HOLY FAMILY NURSING AND MIDWIFERY TRAINING COLLEGE,

BEREKUM

A CLIENT /FAMILY CENTERED MATERNITY CARE STUDY ON MADAM ANTWIWAA OPHILIA

BY

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PREFACE

Client and family centered maternity care is a systematic approach of carrying out holistic and individualized care to both the expectant mother and her family during the period of pregnancy, labour and puerperium. The study is carried out by a student midwife based on a thoughtful understanding of the client as a unique individual with specific problem and needs and to assist her solve them. The client and family are assured of confidentiality.

The aim of the family centered maternity care study is to obtain the best possible healthy outcome for the client and her family members. The study also offers the student midwife the maximum opportunity to use the knowledge acquired in the classroom to assess herself.

The care study is an academic project which gives the student midwife the chance to choose a client and manage her from period of pregnancy to ten days' early puerperium.The student midwife uses the nursing process which involves assessment, diagnose, planning, intervention and evaluation to adequately care for the client.

The care study forms part of the academic exercise and also in partial fulfillment of course requirement by the nursing and midwifery council to enable the student midwife obtains a certificate in midwifery.

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I wish to express my sincere gratitude to God Almighty for granting me the knowledge, wisdom, understanding and strength to reach this far.

My sincere gratitude goes to my client Madam Ophilia Antwiwaa and her family for their cooperation and information which helped me a lot in the writing of this care study.

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I am also grateful to the entire tutors of Nursing and Midwifery Training College, Berekum especially my supervisor Mrs. Abdul-Karim Ubaida for their precious time, energy and during the period of care and marking of the care study. Not forgetting the principal of the school for admitting and giving me the opportunity to be trained as a midwife.

Again, I wish to acknowledge the authors and publishers whose various books were used as references.

Lastly, my heartfelt gratitude goes to my mother, father, friends, siblings and Mr. Kwame Tekyi Agyemang for their support both spiritually and financially.

INTRODUCTION

The client and family centered maternity care study refers to all the midwifery care rendered to the expectant mother and her family throughout pregnancy, labour and puerperium. It entails every aspect of the woman's social, physical, spiritual and psychological well-being.

The care is considered within the framework of the family and the community with the aim of preparing the pregnant woman to face labour, puerperium and to initiate lactation and subsequent care of the baby.

This particular care study is about Madam Ophilia Antwiwaa at Presbyterian health center Kyeremasu (Bono region), after familiarity was built between myself and Madam Ophilia at the antenatal clinic. It was her sixth antenatal visit and her gestational age was also 36 weeks. After a comprehensive introduction of myself to her, she was informed about my idea of using her for my family centered maternity care study which she happily agreed. She was thanked for her cooperation and accepting my request.

Madam Ophilia was cared for, during the antenatal periods. Visitation to her home was made to know her family, her surroundings and the community in which she lives. The client and her entire family were included in the care. The condition from the beginning till the end of the interaction was good and satisfactory. Madam Ophilia had a successful pregnancy, delivered spontaneously on 30th of August, 2023 to an alive baby boy. She had a successful puerperium and was in good health. She was then handed over to the midwife in-charge at Health Center for continuity of care on the 8th of September, 2023.

She was taken as my client with the aim of educating her and the family on minor disorders in pregnancy, birth preparedness and complication readiness plan, signs of labour, assisting her in managing minor disorders and also manage her during first, second, third and fourth stages of labour, puerperium and withstanding subsequent care of the baby.

This care study is in four chapters;

The Chapter One reveals client's particulars such as social, family, obstetric, medical and surgical histories. Chapter Two talks about the antenatal care rendered to Madam Ophilia throughout her pregnancy.

Chapter Three is concerned about management of Madam Ophilia during labour.

Chapter Four is also concerned about management of Madam Ophilia during puerperium. The chapter two, three and four has care plan attached to each. The source of information obtained is from the client herself, her family, antenatal record book and other relevant text books.

LITERATURE REVIEW

Perry (2014) defines pregnancy as a period of physical and psychological preparation for birth and parenthood. Prenatal visit ideally begins soon after the first missed menstrual period to ensure good health of the expectant mother and the fetus. He also said that, normal pregnancy lasts for 40 weeks or 280days and health care providers refer to early, middle and late pregnancy as trimesters. The first trimester lasts from week 1 to week 13, the second from week 14 through to week 26 and the third from week 27 through to week 40. A pregnancy is considered to be term if advances to 38 and 40 weeks.

According to Marshall J. And RaynorM. (2014), pregnancy is a period of having an embryo in the uterus. During the period of pregnancy, there are some anatomical and physiological changes that affect every system in the body due to the alteration of pregnancy hormones like progesterone, estrogen, and human chorionic gonadotropin. Some of these physiological changes are nausea and vomiting, constipation, heartburns, headache, leg cramps, frequent micturition, anorexia and waist pains which occurs as minor disorders of pregnancy. The hormonal effects also cause a change in the woman's emotional state. This helps in the development of the fetus, prepares the expectant mother for labour as well as puerperium. The book further explains that every pregnancy is a unique experience for every woman. It is therefore important for the midwife to have knowledge and understanding of the minor disorders of pregnancy in order to educate the woman to understand the physiology of that disorder and how to manage it. Some Signs of pregnancy include; Possible (presumptive) signs: Early breast changes (unreliable in multigravida), amenorrhea, morning sickness, bladder irritability, quickening. Probable signs: Presence of

human chorionic gonadotrophin (HCG) in urine and blood, softened isthmus (Hegar's sign), bluing of vagina (Chadwick's sign), pulsation of fornices (Osiander's sign), uterine growth, changes in skin pigmentation, Braxton Hicks contractions, ballottement of fetus. Positive signs: visualization of gestational sac by transvaginal and transabdominal ultrasound, auscultation fetal heart sound by transvaginal and transabdominal ultrasound, fetal heart sounds by Doppler and fetal stethoscope. Fetal movement both palpable and visible, visualization of fetus by ultrasound scans. The aim of antenatal care is to monitor the progress of pregnancy to optimize maternal and fetal health. To achieve this, the midwife critically evaluates the physical, psychological and sociological effects of pregnancy on the woman and her family. This process requires engagement by the Midwife, as outlined below; Developing a trusting relationship with the woman. Providing a holistic approach to the woman's care that meets her individual need. Making a comprehensive assessment of the woman's health and social status, accessing all relevant sources of information. Promoting an awareness of the public health issues for the woman and her family. Exchanging information with the woman and her family, enabling them to make informed choices about pregnancy and birth. Being an advocate for the woman and her family during her pregnancy, supporting her right to choose care appropriate for her own needs and those of her family. Identifying potential risk factors and taking the appropriate measures to minimize them. Timely sharing of information with relevant agencies and professionals. Accurate, contemporaneous documentation of assessments, plans, care and evaluation. Recognizing complication of pregnancy and appropriately referring women to the obstetric team or relevant professionals or other organizations. Preparing the woman and family to meet the challenges of labour and birth and facilitating the development of a birth plan. Facilitating the woman to make an informed choice about methods of infant feeding and

giving appropriate and sensitive advice to support her decision. Offering parenthood education with a planned or on an individual basis.

According to Konar H. (2015), pregnancy last between nine and ten months. The duration of pregnancy is divided in three trimesters

First trimester 1st week- 12th weeks

Second trimester 13th week- 28th weeks

Third trimester 29th week – 40th weeks

Fraser and Cooper (2013) Pregnancy is the period when the fertilized ovum embeds in the maternal uterus until it is born thus the state of conception till the delivery of the fetus. The normal duration is 280 days or 40weeks counting from the last day of the menstrual period, she further states that uterine blood flow in pregnancy supplies the myometrium, endometrium and placenta, with the latter receiving nearly 90% of the total uterine blood flow near term. It further states that, the anatomical and physiological adaptations occurring throughout pregnancy affect virtually every body system. The timing and intensity of the changes vary between systems but all are designed to support fetal growth and development and prepare the mother for birth and motherhood. The uterus protects and supports the foetus, placenta and amniotic fluid. For most of the 40 weeks of pregnancy, the uterus expands to accommodate the growing foetus and remains relatively quiescent, yet at the time of labour it is able to contract regularly and forcibly to expel the foetus due to its unique properties of contractility and elasticity. She also says, the vagina also increases vascularity which results in the violet colour characteristic of Chadwick's sign. There is increased volume of vaginal secretions due to high level of estrogen resulting in thick,

white discharge known as leucorrhoea. Larger amount of glycogen is deposited in the vaginal epithelium due to high estrogen availability. The glycogen is metabolized to lactic acid by the lactobacillus
acidophilus, (Doderlein's bacillus), and this leads to increase vaginal acidity.

Ricci, (2016) said that, the client is usually the first person to suspect pregnancy. Her suspicion is often based on the fact that she has missed her period. The amenorrhea occurs because, after implantation of the fertilized ovum, the increase secretion of estrogen and progesterone by the ovary converts the endometrium of the uterus to decidua of pregnancy and menstruation ceases.
He further mentioned that, the morning sickness, continuous enlargement of the breasts, fetal movement, painless contractions, and others are some of the signs and symptoms that occurs at different stages of pregnancy.

Weller (2014) defines pregnancy as being with child, the condition from conception to the expulsion of the fetus. During this period, a lot of physiological and psychological changes take place in the woman. This affects the entire system as a result of hormonal influence, some women suffer minor disorders like vomiting, heart burns, constipation, waist pains, nausea, ptyalism (excessive salivation), food craving and others which most of these changes go away after delivery. Also, if these are not treated early, they can lead to severe complications which could be life threatening, therefore, it is important for the pregnant woman to attend antenatal clinics as soon as she realizes she is pregnant, for supervision, observations, investigations, and examinations for early detection and treatment of any deviation from normal. During this period, the expectant mother needs special education,

encouragement and care, in order to cope with these minor disorders. These educations are given at the antenatal clinics by the attending midwife. Antenatal care is a special care to promote a healthy mother and fetus. Focus antenatal is a special care given to a pregnant woman by the attending midwife and an obstetrician, during pregnancy to ensure that, maternal and fetal health are normal. The aim of focus antenatal is to detect early and treat any abnormalities, prevent complications, promote health and educate mothers on complication readiness.

LABOUR

According to Konar (2015), labour is characterized by the presence of regular uterine contractions with cervical effacement and dilatation, descent and expulsion of products of conception. Konar also describes labour as normal if it fulfills the following criteria; spontaneous in onset and at term, with vertex presentation, without undue prolongation, natural termination with no aid and without any complications affecting maternal and/or baby's health. He stated under rest and ambulation; if the membranes are intact, the patient is allowed to walk. The attitude prevents vena caval compression and encourages descent of the head. Ambulation can reduce the duration of labour is monitored electronically of analgesic drug (epidural analgesia) is given, she should be in bed.

He further went on to state that, assessment of progress of labour and partograph recording are also done. Partograph is the tool that allows 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 rates of prolonged abnormal, oxytocin use, caesarean sections and intrapartum morbidity/ mortality as compared to usual care. Use of the partograph is initiated during presumed active labour.

Marshall J. and RaynorM. (2014) says immersion in a warm bath or birthing pool can be an effective form of pain relief for laboring women that facilitates increased mobility with no increased incidence of adverse outcome for the woman or fetus. The midwife should invite the woman who is mobile to have a bath or shower whenever she wishes during labour.

Elizabeth (2013) says series of event that takes place in the genital organs in an effort to expel the viable product of conception out of the womb through the vagina into the outer world is called labour. They added that labour is said to be normal if it fufill the following:

Spontaneous in onset and at term

With vertex presentation

Without undue prolongation

Natural termination with minimal and without having any complications affecting the health of the mother and baby. She continues to say that management of labour aims at minimal observation with minimal active intervention. The idea is to maintain the normalcy and detect any deviation from normal at the earliest possible movement.

PUERPERIUM

According to Marshall J. and Raynor M. (2014) puerperium starts immediately after delivery of the placenta and membranes and continues for six weeks. It further states that the overall expectation is that by the end of the sixth weeks after birth all the system in the

woman's body will have recovered from the effects of pregnancy and the process of parturition.

He also 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 and Redshaw (2013) state that, the falling progesterone levels affect the alimentary tract. The smooth muscle tone gradually improves throughout the body, and symptoms of heartburn the woman may have experienced should resolve. Constipation may however remain a common problem during the postnatal period.

Konar H. 2015) also defines puerperium as the period following childbirth during which the body tissues, especially the pelvic organs revert back approximately to their pre pregnant state both anatomically and physiologically. He further explained that, lochia is the vaginal discharge for the first fortnight during puerperium. The discharge originates from the uterine body, cervix and vagina. Depending on the variation in the colour of the discharge, it is named as:

Lochia Rubra: consists of blood, shreds of fetal membranes and decidua, vernix caseosa, lanugo and meconium. It is red in color and it last for the first 1-4 days.

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

Lochia Alba: contains plenty decidua cells, leukocytes, mucous, cholesterol crystals, fatty and granular epithelial cells. It lasts for 10-15 days and it is pale white in color.

The American Academy of Pediatrics (2014) stated the essential Care for Every Baby as all

babies must be given eye care by instillation of tetracycline/chloramphenicol eye drops/ointment to prevent eye infections and also administering of vitamin k injection to prevent hemorrhagic disease of the newborn as well as cord dressing.

WHY I CHOSE MY CLIENT

Madam Ophilia G2 P1 reported to the antenatal clinic on 14th August, 2023 client complained of frequency of micturition and she was explained to her that her previous pregnancy was not like that. Client was advised that every pregnancy was different and that she should not worry. The physiology of micturition was explained to her that due to the growing uterus exerting pressure on the bladder. And she was encouraged to put chamber pot in reach of her bed and she was educated to take less water in the evening to so that it not disturbed her sleeping. Opportunity was taken for introduction as a student midwife from Holy Family Nursing and Midwifery Training College, Berekum on community midwifery practical. Permission was sought from her if she could be used for the study. She agreed and was told to share her problems. The midwife in-charge was informed and permission was granted. After going through the normal antenatal process, she gave the direction to her house, her phone number was taken and she was promised of a visit. Appreciation was express.

CHAPTER ONE

ASSESSMENT OF CLIENT / FAMILY

1.0 INTRODUCTION

This chapter gives the preview on various information about the client social, family, medical, surgical, menstrual, past and present obstetrical histories as client lifestyle, hobbies and her community in whole.

1.1 PERSONAL AND SOCIAL HISTORY

Madam Ophilia Antwiwaa gravida 2 para 1 alive is a 33year old lady who comes from Amaasu in Bono Region and stays at Amaasu. Madam Ophilia house is near the Presbyterian church. She is dark in complexion, weighs 75 kilograms and 165 centimeters in height at booking. Madam Ophilia is a catering. She is a Christian and fellowships at Methodist church at Amaasu. Madam Ophilia is a senior high school graduate. Client speaks and understand Twi and English. Client next of kin is her husband Richard Obeng.

1.2 FAMILY HISTORY

Madam Ophilia is first born to Mr. Christopher Appiagyei and Madam Susuana Amoateng. Her father is a trader and her mother is a business woman. Among the five children, there are four females and one male. No known histories of any chronic or hereditary diseases such as cancer, diabetes mellitus, epilepsy, hypertension, sickle cell disease, mental illness in the family. She has twins in her family but no congenital abnormality such as extra digits, cleft palate, cleft lip, spinal bifida in the family.

1.3 MENSTRUAL HISTORY

Madam Ophilia had her menarche at the age of fifteen (15) years which lasts for seven (7 days with normal flow. Madam Ophilia does not take any medication during her period normally uses two (2) pads a day during her menses to promote personal hygiene. She has never experienced dysmenorrhea in her life. Her last menstrual period was 29th December, 2022 and her expected date was 6th September, 2023.

1.4 SURGICAL HISTORY

Madam Ophilia, has never undergone any surgical procedure and has never been involvedroad traffic accident which could have affected her pelvis. She also added that she has neither donated nor received blood transfusion.

1.5 MEDICAL HISTORY

According to Madam Ophilia, she has no known medical history of conditions such as anemia, heart disease, respiratory disorders, epilepsy, hypertension etc.

1.6 LIFESTYLE AND HOBBIES

Madam Ophilia normally wakes up around 5:00am, she prays and brushes her teeth with toothbrush and toothpaste after which she sweeps her room and compound. She then goes to throw her rubbish away at the dump site which is 10minutes walk away from her house. And her husband helps her with fetching of water which is 2minutes walk away from their house, bath their first son who is 2years of age and dress him. By 7:00 am she has done her house chores and prepare their breakfast after that she takes her bath.

She takes her porridge with bread and egg in the morning, ampesi with palava sauce in the after afternoon and fufu with groundnut soup with beef and chicken in the evening. She added that, she then goes to work and close around 4:00pm. She then goes home to prepare their evening meal which mainly fufu with groundnut soup since that is her favorite. Client said during her leisure time, she rests on her bed or watch television. Client urinates frequently when she takes in enough fluid and empties her bowel at least once a day.

1.7 PAST OBSTETRIC HISTORY

Pregnancy; Madam Ophilia gravida 2para 1 alive and healthy went through all her pregnancy successfully without any complications. She had her first pregnancy in the 2020. She said she took the two doses of Tetanus` diphtheria injection as well as 5 doses of Sulphadoxine Pyrimethamine (SP)) in her first pregnancy. She delivered her child at term. She said during her pregnancy, she only experienced some minor disorders such as backache, waist-pains, nausea and vomiting of which she reported to the clinic and they were explained to her as a normal physiological change in pregnancy which would resolve as pregnancy progressed. She has never suffered any pregnancy induced conditions such as pregnancy induces hypertension, preeclampsia and gestational diabetes. She visited the antenatal clinic for at least 5 times during her pregnancy. According to client the interval between the first child and the current pregnancy is 2 years.

Labour: According to Madam Ophilia, her previous delivery took place at health center by spontaneous vaginal delivery. Client first child was delivered at Presbyterian Health Center Kyeremasu

who was a male and weighed 3.1kg at birth per records. The duration of labour for the first born did not exceed 14 hours. Client said the placenta was delivered few minutes after the baby was born, and the child was in good health after delivery. Abnormalities such as cleft palate, cleft lip, extra digit were not detected at birth. Amount of blood loss was 150mls in her previous delivery.

Puerperium; Madam Ophilia went through puerperium successfully without any complications such puerperal infection and sepsis. She started breastfeeding her child after delivery. Her child looked healthy and normal. Her child was fully immunized against the childhood preventable diseases. She practiced exclusive breastfeeding for six months and weaned after 1year 6months. Client also stated that her familysupported her in taking care of the baby and some of the household chores. She uses the natural family planning method thus lactational amenorrhea method. She said her child was fully immunized against vaccine preventable disease according to schedules. She did not experience problems like puerperal sepsis and etc.

1.8 PRESENT OBSTETRIC HISTORY

Madam Ophilia G2P1alive first visited the clinic on the on 20th Feburary, 2023, she was 16weeks plus 1day of gestation and symphysio-fundal height was 14cm. Client last menstrual period was on the 29th December, 2022 and her expected date delivery was calculated as 6th September, 2023. Ultrasound scan gave her on 5th September, 2023. Her vital signs and laboratory investigations on that day were as follows;

Temperature	36.8 degree celsius
Pulse	85 bpm
Respiration	22cpm
Blood pressure	116/72mmHg
Weight	75 kg
Height	165cm
Lab Investigations	
Haemoglobin	13.1g\dl
Sickling	Negative
Blood Group	O
Rhesus factor	Positive
Urine for pregnancy test	Negative
Hepatitis B	Negative
VDRL	Non-Reactive
Protein in urine	Negative
Glucose in urine	Negative
G6PD	Negative
Urine albumin	Negative
Antibody screening for HIV	Non-Reactive
Stool test	Negative

On head to toe examination, there was no abnormalities detected. Education on danger signs was given. She was educated on the need to attend Antenatal Clinic regularly. She was put on the following drugs.

Tab Ferrous sulphate	200mg-1dly×30 days
Tab Folic acid	5mg 1dly×30 days
Tab Multivitamin	200mg 1dly×30 days

CHAPTER TWO

ANTENATAL CARE

2.0 INTRODUCTION

This involves the care rendered to Madam Ophilia during pregnancy. This includes first contact with client, first antenatal home visit, physical environment, psychosocial assessment, subsequent home visit, subsequent visit to the clinic and nursing care plans drawn to solve problems encountered by the client during this period.

2.1 FIRST CONTACT WITH CLIENT

Client was met for the first time on the 14th August, 2023 at 11:00am, when she was thirty-six (36weeks +5days) gestation and was attending her 7th antenatal visit at Presbyterian health center Kyeremasu. Madam Ophilia complained of frequency of micturition and the physiology of frequency of micturition was explained to her during pregnancy uterus stretches to compress on bladder so little urine that will enter bladder she will feel urge to urinate. She was educated that after she finished urinating she should clean her vulva with tissue from anterior to posterior. Self- introduction was made to Madam Ophilia as a student midwife from Holy Family Nursing and Midwifery Training College Berekum who has been stationed there for 6weeks clinical to write care study and would use her as client. Her antenatal booklet was taken and her previous antenatal records. Client was encouraged to ask question and also thanked for her cooperation. Client vital signs were checked below.

Temperature	36.3 degree Celcius
Pulse	83bpm
Respiration	21cpm
Blood pressure	102\65mmHg
Weight	78kilogram
Height	165 centimeters
Haemoglobin level	12.3g\dl

Urine Testing

Client was directed to the washroom with labelled sample bottle given to her for collection of sample of her urine specimen for testing for the presence of protein and glucose by the use of a urine reagent strip.

Protective clothing like apron and gloves were worn. The quantity, colour, odour, smell and sediment were noted. Urine strip was picked and dipped into the urine sample. The strip was immediately removed and the edge of the strip tapped against side of urine container to prevent spilling of urine onto the clothes. After one (1) minute, the stick was compared with colors on the container. There was no change in colour of the strip indicating negative result for both protein and glucose. This procedure was aimed at detecting and ruling out any abnormalities and to provide sharp intervention where necessary.

GENERAL PHYSICAL EXAMINATION

A tray was set containing the following items;

1. A sterile gallipot with sterile cotton wool swabs with a lid.
2. A receiver for used cotton wool swabs.
3. A tape measure
4. A fetal stethoscope
5. A watch with a second land
6. Client's folder with a blue pen

A couch was screened for privacy, she was assisted to change her dressing and wear examination gown after having emptied her bladder. Permission was sought for head to toe examination to be carried out and she granted. Madam Ophilia was assisted unto the couch of lateral position. Hands were washed with soap under running water and dried with clean dry towel. She positioned herself dorsally for physical examination under the supervision of the midwife in charge.

Head and Neck Examination,

On examination of the head and neck, the hair was nicely and neatly braided without dandruff. The face was not puffy, pink conjunctiva with no discharge from both eyes and was in aligned with the ears. Teeth was cleaned without any calculus, dental carries and dental diseases and no offensive odour of the mouth. No cracked lips, and the lips were also dried. The neck was also palpated for lymph nodes, and distended neck vein but nothing was found.

Breast Examination,

On breast examination, before the breast was palpated, the breast was exposed to check for size, shape, signs of pregnancy, dimpling and nipple retraction and condition of her breast skin. The breast was palpated systematically in a circular manner using the inner aspect of the fingers and client was reminded of self-examination. There was no lymph node and no discharge from the nipple when squeezed. The same was done to other breast and no abnormality was found. Breastfeeding history was asked and her desire to breastfeed was positive as her previous child.

Extremities

The upper extremities of both left and right upper limbs showed equal size and length. No oedema of the hands and the finger nails were well trimmed short and neat with no extra digit.

Lower extremities no varicose veins on legs was found, legs were examined for size, and equality and palpated for oedema, tenderness in the calf.

Back

The back was examined and palpated for spinal or vertebra abnormalities and there was none, sacral region were inspected for signs of oedema or rash on her buttocks.

ABDOMINAL EXAMINATION,

Inspection

The abdomen was inspected for medium in size and ovoid in shape. Linear nigra was present and scars and striae gravidarum were absent.

Symphysio fundal measurement,

The zero end of the tape measure was placed on the fundus of the uterus and was extended to the upper border of the symphysis pubis and the symphysio fundal height was obtained as 35 centimeters.

Fundal palpation

Palms were rubbed together to prevent induced contractions, standing at the right-hand side of the woman and facing the head to monitor her facial expression, fundus was palpated with both hands and fingers curved around the fundus and the buttocks of the foetus which feel soft were felt occupying the upper pole of the uterus. The fundus was at the xiphisternum.

Lateral Palpation

On lateral palpation; one hand was used to stabilize one side of the uterus and the other hand was moved gently in a circular manner at the right side of the abdomen and the foetal limbs were palpated which were rough. This was repeated at the left side of the abdomen and the foetal back was felt. Foetal position was left occipito anterior.

Pelvic Palpation

On pelvic palpation; upon facing the lower limbs of the client at her right-hand side, both hands were placed closely together and pointing downwards and inwards below the umbilicus, the presentation was cephalic and the lie was longitudinal.

Descent

The anterior shoulder was first located using two fingers. The upper border of the symphysis pubis was also located. Five fingers were admitted between the anterior shoulder and the upper border of the symphysis pubis indicating decent of 5/5th above the pelvic brim.

Auscultation

Fetal stethoscope was warmed by rubbing it in the palm and placed on the right side of the abdomen where the back was located. Fetal heart rate was listened and counted for one full minute

while comparing it to the maternal pulse, the fetus heart rate was 132

beats per minute.

Vulva Examination

Permission was sought from client and she agreed. Examination glove were put on and the vulva was inspected. There was no rash, giving critical attention to the groins, there was no offensive discharge, no scars, vulva warts and varicosity. She was asked to stretch her legs and lie to relax, while gloves were removed and placed them into the kidney

dish. She was thanked for her cooperation and hands washing was done, she was asked to lie on her lateral side then sit up before getting off the couch. She was assisted

to redress. Details of the examination were made known to her and findings was also communicated to her. Findings were recorded in her Maternal Record Book; she was given the platform to asked question and if she has any complains. client reply of no complains and no question. She was educated to take more fruits, vegetables, whole grain and to put pillow on her back when sleeping. Education was given on birth preparedness and complication readiness as well as the need for family planning after delivery. Her medications given were as follows;

Tablet multivitamin	200mg 30days,
Tablet Folic Acid	5mg daily for 30 days,
Tablet Ferrous Sulphate	200mg daily for 30days

. After conversation, she was asked the direction to her house and reminded of her next visit to the clinic on the 25th August and wished her well and bid her goodbye.

2.2 FIRST ANTENATAL HOME VISIT

The first visit to Madam Ophilia home was on 16th August, 2023. It was Wednesday at her residence around 4:30pm after informing her of a visit to the house. The goal of the visit was to observe the environment where she lives and make assessment of her home situations to avoid health threatening conditions and to provide continuous care after delivery. It was really a warm welcome to the house by the family, after exchanging greetings, an introduction was made to her mother. She was asked of the general condition of the family and she responded, they are doing well. She was further asked of if she has complaints and she complained of constipation, and waist pain and

physiology of waist was explained to her that it is due to relaxation of muscle in the sacral region and also the physiology of constipation was explained to her that due to the excess production of progesterone which causes relaxation of the muscles of the intestines prevents smooth movement of faeces in the intestines. She was then educated to eat more fruits and vegetables and also eat food rich in fiber and roughage and take in more fluids. She was asked whether she is taking her routine d irugs as prescribed and responded yes and she was encouraged to continue the medication and if she is having any problem about her health she should report to the clinic.

PHYSICAL ENVIRONMENT

The house was built with cement b ricks and roofed with aluminum sheets. Client occupies a big room with her child and husband. The room has two windows were well arranged for proper ventilation and she was congratulated and asked to keep it up again she was asked whether she sleeps under insecticide treated net and she said yes She was again educated on the importance of sleeping under an insecticide net. The kitchen was well kept, her bathroom was kept clean, but the toilet was outside the house which is public toilet. The source of water was good, and the source light is electricity. The house was neatly kept with good drainage system. She was thanked and permission to leave was sought. She was informed about the next visit to the clinic.

PSYCHOSOCIAL

Madam Ophilia and her family have cordial relationship with each other. Madam Ophilia has a warm and friendly relationship with the tenants and other family members staying around the house and her neighbors. Her friends most at times visit her and she also visit them at her leisure time. Madam Ophilia introduced me to her neighbors. She has

respect for humans and likes to makes new friends. Madam Ophilia attend to social gatheringlikes funerals and wedding ceremony at all times.

2.3 SECOND ANTENATAL HOME VISIT

The second visit to Madam Ophelia's house was on the 23rd August, 2023 which was Tuesday at 4:00pm. She was met when almost done with preparation of her food. She was greeted, warm welcome was given and seat offered. The aim was to inquire about her general condition and client complained of lower abdominal pain and frequent micturition. Client was asked about her previous complains and she said she is coping with the waist pain but since there was no fruits and vegetables available at that time of the season she took in more fluid as she was advice and now she has been relieved of constipation. The physiology of lower abdominal pain was explained to her that stretching of round ligament due to fetal movement and client was encouraged to wear low heel fitting shoes also the physiology of frequent micturition was explained to her that, due to the pressure on the bladder caused by the growing uterus and baby can cause the need to empty your bladder more frequently. She educated to. Client was asked to bring her things she will send to hospital for inspection if everything is well packed. Some of the items included delivery pads, six cot sheets, six old sheet, two toilet rolls, two carbonic soap, one antiseptic solution, two rubber mackintosh for delivery, baby socks, cap, and baby dress. Client was educated on danger signs and birth preparedness and complication readiness. Madam Ophilia vital sign was checked and recorded as

Temperature	36.5degree celsius
Pulse	85bpm
Respiration	22cpm
Blood pressure	108\70mmHg
Smphysio fundal height	36cm

Fetal heart rate	135bpm

Client and relatives were thanked for nice reception for their time and permission was sought for departure.

2.4 SUBSEQUENT VISIT TO THE CLINIC

Madam Ophilia visited the clinic on 25th August, 2023 at 10:00am. Client complains of backache and the physiology of backache was explained to her that it was caused by increased release of relaxin which causes ligament laxity. She was asked of her previous complain during home visit and she said she could now cope with the lower abdominal pain, waist pain, constipation, and frequent micturition. Routine examination was conducted and recorded as;

Temperature	36.7 degree celsius
Pulse	80bpm
Respiration	21cm
Blood pressure	105\72mmHg
Weight	76kg
Symphyio fundal height	37cm
Fetal heart rate	138bpm

All procedures be carried out on her to gain her cooperation and sought her consent. She was asked to empty her bladder. Provision of privacy was done by screening the bed and then helped her to undress and assisted her onto the couch. Thoroughly hand washing was done and cleaned with clean hand towel and started with the head to toe examination under the supervision of midwife in-charge. Her general appearance was good and no abnormality was detected.

Abdominal examination was carried out. On inspection, the abdomen was globular, striae gravidarum and linear nigra were present with no scar. On palpation, the symphsio-fundal height was 37cm with gestational age of 38weeks. On lateral palpation, fetal back was at right side and lie was longitudinal, presentation was cephalic with head descent 5\5th

Problem Identified During Antenatal

Madam Ophilia complained of the following;

1. On 23th August, 2023 client complained of frequency of micturition

2. On 16th August, 2023 client complained of constipation

3 On 16th August, 2023 client complained of waist pain

4. On 23th August, 2023 client complained of lower abdominal pain

5. On 25rd August,2 023 client complained of backache

Short Term Objectives

1. Client will be able to cope with frequency of micturition 24 hours after delivery.
2. Client would be able to pass stool at least once a day within 48 hours.
3. Client's waist pain will be reduced and cope with it throughout pregnancy within 24hours.
4. Client's lower abdominal pain will be reduced and cope with throughout pregnancy within 24 hours.
5. Client backache will be reduced and cope with throughout pregnancy.

Long Term Objectives.

Madam Ophilia will go through pregnancy, labour and puerperium successfully without any complication to herself and the foetus.

CARE PLAN DURING ANTENATAL

DATE/ TIME	NURSING DIAGNOSIS	NURSUNG OBJECTIVES/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTIONS	DATE/ TIME	EVALUATION	SIGN
14/08/23 10:00am	Frequency of micturition related to growing uterus exerting pressure on the bladder.	Client will be able to cope with frequent micturition 24 hours after delivery as evidence by client verbalizing that frequent micturition as reduced. 2. Midwife observing tis able to cope with frequency micturition.	1.Assure client that frequent micturition will subside. 2.Educate client on the physiology of micturition. 3.Encourage client on perineal hygiene. 4.Educate on fluid client on fluid intake. 5.Encourage client to keep pail in reach of her.	1. client was reassured that her micturition will subside because it is normal physiology 2.Client was educated that it is due to the growing fetus exerting pressure on the bladder. 3.client was encouraged on the use of panty liners. 4.Client was educated to limit fluid intake in the evening and at bed time. 5.client was encouraged to pail in reach of her during bed time.	15/8/23 10:00am	Goal fully met as evidenced by client understanding education given and practicing coping method. .	AH

DATE/TIME	NURSING DIAGNOSIS	OBJECTIVES/OUTCOME CRITERIA	NURSING ORDERS	INTERVENTION	DATE/ TIME	EVALUATION	SIGN
16/8/23 4:00pm	Constipation related to activity of progesterone as evidenced by patient verbalizing she has not pass stool for two days.	Client will pass stool more than one within 48 hours as evidenced by Client verbalizing that she was able to pass stool more than one in 48 hours.	1.Reassure client that. 2. Explain the physiology behind constipation to client. 3.Encourage her to take in foods that are rich in fiber. 4.Encourage her to take in more water. 5.Educate the client to do exercise and visit toilet regularly.	1 Client was reassured that her constipation would be relieved after intervention 2.physiology of constipation was explained to her that, due to the relaxation of the smooth muscle of the large intestines. 3.Client was encouraged to eat fiber rich diet such as cereals and whole grains 4.Client was encouraged to drink at least 8 to10 cups of water every day. 5. client was educated to do exercise such as walking and visit the toilet when she feels the urge.	17/8/23 4:00pm	Goal fully met as Client verbalizing that she passed stool once within 24 hours and is relieved from discomfort of constipation.	A H

CARE PLAN DURING ANTENATAL

DATE/ TIME	NURSING DIAGNOSIS	OBJECTIVES/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTIONS	DATE/ TIME	EVALUATION	SIGN
16/8/23 4:00pm	Waist pain related to relaxation of pelvic ligament.	Client will be to cope with waist within 48 hours as evidenced by: 1.Client verbalizing that her waist has reduced and can now cope with it. 2.Midwife observing client perform daily activities without complains of waist pains.	1. Reassure client. 2.Encourage client to rest. 3.Encourage client to seat while doing her activities. 4.Educate client on the physiology of waist pain 5.Administer prescribed analgesics.	1. Client was reassured that her waist pain will subside after intervention 2. Client was encouraged to have rest in between activities. 3.Client was encouraged to sit down when performing house hold chores like washing 4.Client was educated on the physiology of waist pain is due to descent of fetal head putting pressure on sacral nerves. 5. Client was served with 1g of paracetamol when needed.	18/8/23 7:30pm	Goal fully met as evidenced by client verbalized that pain has reduced and can cope wit pain.	A H

CARE PLAN DURING ANTENATAL

DATE/ TIME	NURSING DIAGNOSIS	OBJECTIVES/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTIONS	DATE/ TIME	EVALUATION	SIGN
20/8/23 7:40pm	Lower abdominal pains related to descent of the fetal head in late pregnancy.	1. Client's lower abdominal pain will be reduced and cope with throughout pregnancy within 24 hours as verbalizing by client the pain has subsided 2. Midwife observing that client can cope with lower abdominal	1. Reassure client that abdominal pain will subside. **2.**Explain the physiology of lower abdominal pains to client. 3.Encourage client husband to help her with the house hold chores. 4.Encourage client to rest. 5.Educate client comfort measures.	1.Client was reassured that pain will subside after delivery 2.The physiology of lower abdominal pain was explained to her that is due to pressure of the presenting part. 3.client husband was encouraged to help her with activities like washing and cooking. 4.Client was encouraged to rest in between activities. 5.Client was educated to support her back with pillow when sitting	20/8/23 9:40pm	Goal fully met as evidenced by client verbalizing that she can cope with pain and Midwife observing that client has cheerful facial expression,	A H

ANTENATAL CARE PLAN

DATE/ TIME	NURSING DIAGNOSIS	OBJECTIVES/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERV NTIONS	DATE/ TIME	EVALUATION	SIGN
23/8/23 **9:**00am	Backache related to physiological adjustment of growing uterus causing change in posture.	Client backache will be reduced and cope with throughout pregnancy as within 4 hours as evidenced by 1.client verbalizing that backache has reduced 2. Midwife observing that backache has subsided.	1. Reassure client to allay anxiety 2. Explain the physiology of backache in late pregnancy to client 3.Encourage client to assume appropriate sitting position. 4.Encourage client on passive exercise.	1. Client was reassured that backache will be relieved after intervention. 2.physiology of backache in late pregnancy was explained to client that due to the growing fetus exerting pressure on the back 3.client encouraged to assume an upright position and support her back with pillow when sitting 4. client was educated on passive exercise like walking for some time	**24/8/23** **7:**00pm	Goal fully met as evidenced by client verbalizing that pain has reduced and can cope with pain.	A H

CHAPTER THREE

INTRAPATAL CARE

3.0 INTRODUCTION

This chapter describes the management of labour, immediate care of the newborn, examination of the newborn and care plan drawn for the management of the problems encountered during labour and delivery.

3.1 ADMISSION AND MANAGEMENT OF FIRST STAGE OF LABOUR

On Wednesday 30th August, 202,3 Madam Ophilia reported to the facility Presbyterian health center Kyeremasu, at around 5:40am with mother complaining of lower abdominal pains and she was assured that it is due to the pressure of descent of the fetal head pressing on the sacral nerves and it will resolve soon after delivery. They were welcome and offer a seat while glancing through her ANC book and with help of midwife in-charge and her expecteddate of delivery was 6th November, 2023. Her hemoglobin was 12.5g\dl and she was 38weeks+ 3days. Madam Ophilia complain of waist pains and noticed blood stained mucus at around 4:00am. Even her facial expression during interaction shows that she was in pains. Inquiries about her last meal was made and she said she ate rice with palava sauce at 6:00pm. Madam Ophilia's mother was reassured that everything was going to be alright. She was sent to the examination room and assisted to change her clothing. Procedures going to be done were explained to her and permission was sought to carry on. She was asked to empty her bladder which was tested for sugar, albumin and acetone amount 150mls but was all negative. She was assisted to lie on the couch and a quick

examination from head to toe and no abnormality was detected but during the examination, her face looked anxious. Abdominal examination was then conducted. On inspection, abdomen looked globular in shape with no scar and fetal movement was noticed. Linear nigra and striae gravidarum were also present.

On palpation at 5:50am, the symphysio -fundal height measured 38cm. Fundal palpation revealed the buttock in upper pole, lateral palpation revealed back of the fetus at the right side of abdomen and limbs at left side. The lie was longitudinal, presentation was cephalic and the position left occipito anterior. Descent was 4\5th above the pelvic brim. On auscultation, fetal heart rate was 140bpm with regular and rhythmic volume. Uterine contractions were checked and recorded as 2 in 10 minutes lasting for 32 seconds.

The procedure was explained to her that she was going to be examined vaginally. A tray was set up for vaginal examination. Hands were washed with soap under running water and dry with clean towel and sterile gloves were worn on both hands. She was put in lithotomy position with knees flexed and legs separated. The vulva was swabbed with 5 sterile cotton wool swabs soaked in savlon, swabbing the majora first, then minora and vestibule.

Inspection of the vulva for oedema, warts, scar varicosities was done and no abnormalities were detected. The vulva was shaved neatly. The vagina examined and it was warm and moist with no offensive discharge, cervix was soft and thin and there was evidenced of show. Cervical dilatation was 4cm, cervix had effaced and was soft and thin with membrane intact and there was no moulding. The sacral promontory was not

reached and ischial spine were blunt. Sub-pubic angle accommodated two fingers in the arch.

She was cleaned and applied clean perineal pad at the vulva. Gloves were remove and disposed and hands were washed with soap under running water and dry with clean towel. Client's bed was shown to her, findings was communicated to her and progress of labour and how far cervix had dilated to her and documented findings on the partograph sheet. She was encouraged to micturate frequently to helps in descent of fetal head. Madam Ophilia was advised not to be bearing down prematurely to prevent cervical tear and edematous cervix. Her vital signs checked and recorded as follows,

Temperature	36.5 degree celsius
Pulse	85bpm
Respiration	20cpm
Blood pressure	110\60mmHg
Hemoglobin	12.5g\dl

3.2 MANAGEMENT OF THE FIRST STAGE OF LABOUR

Uterine contraction, maternal pulse and fetal heart rate were checked half hourly and urinalysis, temperature was checked every two hourly and vaginal examinations, bloodpressure were done four hourly and recorded on the partograph.

At 6:20am, fetal heart rate was 130bpm with good volume and rhythm. Uterine contraction was 2 in 10 minutes lasting for 32 seconds, maternal pulse was 80bpm.

At 6:50am fetal heart rate 134bpm and uterine contraction was 2in10 minute lasting for 33 seconds and maternal pulse 84bpm. Client looked anxious because of severe pains and worried about unknown outcome of labour and so client was reassured to allay anxiety.

At 7:20am fetal heart rate was 132bpm and uterine contraction was 3in 10 minutes lasting for 35seconds and maternal pulse 82bpm.

At 7:50am fetal heart rate was 140bpm and uterine contraction was 3 in 10 minutes lasting for 36seconds and maternal pulse 78bpm.

At 8:20am fetal rate was 136bpm and uterine contraction was 3in 10 minutes lasting for 38 seconds and maternal pulse was 80bpm.

At 8:50am fetal heart rate was 138bpm and uterine contraction was 4 in 10 minutes lasting for 38 seconds, maternal pulse 82bpm.

At 9:20am fetal heart rate was 138bpm with good volume and uterine contraction was 4in 10 minutes lasting for 39 seconds and maternal pulse was 86bpm

At 9:50am maternal temperature 36.2degree celsius, pulse 86bpm, blood pressure 110\60mmHg, urine passed measured 120m\s and protein and acetone were tested and negative for both. Fetal heart rate was 140bpm with good volume and regular rhythm. Uterine contraction was 4 in 10 lasting for 41 seconds, examination was done, cervical dilation was 8cm, head descent was done abdominally and read 2\5th above pelvic brim. Membranes were intact and there was no moulding.

At 10:20am maternal pulse was 76bpm, uterine contraction 4 in 10 minutes lasting 42 seconds. Fetal heart rate was 134bpm.

At 10:50am fetal heart rate was 135bpm with good rhythm and contraction was 4 in 10 lasting for 44 seconds and maternal pulse 82bpm. Madam Ophilia was sweating profusely so her face towel was soaked in water and used it in cleaning her body. The window opened and switched on the fans to ventilate the room adequately.

At 11:20am, fetal heart rate was 140bpm and uterine contraction was 4 in 10 minutes lasting for 46 seconds and maternal pulse was 88bpm. She complained of fatigue and was encourage to calm down to prevent maternal exhaustion during contractions and diversional therapy employed by engaging her in conversation.

At 11:50am uterine contractions became stronger and expulsive in nature counting 4 in 10 lasting for 48 seconds. Fetal heart rate was 130bpm with good volume and rhythm, maternal pulse was 90bpm. Membranes ruptured spontaneously at the same time and the liquor was clear, vaginal examination was done to rule out cord prolapsed, confirm full dimjjjjjjjjjjttlatation of the cervix and it was 10cm dilated. Head was 0\5th on pelvic examination, there was moulding (++) and there was no caput formation. The progress of labour was communicated to the midwife in charge and she confirmed findings with another vaginal examination. Perineum was bulging and anus was gaping.

PREPARATION FOR BIRTH

A helper was identified both skilled (ward in charge) and the non- skilled (client mother) to assist in the delivery when needed. Emergency plan was also reviewed which includes, calling of referral center and calling of taxi driver to help in transportation of client to referral center, an obstetrician and pediatrician when need arise and then resuscitation table was prepared. Client was reminded that she will be assisted to wash her hands and chest when second stage is eminent to prepare

for skin to skin care to prevent infections to baby. The room was well lighted and portable lamp was also in place when lights out. Preparation of the area for ventilation and checking of equipment was also done and prepare dry, flat and safe space for receiving the baby for ventilation when needed and equipment to help in resuscitation were checked for their functioning. The items include the suction device, ventilation bag and mask, stethoscope, scissors, timer, head covering, cloths and gloves. Delivery set and emergency drugs were readily available when checked. Her vital signs and other observation were checked and recorded as,

Temperature	36.7 degree celsuis
Pulse	82bpm
Respiration	22cpm
Blood pressure	110\70mmHg
Fetal heart rate	138bpm
Descent	0\5th
Contraction	4 in 10minutes lasting 48 seconds

SETTING OF TROLLEY

AT 10:50am, the trolley was cleaned and a sterile delivery with other clean items were made available on both top and bottom shelf as below; up per shelf containing the following packed in thedelivery set;

Top shelf

- Delivery pack containing; four clean towels
- Two artery forceps
- Two dissecting forceps
- Two gallipots with cotton swabs and gauze respectively
- One cord scissors
- Receiver
- Episiotomy scissors

Lower shelf

- Bed pan
- A receiver for placenta
- Container with syringes and needles
- Foetoscope
- A syringe containing oxytocin drug in a covered container
- Antiseptic lotion. Example Savlon
- Extra perineal pad
- Sterile gloves
- Small cap containing water and bulb syringe
- Cord clamp
- Two cot sheet
- Lidocaine

3.3 MANAGEMENT OF SECOND STAGE OF LABOUR

She was positioned in a lithotomy position as client opted for this position. A gown, mackintosh apron, mask and boots were warned. After that, hands were washed with soap under running water and dried. Sterile gloves were warned. Fetal heart rate and maternal pulse was checked and recorded after each contraction. Vaginal examination was done to confirm full dilation of the cervix, perineum, pubis and inner thighs of the client were swabbed with gauze soaked in savlon solution and client was draped with a clean towel. A clean perineal pad was applied over the anus to prevent fecal matter from contaminating the delivery field. Client complained of inadequate food intake and was served with malt. Her perineum was shiny and over stretched, so she was instructed to place buttocks down to prevent tears. She was encouraged to push with contraction and flexion was maintained by placing fingers of the right hand on the advancing head in order to allow the smallest diameter to distend the perineum. Decent of the fetal head continued till it crowned. As soon as the baby's head crowned, she was asked to breathe through her mouth and give only small pushes with contraction to prevent rapid expulsion of the fetal head which could result in perineal tears and intra cranial injury. The sinciput, face and chin swept the perineum and the head was delivered by extension. Mouth and nose were gently cleaned with sterile gauze. The eyes were wiped with sterile cotton wool swab from the inside out as well as the face. The neck was quickly felt for cord around neck. The mother was reminded that the baby will be delivered on to her abdomen whiles waiting for restitution and external rotation of the fetal head. This was accompanied by internal rotation of the shoulders.The anterior shoulder was delivered by pressing the head down gently and the posterior shoulder swept the perineum to be delivered. The rest of the body was delivered by

lateral flexion onto the mother's abdomen at 12: 00pm, baby cried immediately after birth, baby was dried with the sterile cot sheet on the mother's abdomen for one hour and covered with a sterile cot sheet to prevent heat loss, provide warmth and to promote bonding.

3.4 IMMEDIATE CARE OF THE BABY

This commenced as soon as the head of the baby was delivered. The eyes were cleaned with a sterile swab from within outwards the neck was felt for cord around was absent. Baby was delivered unto mother abdomen. The baby was dried thoroughly to keep the baby warm and stimulate breathing. The umbilical cord was clamped about 2 centimeters away from the baby's abdomen and again, clamped 3centimeters away from the first clamp with artery forceps. The cord was cut in between the two clamps by coveringthe scissors with gauze to prevent splashing of blood. The baby was shown to the mother to confirm the sex of the baby and she said is a male. This was done 3 minutes after delivery of the baby. The baby was dried and head covered with cap and place on the mother's abdomen to initiate skin to skin and covered baby and mother with a warm cot sheet to maintain warmth. The baby's APGAR score assessed at the first and fifthminutes were 8/10 and 9/10 respectively. An identification band with mother's name, sex of the baby, date and time of delivery was put around baby's wrist. The baby was breathing quietly and easily.

APGAR SCORE

TIME	COLOUR	BREATH	HEART	TONE	REFLEX	TOTAL
1 MINUTE	2	2	2	1	1	8/10
5 MINUTES	2	2	2	2	1	9/10

3.5 MANAGEMENT OF THIRD STAGE OF LABOUR

Madam Ophilia was informed and procedure was explained to her. Client still in the lithotomy position, the cord clamped and cut end of the cord was placed in a receiver in between the thighs near the perineum to receive the placenta, membranes and blood loss. A gentle palpation of the uterus was done, and the in-charge was asked to confirm, to rule out undiagnosed twin. There was no other fetus, so 10unit of oxytocin were given intramuscularly on the thigh of the mother by the midwife in-charge to aid in contraction of the uterus and expulsion of the placenta. Cord was re-clamped closer to the perineum and the cord with artery forceps were held with the dominant hand. The non-dominant hand was place on the fundus to check for contraction. With contractions, the hand was repositioned just above the symphysis pubis with the palm facing the woman's umbilicus. The uterus was pushed in an upward direction to serve as counter traction to prevent inversion of the uterus. The cord and forceps were also held firmly at the same time with downward traction, the process was repeated until the placenta became visible at the

vulva. The placenta was cupped by both hands and twisted to remove pressure on the fragile membranes. The placenta and membranes were delivered completely at 12:03pm. Quick examination of the placenta was done to make sure there are no retained products. The placenta was placed in a receiver for thorough examination to be done. The perineum was cleaned and gauze was used to wrap two fingers of each hand to inspect the vagina and cervix but no tear or laceration was detected. The uterus was massaged to expel clot. Client was taught how to massage the uterus and was asked to feel for immediately. She was educated to massage the uterus by herself and report any change immediately. Client was clean off the liquor and blood with a clean pad after examination. A new perineal pad was applied at the vulva and she was made comfortable in bed. She was asked to cross her legs to keep the perineal pad in position.

3.6 EXAMINATION OF PLACENTA AND MEMBRANES

The placenta was sent to the sluice room and it was immersed in 0.5% chlorine solution for examination. The cord was situated at middle of the placenta with two arteries and a big vein in the cord with no knot. The cord with membranes hanging and membranes were examined for completeness and it was intact. The placenta was then laid on the flat surface for further examination. The amnion was peeled from the chorion up to the umbilical cord and fully viewed, the lobes fitted together without any gab, this indicated that there were no missing lobes and edges also forming uniform circle at maternal surface, there was no infarcts on the maternal surface, there was also no blood vessels radiating into the membranes which indicated absence of succenturiate lobe. The cord was situated at the center of placenta. The fetal surface was intact with no abnormality. Blood clots from the maternal surface were added to the blood loss. Blood loss 200m\s.

After the examination the instruments were immersed in 0.5% chlorine solution for 10 minutes. The instruments were removed, washed, rinse, dried and made ready for sterilization. She was asked to urinate when she had the urge for the uterus to contract and was told that if she should feel any change, she should not hesitate to report.

3.7 PREVENTION OF DISEASES

Cord was dressed with Methylated Spirit and client was to observe the cord for redness and discharge from the cord. Injection 1mg of vitamin K was given intramuscularly to prevent bleeding disorder. Chloramphenicol eye drop on each eye to prevent infection. Hands were washed under running water with soap and cleaned with a clean towel. Mother was educated to wash hands before and after breastfeeding baby. She was further explained to breastfeed on demand.

3.8 MANAGEMENT OF THE FOURTH STAGE OF LABOUR

During this period mother and baby was observed. Client was asked of the complains during labour and she said all the complains has resolved.

Examination of the New Born

Procedure was explained to my client, gloves were worn. The head was examined first, for bulging and fontanels, size, shape, laceration and caput succedaneum but none was present. Head circumference was measured and it was 34cm using the tape measure from occipital protuberance to supra orbital ridges and its length was 51cm. Mouth

was inspected for any false teeth, tongue tie, cleft palate etc. Nostrils was checked for any deviations. The neck for congenital goiter and lymph node. Chest was inspected for size,

shape and chest wall movement with respiration and respiration rate was 43 cycles per minutes and the apex heart beat was 142 beat per minute. Breast were palpated for masses and nipple for extra nipple but was normal. Examination of both upper and lower extremities was done and normal. Examination of both upper and lower extremities was examine for oedema, fracture for hand and legs and no abnormality was detected. Abdomen was inspected for shape and size. Baby's back was examined for swelling, spinal bifida or missing vertebrae but none was noticed. Skin was pink and no abnormality found. Anus and rectum were inspected for petency and the scrotum was also examined if testes is well descended, number and position and no abnormality was found. Baby's weight was recorded as 3.2kg. And vital signs were recorded as,

Temperature 36.5degree celsius

Apex heart rate 136bpm

Respiration 43cpm

Hand washing was done and findings was communicated to mother. Baby was wrapped in a warm cot sheet and was placed beside her for breastfeeding.

Management of Mother

Madam Ophilia and her baby were transferred into the lying –in room, made comfortable and also congratulated for her corporation. Uterus was felt for contractions symphysio fundal height 18cm. The total blood loss after fourth stage 200mls. Lochia was red in colour (rubra), moderate in quantity and had no smell, urine passed was 90mls and her vital signs together with bleeding were monitored every 15minutes for 2 hours, 30

minutes for 1hour till the end of the 6 hours. The baby condition was checked alongside with monitoring of the mother. There was no bleeding from the cord and no other abnormality was detected. Client was educated on frequency of 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. Client was seen fatiqued due to stress of labour. Client mother was allowed to see her and she was served with beverage and bread. The first post-delivery vital signs were checked and recorded as follows; and the rest were recorded on partograph.

Temperature	36.8 degree celsius
Pulse	78bpm
Respiration	22cpm
Blood pressure	110\80mmHg

SUMMARY OF LABOUR

Client was admitted to the ward with her mother complaints of waist pain and lower abdominal pain and when assessed labour started and was monitored. Labour progressed normally and spontaneous vaginal delivery of live male child at 12:00pm. Active management of Third stage of labour was done. Perineum was intact and blood loss was small (200mls). Condition of the baby was very good as well as mother. The placenta and its membranes were intact. Duration of labour lasted for six (6) hours.

CONDITION OF THE MOTHER

Fundal height	18cm
Uterus	Contracted
Lochia	Red (rubra)
Urine output	100mls

Condition of Baby At Birth

General examination of the baby was done and no abnormalities detected. The baby had 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	36.5 degree celsius
Apex heart rate	136bpm
Respiration	43cpm
APGAR in first minute	8\10
APGAR in fifth minute	9\10
Sex	male
Head circumference	34cm
Full length	51cm
Abnormality	None
Condition of baby	Very good
Birth weight	3.2kg

APGAR SCORE

Apgar score at first minute 8/10, Apgar score at fifth minute 9/10 and Baby condition was satisfactory.

Duration of Labour

1st Stage	5 hours 35 minutes,
2nd Stage	45minute
3rd Stage	10 minutes.
The total duration of labour	6hours 30 minutes

Record of Mother

Date of Delivery	30th August, 2023
Time of delivery	12:00pm
Mode of delivery	Spontaneous vaginal delivery
Perineum	Intact

3.9 NURSING CARE PLAN ON LABOUR

Problems Identified

1. Lower abdominal pains
2. Waist pain
3. Anxiety
4. Fatigue
5. Inadequate food intake

Short Term Objectives

1. Client will be relieved of abdominal pains within 24 hours
2. Client will be relieved of waist pain within 3 hours.
3. Client will be relieved of anxiety by the end of labour
4. Client will be relieved of fatigue within 1hours.
5. Client will eat half of her meal served.

Long Term Objectives

Client will deliver a healthy and an alive baby without complications to mother and the baby during labour and puerperium.

NURSING CARE PLAN ON LABOUR

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES	NURSING ORDERS	NURSING INTERVENTIONS	DATE/ TIME	EVALUA -TION	SIGN
30/8/23 5:40am	Lower abdominal pains related to cervical dilatation and painful uterine contraction.	Client will be able to cope with lower abdominal pains within 3hour as evidence by 1. Client verbalizing she is coping with the pain. 2. Midwife observing relaxed facial expression in between contraction.	1.Aassure client. 2.Educate client on the process of labour. 3.perform sacral massage for client 4.Encourage her to adapt a comfortable position. 5. Encourage client to do deep breathing exercise.	1.Client was assured that she will be relieved of pain after intervention. 2.Client was educated that the process of labour it is due to decent of the presenting part. 3.Sacral region of client was massaged to relief pain. 4.Client was encouraged to lie on her left lateral to cope with the pain. 5.clients was encouraged to do deep breathing exercise during contraction.	30/8/23 6:40am	Goal met as client said that she is coping with the pain	A H

NURSING CARE PLAN ON LABOUR

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES	NURSING ORDERS	NURSING IN INTERVENTIONS	DATE/ TIME	EVALUATION	SIGN
30/8/23 5:40am	Waist pain related to descent of fetal head.	Client will be relieved of waist pains within 3 hours. 2. Midwife observing that client waist pains are subside.	1. Reassure Client. 2.Explain the physiology of waist pains. 3.Give client sacral massage. 4.Engage client in conversation. 5.Encourage client to do deep breathing exercise.	1. Client was reassured that her waist pain is normal and she will be relieved after delivery. 2. The physiology of waist pain was explained to her that it is due descent of fetal head. 3.Client was given sacral massage. 4. Midwife engaged client in conversation to divert her mind of the pain **5.**Client was encouraged to do deep breathing exercise.	30/8/23 8:40am	Goal fully met as client said her waist pain has subsided. Midwife observing that client is no more in pains.	A H

CARE PLAN FOR LABOUR CONT'

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES	NURSING ORDERS	NURSING INTERVENTIONS	DATE/ TIME	EVALUATION	SIGN
30/8/23 6:50am	Anxiety related to the unknown outcome of labour	Client will be allayed from anxiety within 1 hour as evidenced by client verbalizing that she can eat meal served 2. Midwife observing that client is relieved of anxiety	1. Reassure Client. 2. Orient client to delivery room. 3.Encourage client to ask questions. 4.Explain every procedure to client. 5.Be with client.	1. Client reassured that everything will be fine after intervention. 2.Client was oriented to the delivery room and ward to allay anxiety. 3.Client was encouraged to ask questions and was answered briefly and simply. 4. Procedures like vaginal examination was explained to client. **5.**Midwives sat with client throughout labour process.	30/8/23 7:50am	Goal met as client told midwife that she is no more anxious. Midwife observing that her anxiety is relieved.	A H

NURSING CARE PLAN ON LABOUR CONT'

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES	NURSING ORDERS	NURSING INTERVENTIONS	DATE/ TIME	EVALUA-TION	SIGN
30/8/23 11:20am	Fatigue related to stresses in labour	Client will be relieved of fatigue within 1hour as evidenced by 1.client verbalizing she feels less tired. 2. And midwife observing that client has been refreshed	1. Reassure Client. 2.Encourage client to rest in between contraction. 3.Encourage to sips of something. 4. explain to client why she feels tired. 5. encourage client to avoid shouting.	1. Client was reassured that the situation can be managed. 2.Client was encouraged to rest in between contractions to prevent further maternal exhaustion. 3.Client was encouraged to talk in sips of malt to prevent exhaustion. 4.client was told that her tiredness is due to labour pain and contraction. 5. she was encouraged to avoid shouting to prevent maternal exhaustion and was encouraged to do deep breathing exercise.	30/8/23 12:20pm	Goal met as client said her is feeling less tired.	A H

NURSING CARE PLAN ON LABOUR CONT'

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES	NURSING ORDERS	NURSING INTERVENTIONS	DATE/ TIME	EVALUATION	SIGN
30/8/23 11:20am	Inadequate food intake related to stress of labour	Client will eat half of her meal served within 2hours as evidenced by client verbalizing she can eat meal served.	1. Reassure client 2. serve client with her best meal. 3.Serve client food attractively. 4.Involve client in planning meal.	1. Client was reassured that she regained her normal eating pattern after intervention. 2.client was served with banku and okuro stew with fish. 3 Client was served by garnishing it to boost her appitere. 4. Client was involved in meal planning.	30/8/23 1:20pm	Goal fully met as evidenced client verbalizing she can eat well and midwife observing client eat.	HA

CHAPTER FOUR

POSTNATAL CARE

4.0 INTRODUCTION

This chapter talks about the management of puerperium thus the care rendered to both mother and baby after delivery. It also throws more on the subsequent care of baby, preparation towards discharge, subsequent post-delivery assessment, home visits, postnatal review and the nursing care plan drawn for the management of problems identified during puerperium.

4.1 DAY OF DELIVERY

Madam Ophilia and Baby were made comfortable in bed. Vital signs of client were checked and recorded as follows;

Temperature	36.8degree celsius
Pulse	78bpm
Respiration	22cpm
Blood pressure	110\80mmHg
SFH	18cm

On examination, breast was firm and the nipples were prominent. Palpation of the uterus 18cm above the symphysis pubis, lochia was heavy in amount, red in colour and with no clots. She was advised to change her perineal pads frequently when soiled and to report any abnormal vaginal bleeding. Client was encouraged to empty the bladder frequently since full bladder interferes with contractions of the uterus with subsequent bleeding.

Client relatives were also allowed to visit mother and baby. Client relatives were asked to bring her any food of her choice. She was educated on fixing baby for breastfeeding. Baby was examined from head to toes for any sign of injury. Vital signs were checked and recorded as follows,

Temperature	36.5 degree celsius
Apex heart rate	140bpm
Respiration	40cpm
Weight	3.2kg

4.2 SUBSEQUENT CARE OF THE BABY

Baby was monitored continuously and condition of baby was good throughout. Baby was bathed six (6) hours after delivery according to the facility's protocol. Immediately after baby bath, cord was checked for bleeding. Baby was dressed and wrapped in warm cot sheet to keep baby warm to prevent hypothermia. Baby temperature was maintained by wrapped baby well and also the temperature was assessed. Client was advised not put anything such as cow dung, herbs, or ointment on the cord. The breathing rate was also checked and was in normal range.

Mother was educated on appropriate breastfeeding and was encourage to breastfeed as many time as possible a day as well as exclusive breastfeeding, proper hand washing and essential care of the new born such as cord care. Then mother was encouraged to report any danger sign such as irregular breathing rate, jaundice, fever, report immediately to the nearest health facility.

FIRST BATH OF THE BABY

At 6:00pm in the evening baby was given the first bath, Madam Ophilia was informed about the need for baby to be bathed, and she agreed gladly.

Requirements;

1. Top Shelf
2. Methylated spirit in sterile gallipot
3. Baby's diapers
4. Sterile cotton wool swabs and gauze in galipot
5. Sterile gloves
6. Sterile water in gallipot
7. Baby's oil
8. Baby sponge and soap in soap-dish
9. Baby's towel
10. Bottom shelf
11. Mackintosh apron
12. Receptacle for used water
13. A bowl for mixing water
14. Kidney dish for used gauze and swab
15. A bowl containing hot and cold water respectively
16. Disposable gloves

All needed items and baby bath trolley were made ready. Water was mixed and temperature was tested with the elbow. Hands were washed and sterile gloves worn. Baby was placed on a protected flat surface, and covered with a single sheet. Sterile cotton was dipped in sterile water and used to clean the baby's eyes from the inner canthus outward and disposed into a receiver. Face was cleaned with a wet towel. Nape of neck was supported by the palm and the ears were plugged with the thumb and middle finger. Baby's head was washed in a circular motion with soapy sponge after which it was rinsed out and dried with a towel. Body was bathed, pay ing particular attention to theskin folds, rinsed and dried with a towel. Vaseline was applied all over the body of the baby to provide warmth. Gloves were removed, hands washed and dried.

Cord Dressing;

Baby's cord was inspected for bleeding and there was no bleeding. Six sterile cottons were used to dress the cord using methylated spirit. One was used to hold the clamp and two were used to swab the base of the cord. The whole cord was swabbed anteriorly and posteriorly with a separate swab each from the bottom upwards, the tip of the cord was then cleaned with the remaining cotton and left opened to heal by dry gangrene. Baby was wrapped nicely to maintain warmth. Mother was asked to fix the baby to breast by ensuring that she sit in a good position to attached baby well to breast feed. Mother was educated that baby should be breastfeed on demand.

DAY OF DISCHARGE

In the morning on 31 August, 2023 Madam Ophilia and her family around 7:00am to find out how they were doing. After exchanging pleasantries, permission was sought to examine her and the baby. Hands were washed with soap under running water.

Vital signs of client and baby were checked and recorded at 7:30am as follows,

Temperature	36.2^{0}C
Pulse	79bpm,
Respiration	22cpm
Blood pressure	120/80mmHg
SFH	16cn.

Client was examined from head to toe and no abnormally found. Client was discharged on 31st August,2023. On examination breast were firm and nipples prominent. Uterus was firm and well contracted. Symphysio-fundal height was 16cm above the symphysis pubis. Client complained of after pains and was encouraged to breast feed on demand as it helps involution of uterus and advised to continue the postnatal exercises to strengthen the pelvic floor muscles about ten to twenty minutes every day. She also complained of backache and was encouraged to sleep on firm mattress and apply a gentle massage over when positioning and attachment. Her vulva was inspected, lochia was reddish brown in colour (Rubra), and flow was small and not offensive. She was also advised to always keep the perineum clean and change pads to prevent infection. Baby was re-examined, and observations were recorded at 10:00am as;

MORNING

Temperature	36.6 degree celsius	
Apex heart rate	142bpm	
Respiration	42cpm	
Weight	3.1kg	
Drugs	Dosage	Route of administration
BCG	0.05mls	left upper arm
OPV O	2drops	Orally

Baby was immunized to protect him against tuberculosis and poliomyelitis respectively. Client was advised not to apply anything at the injection site but to count time the immunization at the child welfare clinic when the child is six weeks old in order to protect her against the childhood diseases like yellow fever, pertussis among others. Client was later informed of discharge. She was helped to pack her belongings and the following drugs were prescribed for the mother.

Tablet Folic Acid	5mg dly × 14days,
Tablet Ferrous Sulphate	200mg bd × 14days,
Tablet Vitamin B Complex	200mg tds × 14days
and Tablet Paracetamol	1000mg bd × 5days

Drugs and dosages were explained to her and the need to take the drugs was stressed. Her NHIS card was used to settle her bills. Client was educated to avoid applying hot water on the baby's fontanelles and sutures. She was recommended to continue using treated mosquitonet and maintained good personal hygiene, she was encouraged to have rest and sleep and was reminded of a visit to her house to continue the care for seven days. The family was bid a farewell.

POSTNATAL HOME VISITS

4.3 FIRST DAY POST OF DELIVERY (FIRST HOME VIST)

In the evening first visit was made to Madam Ophilia on 31st August, 2023 at her mother's house at 5:00pm to find out how they are doing. Both mother and baby looked healthy on arrival. Family was much pleased with the visit. In trying to find out her previous complain, client said her after pain and backache has subsided. Explanation was given to her and permission was sought to examined mother and the baby. Hands were washed with soap under water both were assessed from head to toe to detect any abnormality for early treatment, she was asked to empty her bladder. The fundus was measured and it was 14cm, lochia was red (rubra) and not offensive. Client complained, that breast milk was not flowing as expected and was educated to eat foods that helps in breastmilk production. Observations were recorded at 5:00pm as follows,

EVENING

Temperature	36.6 degree celsius
Pulse	89bpm

Respiration	22cpm
Blood pressure	110/80mmHg
Symphysio fundal height	16cm
Uterus	well contracted
Breast	lactating

Permission was sought to top and tail the baby in front of mother for her to observe and it was granted. Baby was examined thoroughly from head to toe, cord was dry and not offensive. The cord was also dressed with cotton wool soaked in methylated spirit, it was cleaned and kept dry and there was no bad odour. According to client, baby passed meconium about three times and passed urine as well. Observation was record at 5:00pm as follows,

EVENING

Temperature	36.7 degree celsius
Apex heart rate	140 beat per minute
Respiration	42 cycle per minute
Baby weight	3.1kg

Permission was sought to leave and she was reminded that she would be visited the next day.

4.4 SECOND DAY POST DELIVERY (2ND POSTNATAL HOME VISIT)

On 1st September, 2023, the second visit was made to Madam Ophilia house around 8:00am in the morning, she was asked if she has complaints and she complained of breast engorgement and loss of appetite and was encouraged to apply hot compress on the breast. Permission was sought to examine both mother and baby. The head to toe examination was done on her and no abnormality was found. Her perineum was clean, the lochia was found to flow minimal, the colour was red (rubra) and without bad odour. The symphysio fundal height was 12centimeters. She complained of inadequate sleep and was encouraged to have warm bath before going to bed and also limit number of visitors with the baby. Her vital signs were checked and recorded as follows,

MORNING

Temperature	36.3 degree celsius
Pulse	79 beat per minute
Respiration	20 cpm
Blood pressure	10\60mmHg
SFH	14cm
Uterus	Contracted
Breast	lactating and heavy

EVENING 5pm,

Temperature	36.5 degree celsius
Pulse	79 bpm
Respiration	21cpm
Blood pressure	100\60mmHg

SFH	14cm
Breast	Lactating

The baby was top and tailed and general examination was carried out and no abnormality was found. The cord was neatly dressed and was clean and dry with no abnormalities was detected. The baby had passed stools. Observations were recorded at 8am as follows,

Temperature	36.8 degree celsius
Apex heart rate	142bpm
Respiration	56cpm
Weight	3.0kg

EVENING

Temperature	36.8 degree celsuis
Apex heart rate	140bpm
Respiration	42cpm
Weight	3.0kg

Permission was sought to leave and client was very grateful and, appreciated the care that was given to them.

4.5 THIRD DAY POST DELIVERY (3RD POSTNATAL HOME VISIT)

On 2nd September, 2023 the third home visit was made to Madam Ophilia's house at 8:00am, she was greeted. Mother and baby were doing well. She was asked about her

sleep and she said she could now sleep for more than 8hours in a day. Permission was sought to inspect client's perineal pad and it was pink, moderate in flow without any offensive smell. Her breasts were lactating well. Symphysio fundal height was 12centimeters. Her vital signs were checked and recorded as follows;

Morning;

Temperature 36.0^{0}C,

Pulse 78bpm,

Respiration 18cpm

BP 100\70mmHg

SFH 12cm

EVENING

Temperature 36.2

pulse 70bpm

Respiration 12cpm

Blood pressure 109|68mmHg

Symphysio fundal height 12 cm

Breast lactating

Uterus well contracting

General examination was carried out and no abnormality was present. The baby also passed stool and urine. The cord was neatly dressed and it was detaching. Observations were recorded as follows; Morning

Temperature	37.0^0c,
Apex heart beat	134bpm
Weight	2.9kg
Respiration	51cpm

EVENING

Temperature	36.8 degree celsuis
Apex heart rate	135bpm
Weight	2.9kg.
Respiration	46cpm

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

The fourth home visit was made to Madam Ophilia's house at 4:00pm on 3rd September, 2023. Lochia was pink (serosa) with scanty flow without odour on inspection. Head to toe examination was done and everything was normal. Symphysio fundal height was 10centimeters, her vital signs were checked and recorded as follows;

Temperature	36.5^0c
Pulse	74bpm,
Respiration	19cpm,
BP	100/60mmHg
SFH	10cm.

During the examination, it was realized that the cord had fallen off and baby was bathed. Madam Ophilia confirmed that it fell off during the night. The stump was then dressed and the area was cleaned and dried. The baby passed urine and stool which was yellow in colour. Observations were recorded as follows;

Temperature 36.8^{0}c,

Apex heart rate 120bpm,

Respiration 51cpm

Weight 2.8kg.

Client was asked if she has any complained client said she find it difficult to sleep at night and education was given to her on personal hygiene and the need for her to rest during day time.

4.7 FITH DAY POST DELIVERY (FIFTH POSTNATAL HOME VISIT)

The fifth postnatal home visit was on 4th September, 2023 at 4:00pm. Greetings were exchanged with client and her family after which a seat was offered in client's room. Mother and baby were both in a healthy condition when it was inquired. After the head to toe examination, no abnormality was found. Inspection of the lochia was done and the colour was pink (serosa) without any bad odour and flow was scanty. Symphysio fundal height 8 centimeters. Client's vital signs were checked and recorded as follows:

Temperature 36.5^{0}c,

Pulse 72bpm

Respiration 19cpm
BP 100/60mmHg
SFH 8cm

Baby was bathed, head to toe examination was done and no abnormalities were found on the baby. Stump of cord was then dressed and the area was cleaned and dried. Findings were taken and recorded as follows;

Temperature	36.5^0c
Apex heart beat	125bpm,
Respiration	40cpm,
Weight	2.8kg

Madam Ophilia was educated to breastfeed the on demand. Permission was sought to leave.

4.8 SITH DAY DELIVERY (SIXTH DAY POSTNATAL HOME VISIT)

The sixth day postnatal home visit was done on 5th September, 2023 at 5:00pm. Greetings were exchanged with client and her family and mother said the baby's crying has minimized and now has enough sleep. On head to toe examination, no abnormalities were detected. Her breast was lactating well. Inspection of the lochia was done and the colour was pink(serosa) normal flow without any bad odour. Madam Ophilia said the baby had pass stool that evening before arrival. Symphysio fundal height 6cm.

Client vital signs were checked and recorded as follows:

Temperature	36.5
Pulse	79bpm
Respiration	20cpm
Blood pressure	110|70mmHg
SFH	6cm
Breast	Lactating

Baby was already bathed, head to examination was done and no abnormality was found on the baby. The stump was then dressed and the area was clean and dry. Baby vital signs and weight were taken and recorded as follows:

Temperature 36.7degree celsuis

Apex heart beat 142bpm
Respiration 44cpm

Weight 2.9kg

Education was given to her on importance of ensuring good personal hygiene and need to feed the baby frequently on demand. Client said she appreciated a lot and she was thanked for her cooperation. Permission was sought to leave.

4.9 SEVENHT DAY POSTNATAL (SEVENTH POSTNATAL HOME VISIT)

The seventh day postnatal home visit was done on 6th September, 2023 at 4:30pm. Greetings were exchanged with client and family and a seat was offered in client room. Mother and baby were both in a healthy condition. On head to toe examination, no abnormalities were detected. Her breast was lactating well. Symphysio fundal height was 4 centimeters. Inspection of the lochia was done and the colour was pink (serosa) normal flow without any bad odour. Madam Ophilia said baby passed stool in the afternoon before arrival.

Client vital signs were checked and recorded as follow:

Temperature 36.6 degree celsius

Pulse 80bpm

Respiration 21cpm

Blood pressure 120|70mmHg

SFH 4cm

Baby was already bathed, head to examination was done and no abnormality was found on baby. The stump was then dressed and the area was clean dry.

Baby vital signs and weight were taken and recorded as follows:

Temperature	36.6degree celsius
Apex heart beat	135bpm
Respiration	40cpm
Weight	3.0kg

Client was educated on the danger signs in baby like and the need to seek early care. She said she appreciated that a lot, and she was thanked for her cooperation, she was reminded that tomorrow will be her first visit to the clinic and last visit to her house. Permission was sought to leave.

4.10 EIGTH DAY POST NATAL VISIT TO THE CLINIC (8th DAY POSTDELIVERY)

On 7th September, 2023 at 7:30am, Madam Ophilia and her baby came to the facility. A seat was offered to her. Client and baby were healthy. Procedure to be carried out was explained to her and she consented. Madam Ophilia was asked to empty her bladder before the head to toe examination. Midstream urine was taken and checked for protein and sugar and all tested negative. Head to toe examination was done and everything was within the normal range. Lochia was checked and the flow was scanty, the colour was brownish (serosa) with no odour. Privacy was provided and she was assisted to lie on the

couch for the head to toe examination. Hands were washed with soap under running water and dried with a clean towel. Head to toe examination was done on her. On the head, hair was neat, the conjunctiva was pink, no discharges from the eyes, nose and ears. There was no abnormality detected in the mouth. Breast was lactating well, no engorgement, sore or cracked nipples were absent. The abdomen was palpated and there was no tenderness, the uterus was not palpable. Observations were checked and recorded as follows; Temperature 36.2degree celsius

Pulse	74bpm
Respiration	19cpm
Blood pressure	110/60mmHg
SFH	Not palpable
Weight	74kg
Haemoglobin	11.6g\dl

She was thanked for the cooperation and helped to dress up.

Head to toe examination was done on baby and no abnormality was found. Umbilical stumped was dressed, cleaned and dried, baby's weight was 3.3kg. She was also educated on the importance of the child welfare clinic. Mother was reminded that she will be handed over to the midwife in-charge for continuity of care and was educated to consult them in case of any problem. Baby's vital signs was checked and recorded as follows;

Temperature	36.6 degree celsius
Apex heart rate	122bpm
Respiration	44cpm
Baby weight	3.1kg

TERMINATION OF CARE

On 7th September, 2023 at 11:00am, explanation was made to her that the interaction with her was ending that day. Client was reassured of the midwife in-charge's competency. She was educated on the family planning, immunization of the baby till five years old. Client and mother were thanked for their corporation, information was provided to her, that the midwife would be taking care of her from now onwards. Client was also encouraged to register her child at the birth and death registry and she was educated on exclusive breastfeeding for six months. Client was again encouraged to report the facility first any time herself or the baby isn't feeling well and also have rest to regain her strength. Client was accompanied to her house and a seat was offered. Client and her family was thankedfor their cooperation Permission was sought to leave.

CIRCUMCISION OF THE BABY

After examination of the baby, Madam Ophilia was informed that the circumcision is about to be done and asked if she wanted to observe but replied in the negative. The baby was prepared and circumcised by the midwife in charge. Gel was applied to the circumcised area wrapped with gauze after which baby was clothed and given to the mother to breastfeed.

Education was then given to wash hands with soap under running water before handling baby and to always keep the wound dry to prevent infection and report any signs of bleeding, swelling or discharge.

Client was reminded of her second postnatal visit to the clinic. Baby was registered at Birth and Death Registry. Madam Ophilia and her family were thanked for their cooperation and for helping me to achieve my aim.

4.11 SECOND POSTNATAL VISIT TO THE CLINIC (SIX WEEKS POST DEELLIVERY)

According to the midwife in-charge, Madam Ophilia visited the clinic with the baby on 13th October, 2023 for second postnatal care. Both mother and baby were in healthy condition and had no complaints. Physical examination was done on both mother and baby and no abnormality was found. Baby was immunized against the childhood killer disease and they were handed over to the child welfare clinic and family planning unit for continuity of care.

PROBLEMS IDENTIFIED

1. Lower abdominal pains (after pain)
2. Backache
3. headache
4. Inadequate sleep
5. Loss of appetite

Short Term Objectives

1. Client will be relieved of pain within 24 hours
2. Client will be relieved of backache within 48 hours.
3. Client will be relieved of headache within 24 hours.
4. Client will be able to sleep for 4hours within 72hours
5. Client will be able to eat half of her meal served.

Long Term Objective

Client will go through puerperium successfully without any complication to both mother and baby.

4.12 CARE PLAN DURING PUERPERIUM

DATE/ TIME	NURSING DIAGNOSIS	OBJECTIVE/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
31/8/23 4:00pm	Lower abdominal related to involution of the uterus.	Client will be relieved of after pains within 24 hours as evidenced by client verbalizing that she is no more in pains. 2. As midwife observing that client after pain as reduced	1.Assure client. 2.Encourage client to void frequently. 3.Encourage client to breastfeed frequently. 4.Explain the physiology of the pain to client. 5.serve client with prescribed medication.	1. Client was assured that is a normal physiology and will subside after complete involution of the uterus. 2.Client was encouraged to void frequently when she has the urge. 3.Client was encouraged to breastfeed frequently and on demand. 4.The physiology of lower abdominal pain was explained to client that during breastfeeding her uterus shrinks back to its normal shape and size 5.Client was given paracetamol 1g for days.	01/9/23 4:00pm	Goal fully met as client said that she was relieved of pain.	A H

CARE PLAN DURING PUERPERIUM CONT'

DATE/ TIME	NURSING DIAGNOSIS	OBJECTIVE/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUA-TION	SIGN
31/8/23 4:00pm	Backache related to musculoskeletal system changes.	Client will be relieved of backache within 48hours as evidence by; 1.client verbalizing that she has been relieved of back pain. 2. And midwife observing relaxed facial expression	1. Reassure client 2.explain physiology of backache to client **3.**Encourage client to rest 4.Encourage client to assume good posture	1.Client was reassured that she will soon be relieved of back pain 2.The physiology of backache was explained to client that due to changes of muscloskeletal system that persist after delivery due pregnancy hormone. 3.Client was encouraged to have enough rest and sleep on a firm mattress. 4.Client was encouraged to assume an upright position when breastfeeding.	2/9/23 4:00pm	Goal met as client reported that she has been relieved of backache.	**A H**

CARE PLAN DURING PUERPERIUM CONT'

DATE/ TIME	NURSING DIAGNOSIS	OBJECTIVE/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE /TIME	EVALUA- TION	SIGN
01/9/23 9:00am	Headache related to stress of labor	Client headache will be relieved within 24hours as evidenced by 1. client verbalizing that she is relieved of her headache 2.client husband confirm that client stop complaining of headache	1.Reassure client 2. educate client to rest during the day 3.Encourage support person to assist client in taking care of the baby. 4. Educate client to limit the number of visitors. 5. serve prescribed analgesics.	1. Client was reassured that her headache will resolved 2.client was educated to sleep during the day whiles baby is asleep 3.support person was encouraged to take care of the baby to allow client to have some rests 4. Client was educated to limit visitors so that can she have some rest. 5.Prescribed analgesics like paracetamol 1g was served when needed.	02/09/223 9:00am	Goal fully met as client said that her headache has subside	**AH**

CARE PLAN DURING PUERPERIUM CONT'

DATE/ TIME	NURSING DIAGNOSIS	OBJECTIVES/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
03/9/23 4:00pm	Inadequate sleep related to night breast feeding.	Client will be able to have adequate sleep forwithin 72hours evidenced by client verbalizing that she is able to sleep.	1.Encourage client to have rest during the day. 2.Educate client to breast feed baby. 3.Encourage her relative to help her with the household chores. 4.Encourage client to limit the number of visitors.	1. Client was encouraged to have a periodic rest when baby is asleep. 2. Client was educated to breast feed baby to his satisfaction and on demand. 3. client relatives did most of the house hold choices. 4.Client was encouraged to limit the number of visit so that it does not disturb her sleep.	6/9/23 4:00pm	Goal fully met as client verbalized that she had adequate sleep.	**A H**

CARE PLAN DURING PUERPERIUM CONT'

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
01/9/23 9:00am	Loss of appetite related to stresses after labour.	client will be able to regain her normal eating pattern as evidenced by 1.client verbalizing she is able ate 2.support person observing client eating half of meal served	1.Reassure client. 2.Educate on nutrition. 3.serve client food attractively. 4.Administer vitamin supplement. 5. Encourage oral hygiene	1.Client was reassured that she will resume her eating pattern after intervention. 2.client was educated to take in balanced and adequate diet. 3. Client food was served attractively by garnishing the food. 4.vitamin supplement such as folic acid and multivitamin was administered 5.client was encouraged to perform oral hygiene by brushing her teeth twice daily to boost her appetite.	01/9/23 9:00am	Goal fully met as client said that she ate half meal served and midwife observe client eat half meal of her food.	**A H**

SUMMARY AND CONCLUSION

This client and family centered care study was carried out on Madam Ophilia, a 33year old gravida 2 para 1 alive, who comes from Amaasu (Bono region). The care given during antenatal, labour and puerperium was successful without any complication.

She attended her first antenatal Clinic on 20th February, 2023 the first meeting was 14th August, 2023 when she was 36weeks, gestation at Presbyterian Health Center Kyeremasu. Friendship was established, effective was rendered to client throughout pregnancy, labour and puerperium. She attended the clinic till delivery as expected. Education on good nutrition, personal hygiene, and exclusive breastfeeding was given to her She had spontaneous vaginal delivery to a live male child on 30th August, 2023. 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 were solved without any complication to herself and the family.

She had an intensive puerperal care and was handed over to a Public Health nurse for continuity of care. There were proper documentations of all the activities and procedures carried out on her for proper reference.

This study has helped me gain more experience in situation where classroom acquired knowledge was demonstrated on client and the family. It has expanded the knowledge, skills and potentials to render better and quality care to any pregnant woman.

BIBLIOGRAPHY

American Academy of Pediatrics (2014) America .Publisher: Doody's Review Service.

Baker, P. N. & Kenny, L. (2017). *Obstetrics by ten teachers.* (20th Edition). Florida: CRC Press

Elizabeth Marie (2013). Midwifery for Nurses (2nd edition) Publisher: CBS publishers and Distributors Pvt. Ltd

Fraser, D.M & Cooper, M.A (2013): *Myles Text book for Midwives* (16th Ed). London: Churchill Livingstone Elsevier Ltd.

Henderson Christine (2013). Mayes Midwifery (13th edition) UK. Publisher: Sue Macdonald, Gail Johnson

Konar, Hirlalal. (2015). D. C. Dutta's Textbook of Obstetrics (8th edition). Jaypee. Publisher: Jaypee Brothers Medical Publishers

Konar, H. (2013). *Textbook of obstetrics.* (7th Edition). London: New Central Book Agency Ltd

Marshall, J. & Raynor, M. (2014) Myles Textbook for Midwives (16thed). London; Churchill Livingstone

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

Marshal, J & Raynor, M (2014) *Textbook for midwives*. (16th Edition). London: Churchill Livingstone Elsevier Ltd.

Ricci, S. S. (2016). *Essentials of maternity, newborn, and women's health nursing.* (4th Edition). Philadelphia: Lippincott Williams & Wilkins.

Weller, F.B (2014) *Midwifery for Nursing* (4th Ed), Australia.

APPENDIX I

COMPLETE DIAGNOSTIC INVESTIGATION

DATE	SPECIMEN	INVESTIGA-TION	NORMAL VALUE	FINDING	REMARKS
20/02/23	Urine	Sugar protein	Negative Negative	Negative Negative	Normal Normal
	Blood	Haemoglobin level Sickling Grouping Rhesus factor HIV/AIDS Hepatitis VDRL G6PD	12.2g/dl Negative A, B, AB, O Positive/negative Negative Negative Negative Normal	12.9g/dl Negative O Positive Negative Negative Non-reactive Normal	Normal Normal Normal Normal Normal Normal Normal Normal
23/06/2023	Urine	Sugar protein	Negative Negative	Negative Negative	Normal Normal
	Blood	Haemoglobin level	12.2g/dl	12.6g/dl	Normal
14/08/2023	Urine	Sugar protein	Negative Negative	Negative Negative	Normal Normal
	Blood	Haemoglobin Level	12.9g/dl	12.2g/dl	Normal

COMPLETE DIAGNOSTIC INVESTIGATION

DATE	INVESTIGATION	NORMAL VALUE	FINDING	REMARKS
20/08|23	Sugar protein Haemoglobin level	Negative Negative 12.5g/dl	Negative Negative 12.5g/dl	Normal Normal Normal
25/08/2023	Sugar protein Haemoglobin level	Negative 12.3g/dl	Negative Negative 12.3g/dl	Normal Normal Normal

APPENDIX II
PHARMACOLOGICAL DRUGS FOR MOTHER

NAME OF DRUG	CLASSIFICA-TION	DOSAGE	ROUTE	ACTION USES	ACTUAL EFFECT	SIDE EFFECT	SIDE EFFECT EXPERIENCED
Tablet folic acid	Vitamin preparation	5mg daily	Oral	Helps in the formation of normal blood cells	Maturation of red blood cells	Nausea and vomiting	None
Tablet Multivitamin	Vitamin preparation	200mg twice daily	Oral	Increases appetite and helps in the formation of red blood cell	Increased appetite	Gastrointestin al irritation	None
Tablet ferrous sulphate	Iron preparation	200mg daily for 30days	Oral	Helps in the formation of red blood cells	Formation of red blood cells	Abdominal discomfort, diarrhea dark Stool	None
Tablet Sulphadoxine pyrimethamine	Anti-malaria and prophylaxis	3 tablets start from 16 weeks (quickening) and subsequent doses at 4 weeks' interval till birth.	Oral	Prevention of malaria	Prevent malaria in pregnancy	Itching, vomiting, nausea	None

PHARMACOLOGICAL DRUGS FOR MOTHER CONT'

NAME OF DRUG	CLASSIFICATION	DOSAGE	ROUTE	ACTION & USES	ACTUAL EFFECT	SIDE EFFECT	SIDE EFFECT EXPERIENCED
Tetanus toxoid injection	Anti-tetanus	0.5miligram	Subcutaneous	Helps in the prevention of tetanus	Prevention of tetanus	Slight fever and chills	None
Oxytocin	Oxytocic drug	10units	Intramuscular	Increase uterine contraction and control of bleeding.	Increase contractions	Hypotension and hyper stimulation	None
Vitamin A	Group A vitamin supplement	200000unit once daily	Oral	Growth and development proper sight	Growth development, prevent infection and Blindness	Vomiting	None
Tablet paracetamol	Analgesic	500mg	Oral	Helps to reduce increased body temperature and pain	Relieve pain	Liver damage with prolong use	None

APPENDIX III
PHARMACOLOGICAL DRUGS FOR BABY

NAME OF DRUG	CLASSIFICATION	DOSAGE	ROUTE	ACTION USES	ACTUAL EFFECT	SIDE EFFECT	SIDE EFFECT EXPERIENCED
Vitamin K	Group K vitamins	1milliliter	Intramuscular	Production of prothrombin that aids in clotting	No bleeding	Hypersensitive reaction	None
Chloramphenicol eye drop	Antibiotics	2 drops	Instillation	To prevent eye infection	Infection of the eye was Prevented	None	None
Oral Poliomyelitis	Antigen vaccine	2 drops	Orally	Gives immunity against poliomyelitis	Baby is under observation	Diarrhea, fever	None
Injection Bacillus Calmette Guerin	Antigen vaccine	0.05 ml	Intradermal	Production and prevention of tuberculosis	Baby is under observation	Blister formation and slight Fever	Blister was formed

PHARMACOLOGICAL DRUGS FOR BABY

NAME OF DRUG	CLASSIFI-CATION	DOSAGE	ROUTE	ACTION/ USES	ACTUAL EFFECT	SIDE EFFECT	SIDE EFFECT EXPERIENCED
Pneumococcal	Antigen	0.5 milligram	Intramuscularly	Vaccinates neonates against pneumonia	Pneumonia prevention	Redness at the side of injection and fever	None observed
5 in 1 vaccine (Pentavalent)	Antigen	0.5 Milligram	Intramuscularly	Vaccinates neonates against diphtheria, pertussis (whooping cough), tetanus, hepatitis B, haemophilus influenza type B	Prevention of childhood preventable diseases	Low grade fever	None observed
Rota virus	Antigen	1.5 milligrams (2 drops)	Orally	Prevention of gastroenteritis	Gastroenteritis prevention	None	None observed

APPENDIX IV

ANTENATAL CHART

DATE	WEIGHT (KG)	BLOOD PRESSURE (MMHG)	URINE PROTEIN SUGAR	GESTATIONAL AGE	FUNDAL HEIGHT (CM)	PRESENT- ATION	DESCENT	FOETAL HEART RATE	COMPLAINS	TREATMENT	NAME AND SIGNATURE
20/02/23	72.5	123/70	Negative	16weeks	-	Variable	-	Foetal movement	No complain	Tablet (Multivite, folic acid, ferrous sulphate, Sulphadoxine Pyrimethamine)	C R
26/04/23	75	114/65	Negative	21weeks	20	Cephalic	-	133	No complain	Tablet (Multivite, folic acid, ferrous sulphate, Sulphadoxine Pyrimethamine)	C R
24/5/23	78	100/70	Negative	25weeks	24	Cephalic	-	136	No complain	Tablet (Multivite, folic acid, ferrous sulphate, Sulphadoxine Pyrimethamine)	C R

ANTENATAL CHART CONT'

Date	Weight (kg)	Blood pressure (mmHg)	Urine Protein Sugar	Gesta-tional age	Fundal height (cm)	Present ation	Descent	Foetal heart Rate	Complains	Treatment	Name and signature
23/6/23	75	100/60	Negative	29weeks plus 2days	27	cephalic	-	138	No complain	Tablet (Multivite, folic acid, ferrous sulphate, Sulphadoxine Pyrimethamine)	C R
7/07/23	78	100/70	Negative	31weeks	30	cephalic	5/5th	128beat per minute	Sleep disturbance	Tablet (Multivite, folic acid, ferrous sulphate, Paracetamol, Sulphadoxine Pyrimethamine	C R
28/07/23	78	100/60	Negative	34weeks	32	Cephalic	5/5th	133 beat per minute	Frequent micturition	Tablet (Multivite, folic acid, ferrous sulphate) Sulphadoxine Pyrimethamine	C R

ANTENATAL CHART CONT'

DATE	WEIGHT (KG)	BLOOD PRESSURE (MMHG)	URINE PROTEIN SUGAR	GESTATIONAL AGE	FUNDAL HEIGHT (CM)	PRESENTATION	DESCENT	FOETAL HEART RATE	COMPLAINS	TREATMENT	NAME AND SIGNATURE
14/08/23	79	100/70	Negative	36weeks plus 3 days	35	Cephalic	$5/5^{th}$	132 beat per minute	Constipation	Tablet (Multivite, folic acid ferrous sulphate.	A H
20/8/23	79	110/70	Negative	37weeks plus 2days	36	Cephalic	$5/5^{th}$	135 beat per minute	Waist pain Complain	Tablet (Multivite, folic acid and ferrous sulphate.	A H
25/8/23	79	100/60	Negative	38weeks	37	Cephalic	$5/5^{th}$	138 beat per minute	Lower abdominal pains	Tablet (Multivite, folic acid and ferrous sulphate.	A H

WHO Modified Partograph

Registration No. 94/23 Name (Last, First) Antwiwaa Ophilia Age 33yrs
Date 30/8/23 Parity/Gravida P1 / G2 LMP 29/12/22 EDD 6/9/23 Gestation (wks) 38
ROM (Time, Date) 11:50am Labour Durable (Hrs) 6hrs30min Facility/Clinic Name Presbyterian Health Center Kyerem

FETAL HEART RATE

190 180 170 160 150 140 130 120 110 100 90 80 70 60

LIQUOR
MOULDING

I								I			C
0								0			+

CERVIX (CM)

Plot X

DESCENT

10 9 8 7 6 5 4 3 2 1 0

Alert

Action

SRM

SVD at 12:00pm
Sex – LMC
A/S – 8/10, 9/10
Baby wt – 3.2kg
B/L – 200mls
Perineum – intact
3rd stage complete
DL – 6hrs:30min.

HOURS	1	2	3	4	5	6	7	
TIME	5:50	6:50	7:50	8:50	9:50	10:50	11:50	12:50

CONTRACTIONS PER 10 MINS

5 4 3 2 1

Oxytocin U/L
Drops / Minute

DRUGS & IV FLUIDS

BLOOD PRESSURE & PULSE

200 190 180 170 160 150 140 130 120 110 100 90 80 70 60

TEMPERATURE	36.5				36.0

Urine					
Amount	150				120
Protein	Neg				Neg
Acetone	Neg				Neg

LABOR NOTES

Madam Ophilia G2P1 38weeks gestation came to the facility accompanied by her mother and complained of abdominal pain and Painful contraction. Client had SVD to a male baby with Apgar score of 8/10, 9/10. Baby weight at birth was 3.2kg, Head circumference of 34cm, Full length of 51cm, Perineum intact. IM oxytocin 10units given, Placenta was delivered with control cord traction and counter traction. Cord care done, Vitamin K was given, eye care done as well as breastfeeding was established and initiated. Uterus was massage and it was contracted. Bladder was emptied. Mother and baby were cleaned and skin-to-skin contact was initiated in a comfortable bed.

Please circle or write responses.

DELIVERY

DATE: 30/08/23 TIME: 12:00pm METHOD: Spontaneous / Vacuum Extraction / C/S / Other

PERINEUM: **(Intact)** / Episiotomy / Laceration

ANESTHESIA: **(None)** / Local / General

THIRD STAGE

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

PLACENTA: TIME: 12:03pm Complete / Incomplete

BLOOD LOSS AMOUNT:
- **(Small (Less than 250 cc))** 200mls.
- Moderate (250-499 cc)
- Large (more than 500 cc)
- Significant for mother

BABY

Weight: 3.2kg

Sex: **(Male)** / Female

Baby Position: **(Vertex)** / Breech / Other

APGAR

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

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

FOURTH STAGE MONITORING

Frequency	Time	B/P.	Pulse	Fundus	Bleeding	Bladder
Every 15 minutes first 2 hours	12:15	110/70	69	18	200mls	100mls
	12:30	120/60	68	contracted	moderate	—
	12:45	115/60	75	✓	✓	—
	1:00	120/70	72	✓	✓	90
	1:15	120/80	75	✓	✓	—
	1:30	120/75	81	Scanty	✓	—
	1:45	110/60	84	✓	✓	—
	2:00	110/80	79	✓	✓	—
Every 30 minutes For 1 hour	2:30	120/70	72	✓	✓	—
	3:00	120/80	74	✓	✓	100mls

Birth Attendant Adjei Hannah (Student midwife) supervised by Chapman Rebecca (staff) Date

MATERNITY CHART

NAME: Antwiwaa Ophilia

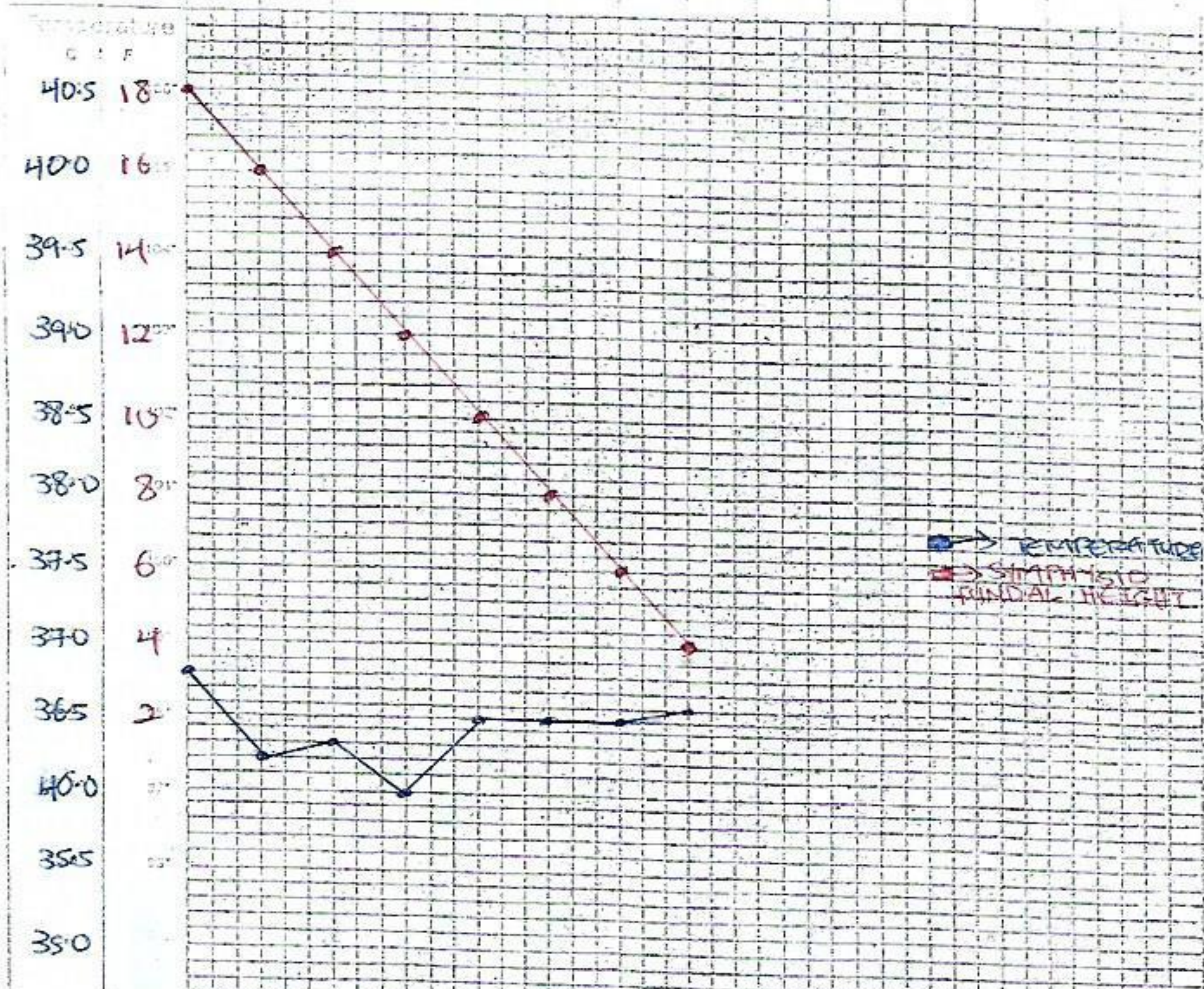
AGE: 33yrs

WARD: lying-in

NO.: 94/23

BED NO.: 2

		30/8/23	31/8/23	1/9/23	2/9/23	3/9/23	4/9/23	5/9/23	6/9/23
		DD							
			D1	D2	D3	D4	D5	D6	D7
	AM		8:00	8:00	8:00				
	PM	1:00	5:00	5:00	4:00	4:00	4:00	4:00	5:00



Pulse		78bpm	79bpm	77bpm	78bpm	74bpm	72bpm	79bpm	80bpm
Resp.		22cpm	22cpm	20cpm	18cpm	19cpm	19cpm	20cpm	21cpm
Bowels		Passed	Passed	Passed	Passed	Passed	Passed	Passed	Passed
Urine		Passed	Passed	Passed	Passed	Passed	Passed	Passed	Passed
B.P.	AM		120/80	110/60	100/70				
	PM	110/80	110/80	100/60	100/68	100/60	100/60	110/70	120/70

NEW BORN EXAMINATION FORM

Name: Baby of Antwiwaa   Date of Assessment: 30/8/23   Time: 1:30pm
Date of Birth: 30/08/23   Time of Birth: 12:00pm   Sex: [✓] M [ ] F   Age at time of Assessment (days/hrs) 90min/hr
Astational Age [ ]   [ ] Mode of Delivery: [✓] Vaginal   Assisted Vaginal   C-Section
APGAR: 1min 9/10 [ ] 5min [ ] 9/10   Birth Weight: [ ] 3.2 kg [ ]   Length: 51 cm   Head Circumference: 34 cm
Temperature at time of Assessment: 36.5 °C   Urine passed: (Yes) No   Meconium passed: (Yes) No
Name of Assessor (Midwife/Doctor): Adjei Hannah

1. Respiration
Rate 43
- [ ] Rate < 30 b/m *
- [ ] Rate < 60 b/m *
- [✓] 30-60 b/m
- [ ] Retractions *
- [ ] Grunting *
- [ ] Stridor *

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

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

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

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

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

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

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

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

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

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

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

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

15. Neck
- [✓] Normal
- [ ] Swelling
- [ ] Webbed
- [ ] Other:

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

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

18. Heart rate
Rate: 142
- [✓] 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 clitoris *
- [ ] Other:

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

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

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

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

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

NEW BORN EXAMINATION FORM

Name: Baby of Ophilia Date of Assessment: 31/08/2023 Time: 7:00am
Date of Birth: 30/8/23 Time of Birth: 12:00 Sex: [x] M [ ] F Age at time of Assessment (days/hrs) 19hrs
Astational Age [ ] [ ] Mode of Delivery: [ ] Vaginal Assisted Vaginal C-Section
APGAR: 1min [ ] 5min [ ] Birth Weight: [ ] 3.1 kg [ ] Length: 51 cm Head Circumference: 34 cm
Temperature at time of Assessment: 36.7 °C Urine passed: (Yes) No Meconium passed: (Yes) No
Name of Assessor (Midwife/Doctor): Adjei Hannah

1. Respiration
Rate 42
- [ ] Rate <30 b/m *
- [ ] Rate <60 b/m *
- [x] 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: 145
- [x] 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
- [x] Normal
- [ ] Undescended testes
- [ ] Abnormal meatus
- [ ] Hernia
- [ ] Other: ______

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

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

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

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

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

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

NEW BORN CHART

Name: Baby of Ophilia No: Birth Weight: 3.2kg

Sex: Male Mother's No: 94/23 Length: 51 cm

Nature of Delivery: Spontaneous Vaginal delivery Diagnosis: Term Baby

Date of Birth: 30/8/2023 Time: 12:00Pm Date of Discharge: 31/08/2023

Date	30/8/23		31/8/23		1/9/23		2/9/23		3/9/23		4/9/23		5/9/23		6/9/23		7/9/23					
No. of Days	DD		D1		D2		D3		D4		D5		D6		D7		D8					
Weight	3.2		3.1		3.0		2.9		2.9		3.0		3.1		3.2		3.3					
	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM
Temperature		36.5	36.6	36.7	36.8	36.8	37.0	36.8		36.8		36.5		36.7		36.6	36.6					
Stools		Passed	Passed	Passed	Passed	Passed	Passed	Passed		Passed		Passed		Passed		Passed	Passed					
Urine		Passed	Passed	Passed	Passed	Passed	Passed	Passed		Passed		Passed		Passed		Passed	Passed					

Remarks:

Head, Neck, Trunk, Gentalia, Lower Limbs — No Abnormality Detected.

TEMPERATURE CHART

NAME: Baby of Ophilis

AGE: New born WARD: lying-in

IP NO.: 94/23 BED NO.: 2

Date	30/8/23	31/8/23	1/9/23	2/9/23	3/9/23	4/9/23	5/9/23	6/9/23	7/9/23
Days in Hospital	OD								
Days P. O.		D_1	D_2	D_3	D_4	D_5	D_6	D_7	D_8
Hour AM		8:00	8:00	8:00	8:00				
Hour PM	1:00	5:00	5:00	9:00	4:00	4:00	4:00	5:00	5:00
Weight (kg)	3.2	3.1	3.0	2.9	2.9	3.0	3.1	3.2	3.3

Temperature.

C	F
40.5	3.3
40.0	3.2
39.5	3.1
39.0	3.0
38.5	2.9
38.0	2.8
37.5	2.7
37.0	2.6
36.5	98°
36.0	97°
35.5	96°
35.0	95°

	30/8/23	31/8/23	1/9/23	2/9/23	3/9/23	4/9/23	5/9/23	6/9/23	7/9/23
Pulse	140bpm	142bpm	142bpm	134bpm	120bpm	125bpm	142bpm	135bpm	122bpm
Resp.	40cpm	42cpm	56cpm	51cpm	51cpm	40cpm	44cpm	40cpm	44cpm
B.M.	Passed	Passed	Passed	Passed	Passed	Passed	Passed	Passed	Passed
Urine	Passed	Passed	Passed	Passed	Passed	Passed	Passed	Passed	Passed
B.P. AM / PM									

SIGNATORIES

NAME OF STUDENT MID WIFE

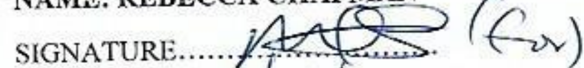
NAME: HANNAH ADJEI

SIGNATURE

DATE....07/06/2024...

THE MIDWIFE- IN -CHARGE (PRESBYTERIAN HEALTH CENTER KYEREMASU)

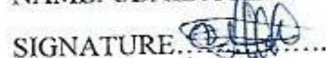
NAME: REBECCA CHAPMAN

SIGNATURE 

DATE..........10/06/2024

THE SUPERVISOR

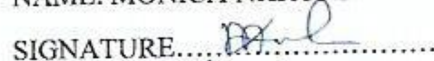
NAME: UBAIDA ABDUL KARIM

SIGNATURE 

DATE: 07/06/2024

THE PRINCIPAL

NAME: MONICA NKRUMAH

SIGNATURE 

DATE:........10/06/2024......

PRINCIPAL
HOLY FAMILY NURSING AND
MIDWIFERY TRAINING COLLEGE
BEREKUM