upon inspection and palpation of the sacral region, no lesion or oedema was detected.

ABDOMINAL EXAMINATION

This procedure was explained to client's understanding. The purpose of this examination was to assess fetal size and growth, auscultate the fetal heart, locate fetal parts and detect any deviation from normal. She was assisted to lie in a dorsal position with arms by her side . Hands were washed with soap and water and dried with a clean dry towel. Standing on her right side, the abdomen was exposed.

On abdominal inspection, the shape of the abdomen was ovoid, medium in size and there was the presence of linear nigra and strae gravidarum. The abdomen was inspected for scars from previous caesarian section and there was none detected

On fundal palpation : Facing Madam Sussana, palms were rubbed together to provide warmth to prevent inducing contractions. The palms were placed on either side of the fundus and was curved around the top of the fundus to determine what lies in the upper pole. A soft mass was felt which indicated the buttocks of the foetus.

Measurement of symphysio fundal height: Hands were warmed, the upper border of the symphysis pubis was located and the zero end of the measuring tape was placed on the upper border of the symphysis pubis. The tape was extended along the midline and along the center to the fundus of the uterus. The symphysio-fundal height measured 38 centimeters and gestational age was 36 weeks.

On lateral palpation: Lateral palpation was done with palms on both sides of the uterus midway between the symphysis pubis and the fundus. The uterus was stabilized with the left hand and palpation was done through the entire midline to the lateral side of the abdomen to locate the foetal back in a rotary manner.

The right hand was also used to stabilize the uterus and the same was repeated for the other half of the abdomen. The right lateral palpation was done at the right side of the woman and a smooth part was felt, which indicated the fetal back and rough part, was located on the left side of the mother.

Auscutation: On auscultation, the fetal stethoscope was warmed by rubbing in the palm and placed at the area where the foetal back was located to listen to the foetal heart rate. With one hand at the maternal radius to ensure that it is not the maternal pulse being listened to, the foetal heart rate was checked for one minute and recorded as 140 beats per minute.

Pelvic examination: This examination was done facing Madam Sussana's feet. She was asked to flex the knee slightly and helped to relax by guiding her to breathe out slowly. The palms were placed just below the level of the umbilicus with the fingers directed towards the symphysis pubis and thumb almost meeting, a hard mass was felt at the lower pole indicating the head of the foetus.

Descent of the head: Location of the anterior shoulder was made and two fingers were placed on it. The symphysis pubis was located with the right ulna border just above the symphysis pubis, that hand was placed between the symphysis pubis and the anterior shoulder. Five fingers occupied the space indicating descent of 5/5. Therefore, from the above, it was deduced that, the lie was longitudinal, presentation was cephalic, descent was 5/5 and the position was right occipito anterior.

Vulva / perineum: Permission was sought to inspect the vulva and it was granted. A pillow was placed under her head and she was draped to provide privacy and modesty. Hands were washed with soap under running water and dried with clean towel. Disposable gloves were worn on both hands and the vulva and perineum were examined for abnormal discharges, rashes, genital warts, ulcers, scars and varicose veins. The labia majora was examined for same size and shape, redness, swelling and tenderness and nothing abnormal was detected.

The client was asked to lie laterally and sit up before getting out of the couch. Madam Sussana was thanked for her cooperation and findings were communicated to her. All items used were decontaminated appropriately. The gloves were removed and discarded. Hands were washed with soap under running water and dried with clean towel and all findings recorded into her antenatal record book. Client was asked of any complains and questions. Client complained of low back pain. She was educated that the pain was due to the weight of the gravid uterus, relaxation of joints by progesterone and relaxin and the position assumed to maintain gravity. Client was encouraged

to have enough rest and sleep and also taught how to perform exercise in pregnancy such as pelvic rock which helps to relieve back ache, head and shoulder lift which helps to strengthen abdominal muscle and kegel exercise which helps to strengthen the pelvic floor muscles that makes delivery easier. She was encouraged to wear low heel shoes.

She was also encouraged to take her drugs as prescribed. Health education was given on birth preparedness and complication readiness then labour and delivery. She was also informed of home visits which she agreed and her phone number with directions to her house were taken. The day for the first home visit was scheduled on 30/10/21. She was thanked for her cooperation and the following drugs were given to her:

Tablet Ferrous Sulphate	200mg daily for 7
Tablet Folic Acid	5mg daily for 7 days
Tablet paracetamol	1g tid for 3 days

Client was informed of her next visit which was on30/10/2021 but was also encouraged to report any problem like severe headache, vaginal bleeding, swelling of the lower limbs, severe abdominal pains and excessive vomiting and other immediately. All activities carried out and findings were recorded and reported.

2.2FIRST ANTENATAL HOME VISIT

Madam Sussana was visited at her house on 30/10/21 at 5:00 pm as planned. The purpose of the visit was to observe her environment and condition of the house, relationship with family and neighbours.

A stroll was first taken around the house before entering. The surrounding of the house was clean with no bushy areas and stagnant waters. The house has no wall around it. On arrival, Madam Sussana was cooking with her sister at their kitchen. A warm welcome was offered by client's sister on arrival and a seat was offered. The health of the client and sister were fine when asked.

Client made the introduction to her sister as student midwife from Holy Family Nursing and Midwifery training college, Berekum for her practical experience. Her mother was happy after explaining the focused antenatal care that will be given to Madam Sussana during her pregnancy, labour and puerperium. The house is located at Derma near the market. The house has two separated boys' quarters with one adjacent to the other as if it is a compound house. The house contains 3 rooms. It was built with blocks, plastered with cement and roofed with aluminum sheets. Some part of the house has been painted with some part left unpainted. The bathroom was built outside the house and there is no toilet in the house

Though the compound was not cemented or terrazoed, it was very clean. There is only one wooden door at the entrance of her room and the room is well ventilated with two windows which were opposite, made of louvres and nets. The client's room is large and spacious with a bed, some electrical gadgets such as fan and television set. The bed was neatly made and hanging over the bed was a treated mosquito net. . Her things in general were well arranged. The place was clean with no unpleasant smell. Client uses electricity as a source of light. They have pipe borne water in the house but still stores water in a plastic container with lid. She uses a plastic bucket with a lid as a waste bin and empties it daily at the community refuse dump about half a kilometre from the house. Client's sister helped her with her daily activities. She was then asked about her preparation towards labour and she said she has bought all the things she would need such as perineal pad, cot sheets and others and had arranged with a driver as told. She also added that her

sister will accompany her to deliver when labour sets in. The items were checked and they were set, packed in a nice bag and kept at a place that would be easy to find. She was encouraged to add a purse of money, her health insurance card and her antenatal book. Client said the lower back pain has reduced when enquired. She also complained of heartburns and fatigue. She was then encouraged to have enough rest and reduce the intake of spicy and fatty foods. Client was reminded of her next visit to the ANC which was on 5/11/21. Client and her sister were congratulated and thanked for their time and co-operation. Permission was sought to leave.

2.3 PHYSICAL ENVIRONMENT

On arrival, it was realized that Madam Sussana lives with her Mother. A warmly welcomed was given and a seat was offered in her room and also water to drink which she was thanked for that. Client was asked how, herself and husband were faring which she responded they were all fine. She was asked whether she was doing something but the response was no so conversation started. During our interaction, it was identified that she lives in a single room with her Mother.

The room was well kept and the furniture neatly arranged, it had adequate lightening, the windows were well arranged for proper ventilation and she was congratulated and asked to keep it up. Again she was asked whether she sleeps under an insecticide treated bed net and she said yes. She was again educated on the importance of sleeping under an insecticide treated net.

Madam Sussana had a kitchen. The kitchen was neatly kept; she has a kitchen cupboard in which she had neatly arranged her utensils. There were no dirty dishes found in the kitchen. Her toilet and bathroom was well kept because she scrubs every day. A dustbin with a well-fitting lid was seen outside the house which she said she empties it every morning into the public refuse dump which is some few matters away from their house. Client fetches water from the next house.

Madam Sussana was educated on the importance of maintaining good personal hygiene and encouraged to continue with her medication. She was asked to bring her layette and was inspected, everything was intact as thought and she was congratulated on that. She was asked to nominate a companion to help her when her time is due and was educated on complication readiness that is to get the contact of a taxi driver. She was asked whether she had any complaint that day and she complained of headache, heartburns which was explained to her as a result of not taking enough rest and was educated to minimize the rate of doing house chores and take a time to relax and heart burns due to the relaxation of the cardiac sphincter of the stomach causing reflux of acidic contents of the stomach into the lower esophagus and was educated to minimize the intake of spicy food, stay away from nauseated things and eat in bit. She was made aware that it was a normal physiology which will resolve after delivery. She was thanked and permission as sought to leave. She was informed about the next visit to be , 12th November 2021

2.4 PSYCHOSOCIAL HISTORY

Madam Sussana explained that there is a friendly relationship between her and other tenants in the house. She said she mostly come out of her house during free time to have chat with them and crack jokes together .Client said she has other friends in the neighborhood that she visit from time to time and they also do same. During my home visiting periods clients, greeted people in her neighborhood and introduced me to them, this conformed to me all that she said. Client mostly attend social gatherings (church, funeral, wedding etc) when there is any in the neighborhood. Accroding to her, she said her husband support her financiall, spiritually and physical

2.5 SECOND ANTENATAL HOME VISIT

Madam Sussana was visited the second time on the 12/11/21 at 11:20 am. The aim of the visit was to check if there had been an improvement in her complaints and the health of her family was good. Client and family were greeted and a warm welcome was given. Client and family were doing well when asked. Madam Sussana was examined and no abnormality was detected. The house was neatly clean. Client was educated on the true signs of labour which include painful rhythmic uterine contractions, the appearance of show and rupture of membranes. Her antenatal book, health insurance card and some money were inspected and kept in her bag. She was asked about her fatigue and heartburn and she verbalized the ability to cope with the weight of conception. Client complained of constipation and lower abdominal pains. She was encouraged to take in lots of fluid, fruits and vegetables and foods containing much roughage.

Client was thanked and permission was sought to leave.

2.6 CLIENT'S SUBSEQUENT VISIT TO THE CLINIC

Madam Sussana visited the clinic again on 19/11/21 at 9:00 am as scheduled. She was welcomed and offered a seat. The general appearance and condition of the client was good and she was well dressed on observation. Client and family were doing well when enquired. Her antenatal book was collected. The procedure was explained to her and her vital signs ,urine, weight and haemoglobin were taken and recorded as follows:

Temperature	36.4 degree Celsius
Pulse	82 beatss per minute
Respiration	20 cycles per minute
Blood Pressure	100 / 70 mmHg

Weight	65.5 kilograms
Haemoglobin level	14.3 g/dl
Urine for protein and sugar	Negative

Madam Sussana was asked to empty her bladder and she did. Procedures were explained to her privacy was ensured and she was assisted to change into examination gown and onto the couch. Hands were washed with soap and under running water and dried with a clean towel. Head to toe examination was done and everything was normal. The abdomen was inspected and it was ovoid in shape and medium in size with visible feotal movements .

On abdominal palpation, symphysio fundal height was 39 centimeters and gestational age was 38 weeks, the descent was 5/5. On auscultation, fetal heart rate was 138 beatss per minute with good volume and regular rhythm, the lie was longitudinal and presentation was cephalic. All findings were communicated to her. Madam Sussana was asked if she had any problem or question and she said none. She was also asked about her constipation and lower abdominal pains and she said she is able to empty her bowels freely as before and she is also able to copping the lower abdominal pain. She was educated on good nutrition, rest and exercise. Her condition was good. She was reminded of her next visit which was on 25/11/21. Her medication was served as follows;

Tablet folic acid 5mg daily for 7 days

Tablet ferrous sulphate 200mg daily for 7 days.

2.7 NURSING CARE PLAN DURING ANTENATAL CARE

PROBLEMS IDENTIFIED

On 29/10/21 client complained of;

1. Waist pain

On 30/10/21 client complained of;

2. Heartburns

On 12/11/21 client complained of;

3. Fatigue

On 19/11/21 client complained of;

4. Constipation

On 25/11/21 client complained of;

5. Lower abdominal pain

SHORT TERM OBJECTIVES

1. Client’s will be able to cope with waist pain with 48hrs.
2. Client’s heartburns will reduce within 12 hours.
3. Client’s fatigue will be able to cope within 48 hours.
4. Client’s will be able to pass stool at least once a day.
5. Client’s will be able to cope with lower abdominal pain till the end of pregnancy

LONG TERM OBJECTIVES

Madam Sussana will go through pregnancy, labour and puerperium without any complication to the mother and foetus.

TABLE A: NURSING CARE PLAN DURING ANTENATAL

DATE/ TIME	NURSING/ DIAGNOSIS	OUTCOME/ OBJECTIVE CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
29/10/21 8:30am	Waist pain related to relaxation of pelvic ligament by progesterone and relaxin.	Madam Sussana will be able to cope with waist pain within 48hrs as evidence by client verbalizing that she is able to cope and midwife visualizing that she no longer complains	1. Reassure client that the pain will reduce. 2. Encourage client to support herself with pillows beneath the knees and abdomen. 3. Encourage client to lie in the left lateral position. 4. Encourage client to apply warm compress to the waist. 5. Educate client on the causes of waist pain.	1. Client was reassured that the pain will subside after delivery reduce. 2. Client was encouraged to support herself with pillows beneath the knees and abdomen. 3. Client layed in the left lateral position. 4. Client applied warm compress to the waist. 5. Client was taught that it is due to the pregnancy hormones	31/10/21 8:30am	Goal fully met as evidence by a).Client verbalizing that she is able to cope .	

TABLE A: NURSING CARE PLAN DURING ANTENATAL CON'T

DATE/TIME	NURSING DIAGNOSIS	OUTCOME/ OBJECTIVE CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
30/10/21 8:20am	Heartburns related to regurgitation of the stomach contents.	Madam Sussana's heartburns will reduce within 12 hours as evidenced by client verbalizing reduction in intensify the heart burns. 2.Midwife visualizing that client looks cheerful	1. Reassure client that her condition can be managed. 2. Encourage client to elevate the head side of the bed by 6 inches. 3. Encourage her to go bed two to three hours after a meal. 4. Encourage client to reduce fatty and spicy meals. 5. Serve prescribed antacid	1. Client was reassured that her heartburns will be reduce. 2. Client did elevate the head side of the bed by 6 inches. 3. Client was encouraged to avoid reclining two to three hours after a meal. 4. Client reduced fatty and spicy meals. 5. 15mls of magnesium tricillicate tds x 3days was served as prescribed.	30/10/21 8:20pm	Goal fully met as evidenced by Madam Sussana verbalizing reduction in heartburns.	

TABLE A: NURSING CARE PLAN DURING ANTENATAL CON'T

DATE/ TIME	NURSING DIAGNOSIS	OUTCOME/ OBJECTIVE CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
5/11/21 8:20am	Fatigue related to weight of product of conception and inadequate rest.	Madam Sussana's fatigue will reduce and body comfort will be restored within 48 hours as evidenced by a). Client verbalizing reduction in fatigue and improvement in her body comfort. b). Midwife visualizing client feeling more comfortable and relaxed.	1. Reassure client that she will be relief of fatigue will reduce. 2.Encourage family members to help with household chores. 3.Encourage client to take up little work 4. Teach client energy conservation techniques. 5. Encourage client to have adequate rest and exercise during the day.	1. Client was reassured that she is in competent hands. 2. Family members were helping client with the household chores. 3. Client took up little work. 4.Client conserved energy through sitting rather than squatting or standing while washing. 5. Client took up adequate rest and exercise during the day.	13/11/21 8:20pm	Goal fully met as evidenced by a). Client verbalizing reduction in fatigue and improvement in body comfort. b). Midwife visualizing client feeling more comfortable.	

TABLE A: NURSING CARE PLAN DURING ANTENATAL CON'T

DATE/TIME	NURSING DIAGNOSIS	OUTCOME/ OBJECTIVE CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
12/11/21 8:20am	Constipation related to decreased gastrointestinal motility.	Client will be able to pass stool at least once a day within 48hrs as evidence by client verbalizing that she is able to empty her bowel daily.	1. Reassure client that she will be relieved of constipation. 2. Educate client on the physiology of constipation. 3. Encourage client on mild exercises . 4. Educate client to take in diet rich in roughages like fruits. 5. Encourage client to take 6-8 glasses fluid of water each day.	1. Client was reassured that she will be relieved of constipation. 2. Client was educated on the physiology of constipation. 3. Client was encouraged to have some mild exercises like walking around the house and some few distances from the house. 4. Client was taking fruits and vegetables as part of her meals served. 5. Client took 6-8 glasses of fluids.	22/11/21 8:20 am	Goal fully met as client said she was able to empty the bowel at least once a day.	

TABLE A: NURSING CARE PLAN DURING ANTENATAL CON'T

DATE/ TIME	NURSING DIAGNOSIS	OUTCOME/ OBJECTIVE CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
25/11/21 9:00am	Lower abdominal pain related to descent of the fetal head.	Client's will be able to cope with lower abdominal pain within 24hrs till the of pregnancy as evidence by client verbalizing that ability to cope.	1. Reassure client that lower abdominal pains will subside after delivery. . 2. Educate client on the physiology of descent of foetal head. 3.Engage client in diversional therapy. 4. Administer prescribed analgesics.	1.Client was reassured that it will wear off after delivery. 2.Client was taught that it is due to pressure from head on the bladder and the 'give of pelvis'. 3.Client was engaged in conversation. 4.Client was served with 1g paracetamol tds x 3days.	26/11/21 9:00 am	Goals fully met as client said she is able to cope with lower abdominal pain.	

CHAPTER THREE

LABOUR

3.0 INTRODUCTION

This chapter talks about how madam Sussana managed from the first stage of labour to the fourth stage of labour.

3.1 ADMISSION AND MANAGEMENT OF CLIENT

On the 26/11/21at 4:55am Madam Susana reported at Derma Health Center with the history of labour pains. She was accompanied by her mother. They were warmly welcomed and were offered seats at the waiting room. History of labour was taken, included last bowel action and any sign of rupture of membranes and whether she has seen 'show'. And her reply for 'show' was positive. According to her, labour pains started around 12:00am. During history taking, Madam Sussana expressed some level of anxiety as to what the outcome of labour would be and she was reassured of a successful outcome. The process of labour was explained to her and she was encouraged to ask any questions that might be bothering her mind and was assured that, she would not be left alone and that she is in safe hands. She was asked the food she had taken and she said she took rice with stew around 4:45 am. She was taken to the labour room and made comfortable in bed.

All procedures to be carried out were explained to her and her consent was sought. Client's haemoglobin level was checked and it was 12.3g/dl. Her vital signs were checked and recorded as follows:

Temperature	36.0 degree Celsius
Pulse	90 beatss per minute

Respiration 20 cycles per minute

Blood pressure 100/70 millimeter in mercury

A specimen bottle was given to client for midstream urine collection for urine examination and a bedpan was also served. The amount of urine produced was 100mls. A urine reagent strip was used to test for glucose, acetone and protein and the result was negative and the colour of the urine was amber, clear and not offensive. Hands were washed with soap under clean running water and dried with clean dry towel. Having explained the procedure and her consent sought, head to toe examination was conducted but no abnormality was detected. The abdomen was inspected

On inspection: Client's abdomen was ovoid in shape and medium in size and there were no scars on it. Striaegravidarum, linear nigra and fetal movement were present.

On palpation: Client's abdomen was palpated and symphysio fundal height was 36cm and the gestational age was 40 weeks, the lie was longitudinal, presentation was cephalic, decent was $4/5^{th}$ palpable abdominally and the position was right occipito anterior.

On auscultation: The fetal heart rate was 135 beats per minute with good volume and regular rhythm. After the auscultation, hands were warmed by rubbing both palms together in order to check for contractions. Contractions timed were 2 in 10 minutes lasting for 30 seconds.

On vaginal examination: This was done to ascertain the extent of dilatation of the cervix, presentation, moulding and to know whether membranes had ruptured or not. The procedure was explained to her, permission was sought from Madam Sussana for vaginal examination to be conducted and she consented. A tray containing sterile swabs soaked in savlon and a pair of sterile

gloves was set. Hands were washed with soap under running water and dried with a clean dry towel, sterile gloves were worn and client was asked to flex her knees. The vulva was inspected for scars, genital warts, sores, oedema, varicosities and any abnormal vaginal discharge and all these were absent. The vulva was swabbed with sterile cotton wool swabs immersed in savlon lotion. The vulva was swabbed with the left hand starting from the labia majora, minora and then the vestibule with a swab at each time. Client's permission was sought and the middle finger of the right gloved hand was inserted into the vagina gently but firmly pressing downwards to relax the vaginal wall and muscles. The index finger was then inserted. The condition of the vagina was warm and moist. The cervix was soft, thin and well applied to the presenting part. The cervix was fully effaced and dilatation at 8;30am, was 5cm. The membranes were intact and there was no moulding. The sacral promontory was not reached. The sacrum was well curved, the ischial spines were blunt and sub pubic angle accommodated two fingers in the arch. Client was made comfortable by wiping the vulva and a perineal pad was applied onto the vulva. The client was asked to lie on her left hand side to prevent supine hypotension syndrome.

Gloved hands were immersed in 0.5% chlorine solution and were removed by turning them inside out and were disposed into plastic container. Hands were thoroughly washed with soap under running water and dried with a clean dried towel. All findings and the progress of labour were explained to client. The dilatation board was used to explain the cervical os dilatation and progress of labour to her. Client was thanked for her co-operation. All information gathered were recorded on a partograph and communicated to the in-charge. She was encouraged to change the perineal pad in case it fell or gets wet, empty her bowel and bladder frequently and walk around to facilitate

in descent of the presenting part and cervical dilatation. Her mother was offered a seat outside and reassured.

3.2 PREPARATION FOR BIRTH

The emergency plan was reviewed and included the means of communication thus, telephone numbers of the referral hospitals were available. The mother of the client was told to inform the taxi driver since his service may be needed as a means of transportation to help in any emergency.

Two helpers were identified, that is a skilled helper and an unskilled helper. With the skilled helper, the midwife in-charge was informed about the progress of client's labour. She was told that her assistance will be needed when the baby does not breath and to supervise throughout the procedure and a ward assistant was also asked to assist in the care of the mother. With the unskilled helper, client's mother was informed to stay around and not to go home since her help may be needed.

The area for delivery was also prepared. The source of light was checked and a portable lamp was made available. Mother was informed that the windows and doors would be closed, fans would be put off and curtains would also be drawn down when the baby is about to be delivered to provide warmth. Madam Sussana was also informed that she would be assisted to wash her hands, chest and abdomen to prepare for skin to skin contact with the baby. The resuscitation table was made clean and the equipment was checked to be adequate and functioning properly.

The delivery sets and emergency drugs were also readily available.

3.3 MANAGEMENT OF THE FIRST STAGE OF LABOUR.

Client was admitted onto partograph on admission when labour was established. Fetal heart rate, contractions and pulse was monitored every 30 minutes and vaginal examination, descent, blood pressure and temperature was done four hourly.

Madam Sussana was asked whether she has any problem bothering her and she complained of waist pains, nausea and severe lower abdominal pains.

She was reassured that she was in the hands of competent midwives so she should not be afraid and that she will have normal labour with a healthy baby without any complication after delivery. The physiology behind the pains was explained to her. She was encouraged to breathe through the mouth when the contractions come to prevent oedema of the cervix. She was encouraged to wash her hands to prevent infections and was also encouraged to walk around the bed and lie on her left side to prevent supine hypotension syndrome. She was taught deep breathing exercises with demonstration and a return demonstration done by Madam Sussana indicating her understanding. Sacral massage was done to relieve pain. She was encouraged to drink more water and take in light nutritious diet in bits as it would help her to prevent dehydrated and urinate frequently to enhance effective contraction and decent of fetal head since full bladder could slow down progress of labour. Bedpan was provided for her to empty the bladder frequently. At 10:30am, Madam Susana took in mashed kenkey and bread.

At 12:00 pm, she was due for the next. On vaginal examination, the vagina was warm and moist, membranes were still intact, the cervix was 9cm centimeters dilated and well applied to the presenting part, fetal heart rate was 140 beatss per minute, moulding was 0, descent was 2/5 and contractions were 3 in 10 minutes lasting for 45 seconds, 48 and 50 seconds respectively.

Vital signs were checked and recorded as follows:

Temperature	36.0 degree Celsius
Pulse	90 beats per minute
Respiration	21 cycless per minute
Blood pressure	120/70 millimeter in mercury

The following investigations were also done and recorded as follows: urine for albumin was negative, glucose was negative. The amount of urine emptied was 100 milliliters.

Client was made comfortable by cleaning all discharges and a new perineal pad was applied. All findings were communicated to client and recorded on a partograph**.** Client verbalized that her anxiety has reduced.

SETTING OF TROLLEY

A delivery trolley was set with the following items on the top and down shelf. On the top shelf it contains the following, a gallipot with sterile cotton wool swabs, episiotomy set containing sterile instrument, one sterile cord scissors, two sterile artery forceps, one sterile gown for midwife, sterile cot sheets, four sterile sheets and a sterile receiver for placenta. The bottom shelf also contain container with syringe containing ten units of oxytocin, identification band, swabbing lotion, examination gloves, measuring jug, sucker in a bowl of water, two cord clamps,

a pair of sterile gloves, perineal pad, 2 urethral catheters, lidocaine and fethoscope.

Madam Sussana was reminded that the baby would be delivered onto her abdomen to promote warmth and bonding. There was spontaneous rupture of membranes with clear liquor at 2:00pm. Vaginal examination was done at once to rule out cord prolapse, it was noticed that cervix was fully dilated, fetal heart rate was 136 beatss per minute, decent was 0/5, moulding was (+), maternal pulse 85 beatss per minute and contractions 4 in 10 lasting 49 seconds.

At 2:01pm, client complained of bearing down, the perineum was bulging and the anus gaped. The in charge was informed of the progress of labour, she was asked to confirm it and she confirmed which marked the beginning of second stage of labour. Client was told that, she has successfully passed the first stage and encouraged to push well when she is asked to push.

The aseptically prepared trolley was taken to the bedside. The client was asked to breathe through the mouth. The first stage lasted for six hours.

3.4 MANAGEMENT OF THE SECOND STAGE OF LABOUR

All procedures to be done were explained to Madam Sussana and reassurance was given that she is in safe hands and she will go through the second stage successfully like she did in the first stage. She was assisted into lithotomy position which was position of choice and her head was supported with pillows. She was reminded that the baby will be delivered onto her abdomen and skin to skin contact will be maintained for an hour to promote bonding and prevent heat loss which she consented. Protective clothing such as plastic apron, boots, face mask, cap and goggles were worn. Hands were washed thoroughly with soap under running water and dried with a clean dry towel. Sterile gloves were worn. The vulva and upper thighs were swabbed with sterile cotton balls soaked in savlon and the abdomen was also cleaned A sterile pad was applied to the perineum to

prevent feacal contamination of the delivery field. Madam Sussana was draped with sterile towels. A sterile cot sheet was placed on the abdomen. She was asked to push with each uterine contractions and pant and blow in-between contractions. As the head advanced, the index and middle fingers of the non-dominant hand was gently placed on the foetal head to aid flexion on the advancing head to allow the smallest diameters to distend the perinium.

At the same time the perineum was supported with the other hand to prevent over distension which could cause perineal tear and lacerations. When the foetal head crowned, client was asked to stop pushing and pant with contractions. This was done to await spontaneous delivery of the head with subsequent contractions to prevent perineal tears. The occiput escaped the pubic arch, extension of the head was aided to allow the sinciput, face and the chin to sweep the perineum for the head to be delivered. After the head was delivered, the eyes were wiped immediately with sterile cotton wool from the inner canthus of the eyes outwards using one swab each at a time. . A finger was passed around the neck to feel for cord around neck but there was none. Restitution was allowed to occur, then external rotation of the head which indicated the internal rotation of the shoulders to lie in the anterior posterior diameter of the pelvic outlet had taken place. Hands were placed on each side of the parietal bones and the client was asked to push gently. Gentle downward traction was applied to deliver the anterior shoulder and with upward traction towards the mother's abdomen, the posterior shoulder was also delivered. The baby was delivered unto themother's abdomen by lateral flexion at 2:30pm.

3.5 IMMEDIATE CARE OF THE BABY

The immediate care of the baby started as soon as the head was born. Following the birth of the head, each eye was cleaned with sterile gauze from the inner canthus to the outer canthus to prevent infection and the face was also cleaned with sterile gauze. The neck was felt for cord around the neck but it was absent. The baby was delivered on to the mother's abdomen. The baby cried immediately after delivery, the first minute APGAR score was 8/10. Quickly the liquor was cleaned off the baby with a clean dry sheet to keep the baby warm , the wet sheet was disposed and another sheet was used to cover her. The cord was clamped with a cord clamp and an artery forcep and it was cut in between the two to separate baby from mother. The baby was put to breast whiles on the mother's abdomen to help initiate breastfeeding, provide warmth and promote bonding. An identification band which bore the name of the baby, sex of baby, mother's name, date and time of delivery was placed on the baby's wrist. 5th minute APGAR score was 10/10. It was a live female child bornat 2:05pm on the 26/11/21.

3.6 MANAGEMENT OF THE THIRD STAGE OF LABOUR

The procedure was explained to Madam Sussana to gain her usual co-operation. Immediately the baby was delivered, the uterus was palpated through the mother's abdomen to exclude the presence of a second baby and there was none. Injection Oxytocin 10 units was injected intramuscularly on the left thigh to enhance the uterus to contract to augment uterine contraction, separation and expulsion of the placenta and its membrane and control bleeding.The placenta was delivered by controlled cord traction and counter traction of the uterus

The cord was re-clamped closer to the perineum with the use of artery forceps and a receiver placed in- between her thighs. The bladder was checked and it was empty. The non-dominant hand was

placed on the fundus to feel for contractions. Immediately there was contractions, the non-dominant hand was placed above the symphysis pubis with the palm facing the mother's abdomen to stabilize the uterus to prevent inversion of the uterus**.** At the same time, the clamped cord was held in the dominant hand and a gentle downward and outward traction was applied to the cord. The counter traction of the uterus with the non-dominant hand at the supra pubic area was maintained while applying traction to the cord.

The process was repeated until the placenta was visible at the vulva. Both hands were released to receive the placenta at the introitus and it was twisted gently to ensure complete delivery of the membranes. The placenta and membranes were delivered completely at 2:10pm.A quick examination of the placenta was done for completeness of lobes and membranes and presence of any retained product of conception before it was placed in a receiver for thorough examination later in the sluice room. The uterus was massaged through the abdomen until it was well contracted and blood clots were expelled. The vulva was cleaned and a sterile gauze was placed around the middle and index fingers of the right hand to examine for tears and lacerations.

The birth canal was examined and there was no tear or laceration of the perineum, vaginal wall and cervix. Client was congratulated and made comfortable by wiping all blood and liquor stains from her body, a clean perineal pad was applied. Estimated blood loss was 130ml.Madam Sussana and her baby were made comfortable in bed and were covered with a piece of cloth to ensure skin to skin contact to promote bonding, provide warmth to the baby and initiate breastfeeding. Client's mother was told about the sex of the baby and allowed to visit her. Madam Sussana was encouraged to urinate frequently to help the uterus to contract well and was told also to report any bleeding immediately. All findings were recorded on the partograph.

3.7 EXAMINATION OF THE PLACENTA AND MEMBRANES

The placenta was placed in a 0.5% chlorine solution and it was examined. The placenta was held by the cord with the membranes hanging, the membranes were examined for completeness and it was intact. The placenta was now 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 length of the cord was checked and it was of normal length. The fetal surface was viewed and the cord was centrally inserted containing one vein and two arteries without any true knot. The placenta was then turned to view the maternal side, the lobes fitted together without any gap, the edges also formed a uniform circle and this meant there were no missing lobes. There were no infart(white patches) and no blood vessels radiating into the membranes. In general there was no abnormality detected. The placenta was discarded . The instruments and equipment used were soaked in 0.5% chlorine solution for 10 minutes. After that, it was washed, rinsed dried and repacked for sterilization. Hands were dipped in chlorine solution before discarding the gloves. Hands were then washed with soap and clean running water and dried with a dry towel.

3.8 MANAGEMENT OF THE FOURTH STAGE OF LABOUR

. During this stage, mother's vital signs were assessed for every 15 minutes for two hours, 30 minutes for one hour, hourly for three hours and recorded on the partograph. During the monitoring, there were no deviation from the normal, uterus was felt and it was well contracted. The perineum observed for active bleeding and there was nothing of that sort. All these observations were made every 15 minutes for 2 hours, 30 minutes for one hour, hourly for three hours and recorded on the partograph. Clean perineal pad was applied over the vulva and client

was transferred to the lying-in. The baby was put to breast to enhance bonding between mother and baby and also to help release natural oxytocin to prevent post-partum hemorrhage.

All findings were recorded on the partograph but the first readings were as follows;

Temperature	36.0 degree Celsius
Pulse	85 beatss per minute
Respiration	19 cycless per minute
Blood pressure	110/70 millimeter in mercury
Symphysio-fundal height	18 centimeter

Madam Sussana was encouraged to void frequently and change her perineal pad when soiled. She was served with bread and porriage brought by her sister to restore her energy loss.

After eating, she was assisted to fix her baby to the breast to ensure suckling and to stimulate milk production and also the release of oxytocin from the posterior pituitary gland to help in the contraction of the uterus. Baby was observed to be suckling well and Madam Sussana's face had a worried facial expression. When asked, she complained of after pains so she was reassured and the physiology was explained to her. She was encouraged to continue breastfeeding despite the pains since it helps in involution of the uterus. Client was told to also assume any position that is comfortable to her. She was served with Tablet Paracetamol 1gram stat. She was also taught how to massage the uterus on her own to keep it contracted and report any excessive blood loss.
General examination of the baby was done and nothing abnormal was detected. The baby's vitals sign was checked every five minutes, and also checked every 15minutes and all were normal.

Vital signs and condition of the baby was also checked and recorded as follows:

Temperature 36.5 degree Celsius

Pulse 130 beatss per minute

Respiration 40 cycless per minute

APGAR score 8/10, 10/10 Abnormalities

None

Condition of baby Satisfactory

Madam Sussana was served with a dose of vitamin A capsule 100,000 units. She was encouraged to have enough rest, feed the baby on demand and always wash her hands before and after feeding baby and after changing perineal pad.

3.9 PREVENTION OF DISEASE

This is done within the first 90 minutes to prevent infections such as opthalmianeonatorum, and haemorrhagic diseases of the newborn and therefore the following treatment were given. The baby's eyes were cleaned with a sterile cotton wool swab with normal saline and chloramphenicol eye drop was instilled. The umbilical cord was dressed with strile cotton wool swabs and methylated spirit. Injection vitamin K was given intramuscularly.

3.10 EXAMINATION OF THE NEWBORN

A head to toe examination was performed on the new born under a good light in the presence of the mother. The procedure was explained to Madam Sussana and she consented. Hands were washed with soap under running water and cleaned with a clean dry towel. Sterile gloves were

worn and the baby was wrapped and put on a warm, flat and safe surface. Baby was exposed systematically as it was examined from head to toe. On observation, the baby's colour was pink.

The head and face : The head and scalp were normal with dark hair, sutures and fontanelles fully formed without any bulginess, sunkeness and caput succedaneum. The eyes were clear with no redness and the nose was patent with the nostrils separated by the nasal septum.

The ear: The cartilages of the two ears were well developed and were in alignment with the eyes. External auditory meatus was patent. The shape and size was also checked and no abnormality was detected.

The mouth: The mouth examined by pressing the angle of the jaw which opened the mouth, upon inspection, there was no tongue tie, palate was intact, there was no false tooth and the baby sucked when a finger was introduced into its mouth.

Neck: The neck was inspected and palpated with no enlarged lymph nodes or congenital goitre and could be turned and flexed.

Chest and abdomen: The nipples on the chest were equally spaced and in alignment, there was no milk and engorgement. Respiration was observed as there was chest movement and it was regular. The abdomen was round. The umbilical cord was inspected for bleeding and it was in good condition, there was one vein and two arteries.

Genitalia anus: The genitalia was examined and the labia majora covered the clitoris and minora . The vaginal and anal opening were visible.

Limbs and digits: The hands were in alignment and of the same size and length. The lower limbs were in alignment and of the same size and length. The digits were not webbed and had no extra

digits. The axillae, elbow, groin and popliteal spaces were examined and they were without abnormality detected.

Spine: The baby was turned into the lateral position and the chest was supported with the nondominant hand and her back was palpated.

There were no swellings, hairy patches and dimples indicating any spinal defect. Her reflexes were all normal as he reacted to various stimuli. The baby was weighed and the weight was

2.9kg, head circumference was 34cm, length 56cm and temperature was 36.5 degree Celsius. There was no abnormality detected. Gloves were removed and disposed aseptically before washing hands with soap under running water and dried with clean dry towel. All finding were communicated to mother and recorded.

Baby was put to breast to aid in involution and create bonding between mother and baby. The general condition of the baby was satisfactory. The uterus was well contracted and all blood clots were expelled. Symphysio fundal height was 18 cm. Mother was made comfortable in bed. The condition of the mother was satisfactory.

3.11 CAREPLAN DURING LABOUR

PROBLEMS IDENTIFIED DURING LABOUR

On 26/11/21, Madam Sussana complained of

1 .Anxiety

2. Waist pains

3. Nausea
4. Lower abdominal pain
5. Fatigue

SHORT TERM OBJECTIVES

- Madam Sussana will be relieved of anxiety within 4 hours before delivery.
- Client will be relieved of waist pain within 24 hours.
- Client will be relieved of nausea within 4 hours after delivery
- Client will be relieved with lower abdominal pain within 12 hours after delivery.
- Client will be relieved of fatigue within 24 hours after delivery.

LONG TERM OBJECTIVES

Madam Susana will go through labour and puerperium without any complication to both mother and baby.

TABLE B: CARE PLAN DURING LABOUR

DATE/ TIME	NURSING DIAGNOSIS	OUTCOME/ OBJECTIVE CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
26/11/21 8:50am	Anxiety related to unknown outcome of labour.	Madam Susana will be relieved of anxiety within 4 hours as evidence by client verbalizing that she is no more anxious.	1. Reassure client that she will deliver without any complication. 2. Explain the stages of labour to the client. 3. Explain every procedure to be carried on client. 4. Allow client to ask questions and answer her appropriately. 5. Educate client on the effects of anxiety on labour.	1. Client was reassured of competent staff. 2. The stages of labour were explained to client using the dilatation board. 3. Every procedure that vital signs vaginal examination contraction were explained to her to gain her. 4. Client client's concerns were addressed appropriately. 5. Client was taught that anxiety prolongs labour.	26/12/21 12:50 pm	Goal fully met as evidenced by client verbalizing that she is able to cope.	

TABLE B: CARE PLAN DURING LABOUR CON'T

DATE/ TIME	NURSING DIAGNOSIS	OUTCOME/ OBJECTIVE CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
26/11/21 8:50am	Waist pains related to pressure of the descending foetus on the sacral nerves.	Madam Susana will be able to cope with waist pain within one hour as evidenced by client verbalizing that waist pain as stopped.	1. Reassure client that she will be relieved of her waist pains. 2. Explain the physiology of waist pains during labour to client. 3. Massage the client's sacral region to relieve her of the pains. 4. Engage client in diversional therapy. 5.Encourage client to rest in between activities	1. Madam Susana was reassured that she will be relieved of her waist pains after delivery. 2.Theclient became aware that it is due to descent of the presenting part into the pelvic during labour was explained to client. 3. Client's sacral region was massaged to relieve her of the pains. 4. Client was engaged in conversation to take her mind off the pains. 5. Client was encouraged to take at least two hour rest during the day	27/11/21 9:50pm	Goal fully met as verbalized by client that she has been relieved of the waist pains.	

TABLE B: CARE PLAN DURING LABOUR CON'T

DATE/ TIME	NURSING DIAGNOSIS	OUTCOME/ OBJECTIVE CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
26/11/21 8:50am	Nausea related to hormonal actions in labour.	Madam Susana will be relieved of nausea within 4 hours after delivery as evidence by client verbalizing that her nausea has stopped.	1. Reassure client that the condition can be managed. 2. Encourage client to eat light foods in bits. 3. Educate client on the causes of nausea. 4.Serve client vomitous bowl to measure the amount of vomitus. .5.Move away all nauseating objects from client.	1. Client was reassured. 2. Client was encouraged to eat light foods in bits. 3.Client enlightered that it is due to hormonal influence. 4. Vomitous bowl was served to the client. 5.Vauseating objects were moved away from client	26/11/21 12:50pm	Goal fully met evidenced by client verbalizing that her nausea has stopped.	

TABLE B: CARE PLAN DURING LABOUR CON'T

DATE /TIME	NURSING DIAGNOSIS	OUTCOME/ OBJECTIVE CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
26/11/21 4:50am	Lower abdominal pains related to uterine contractions.	Madam Susana lower abdominal pain will be relieved within 12 hours after delivery as evidenced by client verbalizing ability to cope.	1. Reassure client. 2. Educate madam Susana on the cause of lower abdominal pains in labour 3. Assist client by providing a quiet and relaxed environment. 4. Perform sacral massage. 5.Teach client to do deep breathing exercise with contractions.	1. Client was reassured. 2. Madam Susana was educated on the cause of lower abdominal pains in labour. 3. Client was assisted by providing a quiet and relaxed environment. 4. Sacral massage was performed. 5. Client was taught to do deep breathing exercise with contractions.	27/11/21 4:50pm	Goal fully met as evidence by client verbalizing that she is relieved with lower abdominal pains.	

TABLE B: CARE PLAN DURING LABOUR CON'T

DATE/TIME	NURSING DIAGNOSIS	OUTCOME/ OBJECTIVE CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
26/11/21 8:50am	Fatigue related to stressful activities during labour.	Madam Susana will be relieved of fatigue within 24 hours after delivery as evidenced by client verbalizing that she is no more tired.	1. Reassure Madam Susana that she will be relieved 2. Encourage client to rest when contractions wear off 3. Give sacral massage 4. Serve client with a cup of water at regular intervals. 5. Perform all nursing activities at a go. 6. Encourage client to do deep breathing exercise.	1. Client was reassured. 2. Client rested whenever contractions wear off. 3. Sacral massage was given. 4. Client drunk the water served at regular intervals. 5. All nursing activities were performed at a go. 6. Client was doing deep breathing exercise with con tractions.	27/11/21 8:50pm	Goal fully met as client verbalized that she was relieved of fatigue.	

CHAPTER FOUR

PUERPERIUM

4.0 INTRODUCTION

This chapter consists of the care given to the mother and the baby from the day of delivery till the second postnatal visit.

4.1 DAY OF DELIVERY

Client delivered on 26/11/21 at 2:30pm. Madam Sussana and her baby were transferred to the lying in ward at 10:45pm after postpartum check when her condition and that of the baby was stable. She was given bread and milo drink for energy.

Her vital signs were checked and recorded as follows:

Temperature	36.0 degree Celsius
Pulse	85 beatss per minute
Respiration	39 cycless per minute
Blood pressure	110/70 millimeter in mercury.

Her symphysio fundal height measured 18 centimeters.

The uterus was checked for involution and the perineum was also checked for bleeding at this time. Lochia was red in colour (rubra) and the flow was moderate. The perineum was clean. Client was encouraged to change perineal pad frequently when soiled to avoid infection as well as wash her hands with soap and water after changing the pad and after visiting the lavatory. She was taught how to massage the uterus by on the fundus to help in the involution of the uterus and arrest haemorrhage. She was also educated on exclusive breastfeeding for 6 months and on demand as

this would help the baby grow well. Client was also taught to perform pelvic floor muscles and abdominal exercises to strengthen the muscles and also to aid involution. Head to toe examination was done on the mother and no abnormality was detected. She complained of after pains and she was given 1 gram of tablet paracetamol. Later, she was assisted to the bathroom to take her bath. She felt good and refreshed after bathing.

4.2 SUBSEQUENT CARE OF THE BABY

After six hours of observation, baby was given warm bath and her cord dressed with methylated spirit and cotton wool swabs. Head to toe examination was also done and no abnormality was detected. The baby was given first immunization, which was Bacillus Calmette Guerin (BCG) vaccine 0.05ml intradermal at the right upper arm to prevent tuberculosis and oral polio vaccine 0 (OPV0) 2 drops at the back of the tongue to prevent poliomyelitis. The baby was wrapped in a warm dry sheet to maintain body temperature and she was also placed beside her mother to breastfeed. The mother was advised not to apply anything at the injection site. The vital signs and other measurements were taken and recorded as follows:

Temperature	36.0 degree Celsius
Apex beats	130 beatss per minute
Respiration	39 cycless per minute
Weight	2.9kilograms
Length	49 centimeters
Head circumference	35 centimeters

All findings were communicated to Madam Sussana and recorded.

BABY BATH AND CORD DRESSING REQUIREMENT.

All procedures were explained to mother and she consented. Requirement needed for baby bath and cord dressing such as soap, sponge, cream, sterile cotton in a gallipot, towels, 1big towel and 3 small towels, cot sheet 2, plastic apron, gloves, a clean baby dress, cap socks, 2 jugs containing hot and cold water each, two receptacles for used water and dirty linens and a receiver for used swab were gathered.

A plastic apron was worn. The hands were washed with soap under running water and dried with a clean dry towel. Both cold water and hot water were together and the temperature of the water was checked using the elbow. Examination gloves were worn and the baby was taken from her mother.

The baby was put on a flat surface and the mother was given a seat to observe the procedure. The baby was undressed and wrapped with a cot sheet. Her eyes were cleaned with cotton wool swab soaked in clean water from the inner canthus to the outer canthus of each eye using separate cotton wool swabs. Her face was cleaned with a damp face towel and dried. The nape of the head was supported with one hand. The baby’s ears were plugged with the middle finger and thumb to prevent water from entering into the ears. The head was washed with soapy sponge, the baby was lifted off the flat surface with the body resting in the elbow and still supporting the nape, the washed head was rinsed with clean water and was then dried. The baby was placed on the flat surface with the body been exposed. The neck, arms and front of trunk were bathed paying attention to the skin folds. The back was turned with one arm supporting the chest and the other hand bathing the back down to the feet, paying attention to the skin folds. The baby’s body was supported firmly and was immersed into the warm water with the head supported above the level of the water. The body was rinsed thoroughly. The baby was removed from the water onto the

working surface and was covered with clean dry cot sheet and the body was dabbed thoroughly to dry paying attention to skin folds, with a soft baby towel. Baby oil was smeared on the body and the baby was dressed up. Gloves were removed and hands were washed with soap under running water and dried with a clean dry towel.

CORD DRESSING:

This procedure was explained to the mother to gain her consent. A tray set containing a receiver and galipot with cotton wool swabs soaked in methylated spirit. Hands were washed with soap under running water and dried with clean towel after baby was bathed. The area for cord dressing was exposed and sterile gloves was worn. The clamp of cord was observed for looseness and cord for bleeding but none was detected.

The cord was dressed with strile cotton wool swabs soaked in methylated spirit. Sterile gloves were worn and cord was exposed. A cotton wool swab was used to hold the tip of the cord . The base of the cord was swab 5cm away from the cord, the stem of the cord was swab from base to the cord clamp using a swab for each side. The cord clamp cleaned on both sides with different swabs. Finally, the tip of the cord was swab with cotton wool swab soaked in methylated spirit. Cord was then left exposed to facilitate dry gangrene. Baby was wrapped with clean cot sheet and given to her mother. Mother was also taught to dress baby's cord and offered feedback. The waste materials were discarded according to infection prevention protocol. The gloved hands were removed. Hand washing was done with soap under running water and dried with a clean towel and findings recorded.

EDUCATION TO MOTHER ON BABY

The mother was encouraged not to touch or apply anything to the cord. She was taught and encouraged only to dress the cord with clean cotton wool swabs and methylated spirit. She was also encouraged not expose the baby or bath the baby when the weather is cold. She was also encouraged to breastfeed the baby anytime she wants to feed and allow her to empty one breast completely before she takes the other.

4.3 FIRST DAY POST DELIVERY (DAY OF DISCHARGE)

27/11/21 was the first day after delivery, Madam Sussana and her baby were doing well. She woke up around 6:30am and brushed her teeth. Client's mother has set fire already and was heating water for them to bath.

The baby was being breastfed and she was suckling well. Permission was sought later to examine the baby. Hands were washed with soap under running water and dried with a clean dry towel.

On general examination, there was nothing abnormal detected. An opportunity was taken to demonstrate to the mother how to top and tail the baby. The baby was top and tailed, dressed and wrapped nicely in the presence of the mother and family. The cord was dressed with six sterile cotton wool swabs soaked in methylated spirit. The baby passed urine and meconium which was normal. The mother was educated not to apply hot compress on the fontanelles with the intention causing the so call wound to heal. It was explained to the family that the fontanelles would close by themselves. Client was encouraged to keep the cord clean and not to use local herbs on it. She was also educated on the provision of warmth, maintaining temperature and prevention of infection. Afterwards baby's vital signs and weight were checked and recorded as follows:

Temperature	36.5 degree Celsius

Apex beats 132 beatss per minute

Respiration 44 cycless per minute

Weight 2.8kilograms

Mother’s vital signs were checked and recorded as:

Temperature 36.5 degree Celsius

Pulse 80 beatss per minute

Respiration 18 cycless per minute

Blood pressure 120/80 millimeter in mercury

Procedures to be done on her were explained to her and she consented. Head to toe examination was done and nothing abnormal was detected. Her breasts were lactating and nothing abnormal was observe, the uterus was well contracted, the vulva and perineal pad were inspected after permission was sought and lochia was red (rubra), flow was small and not offensive. She was reminded on changing of perineal pad frequently especially when soiled to prevent ascending infection to the uterus. Client then complained of perineal pain. She was reassured and educated that it was as a result of stretching of the vaginal and perineal tissues during delivery. She was then encouraged to practice good personal hygiene and do warm sitz bath also the kegel’s exercise to help reduce the pain. Then after the examination, client took her bath and finally took rice with tomato stew as her breakfast. She was given 100,000 units of vitamin A supplement. She was educated to practice exclusive breastfeeding on demand especially in the night every two to four hours or at least 8 to 12 times per day and educated on the importance of breast milk to both mother and baby. Education on proper personal and environmental hygiene to prevent infections was

reinforced. Client was also educated on the intake of healthy diets and its importance to her and her baby.

She was encouraged to take enough rest, perform postnatal exercises and ambulate to help her abdominal muscles and pelvic floor muscles gain their tone. She was also reminded on how to perform self-breast examination. The in-charge was informed about procedures and findings and client and baby were reassessed for confirmation. She was informed of her discharge and was helped to pack her things. Routine drugs were prescribed according to the protocol of the facility. She was told to come for one-week post-natal care on the 2th December, 2021.

She was informed about the continuity of care and that she would be visited at home for seven days to check on her condition and that of the baby. Her sister was encouraged to take good care of her and also provide her with physical, emotional, psychological and financial support. She was again educated on the prescribed drugs, its route, dosage and effects and encouraged to register the baby at the births and deaths registry. Client was asked if she had any other complaints or questions and she said no. She was discharged at 8am on the 27th November, 2021 with the following drugs:

Tablet Folic acid	5mg daily for 14 days.
Tablet Multivite	200mg daily for 14 days.
Tablet Ferrous Sulphate	200mg daily for 14 days.
Tablet paracetamol	1g tid for 3 days.

4.4 FIRST DAY POST NATAL HOME VISIT (2ND DAY POST DELIVERY)

Madam Sussana and her baby were visited on 27th November, 2021 in the evening at 6:00 pm respectively. Both mother and baby looked healthy on arrival to their house. Greetings were

exchanged, client was asked about her after pains and she said it has reduced and she even feels more comfortable now. She was informed of the procedures to be carried out. Hands were washed and dried. Head to toe examination was done and no abnormality was detected and baby was top and tailed. Baby passed meconium and urine during the procedure. The cord was also dressed with sterile cotton wool swabs and methylated spirit using aseptic technique, it was clean, dry and not offensive.

The baby was dressed, wrapped and given to the client's mother. Madam Sussana 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 and symphysio fundal height was 17 centimeters. The perineum was clean, dry and intact, lochia was small, red and not offensive. Mother's vital signs were checked and recorded as follows:

Morning at 9:00am

Temperature 36.5 degree Celsius

Pulse 80 beats per minute

Respiration 20 cycles per minute

Blood pressure 120/70mmHg

The baby's vital signs and weight were also recorded as follows:

Morning

Temperature 36.8 degree Celsius

Apex heart rate 139 beats per minute

Respiration 44 cycles per minute

Weight 2.7kg

Baby was given to mother to breastfeed and baby was able to suckle well. Client was asked if she had any question or problem and she complained that she was not able to sleep. She was reassured, encouraged to take naps in the afternoon and sleep whenever baby is asleep or whenever possible.

Madam Sussana was educated on danger signs of the newborn such as breathing difficulties, cyanosis, persistent vomiting, fever, crying weakly, refusal of baby to feed and yellowing of the palms of the hands and soles of the feet. Client and family were congratulated and permission was sought to leave. She was informed of the next home visit the next day.

4.5 SECOND DAY POST NATAL HOME VISIT (3RD DAY POST DELIVERY)

On 28th November, 2021 at 8:30 am and 5:20 pm, Madam Sussana was visited twice to assess her and her baby. On observation, the general condition of the family was good. The procedures to be carried out were explained to her. On examination, client was not pale, breast were lactating and the symphysio fundal height was 16centimeters.The perineum was inspected and it was clean, dry and intact with small lochia which was not offensive. Her vital signs were checked and recorded as follows:

Morning

Temperature 36.4 degree Celsius

Pulse 84 beats per minute

Respiration 20 cycles per minute

Blood pressure120/70 millimeter in mercury

Permission was sought to top and tail and dress baby's cord but before that, head to toe examination was done and no abnormality was detected. Baby was top and tailed and cord was dressed nicely with six sterile cotton swabs and methylated spirit and kept dry. Baby was wrapped in a cot sheet and given to mother for breastfeeding. Baby's vital signs and weight were checked and recorded as follows:

	Morning	**Evening**
Temperature	36.8 degree Celsius	36.9 degree Celsius
Apex heart rate	130 beats per minute	132 beats per minute
Respiration	38 cycles per minute	40 cycles per minute
Weight	2.7kilograms	

Madam Sussana was asked if she had any problem or questions and she complained of backache. She was reassured and she was educated on proper positioning and attachment during breastfeeding. She was also educated on other positions that can be used during breastfeeding such as lying on her side. Client and family were thanked for their cooperation and permission was sought to leave and return the following day.

4.6 THIRD DAY POSTNATAL HOME VISIT (4TH DAY POST DELIVERY)

Madam Sussana was visited at home twice to check on how she and the baby were faring on 29th November, 2021 at 8:00 am and 5:30 pm respectively. Greetings were exchanged and permission to examine mother and baby. So her conjunctina was inspected and it was pale her and breasts wre still lactating well, uterus was also contracted and indicated. Her lochia discharge was pink

serosa and not offensive. Client said perineal pain has stopped when asked. She also said she was able to have enough sleep now. Head to toe examination was conducted and everything was normal. Symphysio fundal height measured 10 centimeters. Vital signs were checked and recorded as:

	Morning	**Evening**
Temperature	36.3 degree Celsius	36.5 degree Celsius
Pulse	88 beats per minute	86 beats per minute
Respiration	18 cycles per minute	19 cycles per minute
Blood pressure	120/80 millimeter in mercury	110/80 millimeter in mercury

Mother was asked to top and tail the baby under supervision which she did very well with few lapses. Head to toe examination was done and everything was normal. Baby's cord was dressed with six cotton wool swabs and methylated spirit and left to dry. The cord was not offensive and the baby passed stools and urine in which stools were brownish yellow in colour. The baby's vital signs and weight were checked and recorded as follows:

	Morning	**Evening**
Temperature	36.5 degree Celsius	36.8 degree Celsius
Apex heart rate	134 beats per minute	130 beats per minute
Respiration	43 cycles per minute	44 cycles per minute
Weight	2.7 kilograms	

Client was thanked for her cooperation and support. She was asked to take her routine drugs and permission was sought to leave.

4.7 FOURTH DAY POST NATAL HOME VISIT (5TH DAY POST DELIVERY)

Madam Sussana was visited again on 30th November, 2021 at 8:00 am. Mother, baby and family looked healthy on arrival. Client said she was relieved of her backache when she was asked about it. Head to toe examination was conducted and no abnormality was detected so baby had already been top and tailed.

Baby's cord was dressed with strile cotton wool swabs and methylated spirit, it was dry and non-offensive and the cord was almost off.

Head to toe examination was carried out on the mother and breast engorgement was detected as the mother expressed pain when the left breast was touched and breast was warm and tensed. On palpation, the uterus was well contracted and the symphysio fundal height was 8 centimeters, perineum was clean and intact. Lochia was small, serosa and not offensive.

Her vital signs were checked and recorded as follows:

Temperature	37.0 degree Celsius
Pulse	82 beats per minute
Respiration	20 cycles per minute
Blood pressure	120/80 millimeter in mercury

The baby's vital signs and weight were checked and recorded as follows:

Temperature	36.9 degree Celsius

Apex heart rate 128 beats per minute

Respiration 41 cycles per minute

Weight 2.8 kilograms

Client was asked of complaints and she complained of heaviness in the left breast. Client was reassured and encouraged o continue with exclusive breastfeeding, express breast milk, massage breast gently before breastfeeding and apply cold compress on the left breast. Mother was encouraged to ask questions. All findings were communicated to her and the necessary documentations were done. Client was thanked and permission was sought to leave.

4.8 FIFTH DAY POST NATAL HOME VISIT (6TH DAY POST DELIVERY)

On the 1st December, 2021, Madam Sussana was visited at 8:00 am. Mother and baby looked healthy on arrival. Head to toe examination was done and no abnormality was detected, baby was top and tailed. The cord was off and the stump was dressed with cotton wool swab and methylated spirit, it was dry and not offensive. Madam Sussana was also examined from head to toe and no abnormality was detected. On palpation, symphysio fundal height was 12cm.

Perineum was clean and lochia was small and serosa in colour and not offensive when inspected.

Madam Sussana's vital signs were checked and recorded as:

Temperature 36.2 degree Celsius

Pulse 80 beats per minute

Respiration 18 circle per minute

Blood pressure 110/70 millimeter in mercury

Baby's vital signs were checked and recorded as:

Temperature 36.6 degree Celsius

Apex heart rate 128 beats per minute

Respiration 40 circle per minute

Weight 2.9kilograms

Baby was given to mother to breastfeed and baby's suckling was good. Mother was encouraged to continue with breastfeeding. Client was thanked and permission was sought to leave.

4.9 SIXTH DAY POSTNATAL HOME VISIT (7TH DAY POST DELIVERY)

On 2nd December, 2021, Client and baby were visited at 8:00 am. Mother and baby looked happy on arrival and the whole family was doing well. Procedures to be done were explained to Madam Sussana, her permission was sought and she consented. Head to toe examination was done for the baby and the mother and no abnormality was detected. The uterus was not palpable on palpation. The perineal pad was inspected and lochia was scanty and brownish red in colour. Her vital signs were checked and recorded as follows:

Temperature 36.4 degree Celsius

Pulse 86 beats per minute

Respiration 19 circle per minute

Blood pressure 120/80 millimeter in mercury

The baby was top and tailed and the umbilical stump was cleaned with cotton wool swabs and

methylated spirit. The cord stump was clean and dry with no offensive odour. The baby looked healthy and active. Her vital signs were checked and recorded as:

Temperature	36.8 degree Celsius
Apex heart rate	130 beats per minute
Respiration	38 circle per minute
Weight	3.0kilograms

Madam Sussana was asked if she had any problem and she said no. Client was reminded of the termination of home visits on the seventh day and permission was sought to leave after a short interaction.

4.10 SEVENTH DAY POSTNATAL HOME VISIT

On the 3th December, 2021, at about 8:35 am, client was visited for the last time. Greetings were exchanged and a seat was offered. Baby and mother were doing well. Madam Susaana's sister top and tailed the baby under supervision and she did it perfectly after head to toe examination was done on both mother and baby and no abnormality was detected. According to client, she was able to cope with pain and heaviness felt in the breast and she was relieved of it as well. The baby passed urine and stools during inspection. The colour of the stool was bright-yellow. The uterus was not palpable on palpation. The perineal pad was inspected and the lochia was scanty and brownish red in colour. The cord stump was dressed with strile cotton wool swabs and methylated spirit by Madam Sussana under supervision and she did it well. The cord stump was clean, dry and not offensive. Mother's vital signs were checked and recorded as follows:

Temperature	36.8 degree Celsius

Pulse	84 beats per minute
Respiration	18 cycles per minute
Blood pressure	120/80 millimeter in mercury

The baby's vital signs were:

Temperature	36.7 degree Celsius
Apex heart rate	134 beats per minute
Respiration	40 cycles per minute
Weight	3.1 kilograms

Madam Sussana was encouraged to continue exclusive breastfeeding for six months, ensure personal and environmental hygiene as she always does. The importance of immunizing the baby against the preventable childhood diseases were also explained to her. She was reminded of her visit to the clinic on the following day. Madam Sussana and her family expressed their heartfelt gratitude. They were thanked for their cooperation and also making the work easier. Permission was sought to leave.

4.11 FIRST POST NATAL VISIT TO THE CLINIC

On 6thJanuary, 2021, Madam Sussana and her baby came to the Maternity home at 9:00 am. They were welcomed and offered a seat. Client and baby were looking healthy and they were nicely dressed in all white. The purpose of this visit was to maintain the physical, psychological and medical wellbeing of mother and baby and also to do further investigations to know the state of health of both mother and baby. Client was asked how she and her family were doing and she said they were fine. General observations were made on her mood, gait and attitude towards baby and

all were okay. All procedures to be carried out were explained to her and her consent was sought. She was asked to empty her bladder and a sample of urine was taken to test for glucose and protein and all tested negative.

Her vital signs and haemoglobin level were checked and recorded as:

Temperature	36.5 degree Celsius
Pulse	76 beats per minute
Respiration	20 cycles per minute
Blood pressure	120/80 mmHg
Haemoglobin level	12.2 g/dl

Privacy was provided and Madam Sussana was helped to undress and lie on the examination bed. Hands were washed with soap under running water and dried with a clean dry towel. Head to toe examination was done on her. On the head, the hair was very neat, plaited in a corn row style and free from lice and dirt. The conjunctiva was pink, there were no discharges from the eyes, nose and ears. There was no abnormality detected in the mouth and there was the absence of enlarged lymph nodes around the neck. The breast was lactating well, there were no sore or cracked nipple and breast engorgement. The abdomen was firm, there was no tenderness, no scars, enlarged liver or spleen on examination. The uterus was not palpable. There was no oedema, varicosities and tenderness in the calf muscle. The perineum was intact and there was no offensive vaginal discharge. The lochia was small and the colour was alba. She was thanked for her cooperation and helped to dress up. The baby was also examined from head to toe and no abnormality was detected. The umbilical stump was inspected and it was healed. The baby looked healthy and active.

The baby's vital signs were checked and recorded as follows:

Temperature 36.9 degree Celsius

Apex heart beats 130 beats per minute

Respiration 38 cycles per minute Weight

3.2kilogram.

Mother was encouraged to ask questions but she said there was none. Client was educated on exclusive breastfeeding and the importance of attending child welfare clinic. All findings were recorded and communicated to mother. She was informed of the six weeks' postnatal visit which was on 24th December, 2021. Madam Sussana was thanked and accompanied to the clinic entrance.

4.12 SECOND POSTNATAL VISIT TO THE CLINIC

According to the midwife in-charge of Derma Health Center,client reported on 24th December, 2021 at 9:30am. She was asked how she and her baby and the rest of her family were doing and she said they were all doing well. Her haemoglobin level was 12.0g/dl and urine test for sugar and protein were negative.

Her vital signs were recorded as:

Temperature 36.2 degree Celsius

Pulse 80 beats per minute

Respiration 20 cycles per minute

Blood pressure 120/80 millimeter per mercury

Baby's weight was 4.8 kilogram and vital signs recorded as:

Temperature	36.6 degrees Celsius
Respiration	40 cycles per minute
Pulse	134 beats per minute

A head to toe examination was carried out on her and no abnormality was detected. Her uterus was not palpable. All reproductive organs had returned to their non-pregnant state and the breast was soft and lactating well. A speculum examination revealed a slit like appearance of the cervical os. She had not resumed menstruation when asked. Madam Sussana was educated on the need to start a family planning method to prevent unplanned pregnancy. The baby was examined from head to toe and no abnormality was detected. All the findings of the procedures carried out on her were recorded in the postnatal book and communicated to her as well. She was congratulated and thanked for her cooperation. Madam Sussana was accompanied to the child welfare clinic for the 6th week immunization.

4.13 CARE PLAN DURING PUERPERIUM

PROBLEMS IDENTIFIED

1. After pains
2. Perineal pain
3. sleeplessness
4. Backache
5. Breast engorgement

SHORT TERM OBJECTIVES

1. Client will be able to cope with after pain within 48 hours

2. Client will be relieved of perineal pain within 48 hours
3. Client will be able to sleep for at least 2 hours in the day and 6 hours during the night within 48 hours.
4. Client will be relieved of backache within 48 hours.
5. Client will be relieved of breast engorgement within 72 hours.

LONG TERM OBJECTIVES

Madam Sussana and her baby will go through puerperium without any complications to both mother and body.

TABLE C: CARE PLAN DURING PUERPERIUM

DATE/ TIME	NURSING DIAGNOSIS	OBJECTIVE/ OUTCOME CRITERIA	NURSING ORDER	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
27/11/2021 10:40pm	After pains related to contractions of the uterus.	Madam Susana will be relieved of after pains will be within 48 hours as evidenced by client verbalizing that pain has subsided	1. Reassure client that the condition is temporal. 2. Explain the physiology of after pains to her. 3. Educate her on postnatal exercises. 4. Encourage client to continue breastfeeding on demand. 5. Encourage client to empty her bladder. 6. Serve her with prescribed analgesics.	1. Client was reassured that pain will subside. 2. Client was told that after pain is due to contraction of the uterus. 3. She was engaged in abdominal and pelvickegel exercise. 4. Client continued to breastfeeding on demand. 5. Client was encouraged to empty her bladder frequently. 6. Client was emptied her bladder whenever she has the urge.	29/11/21 10:40pm	Goal fully met as madam Susana verbalized that she is relieved.	

TABLE C: CARE PLAN DURING PUERPERIUM CONTINUE

DATE/ TIME	NURSING DIAGNOSIS	OBJECTIVE/ OUTCOME CRITERIA	NURSING ORDER	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
28/11/21 7:00 am	Perineal pain related to perineum l and vaginal tissue stretching during delivery.	Client's perineal pain will resolve within 48 hours as evidenced by client verbalizing that her pain has subsided	1. Reassure client that it can be managed. 2. Encourage client to maintain good personal hygiene. 3. Encourage client to do warm sitz bath. 4. Encourage client to breastfeed by lying down to help reduce pain. 5. Administer prescribed analgesic	1. Client was reassured. 2. Client maintained good personal hygiene. 3. Client was doing warm sitz bath morning and evening. 4. Client laied down to breastfeed her baby. 5. Client was given paracetamol 1g tds x 3days	30/11/21 7:00am	Goal fully met as client verbalized that her perineal pain has stopped.	

DATE/ TIME	NURSING DIAGNOSIS	OBJECTIVE/ OUTCOME CRITERIA	NURSING ORDER	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN

TABLE C: CARE PLAN DURING PUERPERIUM CONTINUE

30/11/21 7:30am	Sleeping pattern disturbance (interrupted) related to demand of feeding of baby at night.	Madam Susana will sleep at least 2 hours during the day and 6 hours in the night within 48 hours as evidenced by client verbalizing that she now has adequate sleep.	1. Reassure Madam Susana that the situation is temporal 2. Encourage client's relatives to help her. 3. Encourage client to limit her time spent with visitors. 4. Encourage client to take a warm bath before bed 5. Encourage client to sleep whenever baby sleeps	1.Madam Susana was reassured that it shall be well and normal. 2. Client's relatives were encouraged to helping her in the care of the baby for her to sleep during the day. 3. Client limited time spent with visitors. 4. Client took warm bath before bed each night. 5. Client slept whenever baby sleeps.	02/12/21 7:30am	Goal fully met as client verbalized that she was able to sleep 2hours in a day and 6 hours in a night.	

TABLE C: CARE PLAN DURING PUERPERIUM CONTINUE

DATE/ TIME	NURSING DIAGNOSIS	OBJECTIVE/ OUTCOME CRITERIA	NURSING ORDER	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
1/12/21 8:00 am	Backache related to poor breastfeeding posture.	Client will be relieved of backache within 48 hours as evidence by client verbalizing that pain is no more.	1. Reassure client that something can be done about it 2. Educate client on the correct positions used in breastfeeding. 3. Educate client on the use of good body mechanics during lifting. 4.Educate client on proper attachment to breast. 5. Administer prescribed analgesic.	1. Client was reassured that she is in competent hands. 2. Client was educated on the correct positions used in breastfeeding. 3. Client was taught to bend from her knee to lift or pick object. 4. Client was taught to lift baby to baby to breast. 5. 1g paracetamol tds x3days was administered	02/12/21 8:00 am	Goal fully met as client reported that her backache was no more.	

TABLE C: CARE PLAN DURING PUERPERIUM CONTINUE

DATE/ TIME	NURSING DIAGNOSIS	OBJECTIVE/ OUTCOME CRITERIA	NURSING ORDER	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
02/12/21 8:00am	Heaviness of breast related to inadequate emptying of the breast.	Client will be relieved of heaviness breast within 72 hours as evidenced by client verbalizing that she has been relieved of the pain associated with it.	1.Teach client on how to fix the baby to breast correctly. 2.Demonstrate to client how to correctly position herself when breastfeeding. 3.Encourage client to apply cold compress to the left breast. 4.Encourage client to do gentle expression of the milk. 5.Encourage client to continue exclusive breastfeeding.	1Client was taught on how to correctly fix the baby to breast. 2. Client gave a return demonstration on to client how to correctly position herself during breastfeeding. 3.Client expressed milk applied cold compress to the left breast. 4. Client expressed milk gentlyto feed baby later with it . 5. Client continued exclusive breast feeding.	5/12/21 8:00am	Goal fully met as client verbalized that she has been relieved.	

SUMMARY AND CONCLUSION

This Client / Family centered care study was rendered to Madam Susana who stays at Derma a suburb of Tano South in the Bono Region. A 26 year old gravida3 para 2 who was an attendant at Derma Health Center for antenatal care was chosen among the lot because she fell within the criteria for clients to be chosen for the care study. Friendship was then established to render effective care throughout pregnancy, labour and puerperium.

Minor problems that were encountered during the period of pregnancy, labour and puerperium were all managed using the nursing process. Her successful antenatal care, labour and puerperium were due to the early assessment and analysis of her problems, proper counselling and education. She had a spontaneous vaginal delivery to a live female child on the 26thNovember, 2021 without any complications. All the appropriate care was rendered to her, the baby and her family as a whole. She was also educated appropriately.

She had intensive puerperal care and all visits and examinations were carried out on her as required and hence she had a normal and safe puerperium. The baby also received all appropriate immunizations required at birth for the prevention of any diseases or complications. She was finally handed over to the midwife in charge for the continuity of care. There was proper and accurate documentation of all activities and procedures carried out on her and the baby for easy reference.

The Client / Family Centered Care Study has served as a managerial tool and step for managing any pregnant woman through antenatal, labour and puerperium and therefore should be sustained.

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APPENDIX I COMPLETE DIAGNOSTIC INVESTIGATIONS

DATE	SPECIMEN	INVESTIGATION	NORMAL RANGE	FINDINGS	REMARKS
13/08/21	Blood	Haemoglobin level	11.4g/dl-16g/dl	15.3g/dl	Normal
		Sickling	Negative	Negative	Normal
		Grouping	A,B,AB,O	O	Normal
		Rhesus factor	Positive/negative	Positive	Normal
	Urine	Protein	Negative	Negative	Normal
		Sugar	Negative	Negative	Normal
18/08/21	Blood	Haemoglobin level	11.4g/dl-16g/dl	13.3g/dl	Normal
	Urine	Protein	Negative	Negative	Normal
		Sugar	Negative	Negative	Normal
22/09/21	Blood	Haemoglobin level	11.4g/dl-16g/dl	12.6g/dl	Normal
	Urine	Protein	Negative	Negative	Normal
		Sugar	Negative	negative	Normal

29/10/21	Blood Urine	Haemoglobin level Protein Sugar	11.4g/dl-16g/dl Negative Negative	13.3g/dl Negative negative	Normal Normal Normal
05/11/21	Blood Urine	Haemoglobin level Protein Sugar	11.4g/dl-16g/dl Negative Negative	11.8g/dl Negative Negative	Normal Normal Normal

COMPLETE DIAGNOSTIC INVESTIGATIONS CONTINUES

DATE	SPECIMEN	INVESTIGATION	NORMAL RANGE	FINDINGS	REMARKS
12/11/21	Blood	Haemoglobin level	11.4g/dl-16gdl	12.6g/dl	Normal
	Urine	Protein	Negative	Negative	Normal
		Sugar	Negative	Negative	Normal
19/11/21	Blood	Haemoglobin level	11.4g/dl-16g/dl	12.6g/dl	Normal
	Urine	Protein	Negative	Negative	Normal
		Sugar	Negative	Negative	Normal

LABOUR

DATE	SPECIMEN	INVESTIGATION	NORMAL RANGE	FINDINGS	REMARKS
26/11/21	Blood	Haemoglobin level	11.4g/dl-16g/dl	12.5g/dl	Normal
	Urine	Protein	Negative	Negative	Normal
		Sugar	Negative	Negative	Normal

APPENDIX II

Table 1: PHARMACOLOGY OF DRUGS FOR THE MOTHER

NAME OF DRUG	CLASSIFICATION	DOSAGE	ROUTE	ACTION AND USES	ACTUAL EFFECT	SIDE EFFECT	SIDE EFFECT EXPERI-ENCED
Folic acid	Vitamin preparation	5 milligram once daily	Orally	Proper formation and function of red blood cell	Haemoglobin level increased	Nausea and vomiting	None observed
Tetanus injection	Vaccine	0.5 milligram stat (3rd dose)	Subcutaneously	Protection against tetanus	Tetanus was prevented	Fever and urticaria rash	None observed
Tablet sulphadoxine pyrimethamine	Anti-malaria and prophylaxis	3 tablets given at 16 weeks/quickening repeated at 4-week interval till delivery.	Orally	Prevention of malaria	Prevention of malaria in pregnancy	Nausea, itching, headache, Dizziness	None observed

NAME OF DRUG	CLASSIFICATION	DOSAGE	ROUTE	ACTION AND USES	ACTUAL EFFECT	SIDE EFFECT	SIDE EFFECT EXPERI-ENCED
Tablet paracetamol	Analgesics	1 gram three times daily for three	Orally	Helps to relieve pain	Pain was relieved	Prolong use causes damage to the liver	None observed
Capsule vitamin A	Group A vitamin supplement	200,000 units	Orally	Growth development and proper sight	Normal vision and healthy skin	Vomiting	None observed
Injection oxytocin	Oxytocic drug	10 units	Intramuscularly	Stimulate uterine contractions	Good uterine contraction and control of bleeding	Nausea and vomiting	None observed
Tablet multivitamin	Vitamin preparation	200 milligrams daily	Orally	Increases appetite. Help in the formation of red blood cell	Increases appetite	Gastrointestinal disturbance	Constipation

Table 2: PHAMARCOLOGY OF DRUGS FOR THE BABY

NAME OF DRUG	CLASSIFICATION	DOSAGE	ROUTE	ACTION/ USES	ACTUAL EFFECT	SIDE EFFECT	SIDE EFFECT EXPERIENCED
Vitamin K	Coagulant	1milligram	Intramuscular	Production of prothrombin	No bleeding	None	None observed

Chloramphenicol eye drop	Prophylaxis antibiotic	2-3 drops	Instillation	Prevents eye infection	Infection was prevented	Nephroxicity	None observed
Polio vaccine	Antigen	2 drops	Orally	Production of antibodies against poliomyelitis	Diarrhoea and fever may occur.	None	None observed
Injection Bacillus Chalmette Guerin (BGC)	Antigen	0.05 Milligram	Intradermal	Vaccinates neonates against tuberculosis	Tuberculosis prevention	Blister formation	None observed
Pnuemo coccal	Antigen	0.5 milligram	Intramuscularly	Vaccinates neonates against pneumonia	Pneumonia prevention	Redness at the side of injection and fever	None observed
5 in 1 vaccine (Pentavalent)	Antigen	0.5 milligram	Intramuscularly	Vaccinates neonates against diphtheria, pertusis (whooping` cough), tetanus, hepatitis B, haemophilus influenza type B	Prevention of childhood preventable diseases	Low grade fever	None observed
Rota virus	Antigen	1.5 milligrams (2 drops)	Orally	Prevention of gastroenteritis	Gastroenteritis prevention	None	None observed

APPENDIX III

Table 3: ANTENATAL RECORDS

Date	**Wt**	**Vital Signs (Bp/Tpr)**	**Urine/ ProTein/ Sug-Ar**	**Hb (Gdl)**	**GestAtion In Weeks**	**Fundal HeiGht**	**Pres-Enta-Tion**	**Des-Ce-Nt**	**Fetal Heart Rate**	**Com-Plains**	**Treat-Ment**	**Rem-Arks**
13/08/21	57kg	100/55 36.4^{o}c 78bpm 20cpm	Negative/ Negative	-	24 Weeks	25 cm	Cephalic	-	140bpm	Lower Abdominal Pain	Routine drugs, Paracetamol and Third SP	Well
18/08/21	58kg	128/68 36.5^{0}c 74bpm	Negative/ Negative	12.3g/ dL	28 Weeks	27cm	Cephalic	-	144bpm	Waist Pains	Routine drugs, Paracetamol and Fourth SP	Well

Date	Wt	Vital Signs (Bp/Tpr)	Urine/ ProTein/ Sug-Ar	Hb (Gdl)	GestAtion In Weeks	Fundal HeiGht	Pres-Enta-Tion	Des-Ce-Nt	Fetal Heart Rate	Com-Plains	Treat-Ment	Rem-Arks
22/10/21	61kg	117/63 36.5^{O}c 20cpm 79bpm	Negative/ Negative	12.5g/dL	32 Weeks	30cm	Cephalic	-	138bpm	No complains	Routine drugs and Fifth SP	Well
29/10/21	64kg	112/68 36.4^{0}c 88bpm 23cpm	Negative/ Negative		36 Weeks	33cm	Cephalic		142bpm	Waist pain	Continue routine drugs, Paracetamol	Well
05/11/21	68kg	116/74 36.5^{0}c 82bpm	Negative/ Negative	12.8g/dL	37 Weeks	37cm	Cephalic		141bpm	No complains	Routine drugs and sixth dose of SP	Well

Date	Wt	Vital Signs (Bp/Tpr)	Urine/ ProTein/ Sug-Ar	Hb (Gdl)	GestAtion In Weeks	Fundal HeiGht	Pres-Enta-Tion	Des-Ce-Nt	Fetal Heart Rate	Com-Plains	Treat-Ment	Rem-Arks
12/11/21	69kg	109/73 36.4^{0}c 82bpm 20cpm	Negative/ Negative	13.0g/dL	38 Weeks	37cm	Cephalic	5/5th	145bpm	Heart burns and waist pains	Continue Routine drugs Paracetamol	Well
19/11/21	69kg	108/74 36.2^{0}c 86bpm 24cpm	Negative/ Negative	_	39 Weeks	37cm	Cephalic	5/5th	149bpm	Headache, backache and constipation	Continue Routine drugs Paracetamol	Well
25/11/21	70kg	104/72 36.2^{0}c 86bpm	Negative/ Negative	_	40 Weeks	36cm	Cephalic	3/5th	147bpm	Lower abdominal pain	Continue Routine drugs Paracetamol	Well

APPENDIX IV

DERMA HEALTH CENTER

MATERNITY OBSERVATION CHART

NAME: SUSSANA BOAKYE

DATE: 26/10/21

AGE: 26 YEARS

SIGNATORIES

THE STUDENT MIDWIFE

NAME: APPIAH-KUBI ANITA

SIGNATURE: …………………………….

DATE: …………………………………….

THE MIDWIFE IN CHARGE

NAME: MS. DORIS NYARKO

SIGNATURE: ……………………………

DATE: …………………………………….

THE SUPERVISOR

NAME: MS. ERNESTINA MENSAH

SIGNATURE: ………………………….

DATE: …………………………………….

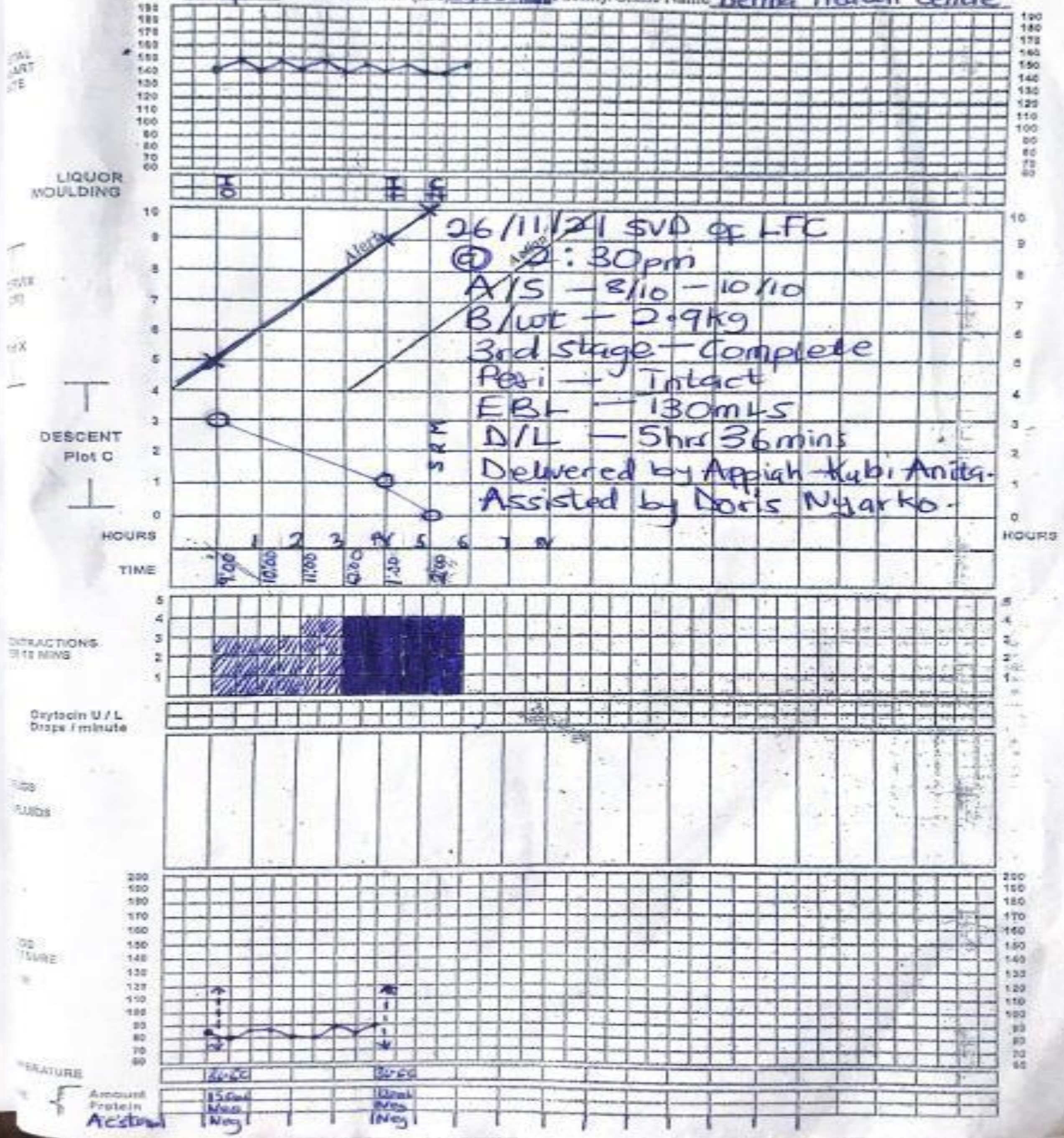
THE PRINCIPAL

NAME: MS. MONICA NKRUMAH

SIGNATURE: …………………………….

DATE………………………………………

STAMP………….…………………………



WHO Modified Partograph

Registration No.: 506/21 Name(Last, First): Boakye Sussana Age: 26yrs
Date: 26/11/21 Parity/Gravida: 2, 3 LMP: 19/02/21 EDD: 27/11/21 Gestation(wks): 40weeks
ROM: 2:5pm Labour Duration (Hrs): 5hrs 36mins Facility/Clinic Name: Derma Health Centre

FETAL HEART RATE

LIQUOR / MOULDING

CERVIX (CM)

DESCENT Plot O

Alert

Action

26/11/21 SVD of LFC
@ 2:30pm
A/S – 8/10 – 10/10
B/wt – 2.9kg
3rd stage – Complete
Peri – Intact
EBL – 130mLs
D/L – 5hrs 36mins
Delivered by Appiah-Kubi Anita.
Assisted by Doris Nyarko.

SRM

HOURS

TIME: 9:00, 10:00, 11:00, 12:00, 1:30, 2:00

CONTRACTIONS PER 10 MINS

Oxytocin U/L Drops / minute

DRUGS / IV FLUIDS

BLOOD PRESSURE

TEMPERATURE: 36.6°C, 36.6°C

URINE: Amount: 150ml, 100ml; Protein: Neg, Neg; Acetone: Neg, Neg

LABOR NOTES

Client admitted at the facility at 4-45am with complains of lo
abdominal pains. Labour progressed well. Client had a spontaneou
vaginal delivery to a live female child with a birth weight of 2.9k
head circumference - 33cm, length 49cm. The third stage was act
managed and complete delivered by C.C.T. Estimated blood loss
130mls. Baby APGAR score for 1minute and 5 minutes were [illegible]
respectively. Mother and baby were active and in good conditio

Please circle or write responses.

DELIVERY

DATE: 26/11/21 TIME: 2:30pm METHOD: Spontaneous / Vacuum Extraction / C/S / Othe

PERINEUM: Intact / Episiotomy / Laceration

ANESTHESIA: None / Local / General

THIRD STAGE

Active Management: Yes / No Medication: Time 2:36pm Type/Dose 10unit oxytocin

PLACENTA: TIME: 2:36pm Complete / Incomplete

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

BABY

Weight: 2.9kg

Sex: Male / Female

Baby Position: Vertex / Breech / Other

APGAR

Time	Color	Breath	Heart	Tone	Reflex	T
1min	2	2	2	1	1	
5min	2	2	2	2	2	1

COMPLICATIONS OF MOTHER / BABY: None / Other:

	Frequency	Time	B/P.	Pulse	Fundus	Bleeding	Blad
FOURTH STAGE MONITORING	Every 15 minutes first 2 hours	3:00pm	110/70	90	18cm		
		3:15pm	110/60	80	18cm	No active bleeding	200
		3:30pm	110/70	82	Well Contracted		
		3:45pm	100/70	76			Emp
		4:00pm	100/60	79			
		4:15pm	110/80	80			Emp
		4:30pm	110/80	84			
		4:45pm	110/60	83			Em
	Every 30 minutes For 1 hour	5:15pm	110/60	82			
		5:45pm	[illegible]/80	80			100

Birth Attendant Appiah-Kubi Anita Date 26/11/21

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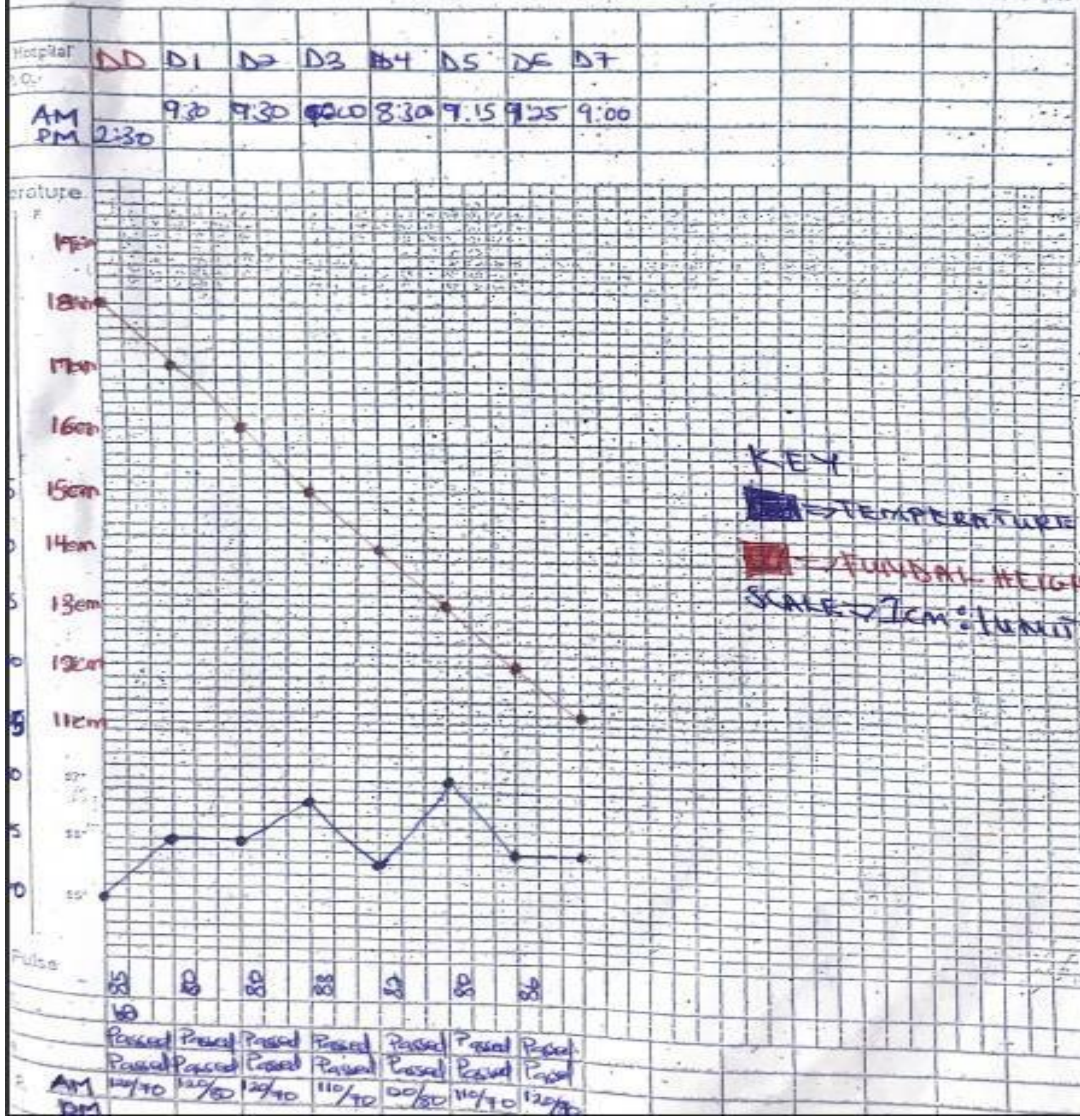

MATERNITY CHART
Madam Sussana
WARD: Lying In
BED NO.:
DD D1 D2 D3 D4 D5 D6 D7
AM
PM 2:30
9:30 9:30 8:30 9:15 9:25 9:00
18cm
17cm
16cm
15cm
14cm
13cm
12cm
11cm
KEY
TEMPERATURE
FUNDAL HEIGHT
Pulse
Passed

NEW BORN EXAMINATION FORM

Baby Sussana Date of Assessment: 27/11/21 Time: 8am

Birth: 26/11/21 Time of Birth: 2:30pm Sex: [ ] M [x] F Age at time of Assessment (days/hrs) 1hr

al Age [ ] 40wks [ ] Mode of Delivery: [x] Vaginal Assisted Vaginal C-Section

: 1min [ ] 5min [ ] Birth Weight: [ ] 2.9 kg [ ] Length 48 cm Head Circumference: 33 cm

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

Assessor (Midwife/Doctor): Appiah-Kubi Anita

iration
- < 30 b/m *
- < 60 b/m *
- b/m
- ctions *
- ing *
- or *

ity/Movemnet
- aneous symmetric ements
- ced/Absent Movement in imb *
- Movement

al
- gy *
- ssed *

ar
- all over
- body but blue hands/feet
- all over *
- *
- iced *

d
- mal
- draining pus
- ling

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

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

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

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

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

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

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

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

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

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

18. Heart rate

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

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

20. Abdomen
- [x] Normal
- [ ] Distended*
- [ ] Scarphoid*
- [ ] Abdominal defect*
- [ ] Masses: ________
- [ ] Other ________

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

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

23. Genitalia

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

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

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

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

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

ndicate severe disease that requires urgent referral

es (if known) Spontaneous Vaginal Delivery

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

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

TEMPERATURE CHART

Baby Sussana

New born .... WARD: Lying in

BED NO.: 2

Date	26/11/21	27/11/21	28/11/21	29/11/21	30/11/21	1/12/21	2/12/21	3/12/21
Day in Hospital	DD	D1	D2	D3	D4	D5	D6	D7
AM		9:00	9:00	9:00	9:00	9:00	9:00	9:00
PM	2:30	5:00	5:00	5:00	5:00	5:00	5:00	5:00
Stool	Passed	Passed	Passed	Passed	Passed	Passed	Passed	Passed

Name: Baby Sussara ....No: ....Birth Weight: 2.9kg

Sex: Female ....Mother's No: DHC-2141/21 ....Length: 49

Nature of Delivery: Spontaneous Vaginal Delivery ....Diagnosis: 2

Date of Birth: 26/11/21 ....Time: 2:30pm ....Date of Discharge: 27/11/21

Date	26/11/21		27/11/21		28/11/21		29/11/21		30/11/21		1/12/21		2/11/21		3/11/21							
No. of Days	DD		D1		D2		D3		D4		D5		D6		D7							
Weight	2.9kg		2.8kg		2.7kg		2.7kg		2.8kg		2.9kg		3.0kg		3.1kg							
	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM
Temperature		36.0°C	36.5°C	36.6°C	36.3°C	36.8°C	36.7°C	36.4°C	36.6°C		36.7°C		36.2°C		36.5°C							
Stools		Passed	Passed	Passed	Passed	Passed	Passed	Passed	Passed		Passed		Passed		Passed							
Urine		Passed	Passed	Passed	Passed	Passed	Passed	Passed	Passed		Passed		Passed		Passed							
Remarks	Head, Neck, Truck, Gentalia, Extermities — No abnormality detected.																					

SIGNATORIES

THE STUDENT MIDWIFE

NAME: APPIAH-KUBI ANITA

SIGNATURE:

DATE 05/10/22

THE MIDWIFE IN-CHARGE

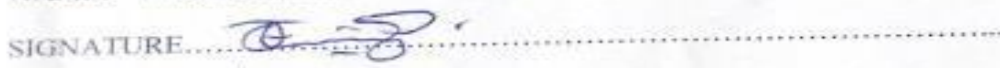
NAME: MS DORIS NYARKO

SIGNATURE:

DATE 05/10/22

THE SUPERVISOR

NAME: MS. ERNESTINA MENSAH

SIGNATURE 

DATE 07/10/22

THE PRINCIPAL

NAME: MONICA NKRUMAH

SIGNATURE:

DATE 10/10/22