HOLY FAMILY NURSING AND MIDWIFERY TRAINING COLLEGE, BEREKUM

A CLIENT / FAMILY CENTERED MATERNITY CARE STUDY

ON

MADAM KONADU EVELYN

BY

MISS QUAICOO ASANTE ESTHER

4122190016

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

AUGUST, 2022

TABLE OF CONTENTS

CONTENTS **PAGES**

TABLE OF CONTENTS ....

LIST OF TABLES IV

PREFACE V

ACKNOWLEDGEMENT VI

INTRODUCTION VII

LITERITURE REVIEW VIII

PREGNANCY VIII

CHAPTER ONE 1

CLIENTS PARTICULARS 1

1.0 INTRODUCTION 1

1.1 PERSONAL AND SOCIAL HISTORY 1

1.2 FAMILY HISTORY 1

1.3 MEDICAL HISTORY 1

1.4 SURGICAL HISTORY 2

1.5 MENSTRUAL HISTORY 2

1.6 CLIENT'S LIFESTYLE AND HOBBIES 2

1.7 PAST OBSTETRIC HISTORY 2

1.8 PRESENT OBSTETRIC HISTORY 3

CHAPTER TWO 4

ANTENATAL CARE 4

2.0 INTRODUCTION 4

2.1 FIRST CONTACT WITH CLIENT 5

2.2 FIRST ANTENATAL HOME VISIT 9

2.3 PSYCHOSOCIAL HISTORY 10

2.4 SECOND ANTENATAL HOME VISIT 10
2.5 SUBSEQUENT VISIT TO THE HOSPITAL BY THE CLIENT 10
2.6 NURSING CARE PLAN DURING ANTENATAL CARE 11
CHAPTER THREE 18
LABOUR 18
3.0 INTRODUCTION 18
3.1 ADMISSION AND MANAGEMENT OF LABOUR 18
3.2 PREPARATION FOR BIRTH 17
3.3 MANAGEMENT OF FIRST STAGE OF LABOUR 17
3.4 MANAGEMENT OF THE SECOND STAGE OF LABOUR 21
3.5 IMMEDIATE CARE OF THE BABY AT BIRTH 23
3.6 MANAGEMENT OF THE THIRD STAGE OF LABOUR 23
3.7 MANAGEMENT OF THE FOURTH STAGE OF LABOUR 24
3.8 MANAGEMENT OF THE MOTHER 26
3.9 CONDITION OF BABY AT BIRTH 27
3.10 CONDITION OF MOTHER AFTER BIRTH 27
3.11 CARE PLAN DURING LABOUR 28
CHAPTER FOUR 33
PUERPERIUM 33
4.0 INTRODUCTION 33
4.1 DAY OF DELIVERY 33
4.2 SUBSEQUENT CARE OF THE BABY 34
4.3 FIRST DAY POST DELIVERY (DAY OF DISCHARGE) 36
4.4 FIRST DAY POST NATAL HOME VISIT (2ND DAY POST DELIVERY) 38
4.5 SECOND DAY POST NATAL HOME VISIT (3RD DAY POST DELIVERY) 40
4.6. THIRD POSTNATAL HOME VISITS (4TH DAY POST DELIVERY) 41
4.7 FOURTH DAY POST NATAL HOME VISIT (5TH DAY POST DELIVERY) 43

4.8 FIFTH POSTNATAL HOME VISIT (6TH DAY POST DELIVERY) 44
4.9 SIXTH DAY POSTNATAL HOME VISIT (7TH DAY POST DELIVERY) 45
4.10 SEVENTH POSTNATAL HOMEVISIT (8TH DAY POST DELIVERY) 46
4.11 FIRST POST NATAL VISIT TO THE CLINIC 47
4.12 SECOND POSTNATAL VISIT TO THE CLINIC 49
4.13 CARE PLAN DURING PUERPERIUM 50
SUMMARY AND CONCLUSION 56
BIBLIOGRAPHY 59
APPENDIX I 60
APPENDIX II 63
APPENDIX III 66
SIGNATORIES 71

LIST OF TABLES

TABLE 2.1: NURSING CARE PLAN FOR ANTENATAL CARE 13
TABLE 3.1: LABOUR CARE PLAN 27
TABLE 4.1: CARE PLAN DURING PUERPERIUM 51
TABLE I: MOTHER'S ANTENATAL CARE 60
TABLE I.I ITN GIVEN – (04/05/21) 62
TABLE II.I ANTENATAL COMPLETED DIAGNOSTIC INVESTIGATIONS 63
TABLE II.II COMPLETE DIAGNOSTIC INVESTIGATION 64
TABLE III.I PHARMACOLOGICAL DRUGS FOR MOTHER 66
TABLE III.II PHARMACOLOGICAL DRUGS FOR BABY 69

PREFACE

Midwifery is a very vital aspect of health care given to the pregnant women and their families. Client and Family centered maternity care study is a systematic, comprehensive and holistic approach used in rendering obstetric care to the expectant mother and her family as a whole throughout pregnancy, labour and puerperium. The case involves data collection, nursing diagnosis, assessment, identification of problems, planning; implementation and evaluation of the data that would help solve the individual’s problems.

The care also focuses on the mother's physical, emotional, spiritual, psychological and social needs to help attain maximum standard of care. The family centered maternity care study also gives the student midwife an opportunity to use her knowledge and skills acquired both practically and theoretically during her period of training to care for a pregnant woman throughout pregnancy, labour and puerperium.

Moreover, the family centered care study helps the student midwife to use the new trend in midwifery like the partograph and nursing process in management of first stage of labour and to diagnose any complication during pregnancy. The nursing process provide framework for solving problems and making decisions in the management of the client and family in a systematic manner. The study also enables student midwife to educate the client and family and also promote cordial relationship between the student midwife, the mother and her family.

Furthermore, the study helps the student midwife to put into practice the concept of safe motherhood initiative which has being adapted to render quality maternity care through antenatal, labour and puerperium which will eventually reduce maternal and neonatal mortality.

The family centered maternity care study is an academic exercise required by the Nursing and Midwifery Council of Ghana so as to enable the student midwife to practice after completion of her training.

ACKNOWLEDGEMENT

My first and most grateful gratitude goes to God Almighty for giving me his strength, guidance, protection and knowledge to write this case study successfully.

I am also most grateful and appreciative to the stuff of Holy Family Nursing and Midwifery Training College, Berekum for their support and encouragement they gave me during the period of my training and writing of this case study, more especially my supervisor Madam Dorcas Osei for her advice and strict supervision. Again, I want to thank the Principal, Miss Monica Nkrumah for her motherly love, care, support and strict supervision in the upbringing of this piece.

Also, my gratitude goes to my client, Madam Evelyn Konadu and her entire family for providing me with all the necessary information, co-operation and hospitality during my time of visit to their home.

Furthermore, I wish to express my gratitude and heartfelt appreciation to all the staffs of Adamsu Health Center, Drobo most especially midwife in-charge, Mrs Elizabeth Obubuafo and all the other staffs for their maximum support given to me throughout my care study. To the entire Tutorial staff of Nursing and Midwifery Training Collage, Berekum, I wish you all well in everything for your hard work and sacrifice exhibited in writing this care study.

Also, gratitude goes to the couples who gave birth to me Mr Christopher Asante and Mrs. Monica Asante; I say may the good Lord bless them in his own way. for encouragement, also remembering me in prayers and given me the necessary support physically, emotionally and finically throughout my years of study I say God bless you abundantly.

Finally, my profound gratitude and sincerity goes to all the authors of books and references used in the study I say thumps up and bravo.

INTRODUCTION

This Client and Family Centered Maternity care study was on Madam Evelyn Konadu, a 27years old, Gravida 2 Para 1 all alive and her family who live at Adamsu. Client was first met on 27th October, 2021 at 37weeks of gestation and in good health. She went through pregnancy, labour and puerperium successfully and delivered a healthy baby girl on the 12th November, 2021. Mother together with her baby was discharged on the 13th November, 2021. To maintain confidentiality, she will be called Madam Evelyn throughout the study. The client was visited at home on several occasions and the entire family as well were included in the care. Her condition and that of the baby were stable and good at the end of the study and both mother and baby were handed over to the midwife in-charge for continuity of care. This study is made up of four chapters namely, chapter one, chapter two, chapter three and chapter four.

Chapter one deals with the particulars of the client that is her personal and social history, family history, medical history, surgical history, menstrual history, lifestyle and hobbies as well as her past and present obstetric histories.

Chapter two deals with the antenatal care of the client, a description of the first encounter with the client and home visit made to her. The nursing care plan used in providing care for the client, where problems were identified, objective set, then an implementation plan used in rendering services.

The third chapter gives report on the admission and management of the first to the fourth stage of labour, including the immediate and subsequent care of the baby and the nursing care plan.

Chapter four gives an account of the management of puerperium with emphasis on care of the mother and baby from day of delivery to the first seven days after delivery and second postnatal clinic visits.

The script also includes summary, conclusion, bibliography, appendix like laboratory investigations, antenatal records, pharmacology of drugs and signatories.

LITERITURE REVIEW

PREGNANCY

Tiran (2009) defined pregnancy as a period from conception to delivery of the foetus. Normal duration is 280 days (40 weeks or 9 months and 7 days), counted from conception to delivery. Henderson (2009) stated that, pregnancy may be suspected by the woman based on the knowledge on her menstrual cycle, sexual activity and the signs and symptoms of pregnancy. They are; amenorrhea, nausea and vomiting, breast changes, enlargement of the uterus, frequent micturition, skin changes and quickening. These signs and symptoms of pregnancy may be considered as presumptive, probable, and positive. They become obvious to the woman as her pregnancy advances. Women may confirm their pregnancy using home pregnancy test.

Henderson (2009) further stated that, confirmation of pregnancy may also be sought form the midwife or doctor. This is established by a detail history and relevant clinic examination based on the signs and symptoms of pregnancy. King et. al, (2014) also stated that, the prenatal period is divided into trimesters, first trimester is considered to be weeks 1 to 12 (12 weeks) because organogenesis is complete at the end of twelve weeks and the end of spontaneous abortion is significantly reduced at time. Historically, the second trimester was considered to be weeks 13 to 28 because prior to the introduction of modern neonatal intensive care technique, 28 weeks was limit of viability. The third trimester extends from weeks 28 to 40. The term post - date or post term is typically used to describe a pregnancy beyond forty weeks (40).

Konar (2013) also added that, during pregnancy, there is progressive anatomical physiological and biochemical change not only confined to genital organs but also to all systems of the body. This is principally a phenomenon of maternal adaption to the increasing demand of the growing foetus. Unless understood, this physiological adaptation to normal pregnancy can be misinterpreted as pathological.

Konar (2013) further stated that, there is enormous growth of the foetus during pregnancy. The uterus which in non – pregnant state weighs about 60g with a cavity of 5 – 10ml and measures about 7.5cm in length, at term, weighs 900 – 1000 g and measures 35cm in length. The capacity is increased by 500 – 10000 times and changes occur in all parts of the uterus. There is increase growth and enlargement of the body of the uterus. Not only individual muscle fibers increase in length and breadth but there is also limited addition of new muscle fibers. These occur under the influence of the hormones; oestrogen and progesterone limited to the half year of pregnancy, pronounced up to twelve weeks (12). Three (3) distinct layer of muscle fibers are

evidenced, outer longitudinal; inner – circular and intermediate. Normal anteverted position is exaggerated up to eight (8weeks). Thus, the enlarged uterus may lie on the bladder rendering it incapable of filling, clinically evident by frequent micturition. Afterwards, becomes erect; the long axis of the uterus conforms more of less to the axis of the inlet.

Fraser & Cooper (2009) also added 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.

Konar (2013) stated that, there is marked congestion with hypertrophy of the muscles and tissues of the wall. In late pregnancy, the bladder mucosa becomes oedematous due to venous and lymphatic obstruction especially in primigravida following early engagement. Increased frequency of micturition is noticed at 6 – 8 weeks of pregnancy which subsides after 12 weeks. It may be due to resetting of osmoregulation causing increased water intake and polyuria. In late pregnancy, frequency of micturition once more reappears due to pressure on the bladder as the presenting part descends down the pelvis. Stress incontinence may be observed in late pregnancy due to urethral sphincter weakness.

According to Konar (2013), the gums become congested and spongy and may bleed to touch. Muscle tone and motility of the entire gastrointestinal tract are diminished due to high progesterone level. Cardiac sphincter is relaxed and regurgitation of gastric acid content into oesophagus may produce chemical oesophagitis and heart burn. There is diminished gastric secretion and delay emptying time of stomach. Risk of peptic ulcer is reduced. A tonicity of the gut leads to constipation while diminished peristalsis facilitates more absorption of food materials.

According to Ghana Health Service (2008), the number of times a client needs to be seen during pregnancy may vary. For the uncomplicated pregnancy, it is recommended that at least four ANC visits should be made according to the following schedule.

- First Visit: From onset of pregnancy up to sixteen weeks (16) gestation.
- Second visit: From the 24th to 28th week of pregnancy.
- Third Visit: at 32nd week of pregnancy.
- Fourth Visit: at 36th week of pregnancy.

LABOUR

Henderson (2009) stated that normal labour naturally follows a sequential pattern that involves painful regular uterine contractions stimulating progressive effacement and dilatation of the cervix and decent of the foetus through the pelvis, culminating in the spontaneous vaginal birth

of the baby, followed by the expulsion of the placenta and membranes. King (2014) also stated that, labour is the process by which childbirth occurs, requiring uterine contractions of sufficient frequency, duration and intensity to cause demonstrable effacement and dilatation of cervix.

Marshall & Raynor (2014) also added that, labour, purely in the physical sense, may be described as the process by which the foetus, placenta and membranes are expelled through the birth canal; however, labour is much more than a purely physical event. What happens during labour can affect the relationship between the mother and the baby and can influence the likelihood and / or experience of future pregnancies.

Marshall & Raynor (2014) again stated that, human pregnancy is considered to last approximately 40 weeks, with labour usually occurring between 17 and 42 weeks gestation. Complex physiology and psychological changes occur during the last few weeks of pregnancy and also during the onset of labour that prepare the woman for the process of labour and birth.

Marshall & Raynor (2014) further stated that, traditionally, three stages of labour are described, the first, second and third stage, but this is a rather pedantic view, as labour is obviously a continuous process. It has also been acknowledged that, there are more than three stages of labour, namely, the latent, active and transitional phases and these not only encompass specific physical changes but should also account for the emotional effect observed in women during this time.

Konar (2013) also stated that, conventionally, events of labour are divided into three stages.

- First stage starts from the onset of true labour pains and ends with full dilatation of the cervix. It is in other words, "Cervical stage" of labour. Its average duration is twelve hours (12) in primigravida and six hours (6) in multipara.
- Second stage starts from the full dilation of the cervix (not from the rupture of the membranes) and ends with expulsion of the foetus from the birth canal. It has got two phases; thus, the propulsive phase starts from full dilatation up to the descent of the presenting part of the pelvic floor and the expulsion phase is distinguished by maternal bearing down efforts and ends with delivery of the baby. Its average duration is two hours (2) in primigravida and thirty minutes (30) in multipara.
- Third stage begins after expulsion of the foetus and ends with expulsion of the placenta and membranes (after-births). Its average duration is about fifteen minutes (15) in both primigravida and multipara. The duration is reduced to five minutes (5) in active management.

- Fourth stage is the stage of observation for at least one hour (1) after expulsion of the after birth. During this period, general condition of the client and the behaviour of the uterus are to be carefully monitored.

Henderson (2009) also stated that under emotional and psychological care, it is important for the midwife to have a good understanding of women's feelings in labour. Attitudes and reactions to childbirth vary considerably and are influenced by differing social, cultural and religious factors. Many women anticipate labour with mixed feelings of fear and excitement.
Henderson (2009) further stated that, throughout labour, there should be a free flow of information between the women and her partner and the midwife, particularly in relation to examinations and their findings. Being fully informed and involved in decision making helps the women to retain a sense of autonomy and control. The midwife should be aware that not all individuals may feel sufficiently secure or able to express fear or anxiety during labour.
Konar (2013) further stated that under bladder care, client is encouraged to pass urine by herself as full bladder often inhibits uterine contraction and may lead to infection.
If the women cannot go to the toilet, she is given a bed pan. Privacy must be maintained and comfort must be ensured. If the client fails to pass urine especially in late first stage, catheterization is to be done with strict septic precautions.
Marshall & Raynor (2014) also stated the following under bath or shower. Immersion in a warm bath or birthing pool can be an effective form of a pain relief for labouring women that facilitates increased mobility with no increased incidence of adverse outcome for the woman or foetus. The midwife should invite the woman who is mobile to have a bath or shower whenever she wishes during labour.
According to Konar (2013), under rest and ambulation, if the membranes are intact, the client is allowed to walk about. This attitude prevents vena cava compression and encourages descent of the head. Ambulation can reduce the duration of labour, need of analgesia and improves maternal comfort if, however, labour is monitored electronically or analgesic drug (epidural analgesia) is given, she should be in bed. According to Konar (2013), assessment of progress of labour and partograph recording are also done. Partographs are tools that allow labour progress to be graphically recorded and visually assessed. They aid in the early detection of abnormal labour progress and are credited by some for decreasing rated of prolonged labour, oxytocin use, caesarean section and intrapartum morbidity/mortality as compared to usual care. Use of partograph is initiated during presumed active labour.

According to Marshall & Raynor (2014), active management of the third stage of labour (AMTSL): An active management policy usually includes the routine prophylactic administration of a uterotonic agent, either intravenously, intramuscularly or (Occasionally) orally, as a precautionary measure aimed at reducing the risk of post-partum haemorrhage. It is applied regardless of the assessed obstetric risk status of the woman, and is usually undertaken in conjunction with clamping of the umbilical cord shortly after birth for the birth and delivery of the placenta by the use of controlled cord traction.

PUERPERIUM

Tiran (2008) stated that puerperium is the period following childbirth during which the uterus and other organs and structures are returning to their non-pregnant state, a period of 6-8 weeks. According to Henderson (2009), the postnatal period or puerperium is traditionally defined as the time from immediately after the end of labour until the reproductive organs have returned as nearly as possible to their pre gravid condition, a period estimated to be around 6-8 weeks. Konar (2013) also stated that puerperium is the period following child birth in which the body tissues, especially the pelvic organs revert back approximately to the pre – pregnant state both anatomically and physiologically.

During puerperium the following physiological changes take place in all women as the body returns to its pre-pregnant state:

- Involution of the uterus and other soft parts of the genital tract.
- Commencement of lactation
- Physiological changes in other systems of the body. It is important that the midwife is familiar with these to ensure that appropriate care and advice are given.

According to Konar (2013), involution is the process whereby the genital organs revert back approximately to the state as they were before pregnancy. The woman is termed as puerperal.

Furthermore, Konar (2013) stated that puerperium begins as soon as the placenta is expelled and lasts for approximately 6 weeks when the uterus becomes regressed almost to the non-pregnant size. The period is arbitrarily divided into immediate-- within 24 hours; early – up to 7 days and remote – up to 6 weeks.

Henderson (2009) stated that the secretion of prolactin from the anterior pituitary gland initiates lactation. Once lactation commences, it is maintained by the baby suckling. This provides the natural stimulus for the release of prolactin.

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

- Lochia rubra: red, 1-4 days
- Lochia serosa: 5-9 days, the colour is yellowish or pink or pale brownish.
- Lochia Alba: 10-15 days, pale white.

Konar (2013) added that, the average amount of discharge for the first 5-6 days is estimated to be 250mls. Normal duration may extend up to 3 weeks. Henderson (2009) stated that changes in the urinary tract include a marked diuresis after delivery which lasts for 2-3 days. This is due to the reduction in blood volume occurring in the immediate postnatal period. The dilatation of the urinary tract, which occurs in pregnancy due to increased vascular volume, resolves and the renal organs gradually return to their pre gravid state.

Fraser & Cooper (2009) also stated that, regardless of whether women are breastfeeding, they may experience tightening and enlargement of their breast towards the 3rd or 4th day. Hormonal influences, encourage the breast to produce milk for women who are breastfeeding, the general advice is to feed the baby and avoid excessive handling of the breast. Simple analgesics may be required to reduce the discomfort.

Henderson (2009) further stated that, the falling levels of progesterone affect the alimentary tract. The smooth muscle tone gradually improves throughout the body and symptoms of heartburn the women may have experienced should resolve. Constipation may however remain a common problem during the postnatal period. Fraser Cooper further stated that it has been traditional to associate after pains with multiparity and breastfeeding. However, women experience after pains regardless of whether they have had previous pregnancies and when they are not breastfeeding. Management of after pain is by an appropriate analgesic.

WHY CLIENT WAS CHOOSEN

On October 27th, 2021 which was Monday at 9:30am Madam Evelyn Konadu was met at Adamsu Health Center. After going through her antenatal card, client was 37weeks pregnant. She was fit to be used as my client for the family cantered care study. All her laboratory results were good and expected date of delivery (EDD). Client was informed about my interest to take her as my client and she agreed. The midwife in- charge was also informed and she gave me the go ahead.

Introduction was made. Client was welcoming and had interest in knowing what I have for her. I had a thorough interaction with her about the physiology of waist pains and other physiological changes in pregnancy. She had little knowledge in pregnancy, labour and puerperium. This made me chose her as my client for the care study.

CHAPTER ONE

CLIENTS PARTICULARS

1.0 INTRODUCTION

This chapter deals with assessment of the client. It gives information about Madam Evelyn Konadu, the client used for the study. Her family community which constitute the social, surgical, menstrual, past obstetrical lifestyle, present obstetrical histories and the environment in which she lives.

1.1 PERSONAL AND SOCIAL HISTORY

Madam Evelyn, a 27-year-old from Sampa in the Bono region but lives at Adamsu with her family. She speaks English and Twi. She is dark in complexion and is 160cm tall. She completed Junior high school at Adamsu R/C. Client's occupation is trading and she is married to Mr Acheampong Kwabena who is also a framer.

They have been married for three years now. Mr Acheampong is 27 years of age and lives at Adamsu. His level of education ended at the SHS. He speaks Twi. He comes from Adamsu. He is dark in complexion and is 170cm tall. The house address of her is NT 23 Adamsu.

Her intention was to deliver at Adamsu Health Center. She is a Christian and attends church at Sunday. She has only one female child who is five is 5years old named Lilian Adjei receiving education at glory star at Adamsu. Her next of kin is her mother.

1.2 FAMILY HISTORY

Opanin Adu Francis and Madam Neketia Afia are the parents of Madam Evelyn. Her mother is a trader and her father is a farmer. She is the fifth born of six children of her parents. According to her, there are no known hereditary conditions such as sickle cell disease, hypertension, mental disorder, epilepsy, diabetes and asthma in her family. She further stated that there is no history of multiple pregnancies in her family. According to her, death in her family was natural.

1.3 MEDICAL HISTORY

According to client, she has never been admitted to the hospital before Client mentioned that she sometimes experiences minor illness which is treated on Out-Patient Department basis. Client said she usually experiences malaria but does not have any condition like asthma, hypertension, diabetes mellitus, tuberculosis and among others. She has no known allergies to food and drugs. She is also not on any medication for any chronic illness.

1.4 SURGICAL HISTORY

According to Madam Evelyn, she has never had an accident that has affected her pelvis and part of her body before. She has neither undergone any surgical operation which has affected her pelvis, spine nor reproductive organ. She also said she has never received blood transfusion or donated blood before.

1.5 MENSTRUAL HISTORY

According to client, she has a thirty (30) days menstrual cycle and bleed for four days. She had her menarche at the age of thirteen (13) and since had a regular menstrual flow with no dysmenorrhea. She uses sanitary pad during her menstruation and she changes it at least twice a day.

1.6 CLIENT'S LIFESTYLE AND HOBBIES

Madam Evelyn wakes up around 6am and goes to bed around 10pm. She washes her face and brushes her teeth with toothbrush and toothpaste. The next thing she does is to sweep her compound. She prepares breakfast for the family. She takes her bath, baths her daughter and prepares her for school. She prepares lunch at 12noon and prepares supper for the family around 5pm. She eats thrice daily and empty her bowel at least once a day. She neither smokes cigarettes nor takes any alcoholic drink. On Saturdays, she cleans the house with the help of her husband. Her dirty clothes as well as that of her husband and the child are washed and dried in the sun. Her favourite food is fufu and groundnut soup. She enjoys conversing and uses her leisure time mostly to sleep. On Sunday, she goes to the church with her family and closes around 12:00pm. She goes to the market every Tuesday (which is a 'market day') to buy foodstuffs in bulk and shops for the items that she would need in the upkeep of the house. She then comes home and prepares food for her family.

1.7 PAST OBSTETRIC HISTORY

Pregnancy

Madam Evelyn, gravida 2 para, alive, went through her pregnancy without any illness and had a term pregnancy. The interval between the first and second pregnancy was four years. There were no complications like ante partum hemorrhage. She had one spontaneous abortion. She said she has had three doses of tetanus -diphtheria injections during her first and second pregnancy and had all the doses of Sulphadoxine pyrimethamine as prophylaxis against malaria. She was a regular attendant to antenatal care until she delivers.

Labour

She had spontaneous vaginal delivery to an alive female child at St. Mary' hospital, Drobo and she weighed 3.2kg. The baby cried as soon as she were delivered. The third stage were actively and properly managed without any complication. She further mentioned that she had no history of retained placenta and the perineum was intact. In the fourth stage, the condition of the mother and the baby were good. She had no postpartum hemorrhage.

Puerperium

Madam Evelyn puerperal period according to her was normal. She had no puerperal psychosis; sub-involution and she visited the postnatal clinic as scheduled. She and her babies were healthy throughout. She practiced excusive breastfeeding for six (6) months and combine supplementary feed like corn dough, porridge and cerelac while she continues with the breastfeeding till the child was two years old. According to Madam Evelyn, all her children received the immunization against childhood preventable diseases. She opted for family planning method which was injection Depo Provera and she received support from her husband and her mother during her previous deliveries. According to her, her children have been healthy since birth.

1.8 PRESENT OBSTETRIC HISTORY

Madam Evelyn G2 P1 visited the antenatal clinic at an early age of the pregnancy on 4th May, 2021 at Adamsu Health Center. According to her, she does not remember her last menstrual period. Her expected date of delivery was calculated to be 12th November, 2021. And her gestational week at booking was twelve weeks

On her first antenatal clinic visit, her history was taken and recorded which included personal, family, medical, surgical and obstetrical histories. Laboratory investigations were also taken and physical assessment was done and recorded. Results of investigations which were carried out were as follows;

Hemoglobin Level - 11.0g / dl

Sickling Test - Negative

Blood group - O

Rhesus factor - Positive

G6PD - Negative

VDRL - Negative

HIV status - Negative

Urine R/E - No abnormalities detected

Stool R/E - No abnormalities detected

The following observations were made and recorded;

Temperature - 36.4^{o} C

Pulse - 80bpm

Respiration - 20cpm

Blood Pressure - 110/70mmHg

Hepatitis B Status - Negative

Other measurements were taken as follows:

Weight - 76kg

Height - 160cm

Records on her antenatal card indicated that she was examined from head to toe and no abnormalities were detected. On abdominal examination, no abnormalities were detected and symphysio-fundal height was not palpable. She had no complaints; therefore, she was served with the following routine drugs;

Folic acid 5mg (1 daily) for 30 days

Tablet Fersolate 200mg (1daily) for 30 days

Tablet Multivitamin 200mg (1 daily) for 30 day

She was scheduled for the next visit which she followed correctly and carried out all the laboratory investigations requested until she was met on the 27th October, 2021 when she was 37 weeks pregnant.

CHAPTER TWO

ANTENATAL CARE

2.0 INTRODUCTION

This chapter is about the care given to client during pregnancy specifically from the 37th week. It lays more emphasis on the first contact with client, various home visits and subsequent visits and also the nursing care plans drawn to solve her problems during pregnancy.

2.1 FIRST CONTACT WITH CLIENT

Madam Evelyn was met on 27th November, 2021 at Adamsu Health Center during the antenatal day when she was 37 weeks pregnant. It was her sixth visit to the hospital. This woman was approachable and ready to share any information. Introduction was made as Esther Asante Quaicoo, a student midwife from Holy Family Nursing and Midwifery Training College, Berekum, on eight weeks placement for community centered midwifery. Her antenatal book was collected and found out that she fell within the criteria and she has been attending antenatal clinic regularly and has no abnormal condition which can be a threat to her pregnancy. Brief information was given to her about the care study and why she was chosen and she accepted it and pledged her full support and co-operation. She was then taken through the general examination when it got to her turn with procedures explained. She was encouraged to question. Her vital signs were checked and recorded as follows;

Temperature	-	36.6^{O}C
Pulse	-	78bpm
Respiratory rate	-	20cpm
Blood pressure	-	120/70mmHg

Other observations made were recorded as follows;

Weight	-	67kg
Height	-	160cm

URINE TESTING

The client was given a clean container to void into it. It was explained to her that midstream urine was needed. Hand was washed and dried with a clean towel and protective cloths worn. Chemically prepared strip was dipped into the urine and compared to the readings on the strip container to exclude the presence of glucose, protein, ketones etc. which all proved negative.

All these findings were recorded in client's antenatal record booklet with findings explained to her. After the above procedures, education was offered to her on the following; warning signs in pregnancy like bleeding per vaginum, and losing of liquor, budgeting and layette, signs of impending labour, taking of medication as prescribed and, sleeping in an insecticide net to prevent malaria and good nutrition.

Client's permission was sought to perform physical examination from head to toe and the procedure was explained to her. She was asked to empty her bladder, privacy was ensured and 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 the supervision of the midwife in-charge.

PHYSICAL EXAMINATIONHEAD AND NECK.

After cleanliness checked on the hair, there were no dandruff, lice, ringworm, loss of hair, scalp infection and no abnormalities were detected. Client was congratulated for keeping the hair clean and was encouraged to keep it up.

The face was inspected for acne, chloasma, oedema and rashes but no abnormality was detected. The ears were inspected and there were no discharges. The eyes were inspected for jaundice of the sclera, pallor of the conjunctiva, alignment with the ears and discharges but nothing abnormal was detected. Also client lips were inspected for pallor, dryness, lesions, sores and mouth for tooth decay, loss of teeth and halitosis but no abnormality was detected. Madam Evelyn's neck was also checked and palpated. Suitably there was no enlarged thyroid gland, lymph gland and no distended neck vein or lumps.

BREAST EXAMINATION

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 the hand of the part to be examined under her head. The breast was palpated systematically in a circular manner using the inner aspect of the fingers and client was taught self-examination. She was advised to examine her breast regularly for early detection and reporting of any abnormalities. Nipples were squeezed gently for fluid (colostrum) and were cleaned with cotton wool swab, and were examined for odor and blood. The same was done for the other breast and no abnormality was noted. Breastfeeding history was asked and her desire to breastfeed was positive as her children were breastfed.

EXTREMETIES

The upper extremities were examined for equality and alignment with the body but both were equal. The hands and fingers were also examined for dirt and grown nails, oedema, pallor of palm and nail bed and all these were absent. Capillary refill of the finger nails was checked by pressing the nail bed and releasing it and the result was good. Client was therefore congratulated and encouraged to continue with her cleanliness. The lower extremities were examined for size and equality, varicose veins and oedema as well as leg cramps, tenderness in the calf muscle but no abnormalities was detected.

BACK

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

ABDOMINAL EXAMINATION AND PALPATION

POSITION AND PROCEDURE: To further reduce inaccuracies, client was assisted to lie in a recumbent or dorsal, with her knees bent and arms by her side to relax the abdominal muscles. Hands were washed with soap and water and dried with a clean dry towel. Standing on her right side, the abdomen was exposed. Before examination, palms were rubbed together to provide warmth to prevent induced contraction. And eye contact was maintained.

INSPECTION: On abdominal inspection, the shape of the abdomen was ovoid, medium in size and there was presence of linear nigra but no striae gravidarium. The abdomen was inspected for scars from previous deliveries and there was none detected and foetal movement was present.

MEASUREMENT OF SYMPHYSIO-FUNDAL HEIGHT: Hands were warmed, the upper symphysio-fundal height measured 36cm and gestational age was 37weeks.

FUNDAL PALPATION: upon facing the head of the woman on her right-hand side, the fundus was palpated with both palms and a smooth surface was felt indicating the foetal buttocks.

LATERAL PALPATION: Lateral palpation assesses the main body of the uterus to confirm the lie and identify the foetal position. This was done with palms on both sides of the uterus midway between the symphysis pubis and the fundus; the uterus was stabilized with a hand. Also, palpation was done through the entire midline to the lateral side of the abdomen to locate the foetal back in a rotary manner. The other hand was also used to stabilized the uterus and the procedure was repeated for the other half of the abdomen. The right lateral palpation was done at the right side of the woman and a smooth part was felt, which indicated the foetal back, which will help to position the fethoscope to listen to the foetal heart rate and the foetal limbs. Lastly, rough part was located on the left side of the mother. The position was right occipito anterior.

PELVIC PALPATION: the client was asked to flex her legs slightly and breathe through her mouth. Facing the woman's lower limbs and placing the palms of both hands on either side of the lower abdomen below the umbilicus pointing downwards and inwards, the head was palpated. The lie therefore was longitudinal, presentation was cephalic and the position was right occipito-anterior.

DESCENT OF THE HEAD: Location of the anterior shoulder was made and two fingers were placed on it. The symphysis pubis was located and the right ulna border was placed just above the symphysis pubis and the anterior shoulder. Five fingers occupied the space indicating decent of 5/5.

AUSCULTATION: On auscultation, the foetal stethoscope was warmed by rubbing in the palm and placed at the area where the foetal back was located to listen to the foetal heart rate. With one hand at the maternal radius to ensure that it is not the maternal pulse being listened to, the foetal heart rate was checked for one minute and recorded as 148beat per minute.

VULVA AND PERINEUM: Permission was sought to examine the vulva and it was granted. Hands were washed under running water with soap and dried with a clean towel and gloves were put on. The mons pubis was well shaved; there were no scars, varicose veins and genital warts. Also, there was evidence of good vulva hygiene so she was applauded for the good work done and was asked to continue with it. She was however advised against the wearing of nylon panties but instead use cotton panties. She was also educated about douching. The client was asked to lie laterally and sit up before getting out of the couch. She was congratulated for allowing the procedure to be done on her. Hands were washed and dried and all findings were explained to her and recorded into her antenatal book.

She complained of pains in the lower abdomen which she thought would affect the baby during delivery and puerperium. She was reassured and educated that it was due to the baby descending into the pelvis thereby exerting pressure on other organs and nerves in the sacral region. She also complained of waist pain and her waist pain was explained to her that it was as a result of the fetal head descending into the pelvic cavity and she was reassured to bend from kneel and also rest in between activities. She was thanked for her cooperation. The stages and true signs of labour were explained to her. That was first, second, third and fourth stages," show" and painful rhythmic uterine contractions. She was advised to report to the clinic if she sees any.

She was served with routine drugs as below;

Tab Fersolate - 200mg daily for 30days.

Tab Multivitamin - 5mg daily for 30days.

Tab folic acid - 200mg daily for 30days.

She gave direction to her house and phone numbers were exchanged. Client having agreed to be used for the study; arrangement was made to visit her house on 27th October, 2021. She was thanked and was escorted to the pick a car.

2.2 FIRST ANTENATAL HOME VISIT

First home visit to Madam Evelyn's house was on the 27th October, 2021 at 5:00pm. The main aim was to know where she lives and meet other members of her family and also talk about birth preparedness and complication readiness plan. The journey was made by car to the client's house by the directions given by her. The house was a little far from the facility. It was located near the Roman Catholic Church in Adamsu town. She was very glad for the visit. A warm welcome and seat was offered. A glass of water was served after than interaction with her started. Introduction was made to the family.

PHYSICAL ENVIROMENT

A quick assessment of the environment was done. Her child by then were playing on the compound. Client lived in a self-contained house. The house was built with blocks and roofed with aluminum sheets. There were 4 bedrooms, a big hall, well arranged kitchen and toilet and bath. They had an uncompleted apartment on the compound in which they live. The client has fenced her veranda with iron rods. Outside the house is painted with blue color while inside of her room is painted with green and white color. Client and her husband have their room whiles her child sleep in a different room. The other two rooms where been occupied by her mother who has come to visit and her younger sister who help her with the house chores respectively. Their surroundings were neat and not bushy. She uses plastic container with a lid to collect her refuse and empties her bin when it is full into a container which is provided by Zoom lion Ghana Limited. The Zoom lion people often empty this container whenever it was full. The used water from the bathroom drains through a pipe and goes into a gutter that is close by.

They have a bole hole in which they fetch water from and have electricity as a sour. They use "life" sachet water as their drinking water. Water used for other purposes such as cooking, bathing, washing is stored in a brown colored barrel covered with a lid. Layette was brought for inspection and it was complete. She was congratulated for purchasing all the items and was advised to add her National Health Insurance card, ANC card and take money along.

As the interaction continued, she was educated on the intake of a well-balanced diet, the importance of having enough rest, lifting of light loads and wearing of loose cloths and low heel shoes. She was again encouraged to keep up on her environmental hygiene. Her mother arrived just as the discussion was about to be concluded. She was advised to give a helping hand to the client to reduce tiredness and promote adequate rest and sleep. Her mother was

advised to help in caring for the child. She was informed about the next visit which was on the 4th November, 2021. Permission was sought to leave. She was very grateful. She was thanked for her co-operation and willingness to heed the advice out.

2.3 PSYCHOSOCIAL ENVIRONMENT

Madam Evelyn, the husband, the child and family- in law have a cordial relationship with each other, She has a warm and friendly relationship with her neighbours, other family members staying around the house . Her friends most of the times visit her and she also visit them at her leisure time. She is very free and likes to crack jokes. She has respect for humans and likes to make new friends.

After all interactions, Madam Evelyn and her family were than appreciated for their warm reception and permission was sought to leave. The next scheduled and then seen off by client.

2.4 SECOND ANTENATAL HOME VISIT

On the 4th November, 2021 at 4:30pm, Madam Evelyn was paid a visit as she was promised. A cheerful welcome was given by client. Client's husband was met, they were all happy. After exchange of pleasantries, she complained of constipation and frequency of micturition but was reassured and the physiological change in pregnancy was explained to disappear after delivery. Client was reminded on the true signs of labour and education was given to her to have enough rest and sleep, intake of fluid and nutritious food. She said her husband was being helpful in performing the household chores since the first visit. We then discussed about postpartum family planning and her husband said that they were interested in it.

2.5 SUBSEQUENT VISIT TO THE HOSPITAL BY THE CLIENT

She reported to the hospital on 6th November, 2021 at 7:30am as scheduled. She was helped through the normal routine procedures and her vital signs were checked and recorded as follows;

Temperature - 36.0oc

Pulse - 80bpm

Respiration - 21cpm

Blood pressure - 110/60mmHg

Other investigations were recorded as follows;

Haemoglobin - 10.8g/dl

Weight - 76kg

Client was asked to empty her bladder; midstream urine sample was tested for protein and sugar and it was negative. She was helped onto the examination couch and privacy was ensured. General examination was carried out under the supervision of the midwife in-charge and no abnormalities were found. On abdominal examination, symphysio-fundal height was 38cm and her gestational age was 38weeks, lie was longitudinal, presentation was cephalic with a descent of 5/5th above the pelvic brim. On lateral palpation, the position was right occipito-anterior. On auscultation, the fetal heart rate was 136bpm with regular rhythm and good volume. Client complained of visible vaginal discharge which was explained to her as leucorrhoea after inspection. All findings were communicated to her and recorded in her antenatal card.

2.6 NURSING CARE PLAN DURING ANTENATAL CARE

Nursing care plan is a document designed to render total, individualized care to client and her family taking into consideration their needs. It involves identifying problems, analyzing them, setting objectives and implementing interventions that will meet the set objectives. The care is then evaluated to know whether set goals have been achieved. In the course of this care study, three nursing care plans were done for Madam Evelyn that were for antenatal, labour, and puerperium.

PROBLEMS IDENTIFIED DURING ANTENATAL CARE

On 2nd November, 2021; Client complained of

1. Lower abdominal pain

On 9 November, 2021

2.Client complained of

2. Constipation.

3. Vaginal discharge (leucorrhoea).

4. Frequency of micturition

SHORT TERM OBJECTIVES

1. Client lower abdominal pains will be relieved and maintained throughout pregnancy.
2. Client will have her normal bowel movement once a day within 24hours
3. Client will cope with vaginal discharge till the end of pregnancy.
4. Client will understand the reason for the frequency of micturition within 72 hours.

LONG TERM OBJECTIVE

Client will go through pregnancy, labour and puerperium successfully without any complication to both mother and fetus.

TABLE 2.1: NURSING CARE PLAN FOR ANTENATAL CARE

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTIONS	DATE/ TIME	EVALUATION	SIGN
2/11/2021 at 8:00am	Impaired body comfort (Lower abdominal) pains related to descent of foetal head.	Client will cope with reduced lower abdominal pains within 48 hours as evidenced by midwife observing client complains less of the pain.	1. Reassure client that her pains would, subside after delivery. 2. Explain the cause of lower abdominal pains to client. 3. Encourage client to reduce household activities. 4. Encourage client to wear low heel shoes. 5. Encourage client's husband to help client with household chores.	1. Client was reassured that her pain would be subsided. 2. The cause of lower abdominal pains was explained to client. 3. Client reduced household activities. 4. Client wore low heeled shoes throughout pregnancy. 5. Client's husband help client with household chores like washing and sweeping.	04/11/21 at 10:00am	Goal fully met as evidenced by client verbalizing that her lower abdominal pains has reduced.	E.Q

ANTENATAL CARE PLAN CONTINUES

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVE/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTIONS	DATE/ TIME	EVALUATION	SIGN
9/11/21 at 8:40am	Alteration in bowel movement (Constipation) related to progesterone causing decrease peristaltic movement of the bowls and relaxation of the smooth	Clients will regain her normal bowel movement once daily as within 24hours evidenced by; 1. Client verbalizing that she is able to empty her bowel freely.	1. Reassure client to allay fear and anxiety. 2. Explain the physiology behind constipation. 3. Educate client on the intake of food rich in fibre. 4. Encourage client to take a lot of fluids every day.	1. Client was reassured to allay fear and anxiety. 2. The cause was explained to client that it is as a result of smooth muscle relaxation by progesterone during pregnancy. 3. Client took food rich in fibre like oranges, banana. 4. Client drank eight glasses of water per day.	10/11/21 at 8:00am	Goal met as; evidence by Client verbalized she has resumed her normal bowel movement once daily, and client husband	E.Q

	muscles of the intestine.	2. Client husband verbalizing that his wife can empty her bowel freely.	5. Encourage the client to engage in tolerable exercises such as walking.	5. Client understood the health benefits of exercising and engage herself in walking.		confirmed what his wife said.	

ANTENATAL CARE PLAN CONTINUES

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTIONS	DATE/ TIME	EVALUATION	SIGN
9/11/21 at 8:40am	Vagina discharge related to increased vascularity and mucus production of the genital during pregnancy.	Client's will understand the physiology and management of vagina delivery within 48hours as evidenced by client: 1. Verbalizing that amount of vaginal discharge has reduced. 2. Midwife observing client complains less.	1. Reassure client that the discharge will stop after pregnancy/ delivery 2. Explain the physiology of vagina discharge to client. 3. Encourage client to wear cotton panties. 4. Encourage client to practice good personal hygiene.	1.Client was reassured that the discharge will reduce. 2. Physiology of vagina discharges was explained to client. 3. Client wore cotton panties. 4. Client practiced good personal hygiene like washing her panties regularly.	11/11/21 at 10:00am	Goal fully met as evidence by client verbalizing that the amount of vaginal discharge has reduced and she is able to manage to vagina delivery.	E.Q

			5. Encourage client to change panties frequently. 6. Encourage client to dry her panties in the sun if possible.	5. Client changed panties frequently to prevent infections. 6. Client dried panties in the sun to reduce the rate of infection when it was possible.			

ANTENATAL CARE PLAN CONTINUES

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTIONS	DATE/ TIME	EVALUATION	SIGN

9/11/21 at 10:00am	Frequency of micturition related to the growing uterus exerting pressure on the bladder	Client will understand the reason for the micturition and cope with the condition within 42 hours after as evidence by client verbalizing: She is able to cope with the frequency of micturition and understand about the condition and Midwife observing that client complains less of the frequent voiding.	1.Reassure client. 2. Encourage her to lean forward when voiding to help empty her bladder. 3. Encourage her to urinate immediately when she has the urge. 4. Educate her on the use of panty liners. 5. Educate client on how to tighten the muscles.	1. Client was reassured and reminded of the frequency of micturition. 2. She leaned forward when voiding. 3. Client urinated immediately when she has the urge. 4. Client used panty liners. 5. Client understood what was taught on how to tighten the muscles around the vagina and anus.	11/11/21 at 8:30am	Goal fully met as evidence by client verbalizing that she understood the frequency of micturition and she has been managing.	E.Q

CHAPTER THREE
LABOUR

3.0 INTRODUCTION

This chapter talks about labour, admission and management of the various stages of labour, the immediate care of the new-born, examination of the new-born and care plans drawn for the management of the problems encountered during this period.

3.1 ADMISSION AND MANAGEMENT OF LABOUR

Madam Evelyn reported to the health center with her husband on 11th November,2021 at 6:40pm which was Thursday with complain of lower abdominal pains. They were warmly welcomed and offered seats and further assured that she is in safe hands and readiness to support her. Client's antenatal card was collected and quickly glanced through with the midwife in- charge to refresh the memory on her past and present histories. Labour history was taken and according to her, she experienced severe lower abdominal pain and has seen show at 4:20pm. It was explained to her that it was engagement of the fetal head which was putting pressure on the sacral nerves. She really looked anxious, so she was therefore reassured to allay anxiety and was seen mishandling her perineal pad by touching it anyhow even when it was not soiled. Her items for delivery were nicely and neatly packed in a bag and it contained all the needed items of which it was collected and labelled. She was asked about the last meal, bowel action and any drug taken. She was made comfortable in bed and all procedures to be carried out were explained to her and her consent was sought. She was encouraged also to ask questions.

Client vital signs were checked and recorded as follows;

Temperature	-	36.6°C
Pulse	-	83bpm
Respiration	-	24cpm

Blood Pressure	-	100/60mmHg

Other observation recorded as

Hemoglobin	-	12.3g/dl

A specimen bottle was given to her for the midstream urine collection for urine examination and a bed pan was also served. The amount of urine produced was 150mls. A urine reagent strip was used to test for glucose, acetone and protein and the result was negative and the color of urine was amber, clear and not offensive. Hands were washed with soap under clean running water and dried with clean dry towel. Having explained the procedure and her consent sought, head to toe general examination was conducted but no abnormality was detected. The abdomen was inspected.

Inspection: Client's abdomen was ovoid in shape and medium in size. Striae gravidarum, linear nigra and fetal movement were present but no scar was found.

Palpation: The abdomen was palpated, symphysio fundal height was 38cm, and gestational age was 39weeks, the lie was longitudinal, presentation was cephalic and descent was $4/5^{th}$ palpable abdominally. Contraction was 3 in 10 minutes lasting for 30 seconds.

Auscultation: The heart rate was 148 beats per minute with good volume and regular in rhythm.

Vaginal Examination: Madam Evelyn was helped onto the lithotomy position at 7:15pm. Hands were washed with soap under running water and dried with a clean towel, sterile gloves were worn for vaginal examination. The vulva was then inspected for scars, sores, warts, edema, clitoridectomy, and abnormal discharge but none was present.

The vulva was then swabbed with sterile cotton wool swabs soaked in savlon solution. After swabbing the vulva, the vagina was entered with the middle finger and then followed by the index finger. On vaginal examination, the vagina was warm and moist, the cervix was soft, thin and the presenting part well applied to it. The membranes intact, cervical dilatation was four (4) centimeters, presentation was cephalic, promontory of sacrum was not reached at 10 centimeters. The sacrum was well curved, ischial spines were blunt and pubic arch was wide. Hands were removed and a fist was made and it fitted into the intertuberous diameter. Madam Evelyn's perineum was cleaned and a perineal pad applied to the vulva. Client was encouraged not to sit for a very long period but encourage to walk around to help manage the pain. Client was encouraged to lie on her left side when she felt tired .She was also encouraged to pass urine frequently and when she felt the urge as that will aid in the descent of the fetal head and effective contractions and also change her perineal pad when soiled to prevent infection. Client was covered with a cloth and made comfortable in bed and was educated on the progress of labour and findings were recorded on the labour chart. She was told to assume any position comfortable to her and sacral massage was done during contractions to reduce pain. She was cautioned not to push when she felt the pains because that would make the cervix edematous and thereby prolonging labour. She was reminded of the importance of deep breathing exercise and how to do it. She was asked if she felt hungry and she replied she was okay. Client's husband was offered a seat outside and he was reassured of safe delivery.

3.2 PREPARATION FOR BIRTH

. **Identification of helper and review of the emergency plan:** The midwife in-charge who was supervising labour was chosen as a skilled helper and was informed that she may be called to help in case of emergency for the baby and mother during and after delivery. The husband of the client who was the unskilled helper was informed to be available in order to run errands when needed. Madam Evelyn had two of her relatives around who were going to donate blood in case of need. The taxi driver was also informed that his service may be needed when there is emergency. The area for delivery was prepared by drawing curtains down, testing of light and making provision for artificial lighting in case of lights out and switching off fans. Madam Evelyn's abdomen was washed and dried to prevent infection to the baby after delivery since the baby will be placed skin to skin on the mother's abdomen. She was assisted to wash and dry her hands .Preparation of an area for resuscitation and checking of equipment was also done by preparing a dry, flat and safe space for receiving the baby for resuscitation when necessary and equipment to help the baby breathe were assembled ,checked and tested for their functioning and they were in good condition. The items included the suction device, ambu bag and mask, stethoscope, scissors, timer, source of light, head covering, clothes and gloves among others. Delivery set and emergency drugs were available when checked.

3.3 MANAGEMENT OF FIRST STAGE OF LABOUR

Client was put on partograph on admission when labour was established Fetal heart rate, constractions and pulse was checked every 30 minutes and vaginal examination, descent, blood pressure and temperature was done 4 hourly. She complained of fatigue and nausea. Sacral massage was done and she was reassured, the physiology behind the pains explained to her and educated on deep breathing exercise during contractions. She was encouraged to take light

nutritious diet and normal fluids in bits to prevent dehydration and to help her during the second of labour. A specimen bottle was given to her for the midstream urine collection for urine examination and a bed pan was also served. The amount of urine produced was 150mls. A urine reagent strip was used to test for glucose, acetone and protein and the result was negative and the colour of urine was amber, clear and not offensive.

At 7:45pm fetal heart rate was 145bpm, contraction was 3:10 lasting for 30sec, maternal pulse was 82bpm. At 8:15pm fetal heart was 144bpm, contraction was 3:10 lasting for 40 sec, maternal pulse was 84bpm. She was also encouraged to adopt left lateral position to prevent supine hypotension syndrome. Findings were also communicated to her. At 8:45pm fetal heart rate was 140bpm, contraction was 3:10 lasting for 30 sec, maternal pulse was 85bpm. At 9:15pm fetal heart rate was 150bpm, contraction was 4:10 lasting for 35sec, maternal pulse 80bpm. Client was encourage to empty her bladder frequently to aid in the decent of the fetal head. At 9:45pm, fetal heart rate was 145bpm, contraction 4:10 lasting for 40sec maternal pulse 84bpm. At 10:15pm, fetal heart rate was 143bpm, contraction was 3:10 lasting for 41sec, maternal pulse was 85bpm. At 10:45, fetal heart rate 144bpm, contraction was 3:41sec, maternal pulse was 84bpm.

At 11:15pm, client vaginal examination repeated, cervix was 8cm dilated with descent 2/5th, contractions 4 in 10 minutes lasting for 45 seconds with membranes still intact, foetal heart rate was 134bpm. Client's vital signs was checked and recorded as follows:

Temperature	-	36.2 degrees Celsius
Pulse	-	84 beats per minute
Respiration	-	23cycles per minute
Blood pressure	-	110/70millimeters per mercury
Fetal heart rate	-	134 beats per minute

Descent - $2/5^{th}$

Contraction - 4 in 10 lasting for 40 and 50 seconds

A specimen bottle was given to her for the midstream urine collection for urine examination and a bed pan was also served. The amount of urine produced was 100mls. A urine reagent strip was used to test for glucose, acetone and protein and the result was negative and the color of urine was amber, clear and not offensive. Hands were washed with soap under clean running water and dried with clean dry towel.

All findings were communicated and recorded on the partograph and client was informed of progress of labour using the dilatation board, she was informed delivery was imminent and during that period she will have the edge to bear down to defecate and therefore asked to call the midwife. The trolley was clean and a sterile delivery with other clean items were made available on both top and bottom shelf as below. Upper shelf containing the following packed in the delivery set;

TOP SHELF

- Delivery pack containing; four clean towels
- Two artery forceps
- Two dissecting forceps
- Two gallipot (with one containing cotton swabs soaked in savlon solution and the other containing gauze)
- One cord scissor
- Receiver
- Episiotomy set
- Cord clump
- Pair of sterile gloves
- 10 units of oxytocin
- Two cot sheet

- Vitamin k injection

LOWER SHELF

- A jug for measuring the amount of blood loss
- Receiver for placenta
- Container with syringes and needles
- Fethoscope
- Antiseptic lotion (savlon)
- Sterile gloves
- Extra perineal pad
- Small cup containing water and bulb syringe
- Cord clamp
- Bed pan
- Identification band
- Examination gloves
- Mackintosh
- Cot sheets
- Drum containing gauze and cotton wool

Cheatle forceps in its container

At 11:45pm, fetal heart rate 144bpm, contraction was 4:45seondc, maternal pulse was 84bpm. Client was encourage to perform deep breathing exercise. At 12:15am, fetal heart rate 150bpm, contraction was 4:45second, maternal pulse was 85bpm. At 12:45am, fetal heart rate 148bpm, contraction was 4:45second, maternal pulse was 87bpm. Client was encouraged to lie on the left lateral position to prevent supine hypotension and also encourage to take more fluid to prevent dehydration.

Labour progressed well, client complained that she wants to defecate. At 1:05am on she ruptured membranes spontaneously, she had the edge to pass stools, vaginal examination was done and the cervix was 10cm dilated, descent was $0/5^{th}$, moulding was (++) which indicated that the bone were overlapping each other but could slip off, liquor was clear, contractions was 444 in 10 minutes lasting 46seconds and fetal heart rate was 137bpm, the perineum bulged and

the anus gaped. The in-charge was informed of the progress of labour and was asked to confirm my findings and she confirmed client was fully dilated and she was which marked the beginning of second stage of labour. Client was again reminded that her baby will be delivered unto her abdomen Client was helped to wash her hands and chest with soap and clean water and dried with clean towel to prepare for skin to skin care. Vital signs and assessment were recorded as follows;

Temperature - 36.8 degrees Celsius

Pulse - 90 beats per minute

Respiration - 24 cycles per minute

Blood pressure - 110/60 millimeters per mercury

Fetal heart rate - 137beats per minute

Descent - 0/5th

Contraction - 5 in 10 lasting for 40 and 50 seconds

3.4 MANAGEMENT OF THE SECOND STAGE OF LABOUR

The second stage of labour starts from full dilatation of the cervix to birth of the foetus. After carrying out vaginal examination, client was informed that she was due to deliver her baby. She was asked about the position she preferred to deliver her baby with and she chose the lithotomy position and was helped to assume that position. All windows were closed and fans were turned off. Protective clothing was then worn, that is plastic apron, boots and face masks. Delivery pack was opened by the midwife in-charge and sterile gloves worn. The vulva was cleaned with cotton wool balls soaked in savlon solution. She was draped with sterile sheets on both thighs, on the abdomen and under the buttocks to maintain a sterile field for the foetus.

Client was reminded that the baby would be delivered onto her abdomen and she agreed. With the second stage being confirmed by the last vaginal examination, she was asked to push with contractions and take rest when the contractions wear off. As she pushed and the head was advancing, a clean perineal pad was placed at the anal region to prevent the stool from contaminating the delivery field and getting in to contact with baby's face.

The middle and index fingers of the right hand were placed on the fetal advancing head to aid flexion and to allow the smallest diameter of the fetal head to distend the vulva; this was done to prevent crack or tear of the perineum. With two contractions crowning took place and the woman was asked to pant with contraction in order to prevent sudden expulsion of the fetal head. Extension of the head occurred in which sinciput, face and the chins swept the perineum and the head was born. The eyes were cleaned immediately with sterile gauze, cleaning from the inner contour of the eyes outward using a swab at a time.

The neck was felt for cord around the neck and there was none. Restitution occurred and external rotation of the head which indicated that internal rotation of the shoulders had occurred. The fetal head was held in both palms, each palm on the parietal bones and with little downward traction, the anterior shoulder was delivered. The posterior shoulder was also delivered with upwards traction as it was allowed to sweep the perineum and with lateral flexion, the trunk and the rest of the body was delivered onto the mother's abdomen. The sex of the baby was noticed to be a male.

The baby coughed and started crying out very loudly. The baby was left on the mother's chest to initiate bonding, breast feeding and to provide warmth. The baby was completely expelled at 1:27 am.

3.5 IMMEDIATE CARE OF THE BABY AT BIRTH

Immediately the head was delivered, sterile gauze was used to clean the baby's eyes from the inner canthus to the outer canthus. The baby was delivered onto the mother's abdomen. The cord was clamped 3 centimeters away from the baby's abdomen and second clamp 2 centimeters from the first clamp. The cord was covered with gauze and cut in between the clamps to separate the baby from the mother within the first three minutes. First minute Apgar score was 8/10. The baby was made warm by wiping off the liquor and was covered on mother's abdomen for skin-to-skin care. The fifth minute APGAR was 9/10. An identification band was placed on the baby's wrist.

The Apgar score assessment was as follows;

INDICATOR	FIRST MINUTE	FIFTH MINUTE
Appearance	2	2
Pulse	2	2
Grimace	1	2
Activity	1	2
Respiration	2	1
Total	8/10	9/10

3.6 MANAGEMENT OF THE THIRD STAGE OF LABOUR

She was in the lithotomy position and a receiver placed near the vulva in between the thighs. Procedure was explained to her. The uterus was palpated to rule out the presence of a hidden twin and ten (10) units of oxytocin was injected intramuscularly on the mother's thigh by the Midwife-In–Charge to aid in the contraction of the uterus and separation of the placenta. Non dominant hand was placed on the fundus to feel for contraction of the uterus. The cord was re-clamped nearer to the perineum with one artery forceps. The cord and artery forceps was held with the dominant hand. As soon as the uterus contracted, the non-dominant hand was removed and placed just above the symphysis pubis with the palm facing the abdomen of the mother to provide counter traction to prevent uterine inversion during removal of the placenta.

At the same time, the dominant hand that held the clamped cord was pulled gently in a downwards direction following the curve of carus. With steady controlled cord traction, the process was repeated until the placenta was visible at the vulva and cupped with the two hands, and was rolled round to gently tease the membranes from the lower segment. The placenta was completely delivered at 01: 32am. A quick examination of the placenta was made where both

the maternal and fetal surfaces were intact. The placenta was placed in a receiver for thorough examination later. The uterus was rubbed for a contraction and clots were expelled.

The client was taught how to massage the uterus. The vulva was cleaned with water, the labia were patted and cleaned. Two sterile gauzes were wrapped on the middle and index finger for inspection using the clockwise method and there were no lacerations on the perineum. The vaginal walls and cervix were inspected but there were no tears. The total blood loss was estimated as 150 milliliters. Client was cleaned and a new perineal pad was applied to the vulva to absorb any lochia and client was made comfortable in bed. Client was congratulated.

EXAMINATION OF THE PLACENTA AND MEMBRANES

The placenta was dip in 0.5 chlorine and removed immediately. The placenta was examined under a good source of light and on a flat surface. The foetal surface was greyish blue with firm amniotic membranes and cord was in the center of the placenta. The maternal surface was dark red in colour. It was covered with chorion which was opaque. The membranes, lobes and cotyledons were inspected and they were intact. No infarct and oedema were seen on the maternal surface, the cord was thick with Wharton's jelly. The tip of the cord was wiped with a dry cloth for inspection. It had two arteries and one big vein. The placenta was placed in 0.5% chlorine solution in the sluice room for decontamination and discarded in the placenta pit. The delivery instruments and equipment used were soaked in 0.5% chlorine solution, gloves were removed and hands were washed. After 10 minutes, instruments were removed with utility gloves, washed in soapy water and rinsed in clean water and was then air dried and packed for sterilization.

3.7 MANAGEMENT OF THE FOURTH STAGE OF LABOUR

During the fourth stage of labour, close observation of the mother and baby were made for about six hours following the expulsion of the placenta, membranes and the subsequent arrest of hemorrhage. During this period, mother and baby were assessed for every fifteen minutes for two hours, thirty minutes for an hour and one hourly for three hours which was recorded behind the partograph. This was done to detect any deviation from normal.

PREVENTION OF DISEASES

The baby was given two drops of chloramphenicol eye drops was instilled on baby's eyes as prophylaxes for eye infection. The cord was dressed with sterile cotton wool swabs and methylated spirit to prevent cord infection. Vitamin K1 was administered intramuscularly to prevent haemorrhagic disease of the new born. No bleeding was noticed. Hands were washed with soap under running water and dried with a clean dry towel afterwards.

EXAMINATION OF THE NEWBORN

Procedure was explained vividly to client, examination gloves were worn and baby was examined from 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 the baby was covered again to be examined from head to toe.

Head and neck: On examination of the head, the index and middle fingers was run through the suture line to check for any bulging fontanelles but no abnormality was detected. There was no laceration on the scalp and no caput succedaneum. The ears were examined for size, shape, patency, position, softness of the cartilage but no abnormality was detected. The eyes were in alignment with the ears and presence of an eyeball. There was no redness of the conjunctiva or jaundice on the sclera. The nose was examined for shape, size, patency to rule out deviated septum and discharges but everything was normal. 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 rigidity, congenital goitre and swelling of the neck.

Nose: The nose was inspected for size and shape and examined for deviated septum but the septum was normal. The nostrils were inspected for patency and discharges and the mucosa for colour and polyps. No abnormality was detected.

Mouth: The mouth was examined by pressing the angle of the jaw which opened the mouth and the tongue, gum and palate were inspected and there was also no false tooth noticed. The palate was high arched, intact and the vulva centrally placed. There was no cleft palate or cleft lip or tongue tie.

Ears: The ears were inspected, the upper notch of the pinnae was at the same level with the canthus of the eye. External auditory meatus was patent and the cartilage in the pinnae was checked for its softness. The shape and size was also noted and no abnormality was detected.

Chest examination: Respiratory movement was normal, nipples were in alignment, and breast had no mass.

Extremities: The upper extremities were inspected for equality, number of palmer creases, clubbed fingers, extra or loss digits. No abnormality was detected. Baby’s ability to perform Moro and grasp reflexes were also checked. The lower extremities were inspected for equality, clubbed feet, extra or loss digits but none was present.

Abdominal examination: The abdomen was examined for shape and size, with no bleeding from the umbilical site and abnormalities such as omphalocele, gastrochisis were absent.

Congenital hip dislocation was also checked using the Ortolani's test and there was no dislocation since a 'clunk' was not heard.

Back examination: The back of the baby was examined for abnormalities like spinal bifida, meningocele, but none was detected.

Genital examination: The vulva was well formed, urethra and anal orifices were patent as it passed urine and meconium respectively.

Measurement: Measurements of the baby were done; Head circumference 34 centimeters, Length of the baby was 46 centimeters. Baby's weight was 3.5 kilograms. Gloves were removed and disposed aseptically before washing and drying hands. Findings were documented and communicated to her. Baby's vital signs and weight were checked and recorded as follows;

Temperature - 36.2 degree Celsius

Apex heart beat - 130 beats per minute

Respiration - 44 cycles per minute

Weight - 3.5kilograms

3.8 MANAGEMENT OF THE MOTHER

Client was reassured and encouraged to have enough rest and sleep. The mother's initial vital signs were checked and recorded as follows;

Temperature - 36.4 degree Celsius

Pulse - 86 beats per minute

Respiration - 20 cycles per minute

Blood pressure - 120/80 milliliters of mercury

The fundus was rubbed to facilitate contraction. Blood clots were expelled and blood loss was 150 milliliters, and the symphysiofundal height was 17 centimeters. Client was transferred to the lying-in-ward and baby put to breast. The total blood loss after the fourth stage was 100 milliliters. At the end of the fourth stage, the amount of urine passed was 100 milliliters. Lochia was red in colour (rubra), small in quantity and had no foul smell. Client was educated on frequent micturition and changing of perineal pads when soaked, how to fix baby to breast, the importance of exclusive breastfeeding for the first six months and feeding on demand was stressed on as well. Client's sister and husband were allowed to see her and she was served with warm porridge and bread to restore energy. General condition of client was good and all labour notes were recorded on the partograph sheet.

SUMMARY OF LABOUR

Client had a spontaneous vaginal delivery to a live female baby on 12th November, 2021 at 1:27am with birth weight 3.5kg with APGAR score 8/10 and 9/10. Placenta and membranes were completely delivered at 1:32am by controlled cord traction. Estimated blood loss was 150mls. Condition of mother and baby was satisfactory and they were made comfortable in bed.

3.9 CONDITION OF BABY AT BIRTH

General examination of the baby was done and no abnormalities detected. The baby had a pink skin colour, umbilical cord was not bleeding. The baby was classified as normal and routine care given. Baby passed urine and meconium within some few minutes after birth. The baby's vital signs were as follows;

Temperature	-	36.4 degree Celsius
Apex heart beat		130 beats per minute
Respiration	-	44 cycles per minutes
APGAR score for first minute	-	8/10
APGAR score for fifth minute	-	9/10
Sex	-	Female
Weight	-	3.5kilogram
Length of the baby	-	46centimeters
Head circumference	-	33 circumference
Abnormalities	-	Nil
Condition of baby	-	Very good.

3.10 CONDITION OF MOTHER AFTER BIRTH

Client was made comfortable in bed and was helped to fix baby to breast. Vital signs were checked and the following examinations were done and recorded as follows;

Blood pressure	-	120/70 milliliters of mercury
Temperature	-	36.0 degree Celsius
Pulse	-	86 beats per minute
Respiration	-	20 cycles per minute
Fundus	-	17 centimeters
Blood loss	-	120 milliliters (small)

Bladder - 100 milliliters

Condition of mother after delivery was good.

DURATION OF LABOUR

Duration of first stage	-	6hours 15minutes
Duration of second stage	-	15 minutes
Duration of third stage	-	10minutes
Total duration of labour	-	6 hours 40minutes

3.11 CARE PLAN DURING LABOUR

Problems Identified During Labour

1. (12/11/21) - Client complained of lower abdominal pains
2. (12/11/21) - Client complained of nausea and vomiting
3. (12/11/21) - Client was anxious
4. (12/11/21) - Risk for electrolyte imbalance.
5. (12/11/21) - Risk for infection

Short Term Objectives

1. Client will cope within lower abdominal pains till delivery.
2. Client will be relieved of nausea and vomiting within two hours.
3. Client anxiety will resolve within one hour.
4. Client will maintain a normal fluid and electrolyte balance within 48 hours.
5. Client will show no sign of infection within 48 hours.

Long term objectives

Madam Evelyn will go through labour ad puerperium successfully without any complication.

TABLE 3.1: LABOUR CARE PLAN

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES	NURSING ORDERS	NURSING INTERVENTIONS	DATE/ TIME	EVALUATION	SIGN
12/11/21 at 8:00pm	Alteration in comfort (Lower abdominal) pains related to uterine contractions in labour	Client will cope with labour pains throughout labour as evidenced by midwife visualising that: 1. Client is not misbehaving and screaming in bed with every contraction.	1. Reassure client the lower abdominal pains will stop after labour. 2. Explain the process of labour to client. 3. Encourage client to practise deep breathing exercise. 4. Encourage client to empty her bladder frequently. 5. Engage client in a conversation as a form of divisional therapy. 6. Encourage ambulation.	1. Client was reassured the lower abdominal pains will stop after labour. 2. The process of first and second stage of labour was explained to the client. 3. Client was encouraged to practise deep breathing exercise. 4. Client was encouraged to empty her bladder frequently. 5. Client was engaged in a conversation. 6. Client was encouraged to walk around her bed.	12/11/21 at 10:00pm	Goal fully met as evidenced by midwife visualised that client cooperated well in the delivery process and had a successful delivery.	E.Q

LABOUR CARE PLAN CONTINUED

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES	NURSING ORDERS	NURSING INTERVENTIONS	DATE/ TIME	EVALUATION	SIGN
12/11/21 at 8:00pm	Risk for electrolyte imbalance Nausea and vomiting related to the physiology of labour	Client's nausea and vomiting will reduce within two hours during labour as evidenced by; 1. Client reporting that she no longer feels nauseated. 2.Midwife visualizing that client has stopped vomiting.	1. Reassure client to allay fear and anxiety. 2. Explain the physiology associated with nausea and vomiting. 3. Hydrate client to prevent dehydration by giving IV fluids. 4. Encourage client to reduce the intake of oily and spicy food. 5. Move away all nauseating objects from client.	1. Client was reassured to allay fear and anxiety. 2. The physiology of nausea and vomiting was explained to her understanding. 3. Client was given oral fluids to replace fluid loss. 4. Client was encouraged on the need to reduce the intake of oily and spicy foods. 5. Nauseating objects was moved away from client.	12/11/21 at 8: 30pm	Goal fully met as evidence by client verbalized that the nausea and vomiting has stopped.	E.Q

LABOUR CARE PLAN CONTINUED

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES	NURSING ORDERS	NURSING INTERVENTIONS	DATE/ TIME	EVALUATION	SIGN
12/11/21 at 8:30pm	Anxiety related to unknown outcome of labour.	Client will be relieved of anxiety 1hour after delivery as evidenced by client delivering a healthy baby without any complication	1.Reassure client that she is in compliant and will delivery successfully. 2. Establish and maintain good interpersonal relationship with client. 3. Explain every procedure before and after implementation. 4. Communicate all findings to client. 5. Encourage client to ask questions and answer them tactfully.	1.Client was reassured and will have successful delivery 2.Good interpersonal relationship was established. 3. Every procedure was explained to client. 4. Findings were communicated to client. 5. Client was encouraged to ask questions and answers were given tactfully.	12/11/21 at 9:00pm	Goal fully met as evidence by midwife visualized that client was relaxed in bed following a successful delivery and client verbalized she was relieved.	E.Q

			6. Introduce client to other staffs who will attend to her.	6. Client was introduced to other staffs.			

LABOUR CARE PLAN CONTINUED

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES	NURSING ORDERS	NURSING INTERVENTIONS	DATE/ TIME	EVALUATION	SIGN
12/11/21 at 8:00pm	Risk for fluid and electrolyte balance (less than the body requirement) related to inadequate fluid intake	Client will go through labour successfully without any sign of dehydration as evidenced by 1.The midwife	1. Reassure client that she will be well hydrated with a normal skin turgor. 2. Perform oral hygiene. 3. Monitor and record vital signs.	1. Client was reassured that she will be hydrated and have a normal skin turgor during labour and puerperium. 2. Oral hygiene was performed. 3. Vital signs were monitored and recorded.	12/11/21 at 8:30pm	Goal was fully met as client had adequate fluid volume with intact mucous membranes and good skin turgor.	E.Q

		Observing that client has normal skin turgor with moist and pink mucus membranes and 2.Client verbalizing that she is able to take sips at least 2 cups of water served.	4. Assess skin turgor and mucous membranes for signs of dehydration. 5. Assess colour and amount of urine output and record. 6. Encourage client to take in sips of water.	4. Skin turgor of client and mucous membranes were assessed for dehydration. 5. Colour of urine and the amount produced were assessed and recorded. 6. Sips of water was taken by client.			

LABOUR CARE PLAN CONTINUED

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES	NURSING ORDERS	NURSING INTERVENTIONS	DATE/ TIME	EVALUATION	SIGN
12/11/21 at 8:00pm	Risk of infection related to mishandling	Client will be able to prevent infection within 48 hours after labor and throughout her stay on admission	1. Reassure client that she will be free from infections. 2. Encourage client to wash her hands before and after touching perineal pad.	1. Client was reassured that she will be free from infections. 2. She was encouraged to wash her hands before and after touching perineal pad.	14/11/21 at 9:00pm	Goal successfully met as evidence by midwife visualized that	E.Q

	of perineal pad.	as evidenced by; The midwife visualizing that she shows no symptoms of infections and recording normal body temperature	3. Educate client on the need to change perineal pad whenever soaked to prevent infections. 4. Educate client not to reapply perineal pad when it falls. 5. Explain to the client the need for proper handling of pad.	3. Client was educated to change perineal pad when soaked to prevent infections. 4. She was educated not to use perineal pad when it falls. 5. The need for proper handling of pad was explained to client.		client showed no signs of infections such as rise in body temperature.	

CHAPTER FOUR
PUERPERIUM

4.0 INTRODUCTION

This chapter deals with the care given to the mother and the baby after delivery, baby's first bath, subsequent care of the baby, first day post-delivery care, post-delivery home visits, preparation towards discharge, post natal review, care plan drawn for the management of the problems encountered during this period.

4.1 DAY OF DELIVERY

Madam Evelyn Konadu and her baby were observed closely for one hour before they were transferred into a warm and comfortable bed in the lying-in with baby still on skin to skin with mother. All observations and examinations done were recorded in the fourth stage notes. Both mother and baby were kept warm. She was encouraged to put the baby to the breast to promote bonding between them and also stimulate uterine contractions to aid involution of the uterus. She was also advised to empty her bladder frequently to help in fast involution of the uterus.
An opportunity was taken to educate her on exclusive breastfeeding for the first six months, emptying of one breast before the other and the need to feed the baby frequently at least 8 to 12 times a day, as well as how to fix the baby to breast. She was also educated to keep the baby warm to prevent hypothermia, and advised to change the baby's soiled napkins and diapers frequently to prevent nappy rash and to make the baby comfortable. She was encouraged to wash her hands under running water with soap after visiting the lavatory, changing her perineal pad, removing the baby's soiled napkins and also before and after touching the baby. It was explained to her the need to change her perineal pad frequently.

Her vital signs were checked and recorded as follows;

Temperature	-	36.3℃
Pulse rate	-	82bpm
Respiratory rate	-	22cpm
Blood pressure	-	120/80mmHg

The symphysio-fundal height was measured to be 17 centimeters. Lochia was also inspected and it was red (rubra) in colour and small in amount with no bad odour. The baby was examined from head to toe and no abnormality was detected. The client's relatives were asked to excuse mother and baby so that they could have some rest. Client complained of lower abdominal pains. Physiology of after pain was explained to her, tablet Paracetamol was served with good

effect. Warm compresses were applied to the lower abdomen. Client was advised to urinate frequently since full bladder could alter uterine contractions and bring about postpartum hemorrhage. She was also encouraged to try and walk about in order to aid in drainage of lochia. Again, she was advised to change her sanitary pad frequently since she was at risk of infection. She was educated on the importance of hand washing before and after changing of her sanitary pad.

Client was encouraged to eat good nourishing and balanced diet, adequate intake of fluids, more fruits and roughages to enhance bowel movement and to help repair all worn out tissues. She was again encouraged to rest and sleep and exercise especially the abdominal and pelvic floor exercises.

Client's mother was advised to assist her in the care of the baby and also the household chores. She was then informed of possible discharge the following day.

4.2 SUBSEQUENT CARE OF THE BABY

Six hours after the delivery, the baby was bathed with warm water. Head to toe examination was done. Cord was dressed with chlorhexidine using aseptic technique and the cord was checked for bleeding and no abnormalities were detected. The baby passed meconium and urine which indicated that urethra and anus were patent. The baby was dressed nicely, wrapped in a warm dry cot sheet to maintain body temperature, and was placed beside her mother to breastfeed. The mother was advised not to place any other items on the cord with the exception of chlorhexidine that will be given to her. She was encouraged to practice exclusive breastfeeding

BABY BATH AND CORD DRESSING

REQUIREMENTS

1. Soap
2. Sponge
3. Cream / powder
4. Sterile cotton in a gallipot or wrapped
5. Chlorhexidine
6. Basin
7. Towels: 1 big towel and 3 small ones
8. Cot sheets 2
9. Apron
10. Gloves

11. A clean baby dress, cap and socks (if available)
12. Mackintosh
13. Two jugs containing hot and cold water each
14. Two receptacles for used water and dirty linen
15. A receiver for used swab

PROCEDURE

The procedure was explained to mother and a tray was set. All windows and door were closed, fans switched off and lights switched on to make the room warm. A plastic apron was worn and hands were washed with soap and water and dried with a clean towel. The water was mixed and the temperature was tested using the back of the palm. Examination gloves were worn and baby was placed on a flat surface. She was undressed and wrapped in a big towel. The eyes were cleaned with cotton wool swabs soaked in clean water from inner canthus outwards. Her face was cleaned with damp face towel and dried. The nape of baby's neck was supported with one hand. Her ears were then plugged using two fingers of the hand and the head was washed with soapy sponge. With the body resting on the elbow and still supporting the nape, the baby was placed at the edge of the bowl to rinse the soap off the head and dried.

She was exposed; arms and front of trunk were washed paying attention to skin folds. The baby's back was turned with one hand supporting the chest and washed back down to feet paying attention to the skin folds. She was immersed in a bath of warm water with the head above the water and rinsed thoroughly. The baby was placed on a flat surface covered with clean sheet. The baby was dried by using a clean small towel paying attention to the skin folds. Baby oil was applied on the skin and baby was dressed leaving the umbilical cord exposed for dressing and the hair combed neatly. Gloved hands were dipped into 0.5 percent chlorine solution were removed and discarded; hands were washed dried with clean towel.

Mother was encouraged to observe bathing and dressing of the cord. She was educated to clean the cord as well as observed at home.

CORD DRESSING

The cord was dressed by wrapping the baby in a towel to keep him warm. Mother was asked to protect him on the table. The tray containing six dry cotton wool swabs in a gallipot containing antiseptic solution which was methylated spirit and a receiver for the used swabs was already set. Hands were thoroughly washed again with soap and under running water and dried in a clean towel. Sterile gloves were worn and cord was exposed. The cord was inspected for bleeding but there was none. The tip of the cord was held with one swab in the non-

dominant hand. The base of the cord was cleaned with another cotton wool swab and was discarded. The whole cord was cleaned using four of the cotton wool swabs from the base upwards. One cotton wool swab was used to clean the posterior part of the cord. The tip of the cord was dried with the swab that was used to hold it. The cord was left expose to air dry.

Baby was dressed nicely, wrapped and given to mother to breastfeed. The waste materials were discarded according to infection prevention protocol. Gloves were removed and discarded. Hands were washed with soap and water before handling the baby.

Vital signs were also checked and the findings were communicated to the mother

Head circumference	-	33centimeters
Length	-	46 centimeters
Weight	-	3.5kilograms
Apex beat	-	142 beats per minute
Temperature	-	36.2 degree Celsius
Respiration	-	44 cycles per minute

Baby's condition was good.

At 5:00 pm mother and baby were seen to find out how they were faring, they were in good condition. They were both examined and their vitals were checked since they were not yet discharged;

Temperature	-	36.4 degree Celsius
Pulse	-	82 beats per minute
Respiration	-	22 cycles per minute
Blood pressure	-	110/70 millimeters of mercury.

4.3 FIRST DAY POST DELIVERY (DAY OF DISCHARGE)

The first day post-delivery was 13th November, 2021. Mother and baby were seen in the lying-in ward at 8:00am to find out how they were faring. Greetings were exchanged and She was asked about how she and the baby were doing and she said they were both doing well, except that she had lower abdominal pains (after pains) while breastfeeding the baby. She was reassured and educated on the physiology of after pain, that is, a normal physiology thus the suckling triggers the release of oxytocin, which causes uterine contraction and therefore causes lower abdominal pain. She was given 1mg Paracetamol to reduce the pain. She also complained of less sleep because the baby cried a lot during the night. She was encouraged to have enough sleep when the baby was asleep. She was urged to change baby diapers when wet. She had

already emptied her bladder and taken her bath. A puerperal assessment was then made. The conjunctiva was inspected for sign of anemia but it was absent. Lactation was good when the breasts were assessed. The uterus had contracted very well and the symphysio fundal height measured 16cm. The perineal pad was inspected and the Lochia was red (rubra), with small flow and there was no offensive odour. She took her baby after she was served with Hausa porridge and a loaf of bread as breakfast.

Madam Evelyn's vital signs were checked and recorded as follows;

Temperature - 36.1 degree Celsius

Pulse - 78 beats per minute

Respiration - 20 cycles per minute

Blood pressure - 110/80 millimeters of mercury

Mother was educated not to apply hot compress on baby's head with the intention of closing the fontanels that was explained to her that the fontanels close naturally. And also how to position herself when breastfeeding, how to put the baby to breast were demonstrated to her to enable her brestfeed well and prevent breast sore.

Baby was also examined with permission from the mother after hand washing was done with soap and under running water and dried with clean towel. A thorough head to toe examination was performed on the baby again but no abnormality was detected. The cord was inspected for bleeding, odour and discharge but there was none. The baby was top and tailed with the cord dressed with methylated spirit. The baby was dressed nicely and wrapped in a clean warm sheet. Baby's vital signs checked and recorded as follows;

Temperature - 36.4 degree Celsius.

Pulse - 134 beats per minute.

Respiration - 44 cycles per minute.

Weight - 3.4 kilograms.

The baby was given the first immunization Bacilli Culmette Guerine (BCG) 0.05millimeters vaccine intra dermal on the right upper arm for protection against tuberculosis. Client was educated that she should not apply anything on the injection site or massage it. She was told that there could be a tissue reaction over the area, a scar formation later indicating that the child had been immunized against tuberculosis effectively. Polio vaccine of 2 drops at de back of the tongue was also given orally to protect the baby against polio myelitis. Vitamin K giving to prevent bleeding. Chloramphenicol eye drop given to prevent infections. Client was educated to continue with baby's immunization schedule at well baby clinic. This would help prevent

baby contracting any of the childhood preventable diseases. Client was also told to register the baby at the birth and death unit and complete all the immunization schedules.

Mother was educated on personal hygiene, post-natal exercise, keeping the baby's cord clean, dry and avoid the application of unprescribed medication on it, change baby's diapers or napkins frequently when soiled and wash and dry in the sun, take in nutritious diet and fruits which are available, provision of warmth to the baby and prevention of infection by changing her perinea pad whenever it was soiled and also she was educated on exclusive breastfeeding and the need to feed on demand and at night which will serve as family planning as well as aiding in involution. Client was informed about her discharge. She was encouraged to sleep under treated mosquito net together with the baby to prevent malaria. I was assisted by her mother, to pack her belongings, and her health insurance card was used to settle her bills. Prescribed drugs were given as below;

- Tablet Fersolate 200mg (1 daily) for 20 days
- Tablet Multivitamin 200mg (1 daily) for 20 days
- Folic acid 5mg (daily) for 20 days
- Tablet metronidazole 400mg (3times daily) for 5 days
- Amoxicillin capsule 500mg (3times daily) for 7 days

The dosage and time for taking the drugs were explained to her. Madam Evelyn was also told that she would be visited for one week to check on her condition and that of the baby and continued with their care. She was discharged that day at 1:00pm and was escorted with her items into a car brought in by her husband. They were reminded of the visit to their house.

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

On 14th November, 2021 a visit was made to Madam Evelyn's house at 8:30am and 5:00pm. On arrival, greetings were exchanged with a warm welcome. She said her condition was getting better and that there had been an improvement on the complaints. She added that the baby was doing well. The family was pleased. Explanation was given to Madam Evelyn that she and the baby were going to be examined from head to toe to detect any abnormality for early treatment. She was encouraged to empty her bladder if she has the urge. The conjunctiva was examined and there was no pallor. The breasts were firm and well lactating. The uterus was firm and symphysio fundal height measured 15 centimetres. The perineum was inspected and was found to be cleaned; lochia was red (rubra) with small amount of flow.

Mother's vital signs were taken and recorded as;

Temperature - 36.0 degree Celsius

Pulse - 78beat per minute

Respiration - 20cycle per minute

Blood pressure - 110/60 millimeters of mercury

Permission was sought to top and tail the baby and it was granted. As the baby was being wiped, it was also demonstrated to Client. The cord was also dressed with chlorhexidine gel. The cord was clean and showed no signs of infection. The baby had passed meconium and urine when the napkin was removed. Baby was examined from head to toe and no abnormality was found. Baby was not jaundiced or pale and was able to suckle well.

Baby's vital signs were taken and recorded as follows;

Temperature - 36.3 degree Celsius,

Heart rate - 136 beats per minute,

Respiration - 40 cycles per minute

Cord - clean

Baby's weight - 3.3 kilograms

At 5:00pm mother was also examined from head to toe and there were no abnormal changes. The fundal height measured 14cm. The perineum was inspected and was found to be cleaned; lochia was red (rubra) with moderate amount of flow.

Mothers' vital signs were taken and recorded as;

Temperature : 36.4 degree Celsius

Pulse : 78beat per minutes

Respiration : 21cycle per minutes

Blood pressure : 110/70 millimeters of mercury

Observation on Baby

Observation	**Evening**
Temperature	36.7 degree Celsius
Apex beat	130 beat per minutes
Respiration	42 cycle per minutes

Cord	Clean
Weight	3.3kg

Client was encouraged to breastfeed the baby on demand. A promise was made to visit them again the following day. Client and her family said goodbye.

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

On the 15th November, 2021 the second visit was made to Madam Evelyn's house at 8:00am and 5:15pm respectively and She said her condition had improved. Baby was also doing well. Permission was sought from client to inspect her perineal pad and perineal area was clean and the Lochia was red, not offensive and the flow was small. She emptied her bladder and the Head to toe examination was also done and everything was normal. The breast were firm and well lactating. Uterus was firm and symphysio fundal height measured 14cm.General examination was carried out on the baby from head to toe and no abnormality was revealed. Baby was toped and tailed. The cord was neatly dressed and it was dry with no sign of infection. The baby passed stools and urine. Mother and baby's vital signs and weight were taken and recorded as follows;

OBSERVATION	MORNING	EVENING
Temperature	$36.3^{0}C$	$36.4^{0}C$
Pulse	80bpm	80bpm
Respiration	20cpm	20cpm
Blood pressure	100/60mmHg	100/60mmHg
Lochia	Rubra	Rubra
Fundal height	14cm	14cm
Condition of the uterus	Contracted	Contracted
Breast	Lactating	Lactating

The baby was topped and tailed paying attention to the skin folds and general examination was

carried out on the baby from head to toe and no abnormality was revealed. The cord was neatly dressed and it was dry with no sign of infection. The baby passed stools and urine according to client. Baby was assessed and recorded as follows;

BABY

OBSERVATIONS	MORNING	EVENING
Temperature	36.0^0C	36.2^0C
Heart rate	140bpm	138bpm
Respiration	38cpm	40cpm
Skin Colour	Pink	Pink
Cord	Clean and dry	Clean and dry
Suckling	Yes	Yes
Weight	3.2kg	3.2kg
Stool Colour	Yellowish	Yellowish

Nothing abnormal was detected during the examination. Madam Evelyn complained of interrupted sleeping pattern because baby normally cries at night. She was reassured and encouraged to breastfeed baby well before bed time and to change her napkin when soiled. She was reminded on exclusive breastfeeding and on demand, maintenance of personal hygiene, eating of fruits and highly nutritious diet and warm saline sitz bath on each visit. Family members were encouraged to help in activities so that mother could have adequate sleep. Permission was sought to leave and Madam Evelyn said she was very grateful and appreciated the care that was given to them.

4.6. THIRD POSTNATAL HOME VISITS (4TH DAY POST DELIVERY)

On the 16th November, 2021, the third home visit was made to Madam Evelyn's house at 8:30am and 5:10pm. Mother and baby were doing well and Madam Evelyn's husband had left for work. Permission was sought to inspect Madam Evelyn's perineal pad and the lochia was serosa (pink) without offensive odour. Head to toe examination was also done and everything was normal. Breasts were heavy and breast milk was flowing freely. Symphysio fundal height was measured 13cm. The baby was top and tailed, assessed and general condition was good and no abnormality was present. The cord was neatly dressed and was dry without bad odour. The baby also passed greenish yellow stools and urine. Mother and baby's vital signs were checked and recorded as follows;

MOTHER 4TH DAY (16/11/21)

OBSERVATIONS	MORNING	EVENING
Temperature	36.0	36.3
Pulse	68bpm	72bpm
Respiration	22cpm	20cpm
Lochia	Serosa	Serosa
Fundal Height	13cm	13cm
Condition of Uterus	Contracted	Contracted
Breast	Lactating	Lactating
Blood Pressure	110/70	110/70

Nothing abnormal was detected during the examination. Baby was topped and tailed paying attention to the skin folds and general examination was carried out and no abnormality was present. The cord was neatly dressed and was dry without bad odour. The baby also passed stools and urine. Baby's vital signs and other observations were taken and recorded as follows;

BABY

OBSERVATION	MORNING	EVENING
Temperature	36.3^0C	36.5^0C
Apex heart beat	136bpm	134bpm
Respiration	44cpm	40cpm
Skin colour	Pink	Pink
Condition of cord	Clean and dry	Clean and dry
Suckling	Yes	Yes
Weight	3.2kg	3.2kg
Stool colour	Dark yellow	Dark yellow

Permission was sought to leave and client said she was very grateful. Client complained of pain in her breasts which was as a result of fullness. She was educated to continue breastfeeding the baby, and to apply cold compress on them to reduce the pain. She was advised to ensure that one breast was empty before the other and appreciated the care that was given to them very much.

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

Madam Evelyn and her baby were visited again on 17th November, 2021 at 8:00am to continue with the postnatal care. She and her baby were physically examined and nothing abnormal was detected. Lochia was pink on inspection. Head to toe examination was done and everything was normal. Symphysio-fundal height measured 12cm. Baby had been bathed by client's mother on arrival so the general examination was carried out. No abnormality was found. The cord was neatly dressed and has shrinked with no abnormality detected. Client complained of fullness in the breast. She was educated to continue breastfeeding the baby, and to apply cold compress on them to reduce the pain. She was educated to ensure that one breast was empty before the other one was given to the baby. The baby passed dark yellow stools and urine. Mother and baby's vital signs were checked and recorded as follows;

MOTHER

OBSERVATION	VALUES
Temperature	36.2^0C
Pulse	80bpm
Respiration	20cpm
Blood pressure	100/70mmHg
Lochia	Serosa
Fundal height	12cm
Condition of the uterus	Contracted
Breast	Lactating but engorged

Baby had been topped and tailed by client's mother in my presence so the general examination was carried out. No abnormality was found. The cord was neatly dressed and no abnormality was detected. The baby passed stools and urine.

Baby's vital signs and other observations were recorded as follows;

BABY

OBSERVATION	VALUES
Temperature	36.5^0C
Heart rate	130bpm
Respiration	48cpm
Skin Colour	Pink
Cord	Dry

Weight	3.3kg
Suckling	Yes
Stool Colour	Dark yellow

Permission was sought to leave and Madam Evelyn was very grateful and appreciated the care that was given to them very much.

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

The fifth postnatal home visit was on 18th November, 2021 at 9:00am. Greetings were exchanged with client and her family after which a seat was offered. Mother and baby were both in a healthy condition and when it was inquired, client said the fullness of the breast had subsided except that the baby still cried a lot and she had not emptied the bowel for three days. She was reassured and advised to feed the baby well and change napkins before she slept and also to take enough fluid and food rich in fiber to aid in peristalsis. Inspection of the lochia was done and the colour was serosa (pink) without any odour indicating that personal hygiene was maintained. She was advised to change pad frequently to prevent infection and she was educated on family planning. After the head to toe examination, no abnormality was detected. Assessment was done and recorded as follows;

MOTHER

OBSERVATION	VALUES
Temperature	36.0^{0}C
Pulse	80bpm
Respiration	20cpm
Blood pressure	110/60mmHg
Lochia	Serosa
Fundal height	11 cm
Condition of the uterus	Contracted
Breast	Lactating but engorged

Baby was given a warm bath paying attention to the skin folds, because the cord was off. Head

to toe examination was done and no abnormality was found on the baby. The cord was dry and not completely off so baby was topped and tailed. The baby urinated and passed yellowish stool and was cleaned immediately.

Vital signs and other observations were recorded as follows:

BABY

OBSERVATION	VALUES
Temperature	36.3^{0}C
Heart rate	136bpm
Respiration	38cpm
Skin Colour	Pink
Cord	Dry
Weight	3.4kg
Suckling	Yes
Stool Colour	Yellow

Madam Evelyn was reminded of the next visit and she said she was very grateful; permission was sought and she was thanked for her cooperation.

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

The sixth postnatal home visit was made on 19th November, 2021 at 8:20 am. Greetings were exchanged with client and her family and a seat was offered in client's room. Mother and baby were both in a healthy condition and client said fullness of breast has subsided except that there are rashes on baby's skin and he cries a lot. She was reassured and encouraged to feed the baby well and change napkins before she sleeps and also educated to dress baby according to weather and use talcum powder on the baby's skin. Symphysio fundal height measured 10cm. Inspection of the lochia was done and the colour was serosa (pink) with odour indicating infection due to poor personal hygiene. She was educated to keep her perineum clean and change pad frequently to prevent infection and educated on family planning. After head to toe examination, no abnormality was detected.

Client was assessed and recorded as follows:

MOTHER

OBSERVATIONS	VALUES
Temperature	36.2^{0}C

Pulse	76bpm
Respiration	21cpm
Blood pressure	110/60mmHg
Lochia	Serosa
Fundal height	10 cm
Condition of uterus	Contracted
Breast	Lactating

Baby was bathed, head to toe examination was done and no abnormality was found on the baby. During the examination, it was realized that the cord had fallen off. The stump was then dressed with cotton wool swab and the area was cleaned and kept dry. Stool was yellowish in colour. Baby looked healthy and active.

Baby's assessments were recorded as follows:

BABY

OBSERVATIONS	VALUES
Temperature	36.6^{0}C
Apex heart beat	134bpm
Respiration	40 cpm
Skin colour	Pink
Cord	Dry
Weight	3.5kg
Suckling	Yes
Stool colour	Light brown

Madam Evelyn was encouraged to continue exclusive breastfeeding. She was thanked for her cooperation and time. And also remembered her of the one-week visit, interacted for a while and permission was sought to leave.

4.10 SEVENTH POSTNATAL HOMEVISIT (8TH DAY POST DELIVERY)

The seventh postnatal home visit was made on 20th November, 2021, Client and baby were visited in the morning at 9:15am. Mother and baby were doing very well and client said the baby's crying had minimized. She complained of backache. She was reassured and encouraged to adopt a good posture when breastfeeding the baby. Inspection of lochia was done and the colour was serosa (pink), flow was scanty without any bad odour. Symphysio fundal height

measured 9cm. After the head to toe examination, no abnormality was detected. Mother and baby's vital signs were as follows;

BABY

OBSERVATIONS	VALUES
Temperature	36.7^0C
Apex heart beat	134bpm
Respiration	40cpm
Skin colour	Pink
Cord	No
Weight	3.6kg
Suckling	Yes
Stool colour	Light brown

MOTHER

OBSERVATIONS	VALUES
Temperature	36.2^0C
Pulse	76bpm
Respiration	21cpm
Blood pressure	110/60mmHg
Lochia	Serosa
Fundal height	9cm
Condition of uterus	Contracted
Breast	Lactating but engorged

Client was encouraged to continue adhering to all the advices and encouragement given to her especially on nutrition, exercise, rest and sleep and maintaining good personal and environmental health.

Client was also encouraged to take good care of the baby and breastfeed exclusively. Client was also reminded to register the baby at the birth and death unit and complete all the immunization schedules. She was again reminded on the circumcision of her baby on the first postnatal visit to the clinic. They were told that day was the last visit.

4.11 FIRST POST NATAL VISIT TO THE CLINIC

Client and her baby reported at the Clinic on 19th November, 2021. She was accompanied by

her sister. Mother and baby looked healthy and cheerful. They were welcomed to the postnatal unit and a seat was offered to them to listen to a health talk on immunization against the preventable childhood disease, exclusive breastfeeding and family planning.

After the talk, client and baby were taken to the examination room to be examined. With permission from mother, baby was undressed and wrapped in a clean cot sheet and was put on a flat surface in the presence of the mother. Procedure was explained to Madam Evelyn and hands were washed and dried. The fontanelles and sutures were examined for any bulging fontanelles or widening sutures but there were none. The eyes, nose and ears were examined and no abnormalities were detected. Baby had no rushes or bruises on the skin. The abdomen was soft, not distended, and the umbilical cord was completely healed. The extremities and the back were also examined and there were no abnormalities.

Baby's weight was 3.5kg and her vital signs checked and recorded were as follows:

Temperature	-	36.6°C
Pulse rate	-	134bpm
Respiratory rate	-	40cpm

Symphysio-Fundal height was 10 cm. All findings were communicated to mother and recorded. Mother claimed the baby has good bowel movement and breastfeeds well.

Midstream urine was taken to check for protein and sugar in urine but they were both negative. Haemoglobin level was 11.8g/dl when the Hb was checked.

Client was also examined and before that, she was asked to empty her bladder after the procedure has been explained to her. She was assisted onto the examination couch and privacy was provided. Hands were washed and dried.

On inspection, client's hair was clean and nicely plaited. Madam Evelyn's conjunctiva and sclera were pink without any pallor. The nose, mouth and ears were clean without any discharges. The breast was heavy, soft and lactating well with healthy nipples. The upper and lower extremities were without oedema and her back was normal. On abdominal palpation, the uterus was no longer palpable. The lochia was serosa. She was helped out of the examination couch after the examination. Findings were communicated to her and documented.

Client was advised to maintain good personal and environmental hygiene in the care of herself and the baby. client was again educated on her nutrition and was asked to eat foods that are rich in proteins and vitamins, she was encouraged to continue with exercise and have adequate

rest and sleep. Client said the backache has subsided. The baby was taken to the birth registry where she was registered and certificate was given to the mother. Client was reminded of the six weeks postnatal visits to the clinic.

Gratitude and thanks were expressed to Client and the entire family for their support and co-operation throughout the writing of the care study. She was finally handed over to the midwife in-charge to continue with the care.

4.12 SECOND POSTNATAL VISIT TO THE CLINIC

According to the midwife in-charge, Madam Evelyn's six weeks postnatal visit was on 24th December, 2021. At 8:00am, she came to the facility with her sister. Head to toe examination was done on her and nothing abnormal was present.

Her vital signs, including the weight were checked and recorded as follows;

Temperature - 36.5℃

Pulse - 80bpm

Respiration - 20cpm

Blood pressure - 110/60mmHg

Weight - 73kg

Madam Evelyn's urine was checked for protein and sugar and it was negative for both, and the hemoglobin was12.0g/dl. Her fundus was not palpable and no lochia observed.

The baby was examined from head to toe and no abnormality was found. The following immunizations were given to the baby;

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

Baby's vital signs and other observations were checked and recorded as:

Temperature - 36.2degree Celsius

Respiration - 42cpm

Weight - 3.7kg

Mother was encouraged to practice exclusive breastfeeding for 6 months to inhibit ovulation and prevent infection or any disease to the baby. Client was congratulated for taking good care

of the baby as seen in the baby's weight gain. She also expressed her gratitude for all the support offered to them. She was also taken to the family planning unit and the child welfare clinic for immunization and continuity of care.

4.13 CARE PLAN DURING PUERPERIUM

PROBLEMS IDENTIFIED

Madam Evelyn complained of:

- On 16/11/21, After-pain.
- On 16/11/21, Altered sleep pattern
- On 18/11/21, Engorged breast
- On 18/11/21, Rash on baby's skin
- On 19/11/21, Backache.

SHORT TERM OBJECTIVES

- Madam Evelyn After pain will resolve within 48 hours
- Client will have at least 6hours at night within 72 hours
- Client's breast engorgement will be relieved within 72 hours
- Client will have a normal bowel movement once daily within 24 hours
- Client's backache will be relieved within 72 hours.

LONG TERM OBJECTIVE

Mother and baby will pass through puerperium without any complications.

TABLE 4.1: CARE PLAN DURING PUERPERIUM

DATE/ TIME	NURSING DIAGNOSIS	OBJECTIVES/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTIONS	DATE/ TIME	EVALUATION	SIGN
16/11/21 at 8:00am	Impaired body comfort (After pain) related to involution of the uterus	Client's pain will be relieved within 24hours as evidenced by: Client verbalizing that after pain has reduced and Midwife visualizing that client is calm and relaxed in bed off after pain.	Reassured client that pains will be stop. 2. Explain the cause of after pain to client. 3. Encourage client to assume any comfortable position of her choice. 4. Encourage client to empty her bladder frequently. 5. Serve her with prescribed analgesics.	1. Client was reassured that the pains will stop shortly after a while. 2. The cause of after pain was explained to client. 3. Client assumed any comfortable position of her choice. 4. Client emptied her bladder frequently. 5. Client was served with analgesics Paracetamol 1g.	17/11/21 at 8:00am	Goal fully met as evidence by Client verbalized that her after pain has reduced.	E.Q

CARE PLAN DURING PUERPERIUM CONTINUED

DATE/ TIME	NURSING DIAGNOSIS	OBJECTIVES/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTIONS	DATE/ TIME	EVALUATION	SIGN
16/11/21 at 8:00am	Altered sleep pattern related to baby's crying and feeding at night.	Client will have at least for 6 hours sleep at night each day within 72 hours as evidenced by: client verbalizing that she now sleeps for at least 6 hours at night and 2 hours during day time	1. Reassure the client. 2. Advise client to practice kangaroo mother care. 3. Encourage client to sleep when baby is asleep. 4. Encourage her support person to help her in the household chores. 5. Advise client to rest during the day.	1. Client was reassured. 2. Client practiced kangaroo mother care. 3. Client slept when baby was asleep. 4. Her relatives helped her in the household chores like washing to enable her to sleep during the day. 5. Client rested during day time.	19/11/21 at 8:00am	Goal was fully met as client verbalized that she's able to sleep well at night and also have a good time in the day.	E.Q

CARE PLAN DURING PUERPERIUM CONTINUED

DATE/ TIME	NURSING DIAGNOSIS	OBJECTIVES/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTIONS	DATE/ TIME	EVALUATION	SIGN
18/11/21 at 10:15am	Engorgement of the breast related to inadequate emptying of the breast.	Client's breast engorgement will be relieved within 72hours; As evidenced by client verbalizing that she feels comfortable in her breast and the midwife visualizing that the fullness is reduced.	1. Reassure client. 2. Teach her how to fix baby correctly to the breast. 3. Teach client how to correctly position herself when breastfeeding. 4. Encourage client to empty one breast before the other. 5. Encourage client to continue breastfeeding the baby exclusively.	1. Client was reassured. 2. Client was taught how to fix baby correctly to the breast. 3. Demonstration was done to client on how to position baby during breastfeeding. 4. Client was encouraged to empty one breast before the other. 5. Client was encouraged to continue breastfeeding the baby exclusively.	21/11/21 at 10:15am	Goal met as client verbalized that she has been relieved of breast engorgement.	E. Q

CARE PLAN DURING PUERPERIUM CONTINUED

DATE/ TIME	NURSING DIAGNOSIS	OBJECTIVES/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTIONS	DATE/ TIME	EVALUATION	SIGN
18/11/21 at 8:00am	Impaired skin integrity (Skin rashes) on baby related to chemical used.	Baby skin rashes will resolve within 72 hours as evidenced by 1. Mother verbalizing that rash has resolved. 2. Midwife observing that baby is having no skin rashes	1. Reassure mother. 2. Explain the physiology of rash to the mother. 3. Educate mother to dress baby with cotton cloths. 4. Educate client not to scratch the rashes.	1. Client was reassured. 2. Physiology of rash was explained to mother. 3. Mother dressed baby with cotton cloths. 4. Client was educated not to scratch the rashes as it would cause more pain and infection.	21/11/21 at 8:00am	Goal fully met as evidenced by Mother verbalized that rashes have resolved and Midwife observing that baby has no skin rashes.	E.Q

CARE PLAN DURING PUERPERIUM CONTINUED

DATE/ TIME	NURSING DIAGNOSIS	OBJECTIVES/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTIONS	DATE/ TIME	EVALUATION	SIGN
19/11/21 at 4:00pm	Altered body comfort (Backache) related to physiological changes during pregnancy	Client will be relieved of backache within 24 hours as evidenced by Client verbalizing she is relieved of backache	1.Reassure client. 2. Explain the physiology of backache to the client. 3. Encourage client to sleep on a firm mattress. 4.Give body massage. 5. Educate client against lifting of heavy loads.	1. Client was reassured. 2. Physiology of backache was explained to client. 3. Client was encouraged to sleep on a firm mattress. 4. Body massage was given. 5. Client was educated on the need to avoid lifting of heavy loads.	20/11/21 at 4:00pm	Goal fully met as evidence by client verbalized that she has been relieved of backache.	E.Q

5.0 TERMINATION OF CARE

This is the period in which the relationship between the midwife and client comes to an end. The family centered maternity care on Evelyn Konadu started on 27th October, 2021 and finally came to an end on 24th December, 2021 at Adamsu Health Center in the Bono Region during her antenatal visit to the clinic. She was rendered a holistic and individualistic care from the time she was met, which was during her third trimester of her pregnancy through to labour and puerperium. She had spontaneous vaginal delivery to a live Female child on 12th November,2021. She encountered some minor problems during pregnancy, labour and puerperium, with laboratory investigations, examinations and nursing care plan. Her identified problems during pregnancy, labour and puerperium was solved without any complication arising.

During her first postnatal visit to the clinic, she and her baby were looking healthy. She was handed over to the midwife in charge for continuity of care.

This study has helped me put into practice what I have learnt in the class room and at the ward. It has also helped me to gain more experience in the antenatal care and care during labour and puerperium.

SUMMARY AND CONCLUSION

Madam Evelyn aged 27 years Gravida 2 Para 1 alive and a native of Adamsu in the Bono Region. She was met when she was 37 weeks pregnant on the 27th of October, 2021 during eight weeks practical experience at the Adamsu Health Centre. She was chosen as a client to help her go through pregnancy, labour and puerperium successfully without any complications after she consented. Various observations, examinations and Laboratory investigations were carried out to aid in her care. Client went through pregnancy with some minor disorders which were managed successfully.

Madam Evelyn's labour and delivery were managed carefully without any complications. She delivered spontaneously an alive female infant with birth weight 3.5 kg on the 12th November, 2021 at 1:27am who cried immediately after birth.

Madam Evelyn's puerperium was successful, mother and baby were visited at home and finally handed over to the Community Health Nurse for further management on 24th December, 2021.

The Family Centered Maternity Care has afforded me the opportunity to identify the various needs of the expectant woman during pregnancy, labour and puerperium.

The knowledge and experience acquired will be translated to other expectant mothers, their families and the community members during my practice as a midwife.

In conclusion, the client/family centered maternity care study has exposed the writer to situation where the knowledge received in the classroom has practically been demonstrated on the client and family from pregnancy to puerperium. This has also enhanced the ability to perform them and render them to any pregnant woman in the course of practice wherever to help reduce maternal and infant morbidity.

BIBLIOGRAPHY

Fraser, D.M. & Cooper, M. A. (2009). *Textbook for midwives.* (15th edition), London: Churchill Livingstone, Elsevier Limited

Ghana Health Service (2008), *National Safe Motherhood Service Protocol*, Accra: Yamen press Limited.

Henderson, C. S. M. (2009). *Mayers' Midwifery* (13th edition), London: Bailliere Tindall Elsevier Limited.

Konar, H. (2013), *D.C. Dutta's Textbook of obstetrics* (6th edition), Kolkata: New Central Book Agency (P) Ltd.

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

Tiran D. (2009), *Bailliere's Midwives Dictionary* (11th edition), London: Tindall Elsevier Ltd.

APPENDIX I

TABLE I: MOTHER'S ANTENATAL CARE

DATE	WEIGHT (KG)	BLOOD PRESSUE	URINE FOR PROTEIN/ SUGAR	GESTATIONAL AGE IN WEEKS	FUNDAL HEIGHT (CM)	PRESENTATION	DESCENT OF FETAL HEAD	FETAL HEART RATE(FH)	TREATMENT GIVEN	COMPLAIN	SIGN
4/05/21	78kg	120/80mmHg	Negative/ Negative	12weeks	19cm	-	-	-	Routine drugs	No complain	A. R
26/05/21	75.6kg	120/70mmHg	Negative/ Negative	16weeks	23cm	-	-	-	Routine drugs	No complain	A. R
23/06/21	76kg	110/80mmHg	Negative/ Negative	20weeks	27cm	-	-	-	Routine drugs	No complain	A.R
21/07/21	75kg	120/70	Negative/ Negative	24weeks	31cm	Cephalic	-	135bpm	Routine drugs	Feels well	A.R
18/08/21	75kg	110/70	Negative/ Negative	28weeks	36cm	Cephalic	-	140bpm	Routine drugs 1G of Paracetamol x7	Waist pain	A.R

MOTHER'S ANTENATAL CARE CONTINUED

DATE	WEIGHT (KG)	BLOOD PRESSUR	URINE FOR PROTEIN/ SUGAR	GESTATIONAL AGE IN WEEKS	FUNDAL HEIGHT (CM)	PRESENTATION	DESCENT OF FETAL HEAD	FETAL HEART RATE (FH)	TREATMENT GIVEN	COMPLAIN	SIGN
27/10/21	76kg	110/70mmHg	Negative/ Negative	37weeks	36cm	Cephalic	$5/5^{th}$	140bpm	Routine drugs	Feels well	E.Q
3/11/21	76.1kg	100/70mmHg	Negative/ Negative	38weeks	37cm	Cephalic	$5/5^{th}$	140bpm	Routine drugs	Feels well	E. Q
10/11/21	76kg	110/80mmHg	Negative/ Negative	39weeks	38cm	Cephalic	$5/5^{th}$	137bpm	Routine drugs 1G of paracetamol tid x 7	Lower abdominal pains	E. Q

TABLE I.I ITN GIVEN – (04/05/21)

TETANUS IMMUNIZATION	PREVIOUS TT		TD 1 Yes TD 2 and TD 3		No	
	CURRENT TD 4th dose		Date: 23/06/21		Date	
INTERMITTENT PREVENTIVE TREATMENT (IPT)FOR Malaria	1ST dose SP* 3 tabs (Directly Observed Therapy) 26/05/21	Gestation age In weeks 16weeks	2nd dose (1 month after 1st dose (Directly Observed Therapy) 21/07/2021	Gestation age In weeks 20weeks	3rd dose (1 month after 2nd dose (Directly Observed Therapy)5/09/21	Gestational age in weeks 24weeks
	4th dose 3 tabs (Direct observed therapy)13/10/21	Gestation age in weeks 28weeks	5th dose 3 tabs (Direct Observed Therapy)10/11/21	Gestation age in weeks 32 weeks		

* NB: - Sulfadoxine _Pyrimethamine – (SP) should be given to pregnant women between 16 weeks (after quickening) or when mother feels baby's movement till delivery and be given at least 1 month after last dose.

APPENDIX II

TABLE II.I ANTENATAL COMPLETED DIAGNOSTIC INVESTIGATIONS

DATE	SPECIMEN	INVESTIGATION	NORMAL VALUES	FINDINGS	REMARKS
29 / 04 / 2021	1. Blood	Haemoglobin level	12g/dl-16g/dl	11.7g/dl	Normal
		Sickling status	Negative	Negative	Normal
		Grouping and Rhesus factor	A, B, AB, and O	O	Normal
		HIV status	Positive and Negative	Positive	Normal
		VDRL	None reactive	Negative	Normal
	2. Urine	Hepatitis status	None reactive	Non-defect	Normal
		G6PD status	Negative	Negative	Normal
		Sugar	None reactive	Non-defect	Normal
		Protein	Negative	Negative	Normal
			Negative	Negative	Normal

TABLE II.II COMPLETE DIAGNOSTIC INVESTIGATION

DATE	SPECIMEN	INVESTIGATION	NORMAL VALUES	FINDINGS	REMARKS
29/05/21	1. Urine	Sugar Protein	Negative Negative	Negative Negative	Normal Normal
29/06/21	1. Urine	Sugar Protein	Negative Negative	Negative Negative	Normal Normal
29/07/21	1. Urine	Sugar Protein	Negative Negative	Negative Negative	Normal Normal
18/08/21	1. Urine 2. Blood	Sugar Protein Haemoglobin Level	Negative Negative 12g/dl-16g/dl	Negative Negative 12.8g/dl	Normal Normal Normal
18/09/21	1. Urine	Sugar Protein	Negative Negative	Negative Negative	Normal Normal

COMPLETE DIAGNOSTIC INVESTIGATION CONTINUED

DATE	SPECIMEN	INVESTIGATION	NORMAL VALUES	FINDINGS	REMARKS
27/10/21	1. Urine	Sugar Protein	Negative Negative	Negative Negative	Normal Normal
	2. Blood	Haemoglobin	12g/dl-16g/dl	12.9g/dl	Normal
03/11/21	1. Urine	Sugar Protein	Negative Negative	Negative Negative	Normal Normal
	2. Blood	Haemoglobin	12g/dl-16g/dl	12.8g/dl	Normal

APPENDIX III

TABLE III.I PHARMACOLOGICAL DRUGS FOR MOTHER

NAME OF DRUG	CLASSIFICATION	DOSAGE	ROUTE	USE AND ACTION	ACTUAL EFFECT	SIDE EFFECT	SIDE EFFECT EXPERIENCED
Tablet multivitamin	Vitamin preparation	200 milligram once daily	Orally	Increased appetite and Helps in the formation of red blood cells.	Increased appetite	Gastrointestinal disturbances	No side effect observed.
Tablet folic acid	Haematinics	5 milligram once daily	Orally	Proper formation and functioning of red blood cell.	Haemoglobin level increase	Nausea and vomiting	No side effect observed
Tablet Ferrous sulphate	Iron supplement	200 milligrams once daily	Orally	Helps in the formation of haemoglobin and red blood cells	Increased haemoglobin level	Gastrointestinal disturbances. Dark stools.	Dark stools

PHARMACOLOGICAL DRUGS FOR MOTHER CONT'D

NAME OF DRUG	CLASSIFICATION	DOSAGE	ROUTE	USE AND ACTION	ACTUAL EFFECT	SIDE EFFECT	SIDE EFFECT EXPERIENCED
Tablet Metronidazole	Antibiotic	400 mg 3 times daily	Orally	Fights against bacterial infection	Fights against bacterial infection	Stomach pain, dizziness, dry mouth, cough, sore tongue	No side effect observed
Tablet Paracetamol	Analgesic and anti-pyretic	1 gram 3 times daily	Orally	Relieve pain and Reduce body temperature	Pain relieved	Prolonged use may cause liver damage.	No side effect observed.
Capsule Amoxicillin	Antibiotic	500mg 3 times daily	Orally	Fights against bacterial infection	Bacterial infection prevented	Nausea, stomach pain, diarrhoea, vomiting	No side effect observed.

PHARMACOLOGICAL DRUGS FOR MOTHER CONT'D

NAME OF DRUG	CLASSIFICATION	DOSAGE	ROUTE	USE AND ACTION	ACTUAL EFFECT	SIDE EFFECT	SIDE EFFECT EXPERIENCED
Tablet Sulphadoxin epyrimetha mine	Antimalarial and Malaria prophylaxis	3 tablets start 1st dose at 16 weeks or after quickening and 4 other doses at 4 weeks interval until delivery.	Orally	Treatment and prevention of malaria	Malaria prevented	Itching Nausea Dizziness Headache	No side effect observed.
Tetanus Injection	Anti-tetanus	0.5 milligrams	Subcutaneously	Provides immunity against Tetanus disease.	Tetanus prevented	Fever Chills Urticarial rash	Pain at the site.
Injection oxytocin	Oxytocic drug	10 units	Intramuscularly	Stimulates uterine contractions	Uterine contractions stimulated	Nausea and Vomiting	No side effects observed.

TABLE III.II PHARMACOLOGICAL DRUGS FOR BABY

NAME OF DRUG	CLASSIFICATION	DOSAGE	ROUTE	USE AND ACTION	ACTUAL EFFECT	SIDE EFFECT	SIDE EFFECT EXPERIENCED
Injection vitamin k	Coagulant (Group K Vitamin)	1.0mg	Intramuscular	Production of prothrombin which aids in clotting	No bleeding	Risk of haemolysis in people with G6PD deficiency	No side effects observed.
Chloramphenicol eye drop	Antibiotic	2 drops	Instillation	To prevent eye infection	Eye infection was prevented	Transient stinging	No side effect observed.
Oral polio vaccine	Antigen vaccine	2 drops	Orally	Production of antibodies to prevent poliomyelitis.	Poliomyelitis was prevented.	Diarrhoea and Fever.	Observed.

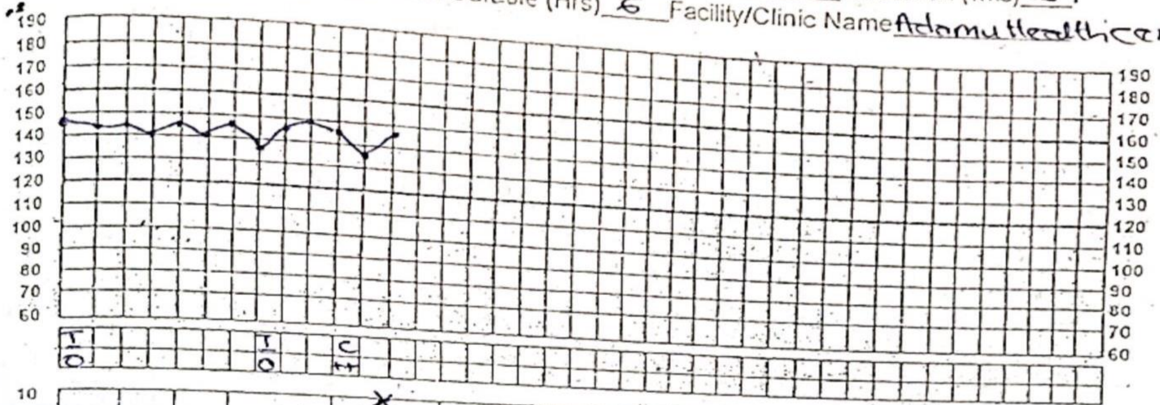
PHARMACOLOGICAL DRUGS FOR BABY CONTINUED

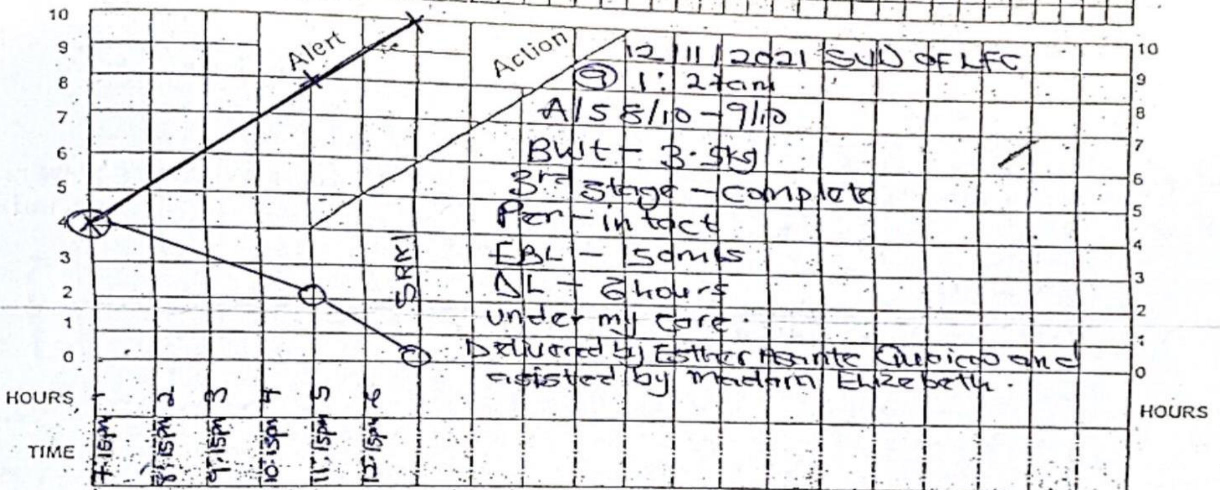
NAME OF DRUG	CLASSIFICATION	DOSAGE	ROUTE	USE AND ACTION	ACTUAL EFFECT	SIDE EFFECT	SIDE EFFECT EXPERIENCED
Capsule vitamin A	Group A vitamin supplement	200,000 unit for 2 days	Orally	Growth, development and proper sight	Normal vision and healthy skin	Vomiting	No side effect observed.
Injection Bacillus Calmette Guerin (BCG)	Antigen vaccine	0.05 milligrams	Intradermal injection	Production of antibodies against tuberculosis	Still under observation	Blister formation and fever	Blister observed

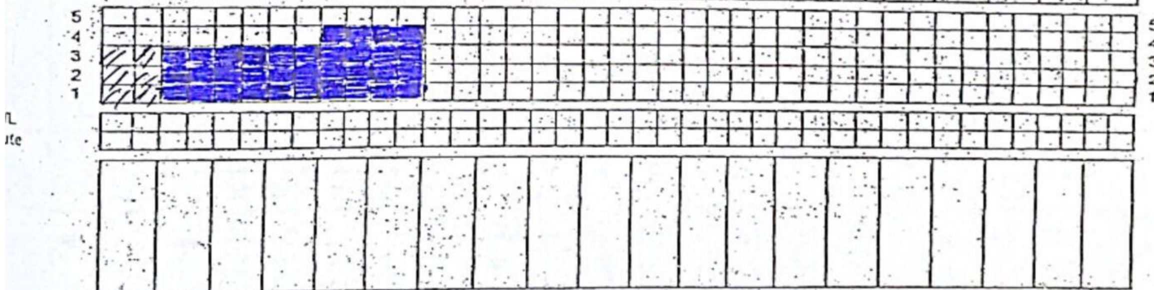
C

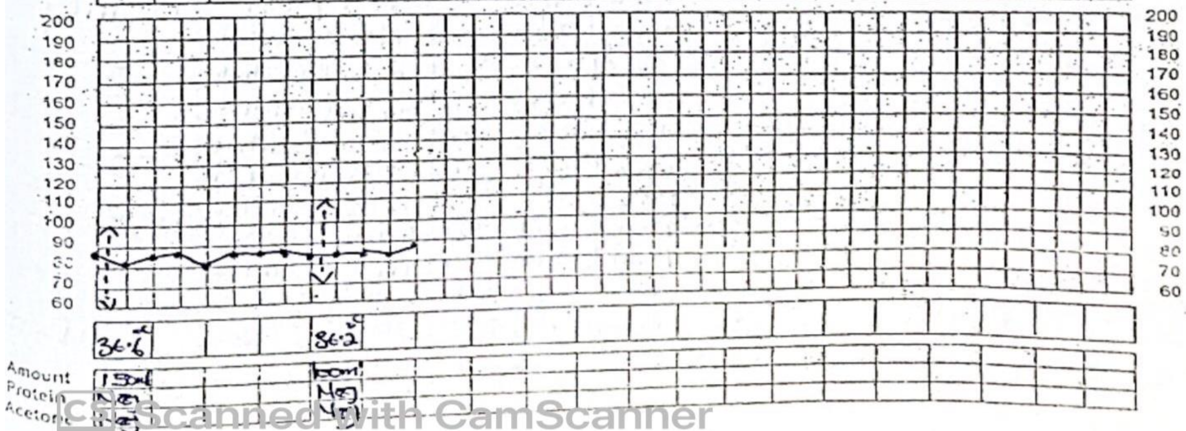
WHO Modified Partograph

Registration No. 69 /2021 Name (Last, First) Konadu Evelyn
Date 11/11/21 Parity/Gravida P1 / G2 LMP 5/2/21 EDD 12/11/21 Age 27
ROM (Time, Date) 1: 05am Labour Durable (Hrs) 6 Facility/Clinic Name Adomu Health center Gestation (wks) 39









Scanned with CamScanner

LABOUR NOTES

On 11/11/2021 at 6:40pm, client reported to the ward with the history of abdominal pain, accompanied by her husband. On an examination, sy[illegible] fundal height was 38cm, gestational age was 39weeks, the lie was [illegible] presentation was cephalic and descent was 4/5th, dilatation was [illegible] contraction was 3in 10 lasting for 50second, temperature was 36.6 p[illegible] 82bpm, BP was 100/60mmHg. Client was made comfortable in bed

Please circle or write responses.

DELIVERY

DATE: 12/11/2021 TIME: 1:27am METHOD: (Spontaneous) / Vaccuum Extraction / C/S

PERINEUM: (Intact) / Episiotomy / Laceration

ANESTHESIA: (None) / Local / General

THIRD STAGE

Active Management: (Yes) / No Medication: Time 1:28am Type / Dose Oxytocin 10unit

PLACENTA: Time: 1:32am (Complete) / Incomplete

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

BABY

Weight: 3.5kg

Sex: Male / (Female)

Baby Position (Vertex) / Breech / Other

APGAR

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

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

FOURTH STAGE MONITORING

Frequency	Time	B/P	Pulse	Fundus	Bleeding	Bl[illegible]
Every 15 minutes first 2 hours	1:45am	100/70	88bpm	17cm	150mL	5[illegible]
	2:00am	100/70	86bpm	well contracted		
	2:15am	100/70	86bpm	well contracted	[illegible]	En[illegible]
	2:30am	100/70	86bpm	well contracted	[illegible]	
	2:45am	100/70	84bpm	well contracted	[illegible]	50
	3:00am	100/70	84bpm	well contracted	[illegible]	
	3:15am	100/60	84bpm	well contracted	[illegible]	En[illegible]
Every 30 minutes for 1 hours	3:45am	100/60	84bpm	well contracted	[illegible]	En[illegible]
	4:15am	100/60	84bpm	well contracted		En[illegible]

Birth Attendant Esther Asante Quaicoo Date 12-11-202[illegible]

CS Scanned with CamScanner

SSI-4th Edition draft-ACNM (to be published 2008)

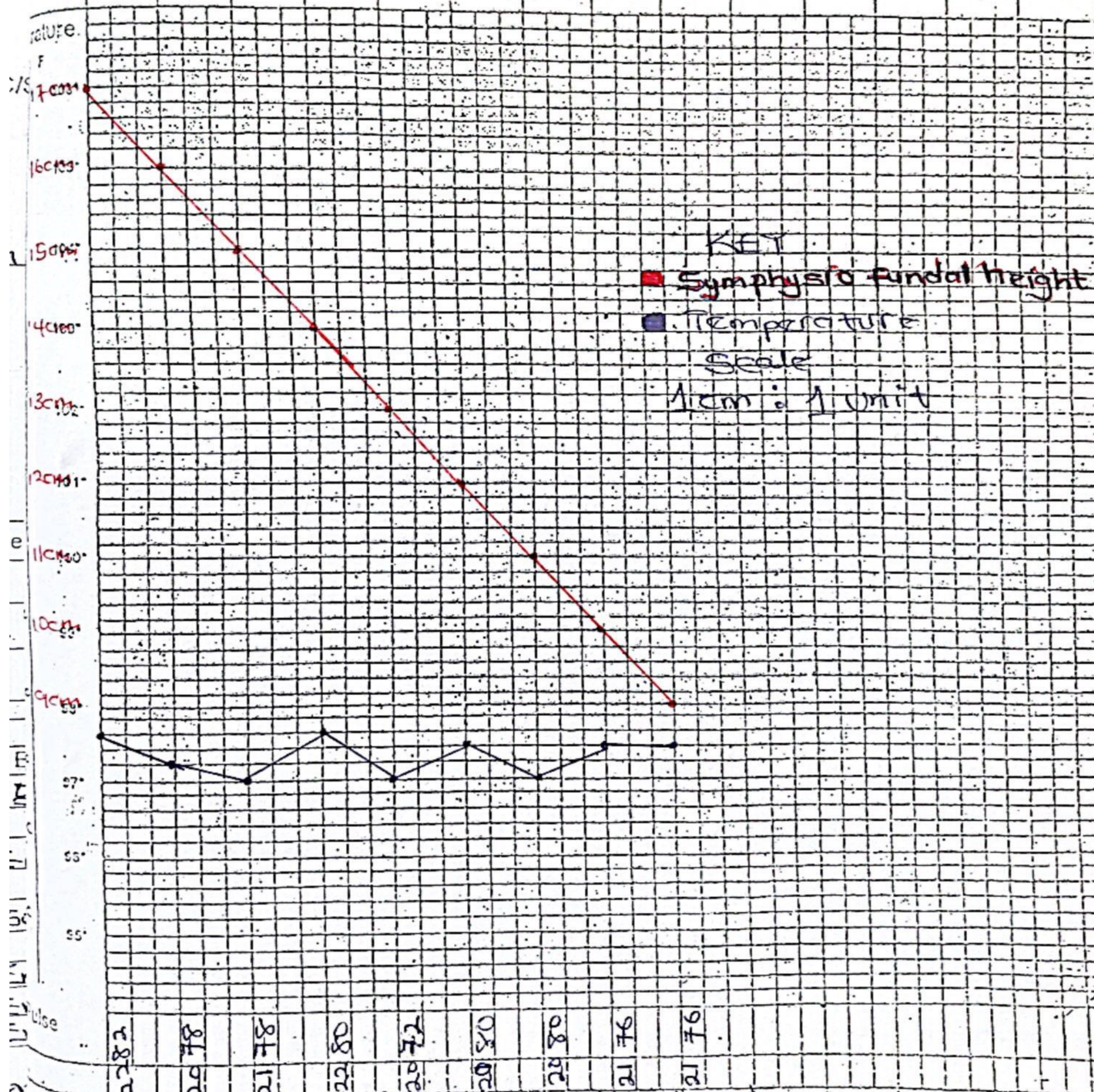
MATERNITY CHART

...welyn Konadu

27 .... WARD: Maternity

69/2021 .... BED NO.: ....

	12/11/21	13/11/21	14/11/21	15/11/21	16/11/21	17/11/21	18/11/21	19/11/21	20/11/21
...spital	DD	D1	D2	D3	D4	D5	D6	D7	D8
Am		8:00	8:30	8:00	8:30	8:00	9:00	8:30	9:15
Pm	5:00		5:00	5:15	5:30				



Pulse	82 / 22	78 / 20	78 / 21	80 / 22	72 / 20	80 / 20	80 / 20	76 / 21	76 / 21
	Passed	Passed	Passed	Passed	Passed	Passed	Passed	Passed	Passed
	Passed	Passed	Passed	Passed	Passed	Passed	Passed	Passed	Passed
B.P. Am	120/80	110/80	110/60	100/60	110/70	110/70	110/60	110/60	110/60
Pm	110/70		110/70	100/60	110/70				

Scanned with CamScanner

NEW BORN EXAMINATION FORM

by Afia Konadu
Time of Birth: 1:27am Date of Assessment: 12/11/21 Time: 1:32am
Sex: [ ] M [✓] F
[ ] 39 [ ] Mode of Delivery: [✓] Vaginal Age at time of Assessment (days/hrs) 1 hour
9/10 5min [ ] 9/10 Birth Weight: [ ] 3.5 kg [ ] Assisted Vaginal C-Section
at time of Assessment: 36.2 °C Length: 46 cm Head Circumference: 33 cm
Urine passed: Yes No Meconium passed: Yes No
Assessor (Midwife/Doctor): Esther Asante Quaicoo

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: 130bpm
- [ ] 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
- [✓] None
- [ ] 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

(Left margin, partially cut off:)
on
cpm
b/m *
b/m *
s*
Movemnet
us symmetric
s
Absent Movement in
nent
ver
/ but blue hands/feet
ver *
l*
ing pus

icate severe disease that requires urgent referral
(if known)

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

CS Scanned with CamScanner

NEW BORN EXAMINATION FORM

Name: Baby Afia Konadu
Date of Birth: 12/11/21 Time of Birth: 1:27am Sex: [ ] M [x] F Date of Assessment: 13/11/21 Time: 7:...
Astational Age [ ] 39 [ ] Mode of Delivery: [x] Vaginal Assisted Vaginal C-Section Age at time of Assessment (days/hrs) 1day
APGAR: 1min 8/10 5min [ ] 9/10 Birth Weight: [ ] 3.4 kg [ ] Length: 46 cm Head Circumference: 33 cm
Temperature at time of Assessment: 36.7 °C Urine passed: Yes No Meconium passed: Yes
Name of Assessor (Midwife/Doctor): Esther Asante Quaicoo

1. Respiration
Rate 44cpm
- [ ] Rate < 30 b/m *
- [ ] Rate < 60 b/m *
- [ ] 30-60 b/m
- [ ] Retractions *
- [ ] Grunting *
- [ ] Stridor *

2. Activity/Movemnet
- [x] Spontaneous symmetric movements
- [ ] Reduced/Absent Movement in ≥1 limb *
- [ ] No Movement

3. Tone
- [x] Normal
- [ ] Floppy *
- [ ] Increased *

4. Colour
- [x] Pink all over
- [ ] Pink body but blue hands/feet
- [ ] Blue all over *
- [ ] Pale *
- [ ] Jaundiced *

5. Cord
- [x] Normal
- [ ] Red. draining pus
- [ ] Bleeding

6. Cry
- [x] Normal
- [ ] Shrill *
- [ ] Absent *

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

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

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

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

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

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

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

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

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

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

18. Heart rate
Rate: 134bpm
- [ ] Normal (100-160)
- [ ] <100 *
- [ ] >160*

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

20. Abdomen
- [x] Normal
- [ ] Distended*
- [ ] Scarphoid*
- [ ] Abdominal defect*
- [ ] Maases: ______
- [ ] Other ______

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

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

23. Genitalia
Male Genitalia
- [ ] Normal
- [ ] Undescended testes
- [ ] Abnormal meatus
- [ ] Hernia
- [ ] Other: ______

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

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

25. Resuscitation provide
- [x] None
- [ ] Suction/stimulation
- [ ] Bag and mask
- [ ] Endotracheal Tube
- [ ] Ventilator/CPAP

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

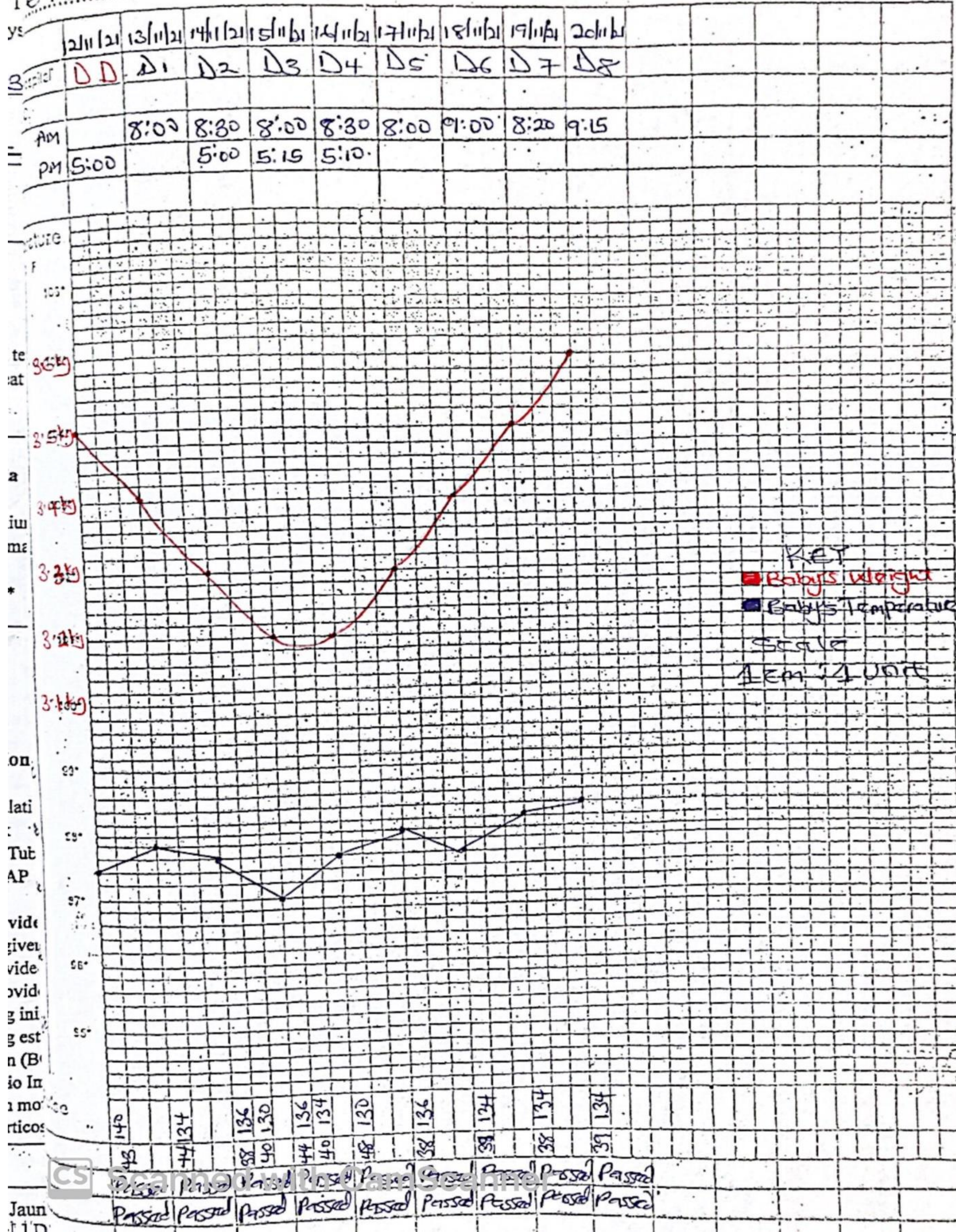
***May indicate severe disease that requires urgent referral**

Diagnoses (if known) ______

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

Scanned with CamScanner

TEMPERATURE CHART



Scanned with CamScanner

Sex: Female .... Mother's No: .... Length: 46cm ....

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

Date of Birth: 12/11/2021 .... Time: 1:27am .... Date of Discharge: 13/11/2021.

Date	12/11/21		13/11/21		14/11/21		15/11/21		16/11/21		17/11/21		8/11/21		19/11/21		20/11/21					
No. of Days	D D		D1		D2		D3		D4		D5		D5		D7		D8					
Weight	3.5kg		3.4kg		3.3kg		3.2kg		3.2kg		3.3kg		3.4kg		3.5kg		3.6kg					
	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM
Temperature	36.2°c	36.3°c	36.7°c		36.4°c	36.7°c	36.0°c	36.2°c	36.4°c	36.5°c	36.8°c		36.3°c		36.6°c		36.7°c					
Stools	Passed	Passed	Passed		Passed	Passed	Passed	Passed	Passed	Passed	Passed		Passed		Passed		Passed					
Urine	Passed	Passed	Passed		Passed	Passed	Passed	Passed	Passed	Passed	Passed		Passed		Passed		Passed					

Remarks

Head
Neck
Truck
Genitalia
Lower Limbs

→ No Abnormalities Detected.

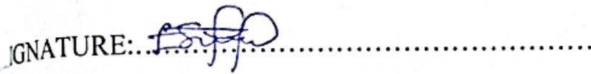
CS Scanned with CamScanner

SIGNATORIES

ANDIDATE NAME

AME: QUAICOO ASANTE ESTHER

IGNATURE:



ATE: 05/10/2022.

THE MIDWIFE IN-CHARGE

NAME: MRS. ELIZABETH OBUBUOFO

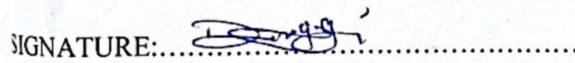
SIGNATURE:

DATE: 06/10/2022

SUPERVISOR

NAME: MS. DORCAS OSEI

SIGNATURE:

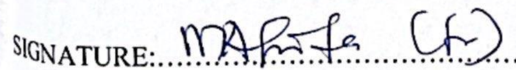


DATE: 07/10/2022

THE PRINCIPAL

NAME: MONICA NKRUMAH

SIGNATURE:



DATE: 10/10/2022

STAMP:

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

CS Scanned with CamScanner