HOLY FAMILY NURSING AND MIDWIFERY TRAINING COLLEGE

BEREKUM

THE CLIENT/FAMILY CENTERED MATERNITY CARE STUDY ON

MADAM ASARE COMFORT

WRITTEN BY

JACHAN PEGGY

4122220091

A CLIENT/FAMILY CENTERED CARE STUTDY SUBMITTED TO THE NURSING AND MIDWIFERY COUNCIL OF GHANA IN PARTIAL FULFILMENT FOR THE AWARD OF LICENSE TO PRACTICE AS A PROFESSIONAL REGISTERED

MIDWIFE

AUGUST, 2024

TABLE OF CONTENT

PREFACE

The client and family Centered Maternity Care study is a systematic approach used in rendering holistic obstetric care to expectant mother and her family. It is necessary as it gives opportunity to student midwife to practice what has been acquired theoretically in the classroom under pregnancy, labour and puerperium.

It is based on a thoughtful understanding of the client as a unique individual with specific problems and needs. This care study involves data collection, assessment, identification of problems, nursing diagnosis, planning, implementation and evaluation that will help solve the client's problems. The care is extended to the family and the community in which the client lives. It is therefore contributing to the health of the client, family and the community at large. The family Centered Maternity care study gives the student the opportunity to use the knowledge and skills she has acquired both theoretically and practically during her training period to care for a pregnant woman.

As demanded by the noble profession, confidentiality of all information obtained from the client and family is assured to make them feel comfortable and to gain their cooperation. As required by Nurses and Midwifery council (NMC), every final year midwifery student is required to undertake this study as partial fulfillment of the two years' midwifery training program.

ACKNOWLEDGEMENT

My first debt of gratitude goes to the Almighty God for His grace, strength, wisdom and guidance throughout my training and writing of this care study.

Sincerest appreciation is to the entire tutorial and non-tutorial staff of Holy Family Nursing and Midwifery Training College, Berekum and more especially to the Principal, Monica Nkrumah, my supervisor, Ms. Ubaida Abdul-Karim for her keen supervision and corrections to make this script a success.

Special thanks to my client, Madam Asare Comfort and her family for allowing themselves to be used for the care study and providing me with the necessary information required in the writing of the script.

Sincere gratitude goes to Palm Avenue Maternity Home Berekum, staff especially MS Grace A Maakwuu for their support and tolerance given to me during my stay with them. To them I say a big thank you and God bless you all. My warmest gratitude and honor goes to my family for supporting me financially, emotionally and psychologically throughout my three year course of study, it's my prayer that the almighty God bless them abundantly.

To the authors and publishers whose books were used as references during the writing of the script, God should continue to grant them abundant knowledge and intelligence to help continue with their good work.

INTRODUCTION

The client/ Family Center Care Study is a learning experience which orientates the student midwife to properly care for the expectant mother throughout pregnancy, labour and puerperium. Client/Family Centered Maternity Care Study is a systematic approach used in rendering holistic obstetric care to the expectant mother and her family based on a thoughtful understanding of the client as a unique individual with specific problems and needs. This care study is also a tool for the student midwife to exhibit the knowledge and the skills which she acquired during the training.

The study is based on the care given to Madam Asare Comfort and family. A 33 years old gravida 3 para 2A, with 36^{+3} weeks cyesis visited the Palm Aveune Maternity. Madam Asare Comfort was cared for during Antenatal, labour and puerperium, she was also visited at home to know her family, environment, and her community where she stays as well. Our interactions came to an end when she was introduced and handed over to the midwife in charge and the public health nurse for continuity of care. The study is in four chapters. Chapter one contains the client's profile, social history, family history, medical history, surgical history, menstrual history, habit of daily living, hobbies, past and present obstetric history. Chapter Two (2) gives a vivid account on the antenatal care given to the client. Chapter three (3) deals with the process of labour whilst chapter four talks about puerperium period till the 7th day post-natal home visit. All the chapters except chapter one have nursing care plan drawn on the problems identified. The name of the client and her family were used throughout the writing.

LITERATURE REVIEW

PREGNANCY

Myles (2014) states that as soon as pregnancy is confirmed, 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 the 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. A variety of care that are rendered to the expectant mothers and their entire families which includes history taking, physical examination (head to toe examination and abdominal examination i.e. inspection, palpation and auscultation), laboratory investigation (urine, blood and stool), administration of routine drugs (folic acid, fersolate and multivitamin), Sulphadoxine Pyrimethamine as malaria prophylaxis and tetanus toxoid, education on minor disorders, danger signs of pregnancy, diet, travelling, rest and sleep, exercise, personal and environment hygiene, birth preparedness and complication readiness

Tiran (2015), stated that pregnancy is from conception to delivery of baby, normal duration for pregnancy is 40 completed weeks plus 6 days, counting from the first day of the last menstrual period to be delivery or 265 fee days from conception to delivery.

Oduro-Kwarteng (2015), also defined pregnancy as the condition of having a developing embryo or fetus in the body as a result of the union of an ovum and spermatozoa. Pregnancy can occur any time after a female begins menstruation (menarche) in conjunction with ovulation until she reaches menopause where ovulation ceases.

Oduro-Kwarteng (2015), further stated that the duration of pregnancy, as the length of pregnancy averagely 280 days from the time of fertilization but normally is countered from the first day of menses prior to conception (approximately 284 days). Furthermore, a full term pregnancy is 40 weeks 0r 9 months or 10 lunar months. Generally, the period of pregnancy is divided into three trimesters, first trimester (0-12 weeks), second trimester (13-24 weeks), and third trimester (25-36 weeks). Oduro-Kwarteng, (2015), again said that, the growth and development of the fetus is affected by many aspect of the mother's health, poor nutritional status, uses of drugs , alcohol and cigarettes, uses of unprescribed or some medications, herbal remedies, medical condition, age at time of pregnancy and prenatal care

Marshall & Raynor (2014) stated that the pregnancy starts from the time conception is confirmed until the beginning of labour and also the midwife facilitates woman-centered care by providing her with accessible and relevant information to help her make informed choices throughout pregnancy. This book went on further to say that the aim of antenatal care is to monitor the progress of pregnancy optimize maternal and fetal health. To achieve this, the midwife critically evaluates the physical, psychological and sociological effects of pregnancy on the woman and her family. The key principles of antenatal care by the midwife:

- Providing a holistic approach to the woman' care that meets her individual needs.
- Recognizing complications of pregnancy and appropriately referring women to the obstetric team or relevant health professionals or other organizations.
- Facilitating the woman and her family in preparing to meet the demands of birth, and making a birth plan.
- Offering parenthood education within a planned programme or on an individual basis.

Marie Elizabeth (2013) defines pregnancy as when the woman's egg and a man's sperm cell unit to form zygote. The duration of pregnancy has traditionally been calculated by the clinicians in terms of 10 lunar months or 9 months and 7 days or 280 days or 40 weeks, calculated from the first day of the last menstrual period. This is called menstrual or gestational age. It is divided into 3 trimesters (29 to 40 weeks). General check-up is done at interval of 4 weeks up to 28 weeks; at interval of two weeks up to 36 weeks and thereafter weekly till the expected date of delivery. Ideally this should be more flexible depending on the need, and the convenience of the patient.

Konar (2013) defines pregnancy as the development of growing foetus in uterus. Konar further explains that the duration of pregnancy has traditionally been calculated by the clinician in terms of 10 lunar months or 9 calendar months and 7days or 280 days or 40weeks calculated from first day of the last menstrual period. This is called menstrual or gestational age. He further explains that the period of pregnancy is divided into 3 sets of months. The first 3months is the second trimester (13- 28weeks) while the last 3 months is known as the 3rd trimester (29-40 weeks). Fraser & Cooper (2013) Pregnancy is the period when the fertilized ovum embeds in the maternal uterus until it is born thus the state of conception till the delivery of the foetus. The normal duration is 280 days or 40weeks counting from the last day of the menstrual period, she further states that uterine blood flow in pregnancy supplies the myometrium, endometrium and placenta, with the latter receiving nearly 90% of the total uterine blood flow near term. It further states that, the anatomical and physiological adaptations occurring throughout pregnancy affect virtually every body system. The timing and intensity of the changes vary between systems but all are designed to support foetal growth and development and prepare the mother for birth and motherhood. The uterus protects and supports the foetus, placenta and amniotic fluid. For most

of the 40 weeks of pregnancy, the uterus expands to accommodate the growing foetus and remains relatively quiescent, yet at the time of labour it is able to contract regularly and forcibly to expel the foetus due to its unique properties of contractility and elasticity. She also says, the vagina also increases vascularity which results in the violet colour characteristic of Chadwick's sign. There is increased volume of vaginal secretions due to high level of oestrogen resulting in thick, white discharge known as leucorrhoea. Larger amount of glycogen is deposited in the vaginal epithelium due to high oestrogen availability. The glycogen is metabolized to lactic acid by the lactobacillus acidophilus, (Doderlein's bacillus), and this leads to increase vaginal acidity.

LABOUR

Myles (2014) assert that, labour may be described as the process by which the foetus, placenta and membranes are expelled through the birth canal. Labour has four stages. Stage one comprises of latent phase and may last 6 to 8 hours in prim gravida. This begins when the cervix is 4cm dilated and in the presence of rhythmic contractions, progressively dilates to 10cm or full dilatation. Second stage of labour is the expulsion of the foetus. It begins when the cervix is fully dilated and the woman has the urge to expel the baby. There is stretching of the clitoris, gaping of the anus and bulging of the perineum. Labour completes when baby is born. In multigravida women, it last 15-30 minutes. Third stage begins after the expulsion of foetus and ends with the expulsion of the placenta and membranes (afterbirth). The fourth stage is a period of careful observation of the mother made to assess excessive bleeding and the firmness of the contracting uterus immediately after the third stage of labour and it last six hours after delivery of the placenta.

Marie Elizabeth (2013) defines labour as a series of events that takes place in the genital organs in effort to expel the viable products of conception out of the womb through the vagina into the outer world. Labour is called normal if it fulfills the following criteria;

1. Spontaneous in onset
2. with vertex presentation
3. without undue prolongation
4. Natural termination with minimal aids
5. Without having any complication affecting the health of the mother and/ or the baby.

The features of true labour signs are:

1.Painful uterine contraction at regular intervals

2.‘’Show’’

3.Progressive effacement and dilatation of the cervix

4.Formation of the “bag of waters’’

The events of labour are divided into four stages; first, second, third and fourth stage. First stage starts from the onset of true labour pain and ends with full dilatation of the cervix. Its average duration is 6 hours in multipara. Second stage starts from full dilatation of the cervix and ends with expulsion of the foetus from the birth canal. Third stage begins after the expulsion of foetus and ends with the expulsion of the placenta and membranes (afterbirth). Average duration is about 15 minutes in both multi and primigravida. Fourth stage is the stage of observation after expulsion of the afterbirth. Four factors are significant in the process of labour; that is the pelvis, passenger, powers and psyche. These are known as the four P’s.

Marshall & Raynor (2014) states that the onset of labor is a process; not an event; therefore, it is very difficult to identify exactly when the painless (sometimes painful) contraction of pre labor

develop into progressive rhythmic contractions of established labor. Diagnosing the onset of labor is extremely important, since it is on basis of this finding that decisions are made that will affect the intrapartum care and support subsequently.

Konar (2013) defined labor as series of events that takes place in the genital organs in an effort to expel the viable products of conception out of the womb through the vagina into the outer world. The onset of labor is determined by a complex interaction of maternal and fetal hormones and is not fully understood. It would appear to be multifactorial in origin, being a combination of hormonal and mechanical factors. Levels of maternal estrogen rise sharply during the last weeks of pregnancy, resulting in changes that overcome the inhibiting effects of progesterone. High levels of oestrogen cause uterine muscle fibers to display oxytoxic receptors and form gap junctions with each other. Oestrogen also stimulates the placenta to release prostaglandins that induce a production of enzymes that will digest collagen in the cervix, helping it to soften.

Marie (2013) defines labour as a series of events that takes place in the genital organs in effort to expel the viable products of conception out of the womb through the vagina into the outer world. Labour is called normal if it fulfills the following criteria; Spontaneous in onset. With vertex presentation. Without undue prolongation. Natural termination with minimal aids. Without having any complication affecting the health of the mother and/ or the baby. The features of true labour signs are: Painful uterine contraction at regular intervals. ‘’Show’’. Progressive effacement and dilatation of the cervix. Formation of the’’ bag of waters’’. The events of labour are divided into four stages; first, second, third and fourth stage. First stage starts from the onset of true labour pain and ends with full dilatation of the cervix. Its average duration is 6 hours in multipara. Second stage starts from full dilatation of the cervix and ends with expulsion of the foetus from the birth canal. Third stage begins after the expulsion of foetus

and ends with the expulsion of the placenta and membranes (afterbirth). Average duration is about 15 minutes in both multi and primigravida. Fourth stage is the stage of observation after the expulsion of the afterbirth. Four factors are significant in the process of labour; that is the pelvis, passenger, powers and psyche. These are known as the four P's.

According to Tiran (2015), normal labour occurs not naturally after 37 weeks gestation with vertex presentation of a single fetus, completed within 24 hours without maternal and fetal trauma, physiology depends on interaction between uterus maternal pelvis and fetus

PUEPERIUM

Myles (2014) states that, following the birth of the baby and expulsion of the placenta, the mother enters a period of physical and psychological recuperation. Puerperium starts immediately after the delivery of the placenta and membranes and continues for six weeks. The overall expectation is that by six weeks after the birth of the baby, all the body systems will have recovered from the effects of pregnancy and return to their non-pregnant state. Myles also stated that puerperium starts immediately after the delivery of the placenta and membranes and continues for six weeks after which all the system in the woman's body will recover from the effects of pregnancy and return to their non- pregnant state. Myles also strikes the difference between exercise and healthy activity verses rest, relaxation and sleep. 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 of benefit to the woman's long term health.

According to Tiran (2015), puerperium is the period of six to eight weeks following child birth, during this period the uterus and other organs has returned to its non-pregnant state.

The period between 4-6 weeks which starts immediately after delivery and ends when the reproductive organs has returned to its non-pregnant State. Multiple anatomic and physiological changes occur during this time and the potential or significant complications such as infection and haemorrhage.

Oduro-Kwarteng (2015), defined puerperium as a period that starts immediately after the delivery of the placenta up to 6-8 weeks. This period is characterized by lots of physiological changes, some of which includes the following;

Lactation is well established.

The reproductive organs return to the non-pregnant state

Other physiological changes which occurred during pregnancy are revised.

The foundation of the relationship between the infant and its parents are laid.

The mother recover from physical and emotional stresses of pregnancy and delivery and assume responsibility for the care and nurture of her infant.

Marie Elizabeth (2013) describes puerperium as the period following childbirth during which the body tissues, especially the pelvic organs revert back 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
- Immediately following delivery, the uterus becomes firmer and retracted with alternating hardening and softening. At the end of 6 weeks, its measurement is almost similar to that of the non-pregnant state and it weighs 60 grams. The lower uterine segment becomes thin, flabby and collapsed structure. The cervix contracts slowly; the external os admits to

fingers for the few days but by the end of the first week, narrows down to admit the tip of a finger only. The external os never revert back to the nulliparous state. Marie Elizabeth further explains that during puerperium the number of muscle fibers is not decreased but there is substantial reduction in the myometrium cell size. The arteries are constricted by contraction of its wall and thickening of the intima followed by thrombosis. New blood cells grow in the thrombi. Soon after birth it takes a long time (4 to 8) for the vagina to involute. The vaginal discharge for the first fortnight during puerperium is the lochia. The lochia originates from the uterine body, cervix and vagina. Depending upon the variation of the colour of the discharge it is named as:

- Lochia rubra (red) 1 -4 days.
- Lochia serosa (yellowish or pink or pale brownish) 5- 9 days.
- Lochia Alba (pale white) 10 -15 days.

The average amount of discharge, for the first 5-6 days is estimated to be 250 ml. With all definitions and changes it can be deduced that puerperium is the period from birth to 6 weeks of delivery.

According to Marie (2013) puerperium is the period following childbirth during which the body tissues, especially the pelvic organs revert back 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. Immediately following delivery, the uterus becomes firmer and retracted with alternating hardening and softening. At the end of 6 weeks, its measurement is almost similar to that of the non-pregnant state and it weighs 60 gram. The vaginal discharge for the first fortnight during puerperium is the lochia. The lochia originates from the uterine body, cervix and vagina. Depending upon the variation of the colour of the discharge it is named as:

Lochia rubra (red) 1 -4 days. Lochia serosa (yellowish or pink or pale brownish) 5-9 days. Lochia Alba (pale white) 10 -15 days. The average amount of discharge, for the first 5-6 days is estimated to be 250 ml

WHY CLIENT WAS CHOSEN

Madam Asare Comfort G3 P2 reported to the antenatal clinic on the 14th August, 2023 at 10:00am where she came for her 6th antenatal visit. She was 36^{+3} weeks pregnant. During the normal antenatal care routine, client complained of difficulty in passing stools. She explained that her previous pregnancy was not like that and she was indeed worried about it. It was observed that client had minimal knowledge on the minor disorders of pregnancy. Client was advised that each and every pregnancy is unique and different and it was a minor disorder of pregnancy which will resolve after delivery. The physiology of constipation was then explained to her. The midwife in-charge was informed about the intention to use Madam Comfort for the care study which permission was granted. Care study and what it entailed was explained to Madam Comfort and she readily agreed to be used and promised to give all she could to help throughout the study. She was assured of confidentiality and quality healthcare. Client gave out directions to her house and phone number to help make visits to her house easier.

CHAPTER ONE

ASSESEMENT OF CLIENT AND FAMILY

1.0 INTRODUCTION

This chapter involves the assessment of the client and her family. It also includes the systematic collection of data from the client and her family and this information was obtained through interview, Observation and antenatal records,

1.1 PERSONAL AND SOCIAL HISTORY

Madam Comfort was born on 2nd March, 1989 and is 33 years of age. She is a native of the Jinijini and reside there too. Madam Comfort is fluent in the Twi dialect. According to her, she had her formal education up to. Tertiary She is a Sonographer. Her children's father Mr. John Anane They have been living for 14 years and are blessed with two children; male and female. The first born is 13years old and the second born is four years old.

The couple, together with their children are Christians by religion and always attend the church. Madam Comfort does not have any social habits like smoking or alcoholism as well as her children's father. According to her, her children's father as well as her mother are very supportive during and after her period of pregnancies. Madam Comfort said her next of kin is her children's father who is a Biomedical Scientist by profession. Fufu and groundnut soup is her favorite meal but sometimes she also enjoys ampesi and kontomire stew. Her hobbies are cooking and singing. She intends to deliver at Palm Avenue Maternity Home.

1.2 MEDICAL HISTORY

According to Madam Comfort she has never suffered from conditions like heart diseases, hypertension, diabetes mellitus, kidney disease, sickle cell disease, and prolong cough for more than one month. She has no known allergies such to food, drugs, and other substances. She is not on any medication except her routine drugs.

1.3 FAMILY HISTORY

Client, according to her is the daughter of Mr. Asare Ameyaw and Ms. Agnes Kyeraa. Madam Comfort has two older siblings; Mr. Set Asare and Mad. Cecilia Asare. They work as a Teacher and a Trader respectfully. According to the client, there is no known history of hypertension, HIV/AIDS, asthma, heart disease, sickle cell disease, mental illness, birth defects and diabetes mellitus in her family but has a history of multiple pregnancy.

1.4 SURGICAL HISTORY

Madam Comfort said she had never undergone any surgical procedure neither had she ever been involved in any road traffic accident that had affected her pelvis or any of her reproductive organs, which may affect the diameters of the pelvis, making labour difficult. Also, she had no history of ectopic pregnancy and had never received any blood transfusion.

1.5 PAST OBSTETRIC HISTORY

Madam Comfort gravida 3 para 2A all alive carried all her pregnancies to term without any history of complications such as still birth, ectopic pregnancy. .She gave birth to her first child on 8th February, 2010 and her second child on 16th March, 2019. Intervals between her previous pregnancies are nine (9) years. According to Madam Comfort, she carried both her pregnancies

to term without any ill health like antepartum hemorrhage, pregnancy induced hypertension, anemia and pre-eclampsia. Madam Comfort said she had all her three doses of Sulphadoxine Pyrimethamine (SP) as an intermittent preventive treatment (IPT) against Malaria for each pregnancy. She said she received her doses of tetanol diphtheria immunization. Madam Comfort had spontaneous vaginal delivery for both of her babies with no assistance like caesarean section, vacuum extraction, forceps delivery or episiotomy. According to her, during her last pregnancy, her labour did not exceed 18 hours and she did not experience any complication like prolonged labour, obstructed labour or cord prolapse. Placenta were delivered completely without any retained products with moderate blood losses in both deliveries. She had an intact perineum following the delivery of her babies. She did not experience any ill health such as post-partum hemorrhage, maternal shock, amniotic fluid embolism or disseminated intravascular coagulopathy following each delivery. Both babies as well as mother were in good health after delivery and did not encounter any ill health condition after delivery. Her first baby who was a boy weighed 3.7kg and the second baby who is a girl weighed 3.4kg. She also did not have any problems during puerperium as such puerperal psychosis, puerperal sepsis or infection. Madam Comfort, according to her, practiced exclusive breastfeeding for both her children and continued for 1year 10months for both children. She gave her children normal diet immediately after weaning them. She resumed menstruation in six months after the delivery of both her children. She used the combined contraceptive pills to control her second pregnancy. According to Madam Comfort, her babies were fully immunized against the various vaccine preventable childhood diseases like tetanus, measles, diphtheria and others. Her mother was around to support her in the household chores and her husband also supported her financially.

1.6 PRESENT OBSTETRIC HISTORY

As recorded in Madam Comfort antenatal card, she first reported to Jinijini Health Centre on 9th January, 2023 when her gestational age was 9 weeks old and later came to palm avenue maternity home on 14//08/23 with the gestational age of 36^{+4}. According to Madam Comfort, her last menstrual period was on 20th November, 2022 and her expected date was calculated as 27 august, 2023 and as according to her scan. Her first fetal movement according to scan was felt at the 16th weeks. According to Madam, Comfort in all her pregnancies she craves for unnatural food substances like dust and clay. During Madam Comfort antenatal visit, past and present obstetrical history were taken. Vital signs, physical examination and monitoring revealed the following; Blood pressure 110/70mmHg, Temperature 36.2°C, Pulse 82bpm, Respiration 22cpm, Weight 88kg, Laboratory investigations results; Haemoglobin 12.4g/dl, Rhesus factor; Positive, Sickling; Negative, VRDL; Negative, Blood group B, Urine for glucose/protein; Negative, HIV screening; Negative, Blood film for Malaria parasite; No malaria parasite seen, HBsAg; Non-reactive, Glucose 6 phosphate dehydrogenase; No defect. Physical assessments were carried out and no abnormalities such as edema of the extremities, pallor and varicosities were detected. Abdominal examination was done. On inspection straie gravidarum and linear nigra were presence. From her records, she complained of lower abdominal pains and waist pains, she was encouraged to have adequate rest, sleep and also avoid strenuous work. She was served the following routine drugs.

Tablet Folic Acid - 5mg daily x 30days

Tablet multivitamin - 200mg once daily x 30days

Tablet fersolate - 200mg tds x 30days

he has received her third doses of tetanol diphtheria and also received her monthly Sulphadoxine Pyrimethamine on direct observational therapies as required.

1.7 SOCIAL HISTORY

According to Madam Comfort, she stays at Jinjini in her childrens father's house together with her two children. She said her house is very neat with toilet and bathroom facility. She also said her house is a Self contain type built with cement blocks and roofed with aluminum sheets. Madam Comfort said her family occupies two rooms with her kitchen . She said she and her family sleep under a well hanged treated mosquito net.

According to Madam Comfort she Has pipe in the house and stores water in a clean container covered. She said their source of light is from electricity and they have a good drainage system. She also said they have a well-covered dustbin in which they dispose their rubbish in and empty it into the public refuse dump every morning. Psychosocially, Madam Comfort said she has a good relationship with her husband as she is very friendly and easily makes friends. She also said she had a good relationship with her children, as well as her neighbor.

1.8 LIFESTYLE

Madam Comfort is a woman who sleeps around 9:00pm and wakes up around 5:00am. According to her, when she wakes up in the morning, she does her routine prayer with the family. After that, she brushes her teeth, sweeps her room and compound, throw her rubbish away at the dumpsite, which is two minutes' walk away from her house, washes her dishes and also start her reparation and also prepare her children for school. Client expressed that she normally prepares breakfast for the family before the children goes to school. After preparing breakfast and she takes her bath and Client said she eats three times daily, but ever since she

became pregnant she eats on demand. She also said that she prepares supper at 4:00pm . She then makes sure supper Is ready for the family to enjoy around 5:40pm. She said they all sit together and take their supper around 5:42pm. She normally baths her children and takes her bath right after supper. Thereafter she supervises the kids to do their homework. At 8:30pm, she sees to it that her children go to bed. Madam Comfort said she normally engages herself in a family chat with her family every night on phone as a means of strengthening their family bond.

CHAPTER TWO

ANTENATAL CARE

2.0 INTRODUCTION

Antenatal care is the specialized care that is given to a pregnant woman from the time that conception is confirmed until the beginning of labour in other to maintain a state of good health of the woman and to improve her chances of delivering a healthy baby at term. This chapter talks about the first contact with client, first and second home visits, her subsequent visits to the clinic, problems identified care plan drawn for the resolution of problems. Antenatal services are important to prevent and promote health care.

2.1 FIRST INTERACTION WITH CLIENT

On 14th August,2023 at 10:00am, client was met at the Palm Avenue Maternity Home, where client was a regular attendant of. Her antenatal booklet was collected and read to note the previous recording. It was realized she was 36^{+4} weeks pregnant and gravida 3 para 2 all alive. The midwife in charge was already informed about a quest to find a client who met the criteria to be used for the client and family centered maternity care study and the midwife in-charge explained and sought consent from the client to be used for the study, the client was found to have met the criteria. Madam Comfort was assisted through the routine laboratory investigations after vital signs were checked and recorded. Her hemoglobin level was 11.8g/dl and her HIV screening result was negative. Client's weight was 93 kilograms. Her vital signs and weight were checked and recorded as: Temperature 36.6°C, Pulse 84 bpm, Respiration 24 cpm, Blood pressure 120/80mmHg, Body weight 93kg, Haemoglobin 12.6g/dl.

After all these procedures, she was asked to empty her bladder and specimen bottle was given to her to collect mid-stream specimen of urine to test for urine protein and glucose. Protective clothing like apron and gloves were worn. The quantity, colour, odour, smell and sediments were noted. A chemically prepared strip was picked and dipped into the urine sample. The strip was immediately removed and the edge of the strip taped against side of the urine container to prevent spilling of urine onto the clothes. After one (1) minute, the stick was compared with the corresponding colour on the container. There was no change in color of the strip indicating a negative result when compared closely with the corresponding color chart on the container. Findings were recorded and discussed with both midwife in-charge and client. Client's permission was sought to perform physical examination from head to toe and the procedure was explained to her. Bladder was emptied, privacy was ensured and she was helped to undress, assisted to lie on the examination couch and covered with a clean cloth. Hands were washed with soap and water and dried with clean dry towel. Client was examined from head to toe, under supervision of the midwife in charge.

Physical examination

HEAD AND NECK

The head was examined first during the physical examination. Client hair was examined for cleanliness, lice dandruff, ringworms, alopecia, skin infection and any other abnormalities but none was detected. Madam Comfort was congratulated and praised for keeping her hair clean and advised to keep it up. Client's face was then inspected for edema, rashes and chloasma and nothing abnormal was detected. Her eyes were also inspected for pallor of the conjunctiva; yellowish (jaundice) of the sclera but no abnormality was detected. The ears were also inspected for discharge and alignment with the eyes and nothing abnormal was detected. The mouth was

inspected for dryness, cracks, and infection of the lips. The gum and tongue for pallor, sores or lesions and the teeth for decay but no abnormality was detected. She was encouraged to brush her teeth two times daily and rinse her mouth after each meal. The neck was palpated for enlarged thyroid gland, distended neck vein and enlarged lymph nodes and no abnormality was detected.

BREAST EXAMINATION

The procedure was explained to client and consent was sought before her breast was exposed. The breast was exposed to check for size, shape, signs of pregnancy, dimpling and nipple retraction and condition of the skin. One breast was covered and she was asked to put her hand of the part to be examined under her head. The breast was palpated systematically in a circular manner using the inner aspect of the fingers and client was taught self-examination. Nipples were squeezed gently for colostrum and were examine for odour, blood which were cleaned with a clean cotton wool swab. The same procedure was done for the other breast and no abnormality was noted. Client breastfeeding history was inquired and client verified desire to breastfeed exclusively 6 months as it done for her son. Client was reminded to examine breast at home as it was done at the facility frequently and if she sees any abnormality she should report to the health Centre.

Extremities: Madam Comfort was asked of tingling and tightness of the finger on making a fist, the hands and fingers were inspected for edema, pallor in the palm and nail bed and no abnormality was noted. The finger nails were well trimmed. The legs were inspected for size and equality and palpated for edema, tenderness in the calf muscles, size, and equally but no abnormality detected. She was encouraged to avoid prolonged standing and to perform regular exercise like walking to enhance proper circulation to prevent varicosity. Back; the back was

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

Abdominal examination

The procedure and the reason for this examination were explained to the client's understanding. The purpose for this examination is to observe the signs of pregnancy, assess fetal size and growth, auscultate for 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 to relax the abdominal muscles. Hand were washed with soap and water and dried with clean towel. Standing on her right hand side the abdomen was exposed. On general palpation of the abdomen there was no tenderness, masses, enlargement of the spleen and liver as well as supra pubic tenderness.

Inspection; during inspection of the abdomen it was observed to be ovoid in shape and medium in size. There was the presence of linear nigra and striae gravidarum. No scars were found on the abdomen which indicates signs of previous surgical procedure performed on the abdomen such as caesarean section and myomectomy. On questioning client about the presences of quickening, Madam Comfort said she felt fetal movement.

Measurement of symphysio fundal height; to measure the Symphysio fundal height the hands were warmed by rubbing palms together before the upper border of the symphysis pubic and the uterine fundus were located. The zero part of the tape measure was placed on the fundus and extended along on the contour of the abdomen along the midline to the upper border of the symphysis pubis. The tape measure was recorded in centimeters. The Symphysio fundal height was 35cm.

Fundal palpation; the procedure was explained to the client and permission was granted. The palm was warmed. The palm was faced and the palm was placed on either side of the fundus after warming them. The fingers were curved around top of the fundus to determine what lies in the fundus or upper pole of the uterus. A soft part was felt in the fundus which indicated the buttocks. The fundal height compared with gestational age. The symphysio fundal height measured 35cm and gestational age was 36^{+3} weeks which corresponded with the expected date of delivery.

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

Descent palpation; by abdominal palpation, descent was assessed in term of fifths of fetal head palpable above the symphysis pubic. The anterior shoulder was located below the umbilicus and two fingers were placed over the anterior shoulder. Symphysis pubic was located and the right ulna border was placed just above the symphysis pubis and the anterior shoulder. Five finger breath were accommodated which is 5/5.

Auscultation; the fetal stethoscope was warmed by rubbing in palm and placed on the right side of the mother's abdomen. Maternal pulse was located. The ear was placed against the stethoscope to listen to fetal heart beat for one minute comparing with maternal pulse. The rhythm and volume was recorded. The fetal heart rate was 138 beats per minute strong and regular. Madam Comfort said she felt fetal movement when she was asked.

Vulva examination: Client permission was sought for vulva inspection and she agreed. A pillow was placed under her head and covered by blanket to provide warmth. The vulva was well shaved and clean. Hands were washed with soap and water and was dried with a clean towel, clean gloves worn on both hands and the vulva and the perineum was examined for abnormal discharges, rashes, warty growth and ulcers, episiotomy scars and varicose veins. The labia majora was examined for size and shape, redness, swelling and tenderness and nothing abnormal was detected.

Madam Comfort was thanked for her cooperation and all findings were communicated to her. all equipment's used were decontaminated appropriately. The gloves were removed and also discarded. Hands were washed thoroughly with soap under running water and dried with a dried towel. Client was encouraged to have enough rest and also taught how to perform exercise in pregnancy such as pelvic rock which will help relieve backache, head and shoulder lift which strengthens abdominal muscles, Kegel exercise which strengthens pelvic floor muscles that makes delivery easier and rib cage lift which strengthen leg muscles and also it improves breathing. Client was also encouraged to her drugs as prescribed. Health was given on birth preparedness and complication readiness plan, eating of nutritious diet that is food that contains energy given food, body building food and protective food to prevent anemia. The following drugs were given to Madam Comfort

- Tab Ferrous Sulphate 60mg daily for 7 days
- Tab Multivitamin 200mg daily for 7 days
- Tab Folic acid 5mg daily for 7 days

- She gave directions to her house and phone numbers were exchanged. Having agreed to be used for the study, arrangement was made to visit her house on 15th August, 2023. She was thanked and saw her off to the exit of the clinic.

2.2 FIRST HOME VISIT TO CLIENT

The first visit to Madam Comfort's house was on 15th august 2023 at 4:00pm. The main aim of the visit was to know where she lived and meet other members of her family and also talk about birth preparedness and complication readiness plan. On the way to her house, it was observed that the road leading to her house was tarred, in good shape and easily accessible by vehicles. it was not too difficult locating the client's house by using the directions given, just behind the Presby cluster of schools. On arrival at madam Comfort's house, it was observed that all members of the family were home . There was establishment of rapport which interaction with her started. Madam Comfort lived with her husband and two children in a well roofed, cream painted block house. The house had enough windows for adequate ventilation. She was educated to open the windows everyday so as to ensure that there was enough fresh air circulating in the room to help prevent the spread of diseases. Their source of water was a stand pipe. Madam Comfort had a big barrel with a well-fitting lid in which she stores her water and use when there is a water shortage. She was educated to have her barrel cleaned regularly with soap and water to prevent the barrel from harboring germs that may contaminate the water stored in it and in turn cause diseases. Her compound was clean and there was a well-covered dustbin at the corner of her house where she disposed her rubbish. Client stated it was emptied daily at a nearby refuse dump. They had a very good drainage system. Madam Comfort and her family were sleeping in a well hanged treated mosquito net. She was commended on the cleanliness of her environment

and was encouraged to always keep her surroundings clean to prevent diseases and breeding mosquitoes. Her partner was encouraged to ensure Madam Comfort keeps physically active during pregnancy so as to help her stay healthy and prevent excessive weight gain and also the exercise should not be strenuous and she should take breaks between activities so as to avoid unnecessary stress. Her family was encouraged to help her in household chores so she could have enough rest. Items for delivery were brought for inspection and it was complete. She was congratulated for purchasing all the items and was encouraged to add her National Health Insurance card and some money along not forgetting her antenatal booklet. Enquiries about her previous complains of constipation and she said she had regained her normal bowel movement and She again complained of mild backache. It was explained to her that it was a physiological disorder during pregnancy and that, it was due to the effects of estrogen and relaxin hormones which relax the sacroiliac ligaments and the exaggeration of the lumber curve by the weight of the gravid uterus. She was then encouraged to have enough rest, practice good posture and wear low heeled shoes to help relieve the backache and to take her drugs as prescribed. She and her family were thanked for their cooperation and left with the promise of visiting her again. She was also reminded of her next visit to the hospital which was on 15th august, 2023.

2.3 SECOND HOME VISIT

The second home visit to Madam Comfort was on 17th august 2023 around 3:30pm. Greetings were exchanged. Her husband was around and her mum and her children were present. The compound was observed and it was clean. She was congratulated on that and told her to keep it up. Enquiries about the rest of the things for confinement was made and it was realized that they were completed and neatly packed. Reinforcement on the education given previously on eating a

healthy diet, exercise, enough rest and sleep was done. She was also educated on deep breathing exercises which she will be using during labour. She was reminded on the signs of true labour, birth preparedness and complication readiness. She was asked if she had any complains and she mentioned she had been having frequent urination and fatigue as well. The physiology was explained to her that it was as a result of pressure of the enlarging uterus on the urinary bladder reducing the capacity of the bladder and thus making her urinate frequently and it was as a result of the stress of pregnancy that made her feel tired(fatigue). She was educated to have enough rest and sleep. Permission was sought to leave. She was thanked for her co-operation.

2.4 SUBSEQUENT VISIT TO THE CLINIC

Madam Comfort reported to the clinic on 19thaugust, 2023. She was warmly welcomed and asked of her health and that of the family members which she responded they were in good health. She was taken through the routine examination and made the following observations which was recorded as; Temperature 36.3°C, Pulse 84bpm, Respiration 24cpm, Blood pressure 120/80mmHg, Body weight 92kg, Urine for sugar and protein; negative.

Madam Comfort was asked to empty her bladder. She was instructed to collect the midstream urine which she did. The urine sample was tested for protein and glucose which both came out as negative. Privacy was provided for her and she was assisted to undress and lie dorsal on the couch. Hand hygiene was performed and under the supervision of the midwife in-charge, she was examined and no abnormalities were detected**.**

During the inspection of the mouth, she was asked if she had consumed any non-nutritious substance and she said no. She was congratulated for complying with the education that was

given to her. An examination was done on her abdomen. On fundal palpation, the symphysio fundal height was 36cm with gestational age of 37^{+3} weeks. Position was right occipito anterior, the lie was longitudinal on lateral palpation and presentation was cephalic. The descent was 5/5th above the pelvic brim on pelvic palpation. On auscultation, fetal heart rate was 138bpm with regular and a good volume. She was helped to get off the couch to dress up. All findings were communicated to her and was recorded in the antenatal record book. About her previous complains on back pains, she said she is coping with the pains. She was able to summarize the education given on backache during the last visit. She was encouraged to take her routine drugs and was also educated to report to the clinic if there is any problem. She was thanked and reminded of my next visit that is on the 19th august,2023 and was accompanied to the road side and bid farewell.

2.5 NURSING CARE PLAN DURING ANTENATAL

Nursing care plan is a guide to nursing care rendered to a client as an individual with specific needs that ought to be addressed. It involves identifying problems, analyzing them, setting objectives and implementing interventions that will meet the objectives. Evaluation is part of the process and it is carried out to ascertain whether the goals or objectives set have been achieved.

PROBLEMS IDENTIFIED DURING ANTENATAL CLINIC

1.Constipation

2. Backache

3. Fatigue

4. Frequent urination

SHORT TERM OBJECTIV

1. Client will be able pass stools at least once every 24 hours.

2. Client will cope with backache within 48 hours and throughout pregnancy.

3. Client's fatigue will be reduced within 48 hours and coped throughout pregnancy.

4. Client will cope with frequent urination within 24 hours and throughout pregnancy.

LONG TERM OBJECTIVES

Client will go through pregnancy, labour and puerperium successfully without any complication to the mother

TABLE 2: NURSING CARE PLAN DURING ANTENATAL

DATE / TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES	NURSING ORDERS	NURSING INTERVENTIONS	DATE / TIME	EVALUATION	SIGN
14/8/2023 10:00am	Constipation related to slow intestinal peristaltic movement.	Client will be able to pass stools once every 24 hours as evidenced by client verbalizing she has regained her normal bowel movement .2 midwife noticing that client no longer complains of constipation	1.Explain the physiology of constipation to client. 2.Encourage client to take in adequate fluid. 3. Encourage client to take in appropriate food. 4. Encourage client to engage in exercise.	1. constipation in late pregnancy was explained to client that is as a result hormonal changes. 2.Client was encouraged to take in 8 sachet of water every day. 3.Client was encouraged to take in fruits and vegetables rich in fiber and roughages a. 4.Client was encouraged to engage exercises such as walking.	14/8/2023 10:00am	Goal fully met as client verbalized that she is now able to pass stools once every 24 hours. Midwife noticing client no longer complains of constipation	PJ

TABLE 3: NURSING CARE PLAN DURING ANTENATAL

DATE / TIME	N URSING DIAGNOSIS	NURSING OBJECTIVE	NURSING ORDERS	NURSING INTERVENTIONS	DATE / TIME	EVALUATION	SIGN
15/8/2023 4:00pm	Backache related to relaxation of the pelvic ligaments by the hormone relaxin.	Client will cope with backache within 48hours and throughout pregnancy as evidenced by client verbalizing that she is coping with the back ache	1.Reassure client. 2.Teach client good body mechanisms. 3.Explain the physiology of the backache to client. 4. Give client sacral massage. 5. Serve prescribed analgesics.	1.Client was reassured that she will be relieved after child birth. 2.Client was taught good body mechanisms like proper positioning in her daily activities. 3 backache was explained to client that it was as a results of hormonal changes. 4.Sacral massage was given to client to relieve pain 5. Prescribed analgesics was served(paracetamol)	17/8/2023 4:00pm	Goal fully met as evidenced by client verbalized that she has been relieved of backache 2 midwife noticing client no longer complains	PJ

TABLE 4: NURSING CARE PLAN DURING ANTENATAL

DATE / TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES	NURSING ORDERS	NURSING INTERVENTION	DATE / TIME	EVALUATION	SIGN
17/8/23 3:30pm	Frequent urination related to descending fetal head pressing on the bladder .	Client will cope with frequent urination within 24hours and throughout pregnancy as evidenced by client verbalizing that she is coping 2 midwife visualizing that client is coping	1. Reassure client. 2.Explain the physiology of frequency of micturition to client. 3.client was educated on her intake of fluid. 4.Encourage client to place a pail 5.Educate client on personal hygiene.	1. Client was reassured of normal micturition after child birth. 2. It was explained to client that the pressure of the fetal presenting parts to the tissues was the cause of her frequency in micturition. 3.Client was encouraged to reduce fluid intake when she is about to go to bed. 4. client was encouraged to put pail close to her at client's reach. 5.Client was counseled to clean her perineum from front to back.	17/8/23 3:30pm	Goal fully met as evidenced by client verbalizing that she is coping 2 midwife visualized client is coping	PJ

TABLE 5: NURSING CARE PLAN DURING ANTENATAL

TIME/ DATE	NURSING DIAGNOSIS	NURSING OBJECTIVES	NURSING ORDERS	NURSING INTERVENTIONS	DATE / TIME	EVALUATION	SIGN
17/8/2023 3:30pm	Fatigue related to stress from pregnancy.	Client's fatigue will be reduced within 48hours and coped with throughout pregnancy as evidenced by client verbalizing that she is relieved of fatigue 2 midwife visualizing client is relieved	1. Reassure client. 2. Encourage relatives to assist 3. Educate client to rest. 4. Encourage client to reduce household activities. 5. Teach client good body mechanisms.	1. Client was reassured that pain will subside. 2. Client's partner was encouraged to assist his wife in household chores. 3. Client was encouraged to rest and sleep for 2hours in between activities 4. Client was encouraged to allocate some of her household activities to others 5. Client was taught how to left thing and how to assume good posture in all her activities.	19/8/2023 3:30pm	Goal fully met as evidenced by client verbalized that she has been relieved from fatigue 2 midwife visualizing client is relieved	PJ

CHAPTER THREE

MANAGEMENT OF LABOUR

3.0 INTRODUCTION

This chapter talks about labour and involves management of the first stage of labour, management of second stage of labour, immediate care of the baby at birth, management of third stage of labour, examination of the placenta and membranes and management of fourth stage of labour.

3.1 ADMISSION AND MANAGEMENT OF FIRST STAGE OF LABOUR

Madam comfort reported to the clinc on 28thAugust, 2023at 9:10pm. Madam Comfort was accompanied by her husband together with her sister and complained of severe waist pains, vomiting, lower abdominal pain and painful rhythmic uterine contraction. They were warmly welcomed, offered a seat. Her antenatal card was collected and quickly glanced through. Her labour history was taken and according to Madam Comfort she started seeing signs of labour such as show and painful uterine contractions around 6:00pm. She was inquired about any intake of drugs at home before coming to the clinic and she said no. She also said she didn't take any food before coming. She was asked if she felt the fetal movement and she said yes. She was also asked if her membranes had ruptured and she said no. She was then admitted into the admission and discharge book and recorded all history and findings as well as documentation of her details in the ward state. Madam Comfort's delivery items were checked and labeled. She appeared anxious and looked tired. She was reassured that she was in safe hands and that she will be taken care of by competent and hardworking staff. She was asked to empty her bladder and the amount

of urine passed was 150mls. Her urine was then collected and tested for protein and glucose which both came out as negative. She was provided privacy at her bed side and was assisted to change into an examination gown and assisted to lie in a left lateral position and her vital signs was checked and recorded as follows;

Temperature 36.3ºC,

Pulse 80bpm,

Respiration 20cpm,

Blood pressure 125/70mmHg

A tray for head to toe examination and another for vaginal examination were set. The procedure was then explained to her which she had knowledge about because she had been previously educated on. Hand hygiene was performed. The hands were warmed and placed on her fundus to time her contractions for 10minutes. Her contractions were 3 in 10 lasting for 25,27 and 30 seconds respectively. On auscultation with the fetoscope, the fetal heart rate was 140bpm with good volume and regular rhythm. She was examined from head to toe and there were no abnormalities. She was informed that she had to be examined on her abdomen using inspection and palpation. She was assisted to lie in a dorsal position for the abdominal examination. On inspection, the abdomen was globular in shape with no scars and the size corresponded to the gestational age which was 38^{+3}weeks. Straie gravidarum and linear nigra were present. Fetal movement was also present. Symphysio- fundal height was 37cm. Fundal palpation was done with the fetal buttock occupying it. On lateral palpation, fetal back was at the right side indicating left occipito anterior position. With her legs bent slightly, she was asked to breathe through the mouth. Pelvic palpation was done on her which revealed the presentation to be cephalic and descent was 3/5th palpable abdominally. Permission from Madam comfort to

perform vaginal examination was sought and she agreed. Still in the dorsal position, she was instructed to flex her knees. Hand hygiene was done and sterile gloves were put on. On inspection, the vulva was clean and the mons veneris was shaved. There was no scar from previous birth, edema, vulva warts or varicose veins. The perineum was intact. The vulva with sterile cotton wool swabs soaked in savlon solution. The middle and index finger were into her vagina. The vagina was warm, moist and its walls were easily distensible. The cervix was soft, elastic and effaced. The cervix was situated at the posterior fornix of the vagina. The presenting part was well applied to the cervix. The cervical dilatation was 4cm with the membranes intact at 9:25pm, no molding felt. Ischial spines were blunt and pubic arch was wide, sacral promontory was not reached at 11cm. There was a blood stained mucoid (Show) on the examining fingers. The midwife in-charge confirmed the findings that Madam Comfort was in true labor. The vulva was then cleaned and she was asked to apply a new clean pad. She was then made comfortable in bed and assisted to lie at the left lateral position to prevent supine hypotension syndrome. The findings were communicated to her and recorded on the partograph and in the nurse's notes. She was thanked her for cooperation and informed that monitoring of her contractions would be done, fetal heart rate and maternal pulse would be checked every 30minutes. It was added that, her cervical dilatation, descent, blood pressure and temperature will also be checked every 4 hours. It was also made known to her that her urine will be checked anytime it was passed out. She was encouraged to empty her bladder frequently to facilitate the descent of the fetal head and improve uterine contractions. She was also encouraged to change her perineal pad whenever it was soiled to prevent infection, to walk around to aid in descent and also told to lie on her left side to allow increased blood supply to the placenta site. She was encouraged to walk around to help alleviate the pain and help labor progress.

Client was thanked for her cooperation and was reassured of competent care. Findings were documented as at 9:53pm uterine contraction 3:10 lasting 25,28 and 30 seconds respectively, fetal heart rate 142bpm, maternal pulse 90bpm. Client was encouraged to assume any position favorable but not harmful to her. She was encouraged to possibly assume a left lateral position to increase placental perfusion and prevent supine hypotension. She was encouraged to ambulate to aid in the descent of the fetal head. A bed pan was provided for her and was encouraged to urinate when she feels the urge to further aid in descent of the fetal head. Client was encouraged to take in water or any sweetened fluid to prevent dehydration. Madam Comfort was reminded of the deep breathing exercises so as to conserve energy for the second stage. Sacral region was massaged during contractions to relieve her from pain and was continuously and closely monitored on the partograph throughout the first stage of labour, maternal and fetal conditions were recorded and labour progressed well. Client was monitored on the partograph as follows; fetal heart rate, uterine contractions and maternal pulse were checked every thirty (30) minutes. The cervical dilation, descent, membranes, molding, blood pressure and temperature were checked every four (4) hours. Urine test for protein and acetone was done every four (4) hours. Client was reassured again of competent care to be rendered and all procedures were explained before their performance. All findings were communicated to her. At 10:24pm, uterine contraction was recorded as 3:10 lasting 30,32 and 33 seconds respectively, fetal heart rate 145bpm, maternal pulse 88bpm. At 10:54pm, uterine contraction was 3:10 lasting 30, 35 and 38 seconds respectively. Fetal heart rate 144, maternal pulse 88bpm.. Madam Comfort complained of lower abdominal pains, she was reassured and the physiology of the abdominal pains was explained to her. She was asked to take deep breathing exercise with each contraction and rest in between. At 11:26pm, uterine contraction was 3:10 lasting 33, 35 and 38 seconds respectively,

fetal heart rate 145bpm, maternal pulse 86bpm. At 11:56pm, uterine contraction was 3:10 lasting 32, 35 and 39 seconds respectively, fetal heart rate 140bpm, maternal pulse 86bpm. At 12:24am, uterine contraction was 3:10 lasting 40, 45 and 48 seconds respectively, fetal heart rate 142bpm, maternal pulse 84bpm. Client complained of hunger and she was given milo beverage which she took about 200mls.And she vomit about 100mls At 12:54am uterine contraction was 3:10 lasting 42, 46 and 48 seconds, fetal heart rate 149bpm, maternal pulse 86bpm. At 1:24am uterine contraction was 4:10 lasting 45, 47 ,48 and 52 seconds, fetal heart rate 145bpm, maternal pulse 86bpm. At 1:25am, vaginal examination was due. The procedure was explained to client and permission was sought from her which was granted. Vaginal examination was done on her under aseptic technique and the cervical dilation was 8cm with descent of $1/5^{th}$ with membranes intact.

PREPARATION FOR BIRTH

In preparing for birth, helpers were identified including the skilled and unskilled personnel. The midwife in-charge was identified as the skilled personnel and the client's mother was identified as the unskilled personnel. The doctor on call was notified about the client's admission. Client's brother had donated blood at the blood bank when an enquiry was made. Emergency boxes (like PPH and Eclampsia) with their appropriate items were available. The delivery room had been already cleaned. Client was encouraged to wash hands and she was informed that the windows will be shut and fans will also be put off to provide a warm environment for the baby when it is time for delivery of which she agreed. Room was well lighted and ventilated. Madam Comfort was also educated that the baby would be delivered onto her abdomen on a sterile towel and she will have to support the baby. She was also informed that her abdomen will be cleaned for skin-to-skin care with the baby. The resuscitation box had all the items needed such as a stethoscope,

scissors, cord clamp, sucker, self -inflating bag and mask of different sizes. The self-inflating bag was tested to see whether it was functioning, also the radiant bulb was switched on to provide warmth to the cot. Other items like cot sheets were also made available. Referral centers and their numbers as well as ambulance and its driver were all checked to be available. Delivery items were also made available. There was + molding. Client passed 200mls of urine which was tested for protein and glucose. Both were negative. Vital signs were checked and recorded as

blood pressure 120/70mmHg,

temperature 36.2ºC, maternal.

At 1:54am uterine contraction was 4:10 lasting 45, 47.50 and 55 seconds, fetal heart rate 139bpm, maternal pulse 86bpm. Client was sweating profusely during the peak of contractions. Her face was wiped with a damp towel and she was also given about 200mls of water to drink which she vomited about 100mls. At

2:00am, uterine contraction was 4:10 lasting 49,50, 55 and 58 seconds, fetal heart rate 145bpm, maternal pulse 84bpm. At 2:25am, madam Comfort complained of feeling the urge to bear down as well as passing faeces. She was informed that it was almost time for the baby to be born. She was encouraged to continue with the breathing exercises and not to push until she was told to do so. Vaginal examination was repeated and cervical dilatation was 10cm which indicated full dilatation. Membranes ruptured spontaneously with clear liquor and ++ molding. The client was encouraged to breathe through her mouth. The perineum was quickly examined, the vulva and anus were gaping, perineum was bulging and a trickle of blood was evident. Progress of labour was communicated to the midwife in-charge which she confirmed client was ready to be deliverer All findings were plotted on the partograph and explained to client. Madam Comfort

was transferred to the second stage room and helped onto the couch. She was reassured of competent working staff.

The trolley

A trolley set containing the following instruments and items on top and bottom shelf was brought to the bedside;

Top shelf

- 2 sterile artery forceps
- Sterile cord scissors
- 4 Sterile drapes
- Sterile gallipot with cotton wool swabs
- Sterile episiotomy set (artery forceps, dissecting forceps, episiotomy scissors, suturing forceps)
- Cord clamp (removed from cover)

Bottom shelf

- Perineal pad
- Cot sheets
- Cheatle forceps in its container
- Drum containing sterile gauze
- Bulb syringe in a bowl of water
- Identification band
- Measuring jug
- Receiver

- Antiseptic solution
- Examination gloves
- Bottle containing antiseptic solution
- Mackintosh
- Injection tray containing oxytocin, vitamin k, syringe and needle
- Lidocaine
- Fetoscope
- Bedpan
- Catheter and urine bag

3.2 MANAGEMENT OF SECOND STAGE OF LABOUR

Madam Comfort was sent to the second stage room at 2:35am and was helped to get onto the delivery bed and positioned in a dorsal position. A sterile delivery trolley was sent to her bedside. Her knees were flexed with thighs wide apart and feet on the stirrups as she lay on the delivery bed. All procedures were explained to Madam Comfort and she was reassured. Her abdomen was covered with a sterile cot sheet. Protective clothing was worn (mackintosh apron, safety boots, goggles, and nose mask). Hand washing was done and two pairs of sterile gloves were put on. Madam Comfort's vulva was swabbed with sterile swabs soaked in savlon solution. A clean pad was applied to her anal region to prevent fecal contamination of the delivery area. She was then told that her baby will be delivered onto her abdomen and reassured her again to help allay her anxiety. Madam Comfort was encouraged to push with each contraction and rest between contractions to prevent exhaustion. The fetal heart rate and maternal pulse were checked in-between contractions. This was to detect any deviation from normal and

give early treatment but all were normal. The fetal head advanced gradually with each contraction. The fingers of the right hand were placed on the advancing head to maintain flexion in order to allow the diameter of the fetal skull to distend the perineum and vulva while supporting the perineum with a pad in the left hand. Descent of the head continued till the head crowned. After crowning, Madam Comfort was told not to push but pant to prevent rapid expulsion of the head which can result in the perineum to tear. The head was delivered by extension as the sinciput, face and chin swept the perineum. Cord around the neck was checked but there was none. The eyes were cleaned with sterile swabs from the inner canthus to outer canthus. There was restitution of the head, internal rotation of the shoulders and external rotation of the head. Hands was placed on both lateral aspects of the head and Madam Comfort was asked to push gently with the next contraction while a gentle downward traction was applied and the anterior shoulder was delivered. The posterior shoulder was also delivered right after the anterior shoulder. The rest of the body was delivered by lateral flexion onto Madam Comfort's abdomen at 2:45am. The baby delivered was a live female infant and she cried soon after birth with an Apgar score in the first minutes of 8/10,and fifth minute 9/10. Client was congratulated on the safe birth of her new born and thanked her for her cooperation and effort throughout the delivery.

IMMEDIATE CARE OF THE BABY

Immediately the baby was born, she was with warm cord sheet. There was no suctioning of the mouth and nose since the baby had a good breath and cried as soon as she was delivered. This indicated patency of airway. A cap was placed on her head and socks on her feet to prevent hypothermia. The baby was placed skin to skin on her mother's abdomen to promote bonding

and provide warmth. The baby was then covered with a warm clean sheet. After three minutes of birth, the first gloves which was by then soiled was removed in order to use the second gloves. The cord was clamped with cord clamp about 3cm away from the abdomen of the baby and the artery forceps was clamped 2cm away from the first clamp. The cord was covered with gauze to prevent splashing of blood and was cut to separate the baby from the mother. The baby was showed to the mother to identify the sex which she confirmed to be a female. Client was assisted to initiate breastfeeding. This was to also aid in the delivery of the placenta. An identification band bearing mother's name, sex of baby, date and time of delivery was placed on the wrist of the newborn. The APGAR score assessed in the first and fifth minute read as follows;

Time	**Colour**	**Breath**	**Heart**	**Tone**	**Reflex**	**TOTAL**
1 minute	2	2	2	1	1	8
5 minute	2	2	2	2	1	9

3.3 MANAGEMENT OF THIRD STAGE OF LABOUR

The third stage of labour starts after delivery of the baby and ends with complete expulsion of the placenta and its membranes and control of bleeding was actively managed. The cut end of the cord was placed in a sterile receiver near the perineum to collect placenta, membranes and blood loss. Her abdomen was palpated for an undiagnosed twin but there was none. Client was then given injection oxytocin 10 units intra-muscularly on her thigh within one minute to help in the active management of 3rd stage. Uterine contraction was felt for and was well contracted. The left hand was placed above the level of symphysis pubis with the palm facing the umbilicus,

pressure was exerted on the upward direction whilst the clamped end of the cord was held with the right hand. Using controlled cord traction, the cord was pulled on gently until the placenta was visible at the vulva. It was cupped with both hands to ease pressure on the friable membranes. The placenta and membranes were pulled gently until they were completely expelled at 2:50am into a kidney dish for further examination. The uterus was massaged immediately after the delivery of the placenta to aid uterine contraction, arresting hemorrhage as well as expelling clots. Consent was sought from client that her cervix, vagina, perineum and vulva would be examined. A good light source was directed to the perineum. Two sterile gauze were wrapped on the index finger for inspection using clockwise method. The vagina and cervix were inspected thoroughly to determine laceration but there was none. Afterwards, the lateral sides were also examined and they were intact. The vulva, perineum and upper thigh were cleaned and a clean perineal pad was applied. Client was wiped off blood and a clean perinea pad was applied to make her comfortable. She was congratulated and her baby was shown to her and she confirmed the sex of the baby. Blood loss estimated was approximately 150millilitres. Instruments used was decontaminated in 0.5% chlorine solution for ten minutes after which the instruments were washed and sterilized. She was encouraged to urinate frequently whenever she had she urge to, so that the uterus can be well contracted and involutedly to prevent post- partum hemorrhage.

EXAMINATION OF THE PLACENTA AND MEMBRANES

A thorough inspection of the placenta and membranes is done in order to ensure that no part of it being retained during delivery. The placenta was immersed in 0.5% chlorine solution and it was examined. The placenta was held by the cord with the membranes hanging and the membranes

were examined for completeness and it was intact. The placenta was then laid on a flat surface for further examination. The amnion was peeled from the chorion up to the umbilical cord and was fully viewed, the lobes fitted together without any gab and edges also forming uniform circle at the maternal surface and this indicated there was no missing lobe, there were no white patches on the maternal surface, there was also no blood vessels radiating into the membranes which indicated absence of succenturiate lobe. The cord was situated at the center of the placenta with one vein and two arteries which were seen in the cord. There was no abnormality detected. The placenta was discarded after decontaminating it according to the protocol of the facility. The instruments and equipment's used were soaked in 0.5% chlorine solution for ten minutes and washed, rinsed, dried and repacked for sterilization. Hands were dipped in chlorine solution before discarding the gloves Hand hygiene was performed and documentation was done as well.

3.4 MANAGEMENT OF FOURTH STAGE OF LABOUR

The fourth stage of labour is a period of close monitoring and observations of mother and baby for the next six hours following the delivery of the placenta, membranes and subsequent arrest of hemorrhage. Client and her baby were transferred to the lying in ward after putting the baby skin to skin for an hour. Monitoring of Madam Comfort and the baby continued strictly for the first 6 hours after expulsion of the placenta and membranes and arresting of hemorrhage. Vital signs were checked every 15minutes for 2hours, 30 minutes for 1hour and one hourly for the remaining three hours and recorded. Post- delivery vital signs were checked and recorded as follows;

Mother**;**

Temperature	36.4 degree Celsius,
Blood pressure	110/70mmhg,
Respiratory	22cpm,
Pulse	82bpm

Baby**;**

Temperature	36.3degree Celsius,
Respiratory	40cpm,
Heart rate	132bpm.

Madam Comfort was asked to empty her bladder frequently in order to help contractions of the uterus. She was educated on how breastfeeding enhances the release of oxytocin which would improve uterine contractions, drainage of lochia, control of hemorrhage and also as a form of family planning. The uterus was well contracted with the Symphysio fundal height 1cm. Her perineal pad was inspected for amount and colour of lochia. On inspection, the lochia was bright red, moderate blood loss and not offensive. Client was encouraged to change her pad frequently when it's soaked and to wash her hands before handling the baby. She was given porridge with bread after which she continued breast feeding. Baby was put to breast and the mother was reminded again on the importance of exclusive breastfeeding and to also breastfeed on demand.

EXAMINATION OF THE NEW BORN

The procedure was explained vividly to the client, examination gloves were worn and the baby was examined head to toe to detect any deviation from normal. Baby was put on a flat surface,

Baby was exposed and the general condition, respiration and skin colour was noted and covered again to be examined from head to toe.

On examination of the head, the sutures and fontanelles were examined with no abnormality detected. There was no laceration on the scalp and no caput succedaneum as well. The head circumference was measured and it was 33 cm. The pinna of the ears was well formed and there were no discharges from the ear. The eyes were in alignment with the ears. There was no pallor of the conjunctiva or jaundice on the sclera. The nose was well formed with septum dividing it. Nose was patent with no discharges. The mouth was examined for the presence of false teeth, cleft palate and tongue tie but there was none. Rooting, suckling and swallowing reflexes were present. There was no enlargement of lymph nodes, rigidity, congenital goiter and swelling of the neck.

On breast examination, there was no engorgement of the breast. The nipple was at the center of the areolar. There was no distention of the abdomen, enlarged spleen or liver as well as bleeding of the cord. There were three blood vessels that run through the cord which indicated two arterial cord vessels and a cord vein. The spine was examined with the baby lying in prone position. The back was palpated for swellings, spinal bifida or a missing vertebra, meningomyelocele but there was none. The skin was examined for skin colour, vernix caseosa, and lanugo, peeling of the skin, rashes and birth mark. There were no abnormalities with some amount of vernix caseosa. The upper extremities were equal with no extra digits. There were palmer creases and no webbed fingers. Grasping and Moro reflexes were present.

The lower extremities were also equal without an extra digit. Both legs were examined with no talipes and congenital dislocation of the hip. Knee flexes were normal. On inspection of the genitalia, there were no abnormalities noticed. Baby passed meconium and urinated soon after

birth indicating the patency of the anus and urethra. Baby' vital signs was checked and recorded as,

Baby

Temperature	36.3
Apex beat	132bpm
Weight	3.2kg

PREVENTION OF DISEASES

Baby comfort was given vitamin K1 to prevent bleeding. Gentamycin eye drop was applied on the eyes to prevent infections. The cord was also dressed with chlohexidine gel. Again, two drops of polio 'O' was given by mouth and injection BCG 0.05ml was administered intradermal to prevent polio and tuberculosis. Client was also educated not to apply anything on the injection site. In all no abnormality was detected. Gloves were removed and disposed of according infection prevention protocol proper hand washing was performed and dried with a clean towel. Baby was given to his mother. All findings were communicated to the mother and recorded. Madam. Comfort was thanked. She was also told that the baby may have swelling at the site of injection which would subside. Baby was wrapped in clean dry sheet and put to breast.

SUMMARY OF LABOUR

Date of delivery	29th August, 2023
Time of delivery	2:45am
Mode of delivery	Spontaneous vaginal delivery
Time placenta and membranes delivered	2:50am

DURATION OF OBSERVABLE LABOUR

1st stage	9:30pm – 2:35am – 5 hours 05 minutes
2nd stage	2:35am – 2:45am – 10 minutes
3rd stage	2:45am – 2:50am – 5 minutes
Total	5hours 20minutes

GENERAL CONDITION OF THE MOTHER

Blood pressure	-	110/70mmHg
Temperature	-	36.4ºC
Pulse	-	82bpm
Respiration	-	22cpm
Fundal height	-	20cm
Condition of perineum	-	Intact
Blood loss	-	Approximately 200mls
Condition of mother		Good

GENERAL CONDITION OF THE BABY

Sex	Female
Weight	3.2kg
Head circumference	33cm
Length	50cm
Condition of the baby	Good

Apgar score 1st and 5th minutes	8/10,9/10
Abnormalities	No abnormality detected

3.5 NURSING CARE PLAN DURING LABOUR

PROBLEMS IDENTIFIED

1. Waist pain.
2. Lower abdominal pain.
3 Anxiety
4. Vomiting

SHORT TERM OBJECTIVES

1. Client will cope with waist pains within 5 hours and throughout labour.
2. Client will cope with lower abdominal within 2 hours throughout labour.
3. Client will be relieved of vomiting within 3 hours.
4. Client will be allayed of anxiety an hour after delivery.

LONG TERM OBJECTIVES

Client will go through labour and puerperium successfully without any complication to the mother and baby

TABLE 2: NURSING CARE PLAN DURING LABOUR

DATE / TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES	NURSING ORDERS	NURSING INTERVENTIONS	DATE / TIME	EVALUATION	SIGN
28/08/23 9:10pm	Waist pain related to descent of fetal head.	Client will cope with the waist pain within 5hours and throughout labour as evidenced by 1 client verbalizing that waist pain have subside 2 midwife visualizing client cooperating during labour	1.Reassure client. 2.Explain the physiology of waist pain to client. 3.client was educated to adopt a comfortable position 4.Perform sacral massage. 5.Encourage deep breathing exercise.	1.Client was reassured pain will reduce after delivery. 2.Client was educated that the waist pain was as a results of changes in hormones 3.Client was helped to adopt a comfortable position such as side lying. 4.Sacral massage was performed to reduce pain. 5.Client was encouraged to do deep breathing exercise with each contraction and rest in between.	29/08/2023 1:00am	Goal fully met as evidenced by midwife observed client cooperated during labour .client verbaling that she can now cope with the pain	PJ

TABLE 2: NURSING CARE PLAN DURING LABOUR

DATE / TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTIONS	DATE / TIME	EVALUATION	SIGN
28/08/23 9:30pm	Lower abdominal pain related to regular, painful rhythmic uterine contractions.	Client will cope with lower abdominal pains within 2 hours as evidenced by 1 client verbalizing that pain have subside .2 midwife visualizing client cooperating during labour	1. Reassure client 2. Explain the physiology of lower abdominal pain. 3. Perform sacral massage. 4. Encourage client to adopt a comfortable position. 5. Encourage client to do deep breathing exercise.	1. Client was reassured that pain will subside after delivery 2. It was explained to client that the pressure of the fetal presenting parts to the tissues was the cause of the lower abdominal pain. 3. Sacral massage was performed for client to relieve pain. 4. Client was encouraged to adopt a comfortable but harmless position. 5. Client was encouraged to do deep breathing exercise with each contraction and rest in between.	29/08/23 11:00am	Goal fully met as evidenced by client verbaling that she can now cope with the labour pain	PJ

TABLE 3: NURSING CARE PLAN DURING LABOUR

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTIONS	DATE / TIME	EVALUATION	SIGN
28/08/23 10:00pm	Vomiting related to hormonal changes.	Client will be relieved of vomiting within 3 hours as evidenced by: 1. client verbalizing that she no longer vomiting. 2. Midwife witnessing that client has stopped vomiting.	1. Reassure client. 2. Explain the physiology associated with vomiting. 3. Remove nauseating items 4. Provide mouth care after each vomiting. 5. Encourage client to take appropriate meals.	1. Client was reassured. 2. Client was educated that it was due to regurgitation of gastric content due to relaxation of the cardiac sphincter. 3. All nauseating items were moved away from client. 4 .Mouth care was given to client by brushing and rinsing her mouth with water after each vomiting. 5. Client was encouraged on the need to reduce the intake of oily and spicy food.	29/08/23 1:00am	Goal fully met as client verbalized that vomiting has stopped.	PJ

TABLE 5: NURSING CARE PLAN DURING LABOUR

DATE / TIME	NURSING DIAGNOSIS	NURSING OBJECTIVE	NURSING ORDERS	NURSING INTERVENTIONS	DATE / TIME	EVALUATION	SIGN
28/08/23 9:30pm	Anxiety related to unknown outcome of labour.	Client will be allayed of anxiety within an hour after delivery as evidenced by client verbaling she is no more anxious 2 midwife observing that client is no longer anxious	1. Reassure client. 2. Explain every procedure to be carried to client. 3. Allow her to ask questions 4. Update client with progress of labour. 5. Allow support person to be with her	1. Client was reassured that labour will end safely. 2. Procedures like checking of vital signs, vaginal examination was explained to client. 3. Client was allowed to ask questions and answers were given tactfully. 4. Client was updated about progress of labour using the dilatation board after V/E. 5. Client's husband was allowed to be with her and massage her sacral region during contractions.	28/08/23 10:30am	Goal fully met as evidenced by client verbalizing that she can now coped with the pain 2 midwife noticing that client no longer complains.	PJ

CHAPTER FOUR

PUERPERIUM

4.0 INTRODUCTION

This chapter describes care of the mother during puerperium thus from the period of delivery to discharge, the management of both mother and baby from day one to sixth week postnatal. Care plans drawn for the management of problems encountered during puerperium. During this period, the reproductive organs return to their non-pregnant stage and lactation initiated. Also health education, counseling, assessment, support for infant feeding and immunization service for baby was done.

4.1 DAY OF DELIVERY

EXAMINATION AND SUBSEQUENT CARE OF THE MOTHER

Madam Comfort was informed of the procedure to be carried on her. Privacy was provided for her and she was asked to empty her bladder. Hand washing was performed. On observation, she looked healthy and there was no sign of postpartum blues. She was helped to lie in a dorsal position afterwards. Her hair was well kept. Upon inspection, her eyes and her conjunctiva were pink with white sclera, with no abnormalities detected in her mouth. Her hands were normally situated and equal upon inspection of her upper extremities. Her palm was pink with shortened finger nails. Both breasts were inspected and were of almost equal in size with normal shapes. The left breast and palpated it first as she supported her occiput with her right palm. Same was done for the right breast and did not detect any abnormalities. Her nipple was prominent and there was no discharge. She was taught self-breast examinations for early detection of any

abnormality. Her breast was soft and there was no redness or cracks on the nipple. No lumps were felt and colostrum was expressed. During inspection of the abdomen, it looked firm and straie gravidarum and linear nigra were present. The uterus was palpated and it felt firm and well contracted. Her Symphysio-fundal height was 18cm. Her back was inspected for any rash, edema and tenderness but there was none found. Her lower extremities were examined and they were equal, normal, and free from edema and pain. Permission was sought from Madam Comfort to carry out a vulva examination on her which she readily agreed to. Hands were washed, dried and surgical gloves were worn. Her pad was removed and inspected for the colour which was bright red. The amount of blood flow was moderate. The odour of the lochia had no foul smell. A new pad was placed on her vulva and the old one was discarded. The used gloves were removed and discarded; hands were washed

Vital signs were checked and recorded as:

Respiration 22cpm,

Temperature 36.4℃

Blood pressure 110/70mmHg,

Pulse 82bpm,

Fundal Height 18cm.

All findings were communicated to her and recorded in the nurse's note. Client was encouraged to urinate frequently to aid in uterine involution. Client was told to change her perineal pad as frequently as it gets soiled to prevent infections. Again, she was encouraged breastfeed her baby on demand and to eat well balanced diets and drink lots of fluids to replenish the fluids lost through labour. It was added that she should have enough rest and sleep in order for her to recover from the stress of labour

DAY OF DELIVER

OBSERVATION OF THE MOTHER

OBSERVATION OF MOTHER	MORNING 7 am	EVENING 4 pm
TEMPERATURE	36.6℃	36.6℃
PULSE	82bpm	85bpm
BLOOD PRESSURE	110/70mmhg	110/60mmhg
RESPIRATION	22cpm	23cpm
SYNPHYSIO FUNDAL HIGHT	18cm	18cm

OBSERVATION OF BABY	MORNING 7am	EVENING 4 pm
TEMPERATURE	**36.20C**	**36.80C**
PULSE	**142bpm**	**140cpm**
RESPIRATION	**45cpm**	**44cpm**
WEIGHT	3.2kg	3.2kg

4.2 SUBSEQUENT CARE OF THE BABY

The baby was examined to exclude any abnormalities or birth injuries in the mother's presence. Before the procedure began, what to be done and the importance of doing the were vividly and clearly explained to the mother. Nearby windows and doors were closed to prevent hypothermia and provide privacy. Hand hygiene was performed and sterile gloves were put on. The baby was placed on a clean flat surface, undressed and wrapped with a cot sheet to prevent hypothermia. The skin was inspected and noted her skin color was pink covered by small vernix caseosa without any birth mark or lacerations. On examination of the head, there was no caput succedaneum or cephahematoma formed, sutures and fontanels were present and normal. Her eyes were normally situated with no yellowish discoloration on the sclera or swelling of the conjunctiva. The nose was evenly placed in relation to the eyes and the ears were in their normal position. The pinnae of the ears were well formed and level with the cantus of the eye. The mouth had no cleft lip or cleft palate and there was no tongue tie or forced teeth. Rooting, suckling and reflexes were present. The neck was normal, easily rotated and no swelling or lymph node felt. The breast tissue was palpated and there were no masses or engorgement. The nipples were centrally situated. On examination of her abdomen, it was round, soft and prominent. Her cord was centrally situated with two arteries and one vein and it was not bleeding. On examining her upper extremities, they were both of equal size and length and she did not have any webbed or extra digits. Palmer creases as well as grasping reflexes was also present. Her legs were well flexed and there was no congenital hip dislocation. Her toes were not webbed and no extra digits detected. The vertebrae were also normal and no spinal bifida detected. Her vagina was normal after it had been examined and so was her urethral orifice. Baby passed urine and meconium which indicated that the urethral and anal orifices were patent. All

findings were communicated to the client and recorded them in the nurse's notes. The baby was wrapped and put to her mother's breast to initiate lactation and bonding.

BABY'S FIRST BATH AND CORD DRESSING

The baby was given her first bath after 6 hours post-delivery at 10:30am. The procedure was explained to Madam Comfort. Preparation for the baby's bath was made and it included setting up a trolley with baby's sponge, face towel, baby's soap, baby's drape, baby oil, powder, bath thermometer, two clean cot sheet, baby's dress, gallipot containing sterile water, cotton wool swabs, jug of cold water, jug of warm water, chlorhexidine gel on the top shelf and plastic apron, bucket for dirty water, bathing towel, disposable gloves, container for used linen on the bottom shelf. Nearby windows and doors were closed and ensured that mother was present before the procedure was started. The jugs of water were mixed and tested with the bath thermometer. Plastic apron was worn, hand washing was performed, and gloves were put on. The baby was put on a clean flat surface and undressed. The baby was wrapped with a cot sheet. The baby's eyes were cleaned with cotton wool swabs soaked in sterile water from the inner cantus to the outer cantus and then cleaned her face with a damp face towel and dried it after. The nape of the baby's neck was supported with the left hand and plucked her ears with two fingers of the left hand supporting baby's head. Her head was washed with a soapy sponge. The baby was lifted off the flat surface, supporting the nape of the neck and body resting on the elbow to the edge of the bowl. Her head was rinsed off the soap and dried it with a clean towel. The baby was put back on the flat surface afterwards and exposed her body. Her arms and front of her trunk were washed, paying attention to the skin folds. The baby was turned with one arm supporting the chest and hand holding the distal arm of the baby. Her back was washed down to her feet, paying attention to the skin folds. The baby was supported firmly and was immersed in a bath of warm

water, with her head above the water and rinsed her thoroughly. The baby was placed afterwards on the flat surface and was covered with a clean cot sheet. A small towel was used to dry the baby. The used gloves were removed afterwards and was discarded. Hand washing was done and new gloves were put on. The tip of the cord clamp was held with a cotton swab and applied Chlohexidine gel thoroughly on the base, stem and cut end of the umbilicus. The cord was exposed to dry and heal. The baby was smeared with her oil, powder and was dressed up. The baby was given to Madam Comfort to fix her to breast. The working area was tidied and disposed of waste materials. After the procedure, hand washing was done and all findings were communicated to Madam Comfort and documented as well.

4.3 FIRST DAY POST DELIVERY (DAY OF DISCHARGE)

PREPARATION AND EDUCATION ON DISCHARGE

On 30th August, 2023, at 11:00 am Madam Comfort woke up healthy with cheerfully looking facial expression. All procedure to be carried out on both mother and baby were explained. Mother then took a warm bath and was served with oats and bread. Permission was sought from client and head to toe examination was done with no abnormalities detected. The breast was soft and lactating. Client complained of interrupted sleep since baby cries a lot. She was encouraged to take naps whenever the baby sleeps. She was also encouraged to breastfeed baby frequently to aid involution. Client vital signs and other observation made and recorded as, Temperature 36.6 degree Celsius, Respiration 22 cpm, Pulse 82bpm, Blood pressure 110/60 mmHg, Lochia Rubra, Fundal height 16cm, Condition of uterus; contracted. The baby was top and tailed and examined from head to toe with no abnormalities detected. The cord was dressed with chlorhexidine gel in the presence of mother. The cord was quite fresh with no odour. Madam Comfort was taught

how to dress the cord. The baby was assessed and recorded as; Temperature 36.1˚C, Apex heart rate 132bpm, Respiration 40cpm, Skin Colour Pink, Cord bleeding -Nil, Condition of cord -Dry, Suckling – Good, Weight 3.1kg, Stool Colour -Greenish.

An opportunity was taken to demonstrate to the mother how to bath the baby. The baby was top and tailed, dressed and wrapped nicely in the presence of the mother and family. The baby passed urine and meconium which was normal. The mother was educated not to apply hot compress on the fontanelles with the intension of closing it as they go home. The baby was then handed over to the mother for breastfeeding. Proper positioning and attachment to the breast was encouraged. Client was reminded on the intake of nutritious diet, fruit and frequent breastfeeding of the baby. Education was given on the change of perineal pad when soiled and the need to wash her hands after removal and before breastfeeding the baby to prevent infections. Client was also educated on postnatal exercises such as kegel, ambulation and family planning as well as exclusive breastfeeding, change of napkins or diapers frequently, wash and dry them in sun and keeping the baby warm always. She was asked to register the baby at the birth and death registry. Madam Comfort 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 husband 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 of administration, dosage and effects.

The baby was reassessed by the Midwife -In- Charge and no abnormality noticed and she confirmed they were ready for discharge was given the following:

Tablet Folic Acid 5mg daily for 14 days

Tablet Ferrous Sulphate 200mg daily for 14days

Tablet Multivitamin 200mg daily for 14 days

Tablet Paracetamol 1g tid for 3days

Client was discharged at 11:00am on the 30th of August, 2023 and was helped to pack belongings after serving her medications. Her hospital bills were settled by the National Health Insurance Scheme. Client was reminded that she will be visited in the evening and it will continue for seven days. Client was congratulated and bade farewell.

HOME VISITS

4.4 FIRST POSTNATAL HOME VISIT.

In the evening of 30th August 2023 at 5:30pm, Madam Comfort and her baby were visited for the first time after delivery. They were both in good condition as well as her family. Permission was sought from my client and also explained procedure to her to examine the baby and herself of which she agreed. She was asked to empty her bladder. Madam Comfort and her baby were examined from head to toe and there were no abnormalities. Her fundus was well contracted. The baby was bathed and the cord was dressed afterwards. Madam Comfort put the baby to her breast and it was noticed that the baby suckled well. Client complained of headache and fatigue. She was reassured and was told that it was due to the stress of labour. Client was encouraged to have enough rest and sleep and also educated her on the need to sleep under treated mosquito net to prevent mosquito bites and malaria

OBSERVATION OF MOTHER	MORNING 7 am	EVENING 5 pm
Temperature	**36.4**	**36.4**
Pulse,	**82bpm**	**78bpm**

Respiration,	22cpm	21cpm
Blood pressure, **stool/urine**	110/60mmhg Passed	**110/70mmHg** **passed**
Fundal height	**16cm**	**16cm**

BABY

OBSERVATION OF BABY	MORNING 7 am	EVENING 5 pm
TEMPERTURE	**36.1℃**	**36.8℃**
PULSE	**132bpm**	**134bpm**
RESPIRATION	**40cpm**	**40cpm**
WEIGHT	**3.1kg**	**3.1kg**

4.5 SECOND POSTNATAL HOME VISIT

On 31st August, 2023 at 7:00am in the morning, Madam Comfort was visited. She, the baby and family were all doing well. A head to toe examination on both the mother and the baby was done and there were no abnormalities. Enquires about her previous complain (headache and fatigue) was made, she said she had been relieved but had difficulty in sleeping. She was encouraged to feed the baby on demand even at night and to take a rest during the day when baby is asleep. Her husband was encouraged to help in the care of the baby and also in the household chores together with her mother so that Madam Comfort could have some rest and sleep to promote her wellbeing. And also encouraged her to comply with the drugs given to her. The was baby bathed

and her cord was dressed aseptically. Vital signs of the baby and mother together with observations made were recorded as follows;

Baby:

Temperature 36.1°C,

Pulse 134bpm,

Respiration 42cpm,

Weight 3.0kg,

Stools passed.

MOTHER

OBSERVATION OF MOTHER	**MORNING 7 00am**	**EVENING 5 pm**
TEMPERATURE	36.2℃	36.3℃
PULSE	78bpm	79bpm
RESPIRETION	22cpm	24cpm
BLOOD PRESSURE	120/70mmhg	120/60mmhg
SYNPHYSIO FUNDFAL HEIGHT	14cm	14cm

BABY

OBSERVATION OF BABY	**MORNING 7 am**	**EVENING 5 pm**

TEMPERATURE	36.1℃	36.2℃
PULSE	134bpm	140bpm
RESPIRATION	42cpm	43cpm
WEIGHT	3.0kg	3.0kg

4.6 THIRD DAY POSTNATAL HOME VISIT

On the 1st september, 2023 8:00am in the morning, Madam Comfort was visited in her house. Greetings were exchanged and a warm welcome and seat was offered. She was asked about her health and that of her family and responded that they are all well. Permission was sought from Madam Comfort to examine her which she agreed. After hand washing was done with soap under running water and dried. The Symphysio fundal height was 12cm. The perinea pad was checked and the colour of the lochia was bright red with no foul smell and scanty in amount. The breast was lactating well. There were no observed abnormalities. Her vital signs were checked and recorded as follows:

Observation of the mother

Observation of the mother	Morning 8am	Eveining 5 pm
Temperature	36.6°C	36.8^{0}c
Pulse	80bpm,	82bpm
Respiration	20cpm	22cpm
Blood pressure	110/70mmHg	120/60mmHg

Synphysio fundal hight	12cm	12cm

BABY

Baby observation	morning	Evening
Temperature	36.5°C	36.8^{o}c
Pulse	140bpm	142bpm
Respiration	42cpm	40cpm
Weight	2.9kg	2.9kg

4.7 FOURTH DAY POSTNATAL HOME VISIT

From the 4th day onwards, Madam Comfort was visited to continue the care. The visits were only in the morning. Both Madam Comfort and the baby were doing well. On the 4th day which was 2nd September, 2023 at 8:00am, Madam Comfort was taken through the routine examinations including a head to toe examination. The uterus remained firm and well contracted. The fundal height was 10cm. Lochia was serosa with moderate flow. All findings after the examinations were within normal ranges. and communicated my findings to her. Baby was bathed and dressed the cord with chlorhexidine gel. The cord was almost off. The cord was dry and loose. Madam Comfort was educated not to pull it off or apply herbs but wait for it to fall off itself. The baby was examined from head to toe in the presence of Madam Comfort. And did not detect any abnormalities. The baby was normal and healthy. Madam Comfort was told to put the baby to breast and the baby suckled well on the breast. Enquiries about previous complain of loss of appetite was made and she said she is now able to eat half of her meals. Vital signs and observations made for mother and baby are as follows;

Baby:

Temperature	36.8ºC
Apex beat	133bpm
Respiration	34cpm
Stool Passed Urine	Passed
Weight	2.9kg

Mother:

Temperature	36.7ºC
Pulse	80bpm
Respiration	23cpm
Blood Pressure	110/70mmHg
Fundal Height	10cm
Urine and stool	passed
Breasts	lactating.

4.8 FIFTH DAY POSTNATAL HOME VISIT

On 3rdSeptember, 2023, at 8:00am Madam Comfort and her family were visited. Both Madam Comfort and the baby were doing well. Madam Comfort and the baby was taken through the routines and all findings were in the normal ranges. They were both healthy. Findings were communicated to her and enquiries about her previous complaints were made which she said she had had enough rest and sleep that day. Baby was examined from head to toe in the presence of Madam Comfort and detected no abnormalities. Baby was normal and healthy. The baby suckled well on the breast. Madam Comfort said that she passes urine at least three times a day and empties her bowel daily. Madam Comfort were examined from head to toe and there were no

abnormalities seen. The uterus remained firm and well contracted. Fundal height was 8cm. Lochia was serosa with moderate flow. They were thanked and left after informing them that, my next visit would be my last visit to their homes.

Mother and baby's vital signs and recorded observations made as follows

Baby:

Temperature	36.8ºC
Apex beat	125bpm
Respiration	42cpm
Stool	passed
Urine	passed
Weight	3.0kg

Mother**:**

Temperature	36.5ºC
Respiration	22cpm
Blood pressure	110/80mmHg
Pulse	87bpm
Fundal height	8cm

4.9 SIXTH DAY POSTNATAL HOME VISIT

On 4th September, 2023, which was the sixth day, at 8:00am Madam Comfort and her family were visited. Madam Comfort and the baby were doing well they warmly welcomed me. The health of the mother and the baby and the response was positive. Madam Comfort and baby were examined and there were no abnormalities detected. They were both healthy. Madam Comfort's fundal height was 6cm. her perineal pad and lochia was serous, moderate with no offensive odor. Baby was toiled and tailed and in the process the cord fell off. Baby was dress neatly and gave the baby to the mother to breastfeed. Baby suckled well on the breast. Madam Comfort and baby's vital signs were checked and recorded the observations were as follows;

Baby:

Temperature	36.7ºC
Pulse	145bpm
Respiration	35cpm,
Stool	passed
Urine	passed
Weight	3.1kg

Mother:

Temperature	36.8ºC
Pulse	90bpm
Respiration	24cpm
Blood Pressure	110/70mmHg
Synphysio Fundal Height	6cm

4.10 SEVENTH DAY POSTNATAL HOME VISIT

On the 5th September, 2023 around 9:00am, Madam Comfort was visited, the baby was doing well as well as the family. Routine examination was carried out on both the mother and baby from head to toe and there was no abnormality detected on any of them. The perineal pad was inspected the lochia was serosa with no odour. The baby was bathed with warm water and kept in a cot sheet. The umbilical cord was dressed well with chlorhexidine gel, urine and stool were also passed. Client made no complains. Client was reminded of the first postnatal visit to the clinic which was on the 23rd September,2023. Client was thanked and permission was sought to leave. Observations as well as vital signs for both mother and baby were also recorded as follows:

Mother:

Temperature	36.4ºC
Pulse	78bpm
Respiration	23cpm
Blood Pressure	110/70mmHg
Fundal Height	4cm.

Baby:

Temperature	36.5ºC
Pulse	130bpm,
Respiration	42cpm,
Stool	passed,
Urine	passed,
Weight	3.2kg

4.11 FIRST POSTNATAL VISIT TO THE CLINIC

Madam Comfort and her baby arrived at the clinic for postnatal care on the 6th September, 2023 accompanied by her mother. Client was neatly dressed and looked cheerful. They were welcomed and given a comfortable seat. Health educations on nutrition, immunization against preventable childhood diseases and family planning as well as care of the baby were given. Client was asked about her condition and that of the baby and she said they were doing well. Client said her baby was able to feed well and always sleeps well. Madam Comfort also confirmed that the baby passed urine and stools regularly. Permission was sought from Madam Comfort to examine the baby generally. She granted the permission and the procedure was explained to her. The baby was taken, undressed and then wrapped with a clean cot sheet and placed on a flat surface for the examination in the presence of the mother. There were no skin rashes detected on the baby as well as no discharges from the eyes, nose and ears. No discoloration of the mucus membranes, palms, eyes, conjunctiva and feet were observed during inspection. Baby's abdomen was not distended and the umbilical stump was almost healed. The baby was neatly wrapped and was given back to the client's mother for Madam Comfort to be examined too. The baby's vital signs were checked and recorded as follows;

Temperature 36.7^0C,

Apex beat 134 bpm,

Respiration 42 cpm,

Weight 3.3kg.

Permission was sought from Madam Comfort to examine her from head to toe. The procedure was explained and she was asked to empty her bladder and a sample of urine was taken and

tested for glucose and protein and all tested negative. Privacy was then provided. Hands were washed and dried and examination was commenced. On inspection, it was observed that the conjunctiva of the eyes was not pale, the nose was not discharging. Client's breasts were soft with no cracks or sore on the nipples. There was also no abdominal tenderness and the Fundus was not palpable Hands were washed and dried. There was no drainage of Lochia on inspection. After that findings were communicated to her. Her vital signs checked and recorded as;

MOTHER

Temperature	36.5 degree Celsius,
pulse	84bpm
respiration	24cpm
Blood pressure	110/70mmHg.

Madam Comfort was advised to complete all immunization scheduled. Client was reminded of her second postnatal visit to the clinic It was explained to Madam Comfort the care being given to her by me has come to an end since the period of the study was over. Madam Comfort and her entire family were thanked for their co-operation and for helping me to achieve my aim. Baby was registered at the Births and Deaths Registry and client was handed over to the public health nurse for continuity of care.

4.12 SECOND POST-NATAL VISIT TO THE CLINIC

According to the midwife in charge, on the 17th October, 2023. Madam Comfort came to the clinic for six weeks visit. They were warmly welcome and they all looked very healthy. General examination was conducted on the client from head to toe as well as vital signs after her permission was sought. Her vital signs and weight were checked and recorded as follows:

Temperature 36.5ºC,

Pulse 80bpm,

Respiration 20cpm,

Blood Pressure 110/70mmHg,

Weight 67kg.

Madam comfort was given a urine sample container to provide some urine to be sent to the laboratory for urine analysis to be performed. She was educated on the need and procedure to provide midstream urine for the examination. A sample of blood was also taken from Madam comfort with her consent to be sent to the laboratory for her haemoglobin level to be tested. The results were explained to her as follows; Haemoglobin 14.6g/Dl, Urine protein Negative, Glucose Negative. No abnormalities were detected on both mother and baby. She was finally referred to the public health nurse for continuity of care but report to the facility anytime she encounters any health related problem.

4.13 NURSING CARE PLAN DURING PUERPERIUM

PROBLEMS IDENTIFIED

1. Headache

2. Fatigue

3.inadequate sleep at night

4. Loss of appetite

SHORT TERM OBJECTIVES

1. Client will be relieved of headache within 24 hours.

2. Client will be relieved of the fatigue within 24 hours.

3. Client will be able to sleep for 2 hours during the day and 6 hours during the night

4. Client will be able to eat half of her meals served within 24 hours.

LONG TERM OBJECTIVE GOALS

Client will go through the puerperal period without any complications to herself and her baby.

TABLE 1: NURSING CARE PLAN DURING PUERPERIUM

DATE / TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES/ OUTCOME CRITERIA	NURSING ORDERS	NJURSING INTERVENTIONS	DATE / TIME	EVALUATION	SIGN
30/08/23 11:00am	Headache related to labour stress.	Client will be relieved of headache within 24 hours as evidenced by: Client verbalizing the absence of headache.	1.Assure client. 2.Educate client to rest. 3. Encourage support person to assist client. 4.Educate client to limit number of visitors. 5.Serve prescribed analgesic.	1.Client was assured that the headache will subside after intervention 2.Client was educated to sleep during daytime while baby is asleep. 3. Her mother and partner were encouraged to take care of the baby to allow client have some rest. 4.Client was educated to limit visitors during the day so that she can rest. 5. Analgesic (paracetamol 1g) was served.	31/08/23 12:00pm	Goal fully met as 1.Client verbalized the absence of the headache.	PJ

TABLE 2: NURSING CARE PLAN DURING PUERPERIUM

DATE / TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES	NURSING ORDERS	NURSING INTERVENTIONS	DATE / TIME	EVALUATION	SIGN
30/8/23 5:30pm	Fatigue related to stress of labour.	Client will be relieved of the fatigue within 24 hours as evidenced by client verbalizing the absence of fatigue. 2. Midwife visualizing client is relieved	1. Reassure client 2. Educate client to have some rest. 3.Encourage support person to assist client . 4. Educate client to eat well balanced diet.	1.Client was reassured that fatigue will subside with rest. 2. Client was encouraged to rest during the day especially when baby sleeps. 3. Partner was encouraged to help with taking care of baby and chores so that mother could have enough rest. 4.Client was encouraged to eat healthy meals rich in protein, calories, vitamins and iron to get enough energy and drink lots of water.	31/8/23 5:30pm	Goal fully met as client verbalized that she has been relieved of fatigue. 2 midwife Visualizing client is been relieved	PJ

TABLE 3: NURSING CARE PLAN DURING PUERPERIUM

DATE / TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTIONS	DATE / TIME	EVALUA-TION	SIGN
30/08/23 11:00am	Sleeping pattern disturbance related to stress of labour.	Client will be able to sleep for 2 hours during the day and 6hours during the night as evidenced by client verbalizing that she can sleep for 2 hours during the day and 6 hours at night 2 midwife noticing client no longer complains	1.Reassure client 2.educate client to breastfeed the baby 3.Ensure a noise free and calm environment. 4.Encourage client to restrict visitors. 5.Encourage client to sleep whenever baby sleeps.	1.Client was reassured that with support she can have enough sleep. 2. Client was educated to breastfeed on demand 3.Mother's room was kept calm and conducive for sleep 4. Client was encouraged to limit visitors to help her sleep. 5.Client was encouraged to sleep immediately baby sleeps.	30/08/2023 1:00pm	Goal fully met as client verbalized that she able to sleep at least 2 hours during day and 6 hours during the night.2 midwife noticing client no longer complains	PJ

TABLE 4: NURSING CARE PLAN DURING PUERPERIUM

DATE /TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES	NURSING ORDERS	NURSING INTERVENTION	DATE / TIME	EVALUATION	SIGN
2/09/23 8:00am	Loss of appetite related to labour stress.	Client will be able to eat half of her meals served within 24 hours as evidenced by support person observing client eating half of her meals served.	1. Reassure client. 2.Encourage client to practice oral hygiene. 3. Serve client's favorite food. 4. Serve client's food attractively. 5.Serve prescribed medications.	1.Client was reassured. 2.Client was encouraged to practice oral hygiene by brushing her teeth at least twice daily to increase her appetite. 3.Client was advised to eat her favorite food, banku and okoro stew. 4.Clients was encouraged to eat food served attractively by garnishing it. 5.Multivitamins were served.	3/09/23 8:00pm	Goal fully met as support person observing client eating half of her meals served.	PJ

SUMMARY AND CONCLUSION

The Client/Family Centred Maternity Care Study was conducted on Madam Comfort Asare a 33-year-old gravida 3 para 2A and her entire family throughout pregnancy, labour and puerperium and she went through these processes safely without any complications. Madam Comfort became a regular attendant to the clinic since 4th May, 2023. She was managed through pregnancy, labour and puerperium safely through which all minor disorders were taken care of using the nursing care plan and goals were met when evaluated. She had a spontaneous vaginal delivery to a life female baby on 29th August, 2023 and discharged the next day. Client and family were visited for the first seven days after delivery. She visited the clinic on her first week and six weeks postnatal. Madam Comfort was given a focused and comprehensive care throughout her pregnancy, labour and puerperium. Madam Comfort and her baby were in a healthy condition and they were handed over to the Midwife-In-Charge for continuity of care. Client and her family were much grateful at the end of the study. The care rendered to Madam Comfort has helped in the equipment of skills necessary to meet the needs of pregnant, labouring and puerperal women. It has also established between us a good interpersonal relationship. The care study is an important and managerial tool which gives opportunity to student midwives to put into practice theoretical knowledge and to be able to deal with obstetric problems as midwifery professional.

BIBLIOGRAPHY

Antenatal Record Book registration number 969/22

Fraser, D.M. (2014) *Textbook for midwives (16th edition),* London: Churchill Livingstone, Elsevier Limited

Marie, E (2013) *Midwifery for Nurses (*2nd Ed.*) New* Delhi: CBS PUBLISHER & Distribution.

Myles Text book for Midwives (16th Ed). London: Churchill Livingstone Elsevier Ltd.

Konar, H (2011*). Textbook of Obstetrics.* (7th Ed). New Central Book Agency. India.

Marshall, J. & Raynor, M (2014) Textbook for Midwives (16th edition). London: Churchill Livingstone Elsevier Ltd.

Tiran, D. (2008). *Bailliere's Midwives Dictionary* (11thEdition), Elsevier: Elsevier Limited

APPENDIX I

MOTHER'S ANTENATAL RECORDS

DATE	WEIGHT (KG)	BP (mmHg)	URINE FOR GLUCOSE AND PROTEIN	PRESENTATION AND POSITION	FETAL HEART RATE (bpm)	GESTATIONAL AGE IN WEEKS	FUNDAL HEIGHT (cm)	DESCENT	COM-PLAINS	TREAT-MENT	SIGN
22/02/23	86	110/80	Negative/ Negative	-	-	15	14	-	No complains	Routine drugs	
27/03/23	88	120/80	Negative/ Negative	_	+	19	17	_	Nausea and vomiting	Routine drugs	
05/06/23	90	100/70	Negative/ Negative	_	+	23+4	22	_	No complains	Routine drugs	
04/07/23	90	110/80	Negative/ Negative	Cephalic	+	26	25	_	No complains	Routine drugs	
08/07/23	93	120/80	Negative/ Negative	Cephalic	+	31+1	30	_	Insomnia	Routine drugs	
01/08/23	95	120/80	Negative/ Negative	Cephalic	+	34+1	34	_	No complains	Routine drugs	
08/08/23	93	110/70	Negative/ Negative	Cephalic	136	36+3	35	5/5th	Constipation, heart-burns	Routine drugs	
15/08/23	95	100/80	Negative/ Negative	Cephalic	138	37+3	36	5/5th	No complains	Continue treatment	

APPENDIX II

LABORATORY INVESTIGATIONS

DATE	SPECIMEN	INVESTIGATIONS	NORMAL VALUE	INVESTIGATION RESULT	REMARKS
22/02/23	Blood	Haemoglobin level	11.5-14g/dl	11.7g/dl	Normal
		Sickling	Negative	Negative	Normal
		Blooding grouping	AB, A, B, O	B positive	Normal
		Rhesus factor	Positive	Positive	Normal
		Antibody screen,	No Defect	Negative	Normal
		MPs	parasite seen	Non-reactive	Normal
		HBSAG	Non-reactive	Non-reactive	Normal
		VDRL	Non-reactive	Non-reactive	Normal
		Syphilis	Non-reactive	Negative	Normal
		PMTCT	Non-reactive		
	Urine	Protein,	Negative	Negative	Normal
		Acetone	Negative	Negative	Normal
		Sugar	Negative	Negative	Normal
	Stool R/E	Worms	Negative	No ova detected	Normal
27/03/23	Urine	Protein	Negative	Negative	Normal
		Sugar	Negative	Negative	
01/05/23	Stool	Worms	No ova	No ova detected	Normal

			Detected		
05/06/23	Urine	Protein Sugar	Negative Negative	Negative Negative	Normal Normal
	Blood	Haemoglobin level	11.5-14g/dl	12.4g/dl	
04/07/23	Urine	Sugar Protein	Negative Negative	Negative Negative	Normal Normal
	Blood	Haemoglobin	11.5-14g/dl	12.2g/dl	Norma8

LABORATORY INVESTIGATIONS

08/07/23	Urine	Sugar Protein	Negative Negative	Negative Negative	Normal Normal
	Blood	Haemoglobin	11.5- 14g/dl	12.4g/dl	Normal
01/08/23	Urine	Sugar Protein	Negative Negative	Negative Negative	Normal Normal
	Blood	Haemoglobin	11.5-14g/dl	12.6g/dl	Normal

APPENDIX III

PHARMACOLOGY OF DRUGS (MOTHER)

NAME OF DRUGS	CLASSIFICAT-ION	DOSAGE	ROUTE OF ADMINISTRAT-ION	ACTION & USE	ACTUAL EFFECTS	SIDE EFFECT OF DRUGS	SIDE EFFECT EXPERI ENCED
Tablet folic acid	Haematinics	5 milligrams once daily	Orally	Proper formation and function of red blood cell	Haemoglob in level increased	Nausea and vomiting	None
Tablet multivitamin	Vitamin preparation	200 milligrams twice daily	Orally	Increased appetite. Helps in the formation of red blood cell	Increase appetite.	Gastro intestinal disturbances	None
Tablet ferrous Sulphate	Iron supplement	200 milligrams 2 twice	Orally	Help in formation of Haemoglobin and red blood	Haemoglob in level increased	Gastrointest inal disturbance	Dark stool

PHARMACOLOGY OF DRUGS USED(MOTHER)

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

APPENDIX IV

PHARMACOLOGY OF DRUGS USED (BABY)

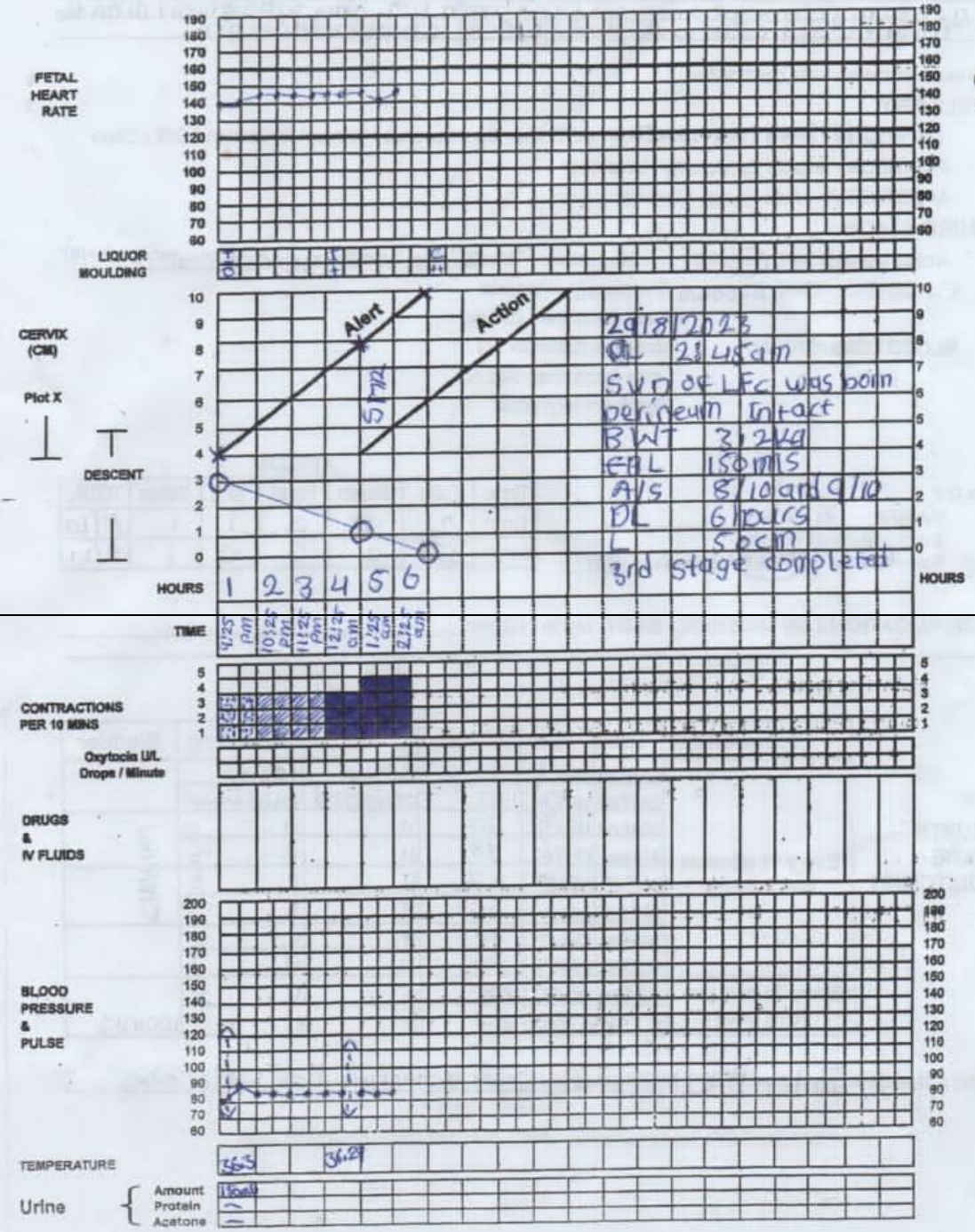
NAME OF DRUGS	CLASSIFICATION	DOSAGE	ROUTE OF ADMINISTRATION	ACTION & USE	ACTUAL EFFECTS	SIDE EFFECT OF DRUGS	SIDE EFFECT EXPERIENCED
Vitamin K	Group K vitamins (coagulant)	1.0mg	Intramuscular	Production of prothrombin which aids in clotting	No bleeding	None	None
Gentamycin eye drop.	Antibiotics	2 drops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

PHARMACOLOGY OF DRUGS USED (BABY) CONTIUED

NAME OF DRUGS	CLASSIFICATION	DOSAGE	ROUTE OF ADMINISTRATION	ACTION & USE	ACTUAL EFFECTS	SIDE EFFECT OF DRUGS	SIDE EFFECT EXPERIENCED
Pneumococcal 1	Antigen	0.5 ml	Intramuscular right thigh	Vaccinates neonate against pneumonia	Under observation	Redness at the sight of injection and fever.	None observed
Pentavalent 1 (5 in 1)	Antigen	0.5 ml	Intramuscular left thigh	Vaccinates neonate against diphtheria, pertussis (whooping cough), tetanus, hepatitis B, homophiles influenza B	Under observation	Low grade fever	None observed
Rotavirus 1	Antigen	1.5 ml	Oral	Prevention of gastroenteritis	Under observation	None	None

WHO Modified Partograph

Registration No. AACU547 Name (Last, First) Abave comfort Age 33 yeurs
Date 28/8/2023 Parity/Gravida 2 / 3 LMP 20/11/2022 EDD 27/8/23 Gestation (wks) 38 + 3 days
ROM (Time, Date) ___/_____ Labour Durable (Hrs) 6 Facility/Clinic Name Plum Avenue maternity home



LABOR NOTES

Asure comfort G3P2A came to the facility on 28/8/2023 and delivered a live female neonate at 2:45am on 29/8/2023 with apgar score 8/10 and 9/10 respectively. placenta was delivered at 2:50 am and 1 unit of oxytocin given at 2:49 am. placenta was completely delivered. blood loss was 150mls, baby weight 3.2kg. eye care was done by given gentamycin eye drop and vitamen k 1.0mg was given I/m on the thigh. cord care was done using chlohexidine gel.

Please circle or write responses.

DELIVERY

DATE: 29/8/2023 TIME: 2:45am METHOD: Spontaneous / Vacuum Extraction / C/S / Other

PERINEUM: Intact / Episiotomy / Laceration

ANESTHESIA: None / Local / General

THIRD STAGE

Active Management: (Yes) / No ·Medication: Time 2:49am Type/Dose injection oxytocin 1 unit

PLACENTA: TIME: 2:50am Complete / Incomplete

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

BABY

Weight: 3.2kg

Sex: Male / (Female)

Baby Position: (Vertex) / Breech / Other

APGAR

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

COMPLICATIONS OF MOTHER / BABY: None / Other:

FOURTH STAGE MONITORING

Frequency	Time	B/P.	Pulse	Fundus	Bleeding	Bladder
Every 15 minutes first 2 hours	3:12pm	120/70	70	18cm	100mls	
	3:27pm	110/70	81	contracted	moderate	
	3:42pm	110/70	80	"	"	emptied
	3:57pm	120/60	78	"	"	
	4:12pm	110/70	82	"	"	
	4:27pm	110/70	80	"	"	
	4:42pm	120/70	76	"	"	
	4:57pm	110/80	84	"	"	
Every 30 minutes For 1 hour	5:27pm	120/80	85	"	No active bleeding	
	5:57pm	110/70	80	"	"	100mls

Birth Attendant Jachan Peggy supervised by Grace A. Maakuu Date 29/8/2023

NEW BORN EXAMINATION FORM

Name: Baby Asare comfort Date of Assessment: 29/8/2023 Time: 9:30 minute

Date of Birth: 29/8/23 Time of Birth: 2:45am Sex: ☐ M ☑ F Age at time of Assessment (days/hrs) 9o minute

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

APGAR: 1min ☑ 5min ☑ Birth Weight: ☐ 3.2kg ☐ Length: 50 cm Head Circumference: 33 cm

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

Name of Assessor (Midwife/Doctor): Jachan Peggy

1. Respiration

Rate _____

- ☐ Rate < 30 b/m *
- ☐ Rate < 60 b/m *
- ☑ 30-60 b/m
- ☐ Retractions *
- ☐ Grunting *
- ☐ Stridor *

2. Activity/Movemnet

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

3. Tone

- ☑ Normal
- ☐ Floppy *
- ☐ Increased *

4. Colour

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

5. Cord

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

6. Cry

- ☑ Normal
- ☐ Shrill *
- ☐ Absent *

7. Suck

- ☑ Good
- ☐ Weak
- ☐ Absent

8. Head swelling

- ☐ Caput succedaneum
- ☐ Cephalhaematoma
- ☐ Subgaleal hemorrhage
- ☑ No swelling

9. Sutures

- ☑ Normal
- ☐ Overlapping
- ☐ Fused
- ☐ Widely Separated *

10. Fontanel

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

11. Eyes

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

12. Ears

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

13. Mouth

- ☑ Normal
- ☐ Cleft palate
- ☐ Cleft Lip
- ☐ Other: _____

15. Neck

- ☑ Normal
- ☐ Swelling
- ☐ Webbed
- ☐ Other: _____

16. Clavicle

- ☑ Normal
- ☐ Swelling/Fracture

17. Chest

- ☑ Normal (Shape/movement)
- ☐ Abnormal _____

18. Heart rate

Rate: _____

- ☑ Normal (100-160)
- ☐ <100 *
- ☐ >160*

19. Femoral pulse

- ☑ Present
- ☐ Not palpable*

20. Abdomen

- ☑ Normal
- ☐ Distended*
- ☐ Scarphoid*
- ☐ Abdominal defect*
- ☐ Maases: _____
- ☐ Other _____

21. Back (spine)

- ☑ Normal
- ☐ Abnormal Swelling *
- ☐ Hairly patch over spine
- ☐ Abnormal dimple
- ☐ Abnormal curvature

22. Limbs

- ☑ Normal
- ☐ Abnormal _____

23. Genitalia

Male Genitalia

- ☐ Normal
- ☐ Undescended testes
- ☐ Abnormal meatus
- ☐ Hernia
- ☐ Other: _____

Female Genitalia

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

24. Anus

- ☑ Patent
- ☐ Imperforate*

25. Resuscitation provided

- ☐ One
- ☐ Suction/stimulation
- ☐ Bag and mask
- ☐ Endotracheal Tube
- ☐ Ventilator/CPAP

26. Services provided

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

*May indicate severe disease that requires urgent referral

Diagnoses (if known) _____

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

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

NEW BORN EXAMINATION FORM

Name: Baby Asare Comfort Date of Assessment: 30/8/23 Time: 11:00am

Date of Birth: 29/8/23 Time of Birth: _____ Sex: ☐ M ☑ F Age at time of Assessment (days/hrs) 9 hours

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

APGAR: 1min 8 5min 9 Birth Weight: ☐ 3.2kg ☐ Length: 50 cm Head Circumference: 33 cm

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

Name of Assessor (Midwife/Doctor): Jachan Peggy

1. Respiration

Rate _____

- ☐ Rate < 30 b/m *
- ☐ Rate < 60 b/m *
- ☑ 30-60 b/m
- ☐ Retractions *
- ☐ Grunting *
- ☐ Stridor *

2. Activity/Movemnet

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

3. Tone

- ☑ Normal
- ☐ Floppy *
- ☐ Increased *

4. Colour

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

5. Cord

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

6. Cry

- ☑ Normal
- ☐ Shrill *
- ☐ Absent *

7. Suck

- ☑ Good
- ☐ Weak
- ☐ Absent

8. Head swelling

- ☐ Caput succedaneum
- ☐ Cephalhaematoma
- ☐ Subgaleal hemorrhage
- ☑ No swelling

9. Sutures

- ☑ Normal
- ☐ Overlapping
- ☐ Fused
- ☐ Widely Separated *

10. Fontanel

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

11. Eyes

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

12. Ears

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

13. Mouth

- ☑ Normal
- ☐ Cleft palate
- ☐ Cleft Lip
- ☐ Other: _____

15. Neck

- ☑ Normal
- ☐ Swelling
- ☐ Webbed
- ☐ Other: _____

16. Clavicle

- ☑ Normal
- ☐ Swelling/Fracture

17. Chest

- ☑ Normal (Shape/movement)
- ☐ Abnormal _____

18. Heart rate

Rate: _____

- ☑ Normal (100-160)
- ☐ <100 *
- ☐ >160*

19. Femoral pulse

- ☑ Present
- ☐ Not palpable*

20. Abdomen

- ☑ Normal
- ☐ Distended*
- ☐ Scarphoid*
- ☐ Abdominal defect*
- ☐ Maases: _____
- ☐ Other _____

21. Back (spine)

- ☑ Normal
- ☐ Abnormal Swelling *
- ☐ Hairly patch over spine
- ☐ Abnormal dimple
- ☐ Abnormal curvature

22. Limbs

- ☑ Normal
- ☐ Abnormal _____

23. Genitalia

Male Genitalia

- ☐ Normal
- ☐ Undescended testes
- ☐ Abnormal meatus
- ☐ Hernia
- ☐ Other: _____

Female Genitalia

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

24. Anus

- ☑ Patent
- ☐ Imperforate*

25. Resuscitation provided

- ☐ One
- ☐ Suction/stimulation
- ☐ Bag and mask
- ☐ Endotracheal Tube
- ☐ Ventilator/CPAP

26. Services provided

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

*May indicate severe disease that requires urgent referral

Diagnoses (if known) _____

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

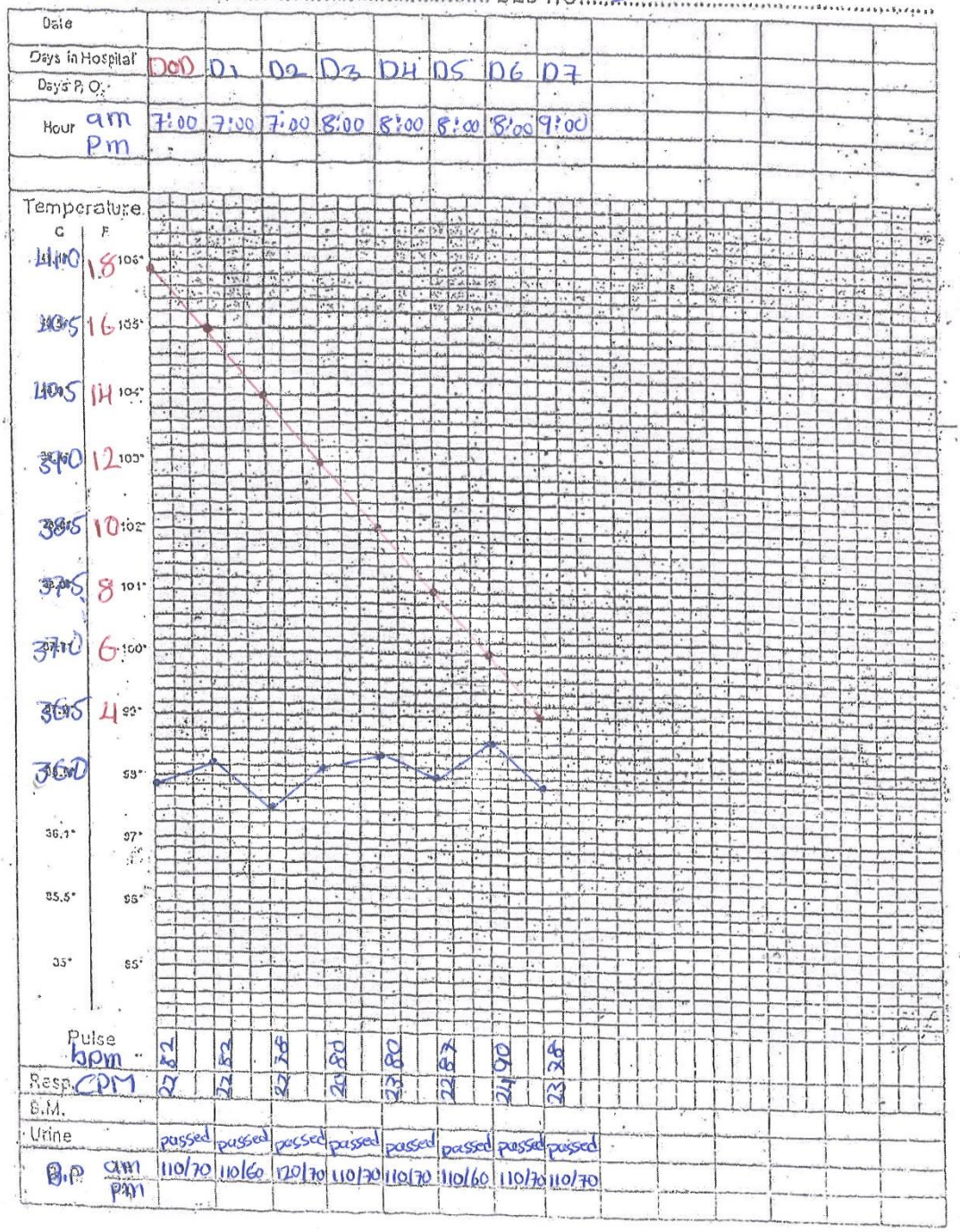
Plan: [ ] Routine Care[ ]Problem. Continue supportive in-patient care [ ] Urgent Referral / Advanced Care[ ] Discharge

MATERNITY CHART

NAME: Madam Asare comfort

AGE: 33 years WARD: LYING - IN

IP NO. 1544/11 BED NO.: 2



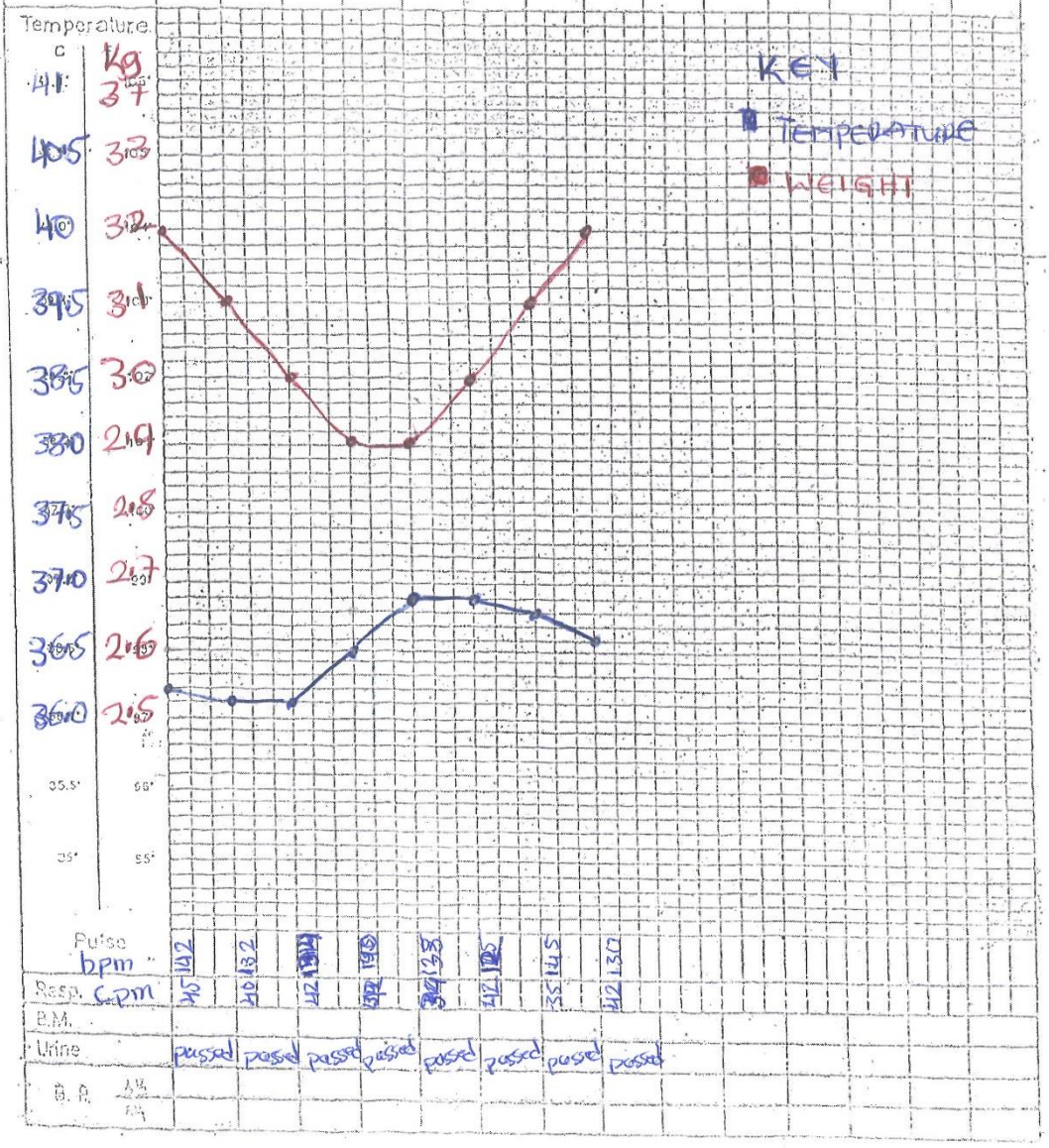
TEMPERATURE CHART

NAME: BABY ASARE COMFORT

AGE: ..... WARD: LYING-IN

IP NO.: 157411 11 ..... BED NO.: 2

Date	29/8/23	30/8/23	31/8/23	1/9/23	2/9/23	3/9/23	4/9/23	5/9/23
Days in Hospital	D00	D1	D2	D3	D4	D5	D6	D7
Day's P. O.								
Hour am	7:00	7:00	7:00	8:00	8:00	8:00	8:00	9:00
Hour pm	-							



Pulse bpm	142	132	134	138	138	136	145	130
Resp. c/pm	36	40	42	38	36	42	35	42
B.M.								
Urine	passed	passed	passed	passed	passed	passed	passed	passed
B. P.								

NEW BORN CHART

Name: Baby Asare Comfort ..... No: ..... Birth Weight: 3.7kg .....

Sex: Female ..... Mother's No: 15444/11 ..... Length: 50cm .....

Nature of Delivery: S.P ontaneous Vaginal delivery ..... Diagnosis: Term baby .....

Date of Birth: 29/8/2023 ..... Time: 2:45am ..... Date of Discharge: 3.0/8/2023 .....

Date	29/8/23		30/8/23		31/8/23		1/9/23		2/9/23		3/9/23		4/9/23		5/9/23							
No. of Days	DO		D_1		D_2		D_3		D_4		D_5		D_6		D_7							
Weight	3.2kg		3.1kg		3.0kg		2.9kg		2.9kg		3.0kg		3.1kg		3.2kg							
Temperature	AM 36.2°C	PM 36.8°C	AM 36.1°C	PM 36.8°C	AM 36.1°C	PM 36.2°C	AM 36.5°C	PM 36.8°C	AM 36.8°C	PM	AM 36.8°C	PM	AM 36.7°C	PM	AM 36.5°C	PM	AM	PM	AM	PM	AM	PM
Stools	passed	passed	passed	passed	passed	passed	passed	passed	passed		passed		passed		passed							
Urine	passed	passed	passed	passed	passed	passed	passed	passed	passed		passed		passed		passed							
Remarks	HEAD NECK TRUNK LMS GENITALIA } NAD																					

SIGNATORIES

THE STUDENT

NAME: PEGGY JACHAN

SIGNATURE .....

DATE 7/6/2024

THE MIDWIFE IN-CHARGE (PALAM AVENUE MATERNITY HOME BEREKUM)

NAME: MS. GRACE MAAKUU

SIGNATURE: ..... (Sr)

DATE 10/06/2024

THE SUPERVISOR

NAME: MS. UBAIDA ABDUL-KARIM

SIGNATURE .....

DATE 07/06/2024

THE PRINCIPAL, HOLY FAMILY NURSING AND MIDWIFERY TRAINING COLLEGE, BEREKUM

NAME: MONICA NKURUMAH

SIGNATURE.....

DATE 10/06/2024

PRINCIPAL
HOLY FAMILY NURSING AND
MIDWIFERY TRAINING COLLEGE
BEREKUM