HOLY FAMILY NURSING AND MIDWIFERY TRAINING COLLEGE

BEREKUM

A CLIENT/FAMILY CENTERED MATERNITY CARE STUDY ON

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BY

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

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PREFACE

Family Centered Maternity Care Study is a midwifery care, and education offered to a pregnant woman and her family from the time of pregnancy throughout labour to the end of the six weeks postnatal.

The client is treated as a unique individual and the family is involved to gain their support. Both negative and positive factors in the client's environment are assessed and managed appropriately. This study gives the student midwife the opportunity to strengthen and broaden her knowledge and skills for professional academic development and also in partial fulfillment for the award of a professional certificate by the Nursing and Midwifery Council of Ghana at the end of the three-year course. The reason for carrying out such a study is to give the student midwife a maximum opportunity to put in to practice what she has learnt in the classroom and be able to assess herself whether she has understood the course. The care study also gives the client the opportunity to express her feeling and voice out any problem that may be bothering her so that the student midwife will manage and help her to come out of such problems. The care study includes the education given to the client throughout pregnancy, labour and puerperium. It also involves the family members and the need for them to give a helping hand to the pregnant woman in carrying out her daily activities.

ACKNOWLEDGEMENT

I wish to express my heartfelt gratitude to God almighty who gave me wisdom and guidance throughout my three year stay in this college and also for giving me strength, knowledge and understanding through this great exercise. This work would not been possible without the cooperation and concern of some noble personalities. I acknowledge with deep appreciation the Principal and the entire tutorial board of Holy Family Nursing and Midwifery Training College, Berekum especially my supervisor, Elizabeth Yeaboah. For the patience, guidance and support given me throughout this study. I also wish to express my sincere appreciation to Madam Mabel Abena and her family for their co-operation throughout the study. I am highly thankful to Boahen Francisca midwife in charge of labour ward, kokoa Health Center and the entire staff of labour ward for their knowledge and encouragement provided to me in the care of Madam Mabel Abena during pregnancy, labour and puerperium. My appreciation also goes to my family especially to my Dad, Mum and Siblings for their prayers, guidance and support in terms of payers and material resources. God bless you. Finally, I would like to extend my profound gratitude to all the authors of the books used and all persons who in diverse ways contributed directly and indirectly to the success of the study.

God bless you all.

INTRODUCTION

A Family Centered Maternity care study is a comprehensive obstetric care that is rendered to the pregnant woman and her family during pregnancy, labour and puerperium. It entails every aspect of the woman including the physical, psychological, spiritual and social wellbeing of a pregnant woman and the care is considered within the framework of the family and the community.

This family centered maternity care is rendered to Madam Mabel Abena twenty-four years old woman gravida 2 Para 1 alive (G2P1A) during her pregnancy, labour and puerperium. According to Tiran 2008 pregnancy is from conception to delivery of fetus; the normal duration is two hundred and eighty days (280) or forty weeks (40) or nine month (9) and seven days counting from the day of last menstrual period to delivery or two hundred and sixty-five days (265) from conception to delivery.

The day of fertilization to the twelfth week of gestation is termed as first trimester. The second trimester is from the twelfth week to the twenty fourth weeks and the third trimester is from the twenty fourth week to fortieth week of gestation. Pregnancy is a normal thing but there may be changes that take place in the woman's body due to the effects of hormones like estrogen and progesterone.

These hormonal changes bring about minor disorders such as pica, ptyalism, nausea and vomiting among others which can lead to complications like hyperemesis gravidarium, anemia which can endanger the life of the fetus and the mother. It is necessary that the expectant mother is educated on the importance of focus antenatal care for proper supervision, explanation and education to be able to adjust to these changes and also for early detection of abnormalities, treatment and immediate referral to prevent further

complications. During the focus antenatal visit, privacy and confidentiality are assured, continues care is provided by the same health care provider.

It is necessary to allay any anxiety to prepare her psychologically, physically and socially towards the delivery of a live healthy and normal baby and also ensure that she goes through puerperium without any further complication to both the mother and baby.

Sources of information use in my case study were from interaction, observation, client's relatives and antenatal records booklet and through other relevant literature source.

The care study has been divided in to four chapters;

Chapter one talks about client's particulars comprising of various histories such as social history, medical history surgical history, menstrual history, lifestyle and hobbies, past and present obstetrical history.

Chapter two also talks about antenatal care given to client from first contact till the time labour starts.

Chapter three consists of how the client was managed during the stages of labour.

Chapter four talks about the care given to client during puerperium

The study involves nursing care plan which is an idea retrieved from the nursing process which deliberates problems solving approach in meeting the health care needs of the client and this involves collection of data, analysis, nursing diagnosis, planning implementation and evaluation with subsequent modification used as feedback mechanism that promotes the outcome of the nursing diagnosis.

The management given at each stage has been outlined together with a nursing care plan drawn at each of the following, Antenatal, labour and puerperium.

Termination of care, summary and conclusion, appendix, bibliography and signatories are included in this script.

During the care study, all information of the client was kept confidential

LITERATURE REVIEW

PREGNANCY

Tiran (2008) defines pregnancy as a condition of having a developing embryo or fetus within the body. It is the state from conception to the delivery of the foetus. The normal duration is about 280 days, 40 weeks or 9 months and 7 days counted from the first day of the last menstrual period to delivery.

Ojo (2006) further explain that when pregnancy occurs, menstruation ceases and returns some weeks or months after delivery. These hormones exert some action on the various systems of the client. The most outstanding of these changes is the growth which occurs in the uterus. The lining of the uterus undergoes changes due to the effect of these hormones and the uterus itself grows to accommodate the growing embryo.

According to Myles (2009) enumerates those changes experienced in a woman emotional state are due to hormonal factors examples of these hormones are progesterone, oestrogen, and human chorionic gonadotropin. These emotional levels help in the development of the fetus, prepares the expectant mother on for labour as well as puerperium There is also anatomical and physiological changes that affect every system in the body during pregnancy. Also, nausea and vomiting, constipation, heartburns, headache and leg cramps, frequent micturition, anorexia, waist pains occur as minor disorders of pregnancy. She also explains that every pregnancy being a unique experience for that woman in each pregnancy. It is therefore important for the midwife to have knowledge and understand the minor disorders of pregnancy in order to educate the woman to understand the physiology of that disorder and teach her how to manage it.

According to Dutta's (2013), pregnancy last between nine and ten months. The duration of pregnancy is divided into three trimesters.

First trimester 1st week-13th weeks

Second trimester 13th week-27th weeks

Third trimester 27th week -40th week.

Ojo (2006) defines antennal care as the advice, supervision and attention a pregnant woman receives to ensure:

Good health, where applicable, early detection and treatment of abnormalities which may affect her health or that of the baby

A pleasant child- bearing experience and adequate preparation for labour and lactation

A live, healthy baby at the end of pregnancy

Myles (2009) states that, 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

LABOUR

Ojo (2006) defines labour as the process by which the uterus empties its content after the 28th week of pregnancy. It entails the contraction and retraction of the uterine muscle fibers, the dilation of the cervical os and the expulsion of the baby liquor amniotic fluid, placenta and its membranes.

Safe motherhood protocol (2008), defines normal labour as when there is a regular, painful, rhythmic uterine contractions lasting at least 20 seconds (timed by a trained observer) occurring at a frequency of at least two contractions in every 10 minutes with a cervical dilatation of at least 3 cm. However, in recent times active management starts from 4cm According to Mayes (2011) labour is divided into three stages; first stage of labour: from the onset of regular uterine contractions, accompanied by effacement of the cervix and dilatation of the os, to full dilatation of the os. In primigravida, this stage lasts for 12-14hours and in multigravida it last for 6-10hours.

Second stage of labour: from full dilatation of the os uteri to the birth of the baby. This stage lasts for 60minutes in primigravida and up to 30 minutes in multigravida.

Third stage of labour: from the birth of the baby to the expulsion of the placenta and membranes. It last 5-30minutes with active management in primigravida and or 5-15minutes with active management in multiparous

The national safe motherhood service protocol (2008), classify labour into four main stages. The first stage of labour is from the onset of labour to full dilatation of the cervix. It is monitored with the use of partograph. Partograph is a graphical tool designed by the

world health organization (WHO) to monitor labour in which salient points are recorded to manage labour, identify any problem and take appropriate action.

The first stage of labour begins from the onset of labour to the full dilatation of the cervix. The second stage of labour starts from full dilatation of the cervix to the birth of the baby. The third stage of labour starts after delivery of the baby and ends with delivery of the placenta and control of hemorrhage. This stage is managed actively by the use of oxytocin, controlled cord traction, counter pressure and uterine massage

Fourth stage is the first six hours following the birth of the placenta. This stage involves monitoring of baby and mother, and examination of baby.

Myles (2011) talks about the management of the stages of labour: in order to provide woman centered care, the midwife should:

Assess the needs of the end expectation of each individual woman regarding labour and birth.

Plan care with each woman in labour, tailored to meet her specific needs and expectations

Put the care plan into practice

Evaluate the care given to measure effectiveness

PUERPERIUM

According to Myles (2014) puerperium starts immediately after delivery of the placenta and membranes and continues for six weeks. It further continues 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.

Verrals (2008) states that, puerperium is a period of from 6-8 weeks following childbirth during which time the genital organs return to their pre-pregnant state, lactation should be established and a new infant should be accepted into the family.

Dutta (2011) 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 there are three types of lochia namely

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

Lochia serosa: which consist of less red blood cells but more leukocytes, wound exudates, mucous from the cervix. It last for 5-9 days and it is yellowish or pink or pale brownish. Lochia alba: contains plenty decidua cells, leukocyte, mucous, cholestrin crystals fatty and granula epithelial cells. It last for 10-15 days and it is pale white in colour

Ojo (2006) further explains during puerperium the bruises heal and the genital organs and any other organ which underwent changes during pregnancy return to the gravid state. Lactation is also established during this period. It last between 6 to 8 weeks.

Verrals (2008) further explained that after delivery the uterus is palpated at the level of the umbilicus. If the uterus is then palpated on each successive day, it is found to be fingerbreadth lower in the abdomen at each examination. By the 10th day it can no longer be palpated abdominally because anteverted and antiflexed are almost complete. She also explained that during puerperium that breastfeeding is initiated and established. Proper fixation of the baby to breast and complete emptying of the breast are needed to maintain lactation during puerperium.

According to Myles (2009) puerperium starts immediately after delivery of the placenta and membranes and continues for six weeks after which all the systems in the woman's body will recover from the effects of pregnancy and return to their non-pregnant state. She also said the provision of midwifery care to women following the birth of their baby aims to encompass aspects of observing and monitoring the health of the new mother and her baby as well as offering support and guidance in breastfeeding and parenting skills.

Mayes (2011) stated some aims of postnatal care as;

To promote and monitor the woman's and the infant's physical wellbeing.

To assist the woman with the successful establishment of her infant feeding

To educate the woman and her family in the needs and development of the infant

To foster good family relationships

To enhance the woman's confidence in her ability to fulfill her role as a mother

WHY CLIENT WAS CHOSEN

Madam Mabel G2P1^{A}, 24 years of age reported to the clinic on the 14th of August 2023, which happened to be her fourth visit and at 37th week gestation by then. On arrival, it was notice that she was worried about the fact that she was experiencing frequency of micturition and waist pain of which she had no knowledge about the causes of those minor disorders. She was interviewed and it was realized that what prompted her to visit the clinic that day was that the waist pain was becoming severe and increase in the frequency of micturition so an opportunity was taken to educate her on the physiological changes that occur in the urinary system during pregnancy. Her gestation and parity of the Nursing and Midwifery Council of Ghana (NMC) needed for the study. With respect of the above information, interest was shown to Madam Mabel and she accepted to be used for the client and family centered maternity care study. Phone numbers were exchanged and direction to her house was given for home visits. Madam Mabel was introduced to the midwife in charge that she was the client chosen for the study.

CHAPTER ONE

1.0 INTRODUCTION

This chapter gives information about the client, her family and her community which includes client's profile/social history, family history, medical history, surgical history, menstrual history, client's lifestyle and hobbies, past and present obstetrical histories.

1.1 PERSONAL AND SOCIAL HISTORY

Madam Mabel Abena Gravida 2 Para 1^{A} is a 24 year old woman, born at kokoa in the Bono Region. She is dark in complexion, 151cm tall and weighed 67kg at booking. She speaks Twi, Nafana, and English. Madam Mabel schooled up to shs and she is a Trader. She is a Christian who attends the church of Pentecost she is married to Mr. Emmanuel Boateng who also attends the same church with her at kokoa. Mr. Emmanuel Boateng schooled up to tertiary and now a farmer. Madam Abena Mabel and Mr. Emmanuel Boateng have a two-year-old son. He attends presby primary and JHS at kokoa. Madam Priscilla Akosua Sewaah is madam Mable's next of kin, her sister.

1.2 FAMILY HISTORY

Madam Mabel is the third born of Mr. Matthew Mensah and Madam Paulina Mensah both from Kokoa in the Bono Region. According to Madam Mabel, there is no known inherited medical condition such as diabetes, hypertension, heart diseases, mental illness and congenital abnormality like cleft lips or palate, imperforated anus, spinal bifida in the family. There is a history of multiple pregnancies. She said death of any family relatives was natural.

1.3 MEDICAL HISTORY

According to Madam Mabel, she has never been admitted at the hospital except occasionally when she suffers from ailment like malaria, and cold and seek for medical care at the outpatient department at hospital. She sometimes suffers from headache and often subsides after taking pain killers which she buys from the chemical shop. Opportunity was taken to educate her that drugs which has not been prescribed by physician is a form of drug abuse if taken is harmful to her health. She also said that she has no medical condition like hypertension, heart diseases, sickle cell diseases, diabetes, jaundice, respiratory diseases, TB, chronic cough, asthma, HIV disease, epilepsy, and mental illness. According to her, she has never experienced any sign and symptoms of sexually transmitted infection like chronic lower abdominal pain, itching/burning sensation/swelling of the genitals, abnormal vagina/urethral discharge, pruritus vulvae or genital sore, painful urination, genital lumps/growth (warts) and chronic lower abdominal pains. She is not allergic to any drug or food

1.4 SURGICAL HISTORY

According to Madam Mabel, she has never undergone any surgical operation like myomectomy, salpingectomy, and laparotomy since childhood and has never been involved in any accident or injury to part of her pelvic. She has never donated blood or been transfused.

Madam Mabel also said she has never experienced any road traffic accident before.

1.5 MENSTRUAL HISTORY

According to Madam Mabel, she attained menarche at the age of 15 and since then she has 28 days menstrual circle with regular moderate flow for 5 days and experienced dysmenorrhea but resolved after her first delivery. She added that she uses two sanitary pads a day and bath twice daily. Madam Mabel gave last menstrual period 20th November 2022 and the expected date of delivery was calculated as 27/08/2023.

According to the first ultrasound scan report, expected date of delivery was 30/08/2023.

1.6 CLIENT LIFESTYLE AND HOBBIES

Madam Mabel start her daily activities at 6:00 am every day. She begins the day with a prayer, brush her teeth and then empties her bowel and bladder when she feels the urge to do so. She sweeps her compound and cleans her room and then prepares breakfast for her family. She baths her son and helps him to brush his teeth and also feeds him and help him prepare for school. She sees him off and then take her breakfast and continue with her household work. She prepares dinner around 3:00pm for her family. She normally washes their dirty clothes and do general cleaning in the house on Saturdays. The food she likes best is fufu with light soup. She neither smokes nor drinks alcohol. She takes her bath around 6:00pm and she sleeps around 9:00pm under a treated mosquito net. Her hobbies are cooking and watching television.

1.7 PAST OBSTETRICAL HISTORY

Pregnancy

Madam Mabel is Gravida 2 Para 1 alive. According to her, she has never had an abortion or still birth. She also said she experienced some minor disorders like vomiting, backache and frequency of micturition in her previous pregnancies. Client also added that she had never experienced any complications such as pregnancy induced hypertension, pre-eclampsia or anemia in her previous pregnancies. Client again added that her previous pregnancy went to term successfully without any complications. She took four [4] doses of sulphadoxine pyrimethamine during her first pregnancy and tetanus diphtheria injection (2 dose) was also administered. She was not admitted during her previous pregnancy.

Labour

Madam Mabel said she had spontaneous vagina delivery without any perineal tear or retained placenta and its membranes. According to Madam Mabel, her duration of labour did not exceed 10 hours. Her baby also cried immediately after delivery. There were no complications such as postpartum hemorrhage and postpartum eclampsia. Client said she was in good health after delivery and she started breastfeeding her baby immediately she was transferred to the lying-in-ward.

Madam Mabel also said her baby had no abnormalities like cleft lip, cleft palate or extra digits and had no ill health after delivery.

Puerperium

Her son was fully immunized against the childhood preventable diseases. According to her, she breastfed her baby exclusively for six months and weaned at 2 years respectively.

She combined lactational amenorrhoea and jaddele as her family planning method but stopped when she wanted to get pregnant. She further added that her support person was her husband and mother.

Client went through puerperium successfully without any complication.

1.8 PRESENT OBSTETRICAL HISTORY

Madam Mabel attended her first antenatal Clinic on 23 March, 2023 at Kokoa Health center, where the midwife who attended to her took her history. Her last menstrual period was 20th November 2022 and the expected date of delivery was calculated as 27/08/2023. And the expected date of delivery according to the first ultrasound scan is 30/08/2023. Detailed information about her personal, menstrual, obstetric, medical, surgical, family and contraceptive histories were taken. She weighed 67kg and her height was 151 cm at booking and her vital signs were checked and recorded as follows:

Temperature	36.8 0C
Pulse	92 bpm
Respiration	23 cpm
Blood Pressure	103/80 mmHg

Other laboratory investigation done and recorded as follows:

Heamoglobin level	11.9 g/dl
HIV Test	Non-Reactive
VDRL/PRP (syphilis)	Negative
Hepatitis B	Negative.
Rhesus factor	Positive.
Blood group	AB
Sickling test	Negative.
G6PD	No defect
Urine for protein and sugar	Negative

Head to toe examination was done on Madam Mabel and no abnormalities were detected and pelvis adequate. Gestational age was 16weeks. She was educated on personal hygiene and danger signs of pregnancy. She was given the following drugs:

Tablet folic acid	5mg daily for 30days.
Tablet ferrous sulphate	200mg daily for 30 days.

Insecticides Treated Net (ITN) given and 0.5mls of tetanus diphtheria (TT) vaccine was administered (3rd dose). The above information was served as a baseline data to be

compared with the subsequent finding to detect any deviation from normal. Madam Mabel was then scheduled for her next visit.

CHAPTER TWO

ANTENATAL CARE

2.0 INTRODUCTION

Chapter two is the antenatal care giving to the client. This includes the first contact with the client, subsequent visit to the clinic, and home visit during the antenatal period and care plans written to solve problems encountered by the client.

2.1 FIRST CONTACT WITH CLIENT

Madam Mabel was met on the 14th August, 2023 during her 5th visit at kokoa Health center and her gestational age was 37weeks. She was greeted and offered a seat. Introduction was made to her as a student midwife of Holy Family Nursing and Midwifery Training College Berekum for district practice. Her antenatal book was collected and found out that she falls within the criteria and she have been attending antenatal clinic regularly and no abnormal condition which can be a threat to her pregnancy was detected.

Her weight was 67kg and vital signs checked and recorded as follows,

Blood pressure	105/80 mmHg
Pulse	90 beat per minute

Respiration 22 cycle per minute

Temperature 36.5 degree Celsius

Another laboratory investigation done and recorded as follows,

Haemoglobin level 11.9g/dl

She was asked to empty her bladder and midstream sample was taken and tested for protein and glucose which were negative. Individualize client centered and family care study was explained to her and the desire to be chosen and she agreed to that. It was explained to her that individualized client and family centered care study is where pregnant woman is taken care of during pregnancy, labour and after birth and family will be involved for support. She was assured that any information provided as the study is concern will be confidential. She was asked to empty her bladder and after that client was sent to the examination room for physical examination. Privacy was provided and client was assisted to undress. The procedure was explained and her consent was sought. Client was assisted unto the couch for head-to-toe examination. All necessary requirement needed for the procedure was arranged on a trolley and sent to the examination room. Before the procedure started, hands were washed under running water and dried with clean towel. Madam Mable complain of constipation and difficulty in breathing and she was assured that she will be relieved of difficulty in breathing.

Head to toe examination

The examination starts from the head to toe of the client. On examination, Madam Mabel's hair was neatly braided, no dandruff and lice were seen on the scalp. There was no edema of the face or eyelids. The conjunctive was checked for pallor and sclera was checked for jaundice but none was detected. The ears were examined for pain and

discharges as well as the nose but none was detected. The lips were examined for cracks or sore but none was detected. Gum was also in good condition; absence of halitosis and the tongue was neither coated nor pale. The neck was inspected and palpated for enlarged lymph nodes, goiter and distended veins but nothing was detected. Madam Mabel was asked to put her right hand under her head and the right breast was examined to detect lumps, axillary lymph nodes and there were no abnormalities seen. She was asked to put her left hand under her head and the procedure was repeated and no abnormalities was detected. The nipples were prominent and centrally situated. Cotton wool was put on the nipple and aerola gently squeezed and the colour of the breast milk was checked. She was educated to examine her breast regularly and report any abnormalities to the clinic immediately.

The upper extremities were in right alignment with the body when inspected. There were no extra digits on the fingers. She was also asked to make a fist to detect any tingling sensation or edema of the hands. The lower extremities were inspected and they were free from edema, tenderness in the calf muscle, varicose veins and they were of equal size. Her back was examined but no edema of the sacral region or deformity of the spine was detected. She was congratulated for a neat and healthy body.

Abdominal Examination

Hands were washed and dried, permission was sought from client. The abdominal

Examination includes inspection, palpation and auscultation.

On Inspection, there were no scars from previous myomectomy or caesarian section, foetal movement seen, linea nigra were present. The shape and size of the abdomen were ovoid and medium respectively. Hands were warmed by rubbing them together to

avoid inducing contractions. The abdomen was palpated for masses, tenderness as well as enlarged spleen and liver but no abnormalities were detected.

Measuring of symphysiofundal height

The upper border of the symphysis pubis was located for measuring the fundal height. Zero mark of the measuring tape was placed on upper border of the symphysis pubis and extended along the midline of the fundus of the uterus and the symphysio fundal height measured 36 centimeters and gestational age was 37 weeks.

Fundal palpation

Facing Madam Mabel, hands were rubbed together to provide warmth to prevent uterine contraction. The hands and the palms were placed on either side of the fundus and fingers curved around the fundus to determine what is occupying the upper pole of the uterus. A soft mass was felt indicating the foetus buttocks.

Lateral palpation

The palms of the hands were placed on both sides of the uterus, midway between symphysis pubis and fundus. The uterus was stabilized with the non-dominant hand and the dominant hand was used to palpate the entire area from the abdominal mid line to the lateral side of the abdomen to locate the foetal back in a rotary manner. The dominate hand was also used to stabilize the uterus and the non-dominant hand was used to repeat the procedure. The left lateral palpation done at the left side of the mother was rough which indicated the foetal limbs and the right lateral palpation done at the right side of the mother, smooth curve was felt which indicated the back of the foetus. The position of the foetus therefore was right occipito anterior.

Pelvic palpation

Facing the feet of Madam Mabel, she was asked to bend her knees slightly and breathe out slowly to make her relax. The palms were placed on either side of the uterus with the palms just below the level of the umbilicus and fingers directed towards the symphysis pubis, thumbs almost meeting. A hard mass was felt indicating the fetal head.

Descent of fetal head

Location of the anterior shoulder was made using two fingers. The symphysis pubis was located and with the ulna border just above the symphysis and the anterior shoulder, five fingers covered the head indicating descent of 5/5th. Therefore, from the above, it was deduced that, lie was longitudinal, the presentation was cephalic, descent was 5/5th and the position was right occipito anterior.

Auscultation

On auscultation, the foetal stethoscope was warmed and placed at the area where the back was located, ear was placed against the fetoscope to listen to the foetal heartbeat. One hand was placed at the maternal radius to differentiate between maternal and fetal pulse, the foetal heart rate was checked for one minute and recorded as 134 beat per minute with good rhythm and volume.

On vulva examination

Permission was sought from Madam Mabel for inspection of her vulva and it was granted. Madam Mabel was draped, hands were washed with soap under running water and cleaned with a dry clean towel. She was asked to bend her knees and assume a lithotomy position. A sterile glove was worn. The mons pubis was neatly shaved. She was informed the inside of her thigh will be touched gently before touching her genitalia.

Her inner thigh was touched before touching her genital area. The labia were inspected, the skin was smooth and clean and pubic hair free of lice. The labia tissue was soft, there were no swelling, redness or tenderness, rashes, sore, scars, warts, edema, varicose veins, no discharges and no sign of fistula. Clitoris and perineum were inspected and no abnormalities were found. Madam Mabel was asked to lie in left lateral position and sit up before getting out of the couch. Madam Mabel was congratulated for her co-operation. Gloved hands were dipped in chlorine solution 0.5% and gloves discarded. Hands were washed with soap and water and dried with towel. Findings were communicated to her and recorded into her antenatal book. She complained of having constipation and difficulty in breathing and she was educated on the causes of constipation in pregnancy, she was encouraged to take in enough fluid, fiber rich diet, and should avoid taking bulky food. Also, she should serve food in small quantity but at regular interval.

Madam Mabel was educated on birth preparedness. Permission was then sought from Madam

Mabel for home visit and she gave the direction to her house as well as her mobile number.

The following drugs were prescribed for her.

Tab folic acid 5mg daily for 7 days

Tab ferrous sulphate 200mg daily for 7 days

4th dose of sulphadoxine pyrimethamine was given.

She was asked to report to the facility in one week and encouraged to come anytime she wasn't well.

2.2 FIRST ANTENATAL HOME VISIT

On 16th August, 2023 around 2:00 pm first antenatal home visit was undertaken. The main reason for the visit was to observe her surrounding and her preparedness towards delivery. Before entering the house, a quick assessment of the environment outside the house was made and it was tidy and clean. On arrival Madam Mabel was in her room with her sister seat was offered , greeting was exchanged and asked how she was doing. She was at home with her sister only , her brothers and her father, husband was not at home. Introduction was made to the father and siblings as a the student midwife taking care of her and they were happy.

2.3 PHYSICAL ENVIRONMENT.

Madam Mabel lives in a boy's quarters of four bedroom built from cement and roofed with aluminum roofing sheets. Each room has two windows made with woods and covered with net facing each other. Her compound was neither bushy nor dirty. She has her bathhouse and kitchen outside the building. Public toilet around the neighborhood. She uses a plastic container with a lid to collect her refuse and emptied her bin when it is full at the public refuse dumping site. Madam Mabel sleeps under treated insecticide net with her family and she was encouraged to continue sleeping in it every day. The items in her room were arranged neatly. There is electricity in the house and she fetches water from a pipe at next house.

Madam Mabel has a good inter personal relationship with her neighbors. She was congratulated on how she has kept her environment clean. She was asked about the preparations she had made so far after the previous discussion on birth preparedness and she said she had a blood donor and her husband also had prepared to support her during that period and she had her items to be used during labour neatly packed and almost all the items needed were in her bag. The items were cross checked such as cot sheet, baby cap and dress, sanitary pad and cloths. She was encouraged to keep purse of money, health insurance, antenatal book and hospital card in her bag and arrange with a taxi driver to take her to the facility when the need arises. Madam Mabel said she can empty her bowel once daily and she is coping with the difficulty in breathing. She was also educated on danger signs of pregnancy like (edema) and true labour signs such as painful regular and rhythmic uterine contraction, a blood-stained mucoid discharge from the vagina and there may be rupture of membranes. She complained of backache and physiology of backache was explain to her and was educated not to lift heavy object. She also complained of frequency of micturition and Physiology of frequency of micturition was explain to her as a result of pressure exerted on the bladder by the growing foetus and, she was also encouraged to reduce fluid intake at night, sleep in the afternoon since her sleep may be disturbed at night. She was also encouraged to ensure perineal hygiene to prevent ascending infection and also to have adequate rest. After our discussion, Madam Mabel was thanked for her hospitality and permission was sought to leave.

2.4 PSYCHOSOCIAL HISTORY

Madam Mabel, her husband, child, Parents and siblings have a very good relationship with each other. She is kind and very friendly with her neighbors. Her friends visit her

and she also visits them at her leisure time. She is very free, humble, has respect for human and likes to make new friends. After all interactions, Madam Mabel and her family were very happy and appreciated of the care given.

2.5 SECOND ANTENATAL HOME VISIT

The second home visit to Madam Mabel house was made on the 21st August, 2023. The aim of the visit was to check on her health status and finally prepare her for the labour since she was at term. She was educated again on true signs of labour like noticing blood stain mucus discharge (show) and regular rhythmic painful uterine contractions. She was educated to practice exclusive breast feeding after delivery and complication readiness. She was also counseled on the practice of family planning after delivery. The need to deliver at the health facility was stressed to prevent any complications like retain placenta, prolong labour, postpartum hemorrhage and importance of deep breathing exercise during labour. Emphasis was made on not to delay at home when labour sets in. Madam Mabel was also educated on the need to continue taking her medications and also nutritious food, fruit and more fluid. She was reminded on her next visit. She was thanked and permission was sought to leave.

2.6 SUBSEQUENT VISIT TO THE CLINIC

On 28th August, 2023, Madam Mabel attended her next visit as scheduled, she arrived at the facility around 9:00am, and she was offered a seat and welcome warmly. Her weight was 67kg. Her vital signs were checked and recorded as follows,

Blood pressure	100 /80mmHg
Pulse	91 bpm
Respiration	20 cpm
Temperature	36.4 0C

Permission was granted to perform head to toe examination after it was explained to her. She was asked to empty her bladder, midstream sample was collected and tested for sugar and protein and results for both was negative. Haemoglobin level checked 12.4g/dl.

In the palpation room, she was assisted to position herself on the examination couch. After hand washing with soap under running water, and well dried with a clean towel. Head to toe examination was done and no abnormality was detected. The abdomen was inspected and there was no abnormality detected. On palpation, the gestation was 39weeks, Symphisio-fundal height was 38cm, lie longitudinal, and presentation cephalic, descent 5/5th, and fetal heart rate was 132bpm on auscultation. She was then congratulated, and helped from the examination couch, findings were communicated to her and documented in her ANC record book. She was asked about how she was coping with the frequency of micturition and back ache, she expressed that because she understood the reason, she was coping well

Madam Mabel complain of lower abdominal pains and she was assured that it will be relive after birth so she copes with it. Madam Mabel was encouraged to ask questions and express her fears. She was encouraged to report to the clinic if there are signs of true labour or if she encounters problems.

Madam Mabel was served with the following drugs,

Tablet ferrous sulphate 200mg daily for 7 days

Tablet Folic acid 5mg for 7 days

2.7 CARE PLAN DURING ANTENATAL

PROBLEMS IDENTIFIED

On 14 /08/2023 ,Madam Mabel complained of,

1. Constipation.
2. Difficulty in breathing

Madam Mabel complained of,

16/08/2023

1. Backache.
2. Frequency of micturition

Madam Mabel complained of,

28/08/2023

Lower abdominal pains

SHORT TERM OBJECTIVES

1. Madam Mabel will be able to pass stool at least once daily within 48 hours.

2. Madam Mabel will be able to cope with difficulty in breathing till the end of the pregnancy.

3. Madam Mabel will cope with reduced back backache within 48 hours.

4. Madam Mabel will cope with frequency of micturition throughout pregnancy.

5. Madam Mabel will be able to cope with lower abdominal pains within 24hours.

LONG TERM OBJECTIVES

Madam Mabel will go through pregnancy, labour and puerperium successfully without any complication to both mother and baby.

CARE PLAN DURING ANTENATAL

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
16/08/2023 8:00am	Impaired bowel action (constipation) related to inadequate intake of fluid and fiber.	Client will regain her normal bowel action (Once daily) within 48 hours as evidenced by client verbalizing that she is able to empty her bowel twice a day.	1. Reassure client. 2. Explain the physiology of constipation. 3. Encourage client to increase her daily fluid intake of at least 8 glasses of water 4. Encourage client on exercises. 5. Educate client to take enough roughage.	1. Client was reassured 2. The physiology behind. constipation was explained to her. 3.Client was encouraged to increase daily intake of fluid at least 8 glasses of water 4.Client was encouraged to do exercises like running ,jogging . 5. Client was educated to take enough roughage.	18/08/023 8:00am	Goal fully met as evidenced by client verbalizing that she now moves her bowel at least once a day	

CARE PLAN DURING ANTENATAL CONT'D

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES	NURSING ORDERS	NURSING INTERVENTIONS	DATE/ TIME	EVALUATION	SIGN
16/08/2023 at 8:00am	Difficulty in breathing related to pressure from the growing fetus on the diaphragm	Client will underststand the physiology behind difficulty in breathing and cope with it within 24hours as evidence by client verbalizing that she understand the physiology and will cope with it.	1.Educate client to reduce strenuous activities 2.Explain physiology of condition to her 3.Educate her to lie on side to enhance breathing 4.Educate client to wear loose clothing 5. Educate client to sit or lie with pillow supported in an upright position.	1.Client was educated to reduce strenuous activities such running and lifting of heavy objects. 2. The physiology of the condition was explained to her that it was due to the foetus pressing the diaphragm. 3.. Client was educated to lie side to enhance breathing 4. Client was educated to wear cotton clothing. 5.Client was educated to sit or lie with pillow	18/08/2023 8:00pm	Goal fully met as evidence by client verbalizing that she is able to cope with difficulty in breathing.	

				supported in an upright position			

CARE PLAN DURING ANTENATAL CONT'D

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES	NURSING ORDERS	NURSING INTERVENTIONS	DAT1E/ TIME	EVALUATION	SIGN
21/08/24/2023 4:00 pm	Backache related to pressure of the foetal head pressing on the sacral nerves.	Client will cope with backache within 48 hours as evidenced by client verbalizing that she is able to cope with it.	1.Encourage client to have adequate rest and sleep. 2.Educate client to maintain a good sitting position. 3.Educate client on normal work and exercise. 4. Educate client to avoid prolong standing. 5. Encourage client to	1.Client was encouraged to have adequate rest and sleep 1hour during the day and 5hours during the night. 2.Client was educated to maintain a good sitting position by resting her back against the chair with pillow supporting. 3.Client was educated on normal work and exercise like walking , jogging. 4. Client was educated to	23/08/2023 4:00 pm	Goal fully met as client verbalized that she is able to cope with the backache.	

			take her prescribed drugs.	avoid prolong standing. 5. Client was encouraged to take her prescribed drugs like ibuprofen , paracetamol.			

CARE PLAN DURING ANTENATAL CONT'D

DATE AND TIME	**NURSING DIAGNOSIS**	**NURSING OBJECTIVES**	**NURSING ORDERS**	**NURSING INTERVENTIONS**	**DATE AND TIME**	**EVALUATION**	**SIGN**
27/08/2023 4:00pm	Frequency of micturition related to pressure of the presenting part on the urinary bladder.	Client will cope with frequency of micturition throughout pregnancy as evidenced by client verbalizing that she understands the situation.	1.Reassure client. 2.Educate her on the physiology of frequency micturition 3.Encourage client to reduce fluid intake at night 4.Encourage client to use chamber pot in her room at night 5. Encourage client to urinate when she has	1. Client was reassured that situation is temporal and will resolve after delivery. 2. Client was educated on the physiology of micturition. 3. Client was encouraged to reduce the intake of fluids at night. 4. Client was encouraged to use chamber pot in her	28/08/2023 4:00pm	Goal fully met as evidenced by client verbalizing that she is able to cope with frequency of micturition and understand the situation.	

			the urge.	room at night. 5. Client was encouraged to urinate when she had the urge.			

CARE PLAN DURING ANTENATAL CONT'D

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATIONS	SIGN
28/08/2023 9:30 am	Lower abdominal pain related to descent of fetal head.	Madam Mabel will be relieve of lower abdominal pains within 24hours as evidenced by midwife visualizing client complains less.	1. Explain the physiology of lower abdominal pains to her. 2. Encourage client to do less strenuous activities. 3. Asses the level of her lower abdominal pain.	1. The physiology of lower abdominal pains was explained to her that is as a result of the descent of the fetal head. 2. Client was encouraged to do less strenuous activities like walking. 3. The level of her lower abdominal pain was assessed using the pain scale rating	29/08/2023 9:30 am	Goal fully met as evidenced by client verbalizing that she understands the physiology of lower abdominal pain and midwife visualized she complains less.	

			4. Educate client to have adequate bed rest and sleep. 5. Educate client to take her prescribed analgesic drugs.	from 1 to 10. 4. Client was educated to have adequate bed rest and sleep 1hour during the day and 5hours during the night. 5. Client was educated to take her prescribed analgesic drugs like acetaminophen.			

CHAPTER THREE

LABOUR

3.0 INTRODUCTION

This chapter talks about labour and it involves, management of first, second, third and fourth stages of labour. Immediate care of the baby at birth, examination of the placenta and membranes, labour notes on condition of client and nursing care plan during labour.

3.1 ADMISSION AND MANAGEMENT OF CLIENT

On 30th August, 2023 at 12:50 am Madam Mabel came to the facility with the history of labour pains. She was accompanied by her mother and sister. They were warmly welcomed and offered a seat. Madam Mabel was given a bed. History was taken to confirm the true signs of labour. Madam Mabel said, she experiences painful uterine contractions and had seen 'show'. Enquiries were made the previous evening about the foetal movement, vaginal bleeding, any medication taken before coming, ruptured membranes, the time of last meal eaten, the type of food taken and the last bowel action. Madam Mabel expressed some level of anxiety as to what the outcome of labour would be. She was assured of the competency of staff present, her safety and a successful outcome. Also, the process of labour was explained to her and she was encouraged to ask any question that might be bothering her mind for clarification. According to Madam Mabel onset of labour pains started on the 30th of August around 9:00pm but the pain intensifiers and she decided to come to the facility. Client complained of severe waist pains and lower abdominal pains. She was encouraged to cope with it since true labour had started and would be reduced after delivery. Explanation of every procedure to be carried on her was given. On admission, Madam Mabel Haemoglobin level was 10.5g/dl and her vital signs was checked and recorded as follows,

Temperature	36.60C
Respiration	25bpm
Pulse	90bpm
Blood pressure	120/80mmHg.

Madam Mabel was asked to empty her bladder before the examination. Privacy was provided and Madam Mabel was served with a bed pan to empty her bladder and a mid-stream specimen of urine were taken for urine testing. The urine was tested for sugar and protein and all was negative. The amount of urine measured was 100 milliliters. Madam Mabel was help to undress and assisted onto the examination bed and a quick Head to toe examination was done, her hair was inspected and it was neatly tied. Her conjunctiva was also inspected and it was neither pale nor jaundiced, nose and ears were also checked for discharges and there were none. The neck was checked, there were no enlarged lymph nodes, the mouth was inspected but there were no cracks and sore, it was smooth. The tongue was as well inspected and it was normal without coating around it. The abdomen was inspected, the shape was ovoid and big in size, linea nigra was present and foetal movement was seen. On palpation, the symphisio-fundal height was 41cm when measured, the lie was longitudinal and presentation was cephalic and position was right occipito-anterior. Descent was also assessed and was 4/5th. On auscultation, a warm foetal stethoscope was place at the left side of the woman's abdomen for one minute to listen to the foetal heart rate and was recorded as 140bpm with a very good rhythm and volume. Contraction was 2 in10 lasting for 30 seconds.

Consent was sought from the client to perform vaginal examination to help know the dilatation and she agreed. Hands were washed with soap under running water and dried with a

clean towel. Sterile gloves were worn and she was asked to flex her knees. The vulva was inspected for edema, sore, warts, scar, vagina discharge but nothing abnormal was detected with the exception of vagina discharge which was normal with normal odour. The vulva was then swabbed with six sterile cotton wool swabs soaked in savlon solution starting from the labia majora, the minora and the vestibule with a swab at a time. Permission was again sought from her and the index and middle fingers of the right gloved hand was inserted slowly and gently into the vagina.

On vaginal examination, the vagina was warm, roomy and moist. The cervix was soft, thin, well applied to the presenting part and cervical dilatation was 4cm, membranes was intact and no moulding. The ischial spines were blunt the sacrum was well curved and the sacral promontory was not reached. Madam Mabel was cleaned nicely and a clean sanitary pad was applied to the vulva. Hands were dip into a 0.5% chlorine solution and gloves were removed and discarded into a waste bin. Used equipment was decontaminated for 10 minutes. Hands were washed with soap under running water and dried with a clean towel. Madam Mabel was help to dress and made comfortable in bed. She was asked to lie on left hand side to prevent supine hypotension syndrome. All findings were communicated to her and recorded on the partograph sheet at 1:00am. The dilatation board was used to explain the cervical dilatation and progress of labour to her. She was thanked for her cooperation.

3.2 PREPARATION FOR BIRTH

Identification of helper and review of the emergency plan:

A skilled and unskilled helper was identified that is, the skilled helper was the midwife in charge and the unskilled helper that was identified was Madam Mabel's mother. The emergency plan was reviewed to Madam Mabel and her relative (mother). Madam Mabel's mother was informed about the birth preparation since her service may be needed when the need arises. The taxi driver was informed about the labour that his services would be needed if the need arises. Telephone numbers of referred point was retrieved.

Preparation of area for delivery:

The room where delivery would be conducted was kept clean, windows and door were closed, fans were switched off and light was switched on to provide warmth for the baby which will help to prevent heat loss from the baby and she agreed. Madam Mabel was assisted to wash her hands with soap and water, and her chest and abdomen was washed and prepare for skin to-skin contact.

Preparation of an Area for Ventilation and Equipment Check

A dry, flat and safe space was prepared for baby to receive ventilation if needed. All equipment and supplies used for ventilation like the ventilation bag and mask was tested and they were functioning properly.

3.3 MANAGEMENT OF FIRST STAGE OF LABOUR

Madam Mabel was made comfortable in bed. She was encouraged to walk around and to lie on her left side when she is tired to enhance blood flow to the placenta site to prevent compression of the inferior vena cava. She was reminded of the deep breathing exercise with demonstration and a return demonstration done by Madam Mabel to know her understanding. She was also encouraged to drink more water to prevent her from becoming dehydrated and also to urinate frequently to enhance effective contraction and descent of the foetal head since full bladder can inhibit progress of labour. Bedpan was provided for her to empty her bladder and bowel whenever she has the urge to do so. Client was also encouraged to change the perianal pad when soiled and wash hands after that to reduce the risk of infection, emphasizing on not applying a pad that has fall on the floor to the perineum. On partograph, foetal heart rate, maternal pulse and uterine contractions were checked every 30minutes, Maternal temperature blood pressure, descent and vagina examination were also checked and recorded every 4 hours till the end of first stage of labour and plotted on the partograph chart. She complained of fatigue and was told to relax since fatigue would be relived after delivery. She was educated on deep breathing exercise to reduce pain.

vaginal examination was repeated at 5:00am and the cervical Os revealed 8cm dilated with a well applied presenting part, membranes are still intact, moulding was (0). On auscultation foetal heart rate was 132 beats per minute contractions timed were 4 in 10 lasting 40 seconds. These findings were confirmed by the midwife in charge.

Vital signs were checked and recorded as:

Temperature	36.8 ^{0}C
Pulse	84 beats per minutes
Respiration	23 cycles per minutes

Blood pressure 110/80mmHg

Urine passed was 150mls. Client was cleaned up; a new pad was applied to the perineum. She was made comfortable in bed for further monitoring and observation. All findings were communicated to client and recorded on a partograph.

Madam Mabel's had a spontaneous ruptured of membranes (SRM) at 6:00am and liquor was clear with moulding of (+) and vagina examination was done to exclude cord prolapse and to confirm full cervical dilatation and client was 9cm, decent was 1/5th. Client's vital signs were checked and recorded as follows:

Temperature 37.0 degrees Celsius

Pulse 82 beats per minute

Blood Pressure 120/70 millimeters per mercury

Respiration rate 20 cycles per minute

Fetal heart rate was 140 beats per minute with good volume. Contractions were 4:10 lasting 44 seconds. She passed 120mls of urine and sample was tested for protein and glucose, which was negative. Hands were washed with soap under running water and dried with a clean dry towel. All findings were plotted on the partograph. She complained of nausea and vomiting, she was reassured and the physiology behind it was explained.

3.4 SETTING DELIVERY TROLLEY

The trolley was with the following items on the top and bottom shelf as,

The top shelf contains,

Delivery pack which contains:

Sterile cord scissors

2 Sterile artery forceps

Sterile receiver

Episiotomy pack containing:

Sterile episiotomy scissor

Sterile dissecting forceps

Sterile suturing forceps

Sterile receiver

Sterile cotton wool/ gauze

Two sterile gloves

Cord clamps

A sterile gallipot for antiseptic lotion

Bottom shelf containing:

1. Cot sheet

2. Baby's cap

3. Catheter

4. Bulb syringe in a small bowel with water oxytocin

5. A jag to measure blood loss

6. Perineal pads

7. Bed pan

8. Antiseptic lotion such as Savlon

9. Examination gloves

10. A box of suture thread

11. Identification Band

12. Anesthesia such as lidocaine

13. Foetal stethoscope

14 . Container containing syringe and needles

15. Mackintosh

At 6:20am, Madam Mabel complained of having the urge to bear down. She was told not to push and also encouraged to do deep breathing exercise through her mouth. The perineum was quickly examined, the vulva and anus were gaping, perineum was bulging and a trickle of blood was evident. Vaginal examination was done and cervical dilatation was 10cm (full dilatation), liquor was clear, moulding was (+), head descent was 0/5th, foetal heart was 140 beats per minute, maternal pulse 94b/m, blood pressure 140/80mmhg Contractions were stronger, that is 4 in 10 lasting 55 seconds. The midwife in-charge was informed to confirm the findings whilst the already prepared trolley was sent to the bed side. She was told that she had successfully passed the first stage and need to push well when she is asked to push. Madam Mabel was transferred to the second stage room and made comfortable on the delivery bed. She was also reminded that her baby would be delivered unto her abdomen. All findings were recorded on the partograph.

3.5 MANAGEENT OF THE SECOND STAGE OF LABOUR

The second stage of labour starts from full dilation of the cervix (10 cm) to the expulsion of the baby. It usually lasts for 30 minutes in multiparous women and 60 minutes in primigravida women. All procedures to be carried on Madam Mabel was explained to her and she was reassured. She was then assisted to assume lithotomy position upon her preference and her head was supported with pillow. Protective clothing such as plastic apron, boot, goggle, face mask,

and cap were worn. Hands were washed with soap under running water and dried with a cleaned towel and the assistant was asked to open the delivery pack whiles surgical gloves were worn. Madam Mabel was draped with a sterile towel. Madam Mabel's vulva and upper thighs were swabbed with a sterile cotton wool ball soaked in a savlon solution. A clean perineal pad was placed to the anus to prevent feacal contamination of the delivery field. A sterile cot sheet was placed on Madam Mabel's abdomen and she was reminded that, the baby would be delivered onto her abdomen to provide warmth for the baby and also to initiate bonding, and she agreed. She was encouraged to push with each uterine contraction and rest in between contraction.

As the baby's head advanced, the index and middle fingers were gently placed on the fetal head to aid flexion, and to allow the smallest diameter of the foetal head to pass through the pelvic outlet and to prevent the fetal head from popping out of the vagina explosively which can result in perineal lacerations and intercranial hemorrhage to the baby. Madam Mabel's vagina was roomy so there was no need for episiotomy. When the fetal head crowned, Madam Mabel was asked to stop pushing and pant with contractions, the occiput escaped the pubic arch, extension of the head was aided to allow the sinciput, face and the chin to sweep the perineum for the head to be delivered. After the birth of the head, the eyes of the baby were gently wiped immediately with sterile cotton wool from inner canthus of the eyes outwards using one swab at a time. Hands was passed around the neck to feel for cord around neck but no cord was felt. After restitution and external rotation of the head and the internal rotation of the shoulders had occurred which indicated that the shoulders were in anterior posterior diameter of the pelvic outlet. Hands were placed on the parietal bones of the fetus extending to the shoulders, the client was asked to push slowly and gently. A gentle downward traction was applied to deliver the anterior shoulder and with upward traction towards the mother's abdomen the posterior shoulder was delivered. The

trunk and the rest of body of the baby was then delivered unto the mother's abdomen by lateral flexion and time of delivery was noted as 6:10 am. The baby cried immediately after birth and the sex of the baby was notice as a female child. The baby was dried thoroughly and was covered with a new sterile cot sheet whiles on the mother's abdomen to promote warmth and bonding as well as skin to skin contact. Madam Mabel was congratulated and she complained of fatigue after the birth of the baby. The first Apgar score was 8/10 and Madam Mabel was again congratulated for her co-operation.

3.6 IMMEDIATE CARE OF THE BABY

The immediate care of the newborn starts as soon as the head is born. Immediately the baby's head was delivered, a sterile gauze was used to clean its face and eyes. The airway was cleared with a sterile gauze from the mouth to the nose. The cord was clamped 3cm from the baby's abdomen and 2cm from the first clamp with two forceps within onet three minutes after delivery of the baby. The cord was cut with a sterile scissors and sterile gauze covering it to prevent splashing of blood. The baby was shown to her mother and she identified the sex of her baby as live female baby. An identification band with mother's name, baby sex, time and date of delivery was placed at the baby's wrist. The fifth minute Apgar score was 9/10. The baby was put on mother's abdomen for one-hour skin to skin contact.

3.7 MANAGEMENT OF THIRD STAGE OF LABOUR

Third stage of labour is the period from the delivery of the baby to the complete explosion of the placenta, its membranes and control of bleeding. Madam Mabel was in the lithotomy position and a receiver placed near the vulva in between the thighs. Procedure was explained to Madam Mabel. The uterus was palpated to rule out the presence of an undiagnosed twin which was

absent and ten (10) international units (IU) of oxytocin was injected intramuscularly on the mother's left thigh at 6:10 am to aid in the contraction of the uterus and separation of the placenta. The placenta and its membranes were then delivered through controlled cord traction and counter pressure to prevent inversion of the uterus. The bladder was emptied when checked. The non-dominant hand was placed on the fundus to feel for contraction of the uterus. The cord was re-clamped nearer to the perineum with one artery forceps. A receiver was placed in between client's thighs to receive the placenta and its membranes. The cord and artery forceps were held with the dominant hand. As soon as the uterus contracted, the non-dominant hand was removed and placed just above the symphysis pubis with the palm facing the abdomen of the mother to provide counter traction to prevent uterine inversion during removal of the placenta at the same time, the dominant hand that held the clamped cord was pulled gently in a downwards traction. With steady controlled cord traction, the process was repeated until the placenta was visible at the vulva and cupped with the two hands, and was rolled round to gently tease the membranes. The placenta and its membranes were completely delivered at 6:15am. A quick examination of the placenta was made where both the maternal and fetal surfaces were intact. The placenta was placed in a receiver for thorough examination later. The uterus was rubbed gently in a circular motion to stimulate contraction and clots were expelled. Madam Mabel was taught how to massage the uterus and how it should feel after massaging. The vulva was cleaned with sterile gauze and savlon the labia were patted and cleaned. Two sterile gauzes were wrapped on the middle and index finger for inspection and there were no lacerations, tears on the perineum. The vaginal walls and cervix were inspected but there were no tears or oedema and there was no sign of active bleeding. The total blood loss was 120 milliliters. Madam Mabel's vulva was cleaned and a new cleaned perineal pad was applied to the vulva to absorb any lochia. Madam Mabel was congratulated and made comfortable in bed

3.8 EXAMINATION OF THE PLACENTA AND MEMBRANES

The placenta was taken to the sluice room for thorough examination under good source of light. The placenta was immersed in 0.5% of chlorine solution. The size and shape of placenta was normal. The placenta was held by the cord with the membranes hanging, the membranes were examined for completeness and it was intact. The placenta was now laid on a flat surface for further examination. The amnion was peeled from the chorion up to the umbilical cord and was fully viewed. The length of the cord was checked and it was of normal length. The fetal surface was viewed and the cord was centrally inserted containing one vein and two arteries without any true knot. The fetal surface was bluish gray in colour and was smooth, shiny surface. There were no blood vessels radiating into the membranes. The placenta was then turned to view the maternal side, the maternal surface was dark red in colour due to maternal blood supply. The lobes fitted together without any gap, the edges also formed a uniform circle and this meant there were no missing lobes. There were no white patches. There was no abnormality detected. Estimated Blood loss was 120mls. The placenta was discarded after decontaminating it. The used instruments were decontaminated in 0.5% chlorine for 10 minutes and then, rinsed with clean water, washed with soap and water and rinsed under running water. The instruments were then dried and made ready for sterilization. Hands were dipped in chlorine solution before discarding the gloves. Hands were then washed with soap under running water and dried with a dry towel. Findings were recorded on the partograph.

3.9 MANAGEMENT OF FOURTH STAGE OF LABOUR

The fourth stage of labour is a period of six hours following the delivery of the placenta, membranes and control of hemorrhage. During this stage of labour, close observation of the baby and mother were made. Inspection of the cord was made and the mother symphisio fundal height

was 16cm. The mother and baby were assessed for every fifteen minutes for two hours, thirty minutes for an hour which was recorded behind the partograph. This was done to detect any deviation from normal, mother was then served with porridge and was also encourage to breastfeed the baby frequently. The lochia was also checked, with its colour being red (rubra) and not offensive. She was again encouraged to empty her bladder frequently to prevent postpartum hemorrhage and also to change soiled pads frequently to prevent infections. She was also educated to wash her hands with soap and water after changing her pad and also before and after attending to the baby.

The mother's vital Signs for every 15 minutes for the first 2 hours ranged from,

Temperature	36.2-36.7 degree Celsius
Pulse	85-86 beats per minute
Respiration	22-24 cycles per minute
Blood pressure	130/75-140/80 millimeter of mercury

Vital Signs for the baby was checked and recorded as follows,

Temperature	36.2 degree Celsius
Apex beat	135bpm
Respiration	40cpm

3.10 SUBSEQUENT CARE OF THE BABY

Immediately the head was born, the eyes were cleaned with cotton wool swabs from inner canthus outwards. Chloramphenicol eye drop (2drops) was instilled unto baby's eye. Cord was dressed with chlorhexidine spirit with a sterile cotton wool in the presence of the mother and was taught on how to dress the cord. Injection vitamin k (1mg) was given intramuscularly on baby's thigh.

3.11 EXAMINATION OF THE NEWBORN

The procedure to be carried out on the baby was explained to the mother and baby was examined in the presence of the mother. Hands were washed and dried with a clean towel. Sterile gloves were worn. The baby was put on a clean warm flat surface. It was exposed systematically as the examination was done from head to toe. Colour of baby was pink all over on observation. The head and scalp were normal with no caput succedanum or cephalhaematoma, bulging or sunken fontanelles, sutures were normal. Baby opened the eyes by itself and it was clear, no discharges were seen. The eyes were in line with the ears. The ears were examined for presence of discharge, shape and size but no abnormality was detected. The nose was patent. The mouth was examined by pressing the angle of the jaw which opened the mouth and the tongue, gum and palate was inspected and nothing abnormal was detected. Reflexes such as suckling, rooting were present, the neck was also palpated for the presence of lymph nodes, congenital goiter and rigidity of the neck but it was normal. The chest was examined, the respiratory movement was inspected by observing the movement of the chest and abdomen. The chest circumference was 32cm. The chest was also inspected for the shape, size. The space between the nipples was noted and the nipples were in alignment. The abdomen was rounded, soft and non-tender. Umbilical cord has three blood vessels, two arteries and one vein. The cord was not bleeding.

Upper limbs were also inspected for alignment, fracture, extra digit, webbing. All ten fingers were present. Examination was also done on the genitalia but no abnormality was found the urethra was patent as it passed urine. The anus was inspected to detect abnormality like imperforate anus but the anus was patent since the baby passed meconium. Lower limbs were also examined, the digits were examined for webbing, extra digits and no abnormality was detected. The femoral pulse was present. The baby's back was also examined but there was no spinal abnormality like bifida. The axillae, elbow groin and popliteal spaces were examined for any abnormality, normal flexion of the wrist and ankle joints was also confirmed and nothing abnormal was detected. The spine was also examined with baby lying in prone position. The back was palpated for swelling, dimpling, hairy patches and no abnormalities were found.

3.12 SUMMARY OF LABOUR

On the 30th August 2023 at 6:10am, Madam Mabel had spontaneous vaginal delivery to a live Female child. At 6:10am, injection of oxytocin 10 units (IU) was given (IM). Apgar score first minute was 8/10, fifth minute 9/10. At 6:15am the placenta and membranes were completely delivered. Sex of baby was a Female. Baby weight 2.8kg. Perineum was intact, estimated blood loss was 120millimeters.

3.13 CONDITION OF MOTHER

Blood pressure	112/62 millimeters per mercury.
Pulse	100 beat per minute.
Respiration	22 cycle per minute.
Temperature	37.0 degree Celsius.

Fundal height	16centimeters.
Uterus	Contracted.
Lochia	Red (rubra) and scanty.
Perineum	Intact.
Condition	Satisfactory.
Estimated blood loss	120mls.

3.14 CONDITION OF BABY

Apgar score

First minute	8/10.
Fifth minute	9/10.
Sex	Female.
Temperature	36.2 degrees Celsius.
Birth weight	2 .8kilograms.
Apex heart rate	135 beats per minute.
Respiration	45 cycles per minute.
Length of the baby	47 centimeters.
Head circumference	36 centimeters.

Meconium	Passed.
Urine	Passed.
Abnormalities	No abnormalities detected.
Condition	Satisfactory.

3.15 CARE PLAN DURING LABOUR

On 30/08 /2023

Madam Mabel complained of

1. Anxiety
2. Waist pains
3. Lower abdominal pain
4. Fatigue
5. Nausea and vomiting

Short Term Objectives

1. Madam Mabel's anxiety will be allayed within 30 minutes.

2. Madam Mabel will be able to cope with waist pain throughout labour.

3. Madam Mabel lower abdominal pain will subside after delivery.

4. Client will be relieved of fatigue after delivery.

5. Madam Mabel will cope with nausea and vomiting within 2 hours.

Long Term Objective

Madam Mabel will go through labour and puerperium successfully without any complications to both mother and baby.

CARE PLAN DURING LABOUR

DATE/ TIME	NURSING DIAGNOSIS	OBJECTIVES	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
31/08/2023 **2:00 am**	Anxiety related to unknown outcome of labour.	Client will be calm and relaxed within 30 minutes after delivery as evidenced by client verbalising that she is no more anxious and midwife visualizing client is more relaxed.	1. Reassure client. 2. Explain to client all procedure to be done on her. 3. Encourage client to express her fears and concerns and address them. 4. Inform client about the progress of labour. 5. Allow client to communicate with relatives.	1. Client was reassured that she would be delivered safely 2. All procedures done on client were explained to her. 3. Client expressed her fears and concerns and they were addressed tactfully. 4. With the dilation board, progress of labour was explained to client's understanding. 5. Client was communicating with her mother.	**31/08/2023** **2:30 am**	Goal fully met as evidence by client reported that she was no more anxious and midwife visualising client is relaxed.	

CARE PLAN DURING LABOUR CONT'D

DATE/ TIME	NURSING DIAGNOSIS	OBJECTIVES	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
31/08/23 **2:30 am**	Waist pain related to the pressure of the descending foetus on the sacral nerves.	Client cope with the waist pains throughout labour as evidence by the midwife visualizing that client is calm and not complaining much.	1. Explain the physiology of pains to the client. 2. Reassure client that waist pain will go off soon after delivery. 3. Allow client to adopt any comfortable position. 4. Massage client sacral region to relieve her of the pains. 5. Engage client in a diversional therapy 6. Support client with pillow.	1. The physiology of waist pains was explained to her that is as a result of the descent of the fetal head. 2. Client was assured of waist pains subsiding soon after delivery. 3. Client assumed the left lateral position. 4. Clients sacral region was massaged to relieve her of her pains 5. Client was engaged in a conversation to take her mind off the discomfort6. Client was	**31/08/23** **6:40am**	Goal achieved as evidence by midwife visualised client was calm and cooperation throughout delivery and labour process.	

				supported with pillow.			

CARE PLAN DURING LABOUR CONT'D

DATE/ TIME	NURSING DIAGNOSIS	OBJECTIVES	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUAION	SIGN
31/08/23 **2:30am**	Altered body comfort (Lower abdominal pains) related to the physiology of labour and uterine contractions.	Madam Mabel will cope with lower abdominal pains throughout labour as evidenced by midwife observing client stop screaming with contractions.	1. Reassure client. 2. Educate Madam Mabel on the causes of lower abdominal pain. 3. Educate client on ambulation and posture. 4. Encourage client to empty bladder frequently. 5. Encourage client to do deep breathing exercises. 6. Perform sacral massage.	1. Madam Mabel was reassured that her pain would help with the descent of the fetus 2. Madam Mabel was informed that the lower abdominal pain is due to contractions and descent of the foetus. 3. Client was educated to lie left lateral and walk around 4. Client was emptying her bladder at least every 1-2 hours. 5. Client was supervised to do deep breathing exercise.	**31/08/23** **6:40am**	Goal met as evidence by midwife visualized client rub her buttons within contraction.	

				6. Client's mother performed sacral massage for her.			

CARE PLAN DURING LABOUR CONT'D

DATE/ TIME	NURSING DIAGNOSIS	OBJECTIVES/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
31/08/ 2023 4:30am	Fatigue related to labour and delivery process	Madam Mabel will be relieved of fatigue within 24hours after delivery as evidenced by client verbalizing that, she is relieved of fatigue.	1. Encourage client to take in oral fluid. 2. Encourage client on deep breathing exercise. 3. Encourage client on a comfortable position. 4. Encourage client to pant and relax in between contractions. 5. Encourage client on	1. Oral fluid was given to the client to hydrate her. 2.Deep breathing exercise was encouraged 3.Client was encouraged to assume a comfortable but harmless position like the lateral position 4.She was encouraged to pant and relax in between contractions. 5.Client was given emotional and physical support	1/09/2023 4:30am	Goal fully met as evidence by client verbalised that she was no longer exhausted and midwife visualized client look cheerful and refreshed	

			given emotional and physical support.				

CARE PLAN DURING LABOUR CONT'D

DATE/ TIME	NURSING DIAGNOSIS	OBJECTIVES	NURSING ORDERS	NURSING INTERVENTION	DATE/TIME	EVALUATION	SIGN
31/08/23 **5:00 am**	Vomiting related to nauseated object at ward.	Client will stop vomiting within 2 hours as evidenced by midwife visualizing client is no more vomiting and client verbalising that the vomiting has stopped.	1. Reassure Madam Mabel that vomiting would stop. 2. Encourage client to take sips of water. 3. Assess the hydration level of client. 4. Assist client to rinse her mouth after vomiting. 5. Encourage client to	1. Madam Mabel was reassured that vomiting would stop by removing the nauseating item from the ward. 2. Client was encouraged to take sips of water. 3. Client level of hydration was assessed 2 hourly. 4. Client was assisted to rinse her mouth after vomiting with water. 5. Client was encouraged to eat	**31/08/23** **7:00am**	Goal was fully met as evidence by midwife observed client ate without vomiting.	

			eat light and dry food. 6 Remove nauseated objects.	light and dry food like soup. 6. Nauseated objects such as bedpan, Dettol and so on were removed.			

CHAPTER FOUR

PUERPERIUM

4.0 INTRODUCTION

This chapter describes the management of both mother and baby from day one to six weeks postpartum. Care plan was drawn for the management of identified problems during puerperium. It is during this stage that the reproductive organs return to their non-pregnant stage, physiological changes that occurred during pregnancy are reversed and lactation is established.

4.1 DAY OF DELIVERY

On the 30th August, 2023, which was Wednesday, Madam Mabel was sent into the ward where she and her baby were made comfortable in bed and observation continued at 8:10 am. She was encouraged to breastfeed her baby and to empty her bladder frequently in order to prevent the occurrence of any postpartum haemorrhage, then early ambulation was established to promote effective circulation and drainage of lochia. She was also educated to change her perineal pad when soiled to help prevent ascending infections and was taught to wash hands with soap and water after removing her perineal pad and after visiting the toilet, before breast feeding the baby.

Symphysio- fundal height was checked and recorded as 16centimeters.

The following were her vital signs:

VITAL SIGNS

Temperature	36.2 degrees Celsius
Pulse	100 beats per minute
Respiration	22 cycles per minute
Blood pressure	112/62 millimeters of mercury

She was served with milo with bread after delivery and she breastfed her baby for a while and slept comfortably for about two hours. Her mother later served her with rice and tomato stew which she ate all after waking up. A head-to-toe examination was performed on the baby for abnormalities in the present of Madam Mabel but none was detected. The baby passed meconium and urine which indicated that her urethra and anus were patent. Vital signs were checked and recorded as follows

VITAL SIGNS

Temperature	36.6 degree Celsius
Apex beat	135 beats per minute
Respiration	45 cycles per minute

With the puerperal examination, the breast was not lactating well and mother was asked to put baby to breast to ensure contraction and milk production, lochia was checked with the colour being red (rubra), and uterus also checked and was well contracted, After the puerperal examination, no abnormality was found on both mother and baby. The mother was once again congratulated for a successful delivery. Madam Mabel was asked to report to the facility immediately if she notices any changes in condition

4.2 SUBSEQUENT CARE OF THE BABY

Six hours after birth, Madam Mabel was informed about the importance of the baby to be bathed and she consented to it. Cord was inspected for bleeding but it was fresh and in good condition without any bleeding after it had been checked. The baby was given a warm bath with much attention given to skin folds. Baby was dried thoroughly and Vaseline was applied over the

body and was then dressed and wrapped in a nice warm sheet with the head covered with a cap to prevent heat loss. Cord was again inspected for bleeding and there was none. Then it was dressed with a sterile cotton and chlorhexidine spirit, baby was then given to mother to breastfeed. Baby was wrapped up in a warm cot sheet to maintain baby's temperature to prevent the baby becoming too cold or too hot. Mother was encouraged to breastfeed baby exclusively and on demand or 8 to 12 times a day. She was also educated on breastfeeding problems and how she will manage it like breast engorgement, sore nipple and cracked nipple and to report if symptoms persist. Mother was advised to use only prescribed drug for cord care. Client was advised to wash hands before and after handling the baby. All findings were communicated to the mother and recorded afterwards.

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

Temperature	37.7 degrees Celsius
Apex beat	136cpm
Respiration	45cpm

All findings were communicated to the mother and documented. Baby's condition was satisfactory.

Baby Bath Items Needed

Basin for water

Hair brush

Mild, unperfumed soap

Gloves

Diaper

Methylated spirit

Cotton wool swabs

Powder/baby oil

Procedure for Baby Bath

Bathing of the baby was done six hours following delivery. Procedure for baby bathing was explained to client to seek for her consent to bath the baby which she accepted. She was asked to watch closely in order to enable her know how to bath her baby at home. Requirement needed for the procedure were gathered.

Plastic apron was worn, cold and hot water were mixed and temperature tested with elbow. Hands were washed with soap and water and dried with gloves worn, and baby wrapped in a sheet and placed in a protected flat surface and undressed and wrapped with cot sheet. Eyes were cleaned from inner cantus outer with clean cotton wool swap, soap and clean water. Face was cleaned with a dumped face towel and dried. The neck was supported with one hand protecting the ear with the middle finger and the thumb. Baby's head was washed with soapy sponge and supporting the body resting on the elbow with head lifted to the edge of the basin. Soap was rinsed off the head and dried. Baby was placed back on protected flat surface and exposed. Arms and front of the trunk were washed paying attention to the skin folds. Baby's back was turn with one arm supporting the chest with the hand holding the distal arm of the baby. The back was washed down to the feet paying attention to the skin folds, genitalia and legs were cleaned. Baby was firmly supported and immersed in warm water and head above water and rinsed thoroughly. Baby was placed on a flat and covered with a cleaned big towel. She was wrapped with a small towel to dry, paying attention to skin folds and gloves were removed. Cord was dressed with chlorhexidine 7.1% digluconate gel using aseptic technique and was dress and covered in a warm

sheet, he was given to the mother for breastfeeding. The working area was tidy up and waste materials disposed of, gloves were removed and hand washing was done with soap and water and dried. Findings were communicated to client, record and made comfortable in bed.

4.3 THE FIRST DAY POST DELIVERY

First day post-delivery 2nd september, 2023. Client woke at 5; 00 am in a healthy state with a good-looking facial expression. All procedures to be carried on both mother and baby were explained. Perineal pad was inspected for the flow of lochia which was small and red (Rubra) in colour with no odour. Mother then took a warm bath and was served with hot milo and butter bread. Permission was sought from client and head - to – toe examination was done with no abnormalities detected. The uterus was well contracted and the symphysio – fundal was 15 centimeters. The breast was soft and lactating well. She complained of not having enough sleep due to after pain on which she was reassured on getting enough sleep when the pain subsided and was asked to cooperate. She was also educated to breast feed baby frequently. Client vital signs were checked and recorded as:

VITAL SIGNS	**READINGS**
Temperature	36.1 degrees
Pulse	84 beats per minute
Respiration	23 cycles per minute
Blood pressure	123/80 millimeters of mercury

The baby was toped and tailed and examined from head –to – toe with no abnormalities detected. The cord was dressed with six (6) cotton wool swabs and chlorhexidine 7.1% digluconate gel in the presence of the mother. The baby's vital signs were checked and recorded as:

VITAL SIGN	**READING**
Temperature	36.0 degree Celsius
Apex beat	135 beats per minute
Respiration	45 cycles per minute
Weight	2.8kg

The baby was then wrapped in a clean and warm cot sheet and handed over to the mother for breast feeding. The position and attachment of baby to the breast was done well under supervision. Client was reminded on the intake of nutritious diet and frequent breastfeeding of the baby. Education was given on the need to change perennial pad when soiled and the need to wash her hands before and after breast feeding of the baby to prevent infection. Client was also educated on post-natal exercise such as Kegel exercise and early ambulation. She was also educated on family planning as well as exclusive breastfeeding, changing of diapers frequently, and keeping the baby warm always. The baby was given oral polio vaccine and Bacillus Calmette Guerin (BCG) vaccine intradermal at the right upper arm as a protection against tuberculosis. Madam Mabel was educated not to massage or apply anything to the injection site. Client was educated to visit the clinic for close monitoring and to continue with baby immunization until the baby is 18 months old. She was made aware that will be tissue reaction over the area and a scar formation will take place which indicate that the baby has effectively

been immunized against tuberculosis. Madam Mabel was informed of the first post-natal visit to the clinic. The baby was re- assessed and no abnormalities noticed and she confirmed they are already discharged.

Madam Mabel was given the following drugs:

Tablet paracetamol 1 gram 8 hourly thrice for five days

Capsule Amoxicillin 250 milligram 8 hourly thrice for seven days

Capsule iron III polymaltose 200 milligram daily for thirty days

Client was discharged and was helped to pack belongings after serving medication. Her hospital bills were settled by the National Health Insurance Scheme. Client was reminded that she would be visited the next day and it will continue for seven days. Client was congratulated and bide fare well.

4.4 POST NATAL HOME VISIT

First Day Post Natal Home Visit

On 3rd september, 2023, at 8:00am and at 5:00 pm, Madam Mabel was visited in her house. She was asked how she and her baby were doing and she said her condition was getting better and her previous complaints had improved and she also said that the baby was doing well. The family was much pleased to be visited. Explanation was given to Madam Mabel that she and the baby were going to be examined from head to toe to detect any abnormality for early treatment and she then emptied her bladder. The client's conjunctiva was examined and there was no pallor, the breasts were firm, soft and were lactating well, the uterus was well contracted and the symphysio-fundal height measured 14 centimeters. The perineum was clean when inspected

lochia was red with moderate flow and no bad odour. Her vital signs were taken and recorded as;

MOTHER

VITALS	MORNING	EVENING
Temperature	36.5 degree Celsius	36.5 degrees Celsius
Pulse	80 beats per minute	82 beat per minute
Respiration	23 cycles per minute	22 cycles per minute
Blood pressure	125/80 millimeters of mercury	120/80 millimeters of mercury

Permission was sought to perform top and tailed of the baby and it was granted. As the baby was being bathed, it was also demonstrated to Madam Mabel and her mother as they were educated that the ears had to be covered with the fingers to prevent water from entering the ears. The cord was also dressed with chlorhexidine7.1%digluconate gel. The baby had passed meconium and urine when the diaper was removed and it was inspected before top and tail. Baby was examined from head to toe and no abnormality was found. He was not jaundiced or pale. Baby's weight was checked and recorded 2.9 kilograms. Baby's vital signs were taken and recorded as follows;

BABY

VITALS SIGNS	MORNING	EVENING
Temperature	36.0 degree Celsius	36.2 degree Celsius
Pulse	140 beats per minute	135 beat per minute
Respiration	40 cycles per minute	40 cycles per minute
Stools	Meconium	Meconium
Sucking	Yes	Yes

Cord Condition	Clean	Clean

Madam Mabel was encouraged to breastfeed the baby on demand and at least 8 to 12 times a day. A promise was made to visit them again the following day and client said good bye and the family were bid fare well. Baby's weight was 2.8 kilogram

4.5 SECOND DAY POST NATAL HOME VISITS

On the 4th september, 2023, the second visit was made to client's house at 8:00am and 5; 00 pm. Madam Mabel now said she can now sleep well as her after pain subsides after greeting was made. The baby was also doing well. Permission was sought to inspect her perineal pad and the lochia was found to flow scanty the colour was red (rubra) and not offensive. The head-to-toe examination was also done and no abnormality was detected the symphysio fundal height was 13centimeters. Her Vital signs were checked and recorded as follows;

MOTHER

VITAL SIGNS	**MORNING**	**EVENING**
Temperature	36.1 degrees Celsius	36.3 degrees Celsius
Pulse	80 beat per minute	81 beat per minute
Respiration	22 cycles per minute	23 cycles per minute
Blood pressure	120/80 millimeters of mercury	120/80 millimeters of mercury

The baby was (top and tailed) due to the cord insitu and general examination was carried out and no abnormality was present. The cord was neatly dressed with no abnormality detected and was

getting dried. The baby passed stools and urine everyday according to Madam Mabel, baby weight was 2.7 and vital signs were taken and recorded as follows;

BABY

VITAL SIGNS	MORNING	EVENINIG
Temperature	36.4degrees Celsius	36.2 degrees Celsius
Apex heart beat	135beat per minute	140 beat per minute
Respiration	42 cycles per minute	40 cycles per minute
Stool	Meconium	Meconium
Cord condition	Shrinking	Shrinking
Sucking	Yes	Yes

Permission was sought to leave and Client said she was very grateful and appreciated the care that was given to them.

4.6 THIRD DAY POSTNATAL HOME VISIT

On the 5th september, 2023, the third home visit was made to Madam Mabel house at 8:00 am and 5; 00 pm, greetings were exchanged. Mother and baby were doing well. Permission was sought to inspect client's perinea pad and it was red, scanty flow without any offensive smell. Her breast was lactating well and uterus well and the symphysio fundal height was 12 centimeters when measured. Her vital signs were checked and recorded as follows;

MOTHER

VITALS	MORNING	EVENING
Temperature	36.4 degrees Celsius	36.2 degrees Celsius
Pulse	78 beats per minute	80 beat per minute
Respiration	20 cycles per minute	22 cycle per minute
Blood pressure	110/70 millimeters of mercury	110/80 millimeters of mercury

The baby was top and tailed and general examination was carried out and no abnormality was present. The cord was neatly dressed with no abnormality detected. The baby also passed stools and urine. Weight was 2.6 kilogram when checked. Baby's vital signs were taken and recorded as follows;

BABY

VITAL SIGNS	MORNING	EVENING
Temperature	36.8 degrees Celsius	36.5 degrees Celsius
Apex heart beat	136 beat per minutes	138 beat per minutes
Respiration	40 cycles per minutes	41 cycles per minutes
Stools	Dark Yellowish	Dark Yellowish
Sucking	Yes	Yes
Cord Condition	Shrinking	Shrinking

Madam Mabel complained of pain in her breasts and heaviness which was as a result of fullness and also waist pain. She was educated to continue breastfeeding the baby on demand and

frequently, and to apply cold compress on them to reduce the pain and was ask to breastfeed baby on demand and to wear well-fitting brassier.

Permission was sought to leave and Madam Mabel said she was very grateful and appreciated the care that was given to them.

4.7 FOURTH DAY POSTNATAL HOME VISIT

The fourth home visit was made to Madam Mabel house at 8:00am on 6th september, 2023. The health status of mother was inquired and she said the pain in her breasts had subsided except the fullness. 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 measured and it was 11 centimeters. Her vital signs were checked and recorded as follows;

MOTHER

VITAL SIGNS	**MORNING**
Temperature	36.0 degrees Celsius
Pulse	80 beats per minute
Respiration	20 cycles per minutes,
Blood pressure	110/60 millimeters of mercury

Baby was top and tailed by client herself on arrival so the general examination was carried out, no abnormality was found. The cord was neatly dressed and no abnormality was detected and baby was doing well. The baby had already passed stools (brownish-yellow) and urine. Her weight was 2.6 kilograms when checked. Baby's vital signs were taken and recorded as follows;

BABY

VITAL SIGNS	**MORNING**
Temperature	36.7 degrees Celsius
Apex heart beat	136 beats per minute
Respiration	44cycles per minute
Stools	Dark Yellowish
Sucking	Yes
Cord Condition	Shrinking

She was encouraged to breastfeed the baby on demand and to ensure adequate warmth to baby. During the visit, client was advised to take nutritious meals and to take in fruits.

4.8 FIFTH DAY POSTNATAL HOME VISIT

The fifth postnatal home visit was on 7th september, 2023 at 8:00am. 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 and when it was inquired, Madam Mabel said the baby sucks very well. Inspection of the lochia was done and the colour was pink (serosa) without any bad odour and flow was scanty. After the head-to-toe examination, no abnormality was detected. Symphysio fundal height was 10 centimeters when checked. Client's vital signs were checked and recorded as follows:

MOTHER

Temperature	36.2 degrees Celsius

Pulse	80 beats per minute
Respiration	20 cycles per minute
Blood pressure	110/70 millimeters of mercury

Baby was top and tailed, head to toe examination was done and no abnormalities were found on the baby. Weight was 2.7 kilograms. During the examination, it was realized that the cord had fallen off and Madam Mabel confirmed that it fell off the previous evening. The stump was then dressed with chlorhexidine 7.1% digluconate gel. Vital signs were taken and recorded as follows:

BABY

Temperature	36.6degrees Celsius
Apex heart beat	136 beats per minute
Respiration	44cycles per minute
Stools	Yellow
Sucking	Yes
Cord	off

Madam Mabel was reminded of the next visit and she said she was very grateful. Permission was sought to leave.

4.9 SIXTH DAY POSTNATAL HOME VISITS

The sixth day postnatal home visit was done on 8th September, 2023 at 8:00am. Greetings were exchanged with client and her family and a seat was offered. Mother and baby were in a healthy condition and Madam Mabel said the baby's crying had minimized and now sleeps a lot. On

head-to-toe examination, no abnormality was detected. Her breast was lactating well and soft. Inspection of the lochia was done and the colour was pink (serosa) flow was very scanty without any bad odour. Measurement of symphysio fundal height was 9 centimeters when checked. She moved her bowel as well as that of the baby.

Client's vital signs were checked and recorded as follows:

MOTHER

Temperature	36.0degrees Celsius
Pulse	78 beats per minute
Respiration	20cycles per minute
Blood pressure	110/70 millimeters of mercury

Baby had already been bathed by client mother, and so head to toe examination was done and no abnormality was found on the baby. Weight was 2.7 kilograms. Baby's vital signs were taken and recorded as follows:

BABY

Temperature	36.7degrees Celsius
Apex heart beat	134 beats per minute
Respiration	42 cycles per minute
Stools	Yellow
Sucking	Yes
Cord	Healing

Education was given to her on the importance of ensuring good posture during feeding the baby and the need to feed the baby continuously on demand and at midnight too. She said she appreciated that a lot, and she was thanked for her co-operation. She was reminded that the next day was going to be the last visit to her house and permission was sought to leave.

4.10 SEVENTH DAY POST NATAL HOME VISITS

The last visit for the week was 8th September, 2023 at 8:00am. The condition of mother and baby was very good. Head to toe examination was done after explaining the procedure to her. Permission was sought and perinea pad was inspected. Lochia was creamy white (Alba) but very little and not offensive. Nothing abnormal was detected. Uterus was not palpable when checked. Client complained of backache and she was reassured and educated on the other positions used in breastfeeding such as lying on her side to breast feed.

Madam Mabel vital signs were taken and recorded as follows;

MOTHER

Temperature	36.0 degrees Celsius
Pulse	78 beats per minute
Respiration	20cycles per minute
Blood pressure	120/80 millimeters of mercury

Baby was bathed by the mother and cord stump dressed and it went on under my supervision afterwards. Head to toe examination was done and no abnormality was found. Weight was 2.8 kilograms. Baby's vital signs were checked and recorded as follows;

BABY

Temperature	36.7 degrees Celsius
Apex heart beat	136 beat per minute
Respiration	44 cycles per minute
Stools	Pink
Sucking	Yes
Cord Stamp	Healing

All the findings were explained to the client and she was educated on the importance of visiting the clinic for the first week post-natal and the importance of immunizing the baby fully. She was thanked for her support and co-operation and farewell was done.

4.11 FIRST POSTNATAL VISIT TO THE CLINIC

Madam Mabel came to the postnatal clinic on 10th September, 2023 at 8:00am with her sister and mother who accompanied her, they were welcomed immediately and offered seats. Client said her family was doing well when asked. Every procedure to be done was explained to her to gain her consent and weight was 68 kilograms when checked and symphysio fundal height was non - palpable. Vital signs were taken and recorded as;

MOTHER

Temperature	36.0degree Celsius
Pulse	80 beats per minute
Respiration	20 cycles per minute
Blood pressure	123/80 millimeters of mercury

She was asked to take specimen as she went to empty bladder. Her urine was tested and it was negative for both protein and sugar. Hemoglobin level was 10.1 grams per deciliter. Privacy was provided and she was helped onto the examination bed and head to toe examination was performed. Client's hair looked very nice with a nice veil when opened. The eyes and nose were inspected and no abnormality was found. The conjunctiva was neither pale nor jaundiced. Breasts were examined but there was no abnormal mass, soreness of the nipples or engorgement present. The upper and lower extremities were inspected and no abnormality was present. On abdominal examination, the spleen was not enlarged and there was no tenderness after palpating the liver. The vulva was examined for infection, and scanty lochia flow. No abnormality was found in all. Findings were communicated to Madam Mabel and she was commended for her co-operation and she also thanked as well.

Baby was also examined from head to toe. Her hair was neatly combed. The conjunctiva was not pale, neither was there jaundice of the sclera nor eye discharges. The ears and nose were inspected as well as the lips and mouth, but no abnormality was found. The umbilical stump was

neatly healed. Baby's weight was 3.0 kilogram when checked. Vital signs were taken and recorded as follows;

BABY

Temperature	36.1 degree Celsius
Apex heart beat	140 beats per minute
Respiration	45cycles per minute
Stools	Pink
Sucking	Yes
Cord Stamp	Healing

After the examinations, findings were communicated to Madam Mabel that nothing abnormal was detected on the baby. Client was educated on family planning to help her and the husband to space their birth and give birth to the number of children they could cater for. She agreed and said that since the husband was not present at that time, she would come later with him for more information but assured to practice the lactational amenorrhea method as a temporal method. Madam Mabel was also reminded on the need to attend child welfare clinic to complete the child's immunization schedules and also attend six weeks post-natal examination.

4.12 SECOND POST NATAL VISIT TO THE CLINIC

According to the midwife in-charge on the 12th September, 2023, Madam Mabel visited the clinic with the baby. Mother now named baby, Emmanuella Asare and they were in healthy condition and had no complaints to be made.

Hemoglobin level of mother was 11.7g/dl as checked and urine test for protein and sugar were negative. Weight was 65 kilograms.

Her vital signs were recorded as;

MOTHER

Temperature	36.2 degree Celsius
Pulse	78 beats per minute
Respiration	20 cycles per minute
Blood Pressure	110/70 millimeters of mercury

Emmanuella Asare's weight was 4.2 kilograms and vital signs were also checked and recorded as;

BABY

Temperature	36.8 degree Celsius
Respiration	34 cycles per minute
Pulse	135 beats per minute
Stools	Pink
Sucking	Yes
Cord	Healed

Physical examination was carried out and no abnormality detected. Breast was lactating well, uterus was well involuted and she was asked if she has resumed menstruation but said no. She was educated on the need to start family planning method to prevent unwanted pregnancy.

Baby's general condition was good on head-to-toe examination; baby's posterior fontanels were closed. Client was handed over to the child health care unit for baby's immunization against polio, diphtheria, tetanus, hepatitis B given to children at six weeks. The extra vaccines namely pneumococcal and rotavirus for protection against pneumonia and diarrhea respectively link reminded to be given. These were recorded in the baby's record booklet. They were then handed over to the child welfare clinic to ensure continuity of care. Client was educated to consult them in case of any problem. All findings were communicated to client and she was congratulated.

4.13 CARE PLAN DURING PUERPERIUM

Problems Identified During Puerperium

1/09/2023

After pains

Inadequate sleep at night

4/09/2023

Breast engorgement

Waist pain

6/09/2023

Backache

Short Term Objectives

1. Madam Mabel will be relieved off after pains within 24 hours

2. Client will be able to sleep for at least 2 hours during the day and 6 hours during the night within 48 hours

3. Client will be relieved of breast engorgement after 48 hours

4. Client will be relived of wait pains within 48 hours

5. Client will be relived of backache within 48 hours.

Long Term Objectives

Madam Mabel and baby Emmanuella Asare will go through puerperium successfully without any complication.

PUERPERIUM CARE PLAN

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
1/09/23 8:00am	Impaired body comfort (After pains) related to involution of the uterus	Client after pains will stop within 24 hours as evidenced by client verbalizing her pain has stop and the midwife visualizing client sleeps well without complains	1. Reassure the client. 2. Encourage client to empty her bladder frequently 3. Encourage client to apply warm compress to the lower abdomen. 4. Encourage client to continue breastfeeding. 5. Encourage client to lie prone with pillow under abdomen. 6. Encourage client to walk around or change position to allow drainage of lochia 7. Encourage relatives to support client 8. Serve prescribed analgesic.	1. Client was reassured that the pain was a sign of involution of the uterus and it would go with time. 2. Client was emptying her bladder whenever she has the urge. 3. Client applied warm compresses to the lower abdomen by using hot water bottle. 4. Client continued breastfeeding the baby. 5. client was lying prone with pillow under abdomen 6. Client was walking around and position was changed to allow drainage of lochia. 7. Relatives supported client. 8. Prescribed analgesic was served like acetaminophen and ibuprofen.	2/09/23 8:00am	Goal fully met as evidence by client verbalized that there was a relief of after pains and midwife visualizing that client slept without any complains	1/12/21 8:00am

PUERPERIUM CARE PLAN CONTINUED

DATE/ TIME	NURSING DIAG NOSIS	NURSING OBJECTVES	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
1/08/23 8:00 am	Interrupted sleep related to excessive crying of the baby at night.	Client will have enough sleep at least 2 - hours during the day and 6hours at night as evidenced by client verbalizing that she was able to sleep at least 6hours during the night and 2 hours during the day and midwife Visualizing that client looks refreshed.	1. Reassure client. 2. Encourage client to take a nap when baby sleeps and whenever possible. 3. Educate partner and relative to support client in household chore and care of the baby. 4. Encourage client to rest in between activities. 5.Encourage family support	1. Client was reassured that she would be able to sleep for at least 6 hours during the night and 2 hours during the day 2. Client took a nap when baby was asleep and whenever possible. 3. Partner and relatives supported client in household chore like cleaning, sweeping, washing and care of the baby was also taken care off. 4. Client was encouraged to rest enough during the day for 2hours at least. 5.Mother and sister were encouraged to support client.	3/08/23 8:00am	Goal was fully met as client verbalized, she slept for 6 hours during the night and 2 hours during the day and midwife visualizing client strong and revived	

PUERPERIUM CARE PLAN CONTINUED

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVE	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
4/08/23 8:00m	Breast engorgement related to poor positioning and attachment of baby to breast	Client will be relieved of engorged breast within 48 hours evidenced by the client verbalizing that she is relieved of breast engorgement	1. Reassure client. 2.Teach client on proper positioning and attachment of the baby to the breast 3.Encourage client on gentle manual expression of breast milk 4. Encourage her to continue breast feeding the baby. 5. Encourage client to apply warm compress on both breasts.	1. Client was reassured that the engorgement will subside. 2. Client was thought on proper positioning and attachment of baby to the breast. 3. Client was encouraged on gentle manual expression of breast milk by using the breast pump. 4. Client was encouraged to continue breast feeding the baby even though she feels the pains. 5. Client was encouraged to apply warm compress on both breasts.	6/08/23 8:00am	Goal was fully met as client reported that her breast engorgement was resolved.	4/08/23 8:00m

PUERPERIUM CARE PLAN CONTINUED

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVE CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN

4/08/23 8:00am	Impaired body comfort (Waist pains) related to poor posture during breast feeding	Client will be relieved of waist pains within 48 hours as evidenced by client verbalizing that her waist pains have subsided	1.Reassure client. 2.Assist client to assume the right sitting position during breast feeding of baby 3.Encourage client not to lift heavy objects for the first few weeks of postpartum 4.Encourage client to lie down sometimes during breastfeeding 5. Serve prescribed medication.	1. Client was reassured that she will be relieved of waist pains. 2. Client was assisted to assume the right sitting position during breastfeeding of the baby like cradle hold. 3. Client was encouraged not to lift heavy objects for the first few weeks of postpartum to avoid the occurrence of the backache. 4. Client was encouraged to lie down sometimes during breastfeeding that is the side lying position. 5.Client was served with prescribed medication like Tablet paracetamol	6/08/23 8:00am	Goal met as evidence by client verbalizing that her waist and body pains have drastically reduced	

PUERPERIUM CARE PLAN CONTINUED

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVE/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
8/09/23 8:00 am	Alternated in body comfort (Backache) related to poor breastfeeding posture	Client will be relieved of backache within 48 hours as evidence by client verbalizing that pain is no more and midwife visualizing that client is relieved of backache and adapt a good posture as she breastfeeds	1. Reassure client. 2. Educate client on the correct positions used in breastfeeding. 3. Educate client on the use of good body mechanics during lifting. 4. Encourage client to wear well-fitting brassier. 5. Educate client on the use of warm compress.	1. Client was reassured that she would be relived of backache. 2. Client was educated on the correct positions used in breastfeeding like cradle hold. 3. Education was given to the client to avoid lifting heavy objects and to use good body mechanics when lifting . 4. Client was encouraged to wear well-fitting brassier. 5. Client was educated on the use of warm compress.	9/09/23 8:00am	Goal met as evidence by client verbalized that her back pain was no more.	

TERMINATION OF CARE

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

Madam Abena Mabel and her family were able to go through pregnancy, labour and puerperium successfully by adhering to all education given to them. After examination both client and baby were handed over to the public health nurse for continuity of care. My profound gratitude was expressed to the client and family for their total cooperation which helped me to achieve my aim. They were also grateful for my care and support.

SUMMARY AND CONCLUSION

This family centered maternity care study was conducted on Madam Mabel and her family. She was an expectant mother who was taken care of from her third trimester at Kokoa Health Center. She was met on 15th August, 2023 in good condition. Holistic and individualized care was rendered to client from the time she was met, which was during third trimester of her pregnancy through to labour and puerperium.

She encountered minor problems during pregnancy, labour and puerperium but they were well taken care of Madam Mabel had a successful care during her antenatal periods, labour and puerperium which were due to quick analysis of problems, good counseling, client's understanding and co-operation and also by involving the family members in her care. She had a spontaneous vaginal delivery on 30th August, 2023 to a live female child without any complications, since she was well managed during pregnancy and the time of labour.

She had a normal puerperium with all visits and her two weeks post-natal examination performed on her as required. She was then handed over to the public health nurse in her community to ensure continuity of care.

In summary, the family centered maternity care study has helped gained more experience in the antenatal care, care during labour and care during puerperium. So wherever taken to render quality health care services, it will be successfully done, during antenatal, labour and taking care of a puerperal women and their babies as well.

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APPENDIX I

COMPLETE DIAGNOSTIC INVESTIGATION

DATE	SPECIMEN	INVESTIGATION	NORMAL VALUE	FINDINGS	REMARKS
17/04/2023	Blood Blood Blood Blood Blood	Haemoglobin Sickling test HIV status Grouping and Rhesus factor	11-16g/dl Negative Negative A, B, AB, O Positive and Negative	11.1g/dl Negative Negative 0 positive negative	Normal Normal Normal Normal Normal
17/04/2023	Urine Blood	Sugar and Protein Haemoglobin level	Negative 11-16g/dl	Negative 10.8g/dl	Normal Normal
14/05/2023	Urine Blood	Sugar and Protein Haemoglobin level	Negative 11-16g/dl	Negative 11.9g/dl	Normal Normal
9/05/2023	Urine Blood	Sugar and Protein Haemoglobin level	Negative 11-16g/dl	Negative 11.2g/dl	Normal Normal
4/06/2023	Urine Blood	Sugar and Protein Haemoglobin level	Negative 11-16g/dl	Negative 11.1g/dl	Normal Normal
31/07/2023	Urine Blood	Sugar and Protein Haemoglobin level	Negative 11-16g/dl	Negative 10.1g/dl	Normal Normal
31/07/2023	Urine Blood	Sugar and protein Haemoglobin level	Negative 11_16g/d1	Negative 10.1g/d1	Normal Normal

APPENDIX II

PHARMACOLOGY OF DRUGS (MOTHER)

DRUG	CLASSIFICA-TION	DOSAGE	ROUTE	ACTION ND USES	SIDE EFFECT
Tab Ferrous sulphate	Iron supplement	200mg 1 daily for 30days	Orally	Help in formation of red blood cell	Diarrhoea and black stool.
Tab paracetamol	Analgesics and Antipyretics	1g 3times daily for 5days	Orally	Relieve pain and fever.	Liver damage on prolong use.
Tab Folic acid	Hematinic	5mg 1 daily for 30days	Orally	Increase formation of red blood cells.	Nausea and vomiting.
Sulphadoxine pyrimethamine	Malaria Prophylaxis	3 tablets stat	Orally	Prevention of malaria	Nausea and vomiting
Tab multivitamin	Vitamin preparation	200mg 1 daily for 30 days	Orally	Increase appetite	Gastrointestinal irritation
Tetanus toxoid injection	Anti- Tetanus	0.5 mg	Subcutaneously	Prevention of Tetanus	Slight fever and chills
Oxytocin	Oxytocin drug	10 units	Intramuscularly	Increased uterine contraction	Hypotension and Hyperstimulation
Vitamin A	Group A Vitamin Supplement	200,000 unit once daily for 2 days	Orally	Growth development, Prevent infection and blindness.	Vomiting

PHARMACOLOGY OF DRUGS (BABY)

DRUG	CLASSIFICATION	DOSAGE	ROUTE	ACTION AND USES	SIDE EFFECT
Tetracycline	Anti- bacterial	Length of a rice	Inner lower eyelid	Prevents eye infection	None
Vitamin K	Vitamins K group	10 units	Intramuscularly	Produces prothrombin that aid in clotting.	None
Bacillus Calmette Guerin (BCG) Vaccine	Antigen	0.05 milligram	Intradermal Injection	Baby is under observation	Blister formation and Fever
Polio Vaccine	Antigen	2 drops	Orally	Baby is under observation	Diarrhoea and fever may occur. Liver damage
Rotavirus vaccine	Antigen	2 drops	Orally	Build immunity against Rotavirus to prevent the baby from diarrhoea	None
Pentavalent (5 in 1 vaccine)	Antigen	0.5 mls	Intramuscularly	Stimulate the production of antibodies against diphtheria, Tetanus, haemophilus-influenza, hepatitis B and pertusis	Low grade fever
Pneumococcal	Antigen	0.5 mls	Intramuscularly	Vaccinates neonates against pneumonia	Pneumonia prevention

ANTENATAL CHART RECORD

DATE	TEMPE-RATURE (0C)	WEIGHT (kg)	BLOOD PRE-SSURE (mmHg)	URINE/ PROTEIN AND SUGAR	GESTA-TION AGE IN WEEKS	FUN-DAL HEI-GHT (cm)	PRESENTATION	DES-CENT	FOETAL HEART RATE (BPM)	COMPL-AINT	TREATMENT	REM-ARKS
17/04/23	36.1	86	103/80	Negative	16	14	_	_	_		Tablet (Multivitamin, Folic acid, Ferrous sulphate, sulphadoxine pyrimethamine, Paracetamol)	
14/05/23	36.5	82	104/79	Negative	20	18	Cephalic	5/5th	positive	Lower abdominal pains	Tablet (Multivitamin, Folic acid, Ferrous sulphate, sulphadoxine pyrimethamine)	Healthy

09/05/23	36.2	83	100/80	Negative	28	26	Cephalic	5/5th	120 beat per minute	Lower abdominal pains	Tab (Multivitamin, Folic acid, Ferrous sulphate, sulphadoxine pyrimethamine, Paracetamol)	Healthy

ANTENATAL CHART RECORD CONTINUED

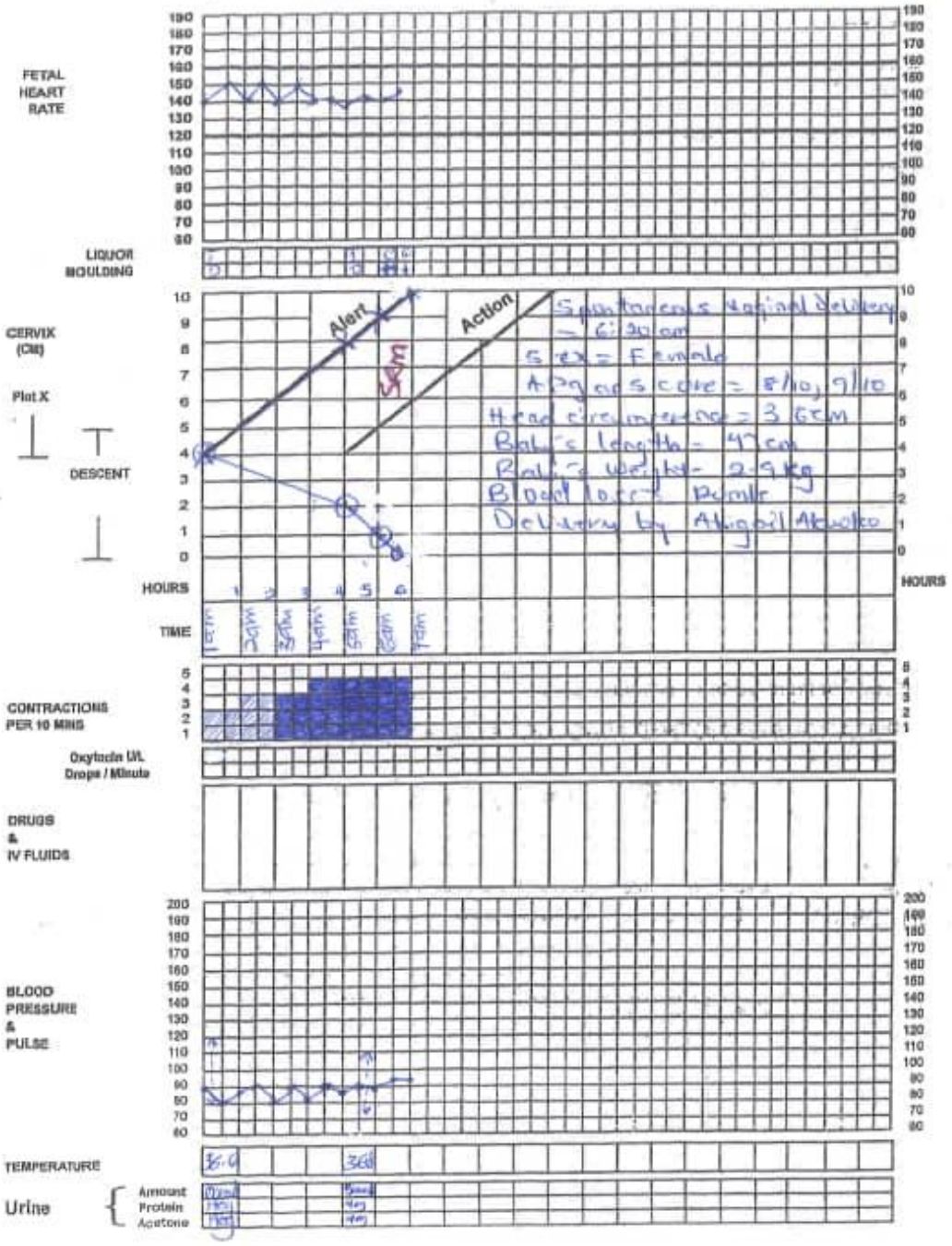
DATE	TEMPERATURE (0C)	WEI-GHT (kg)	BLOOD PRES-SURE (mmHg)	URINE/ PRO-TEIN AND SUGAR	GESTA-TION AGE IN WEEKS	FUN-DAL HEIGHT (cm)	PRESENTATION	DESCENT	FOETAL HEART RATE (BPM)	COMPLAINT	TREATMENT	REM-ARKS
4/07/23	36.1	85	120/80	Negative	32	30	cephalic	5/5th	136 beat per minute	No complains	Tablet (folic acid, ferrous sulphate, multivitamin and paracetamol)	Healthy
6/08/23	36.8	86	105/80	Negative	36	34	cephalic	5/5th	134beat per minute	Constipation	Tablet (folic acid, ferrous sulphate, multivitamin and paracetamol)	Healthy
15/08/23	36.6	86	100/80	Negative	37	36	cephalic	5/5th	132 beat per minute	Lower abdominal pains	Tablet (folic acid, ferrous sulphate, multivitamin and paracetamol)	Healthy

22/08/23	36.7	85	100/80	Negative	38	36	cephalic	5/5th	130 beat per minute	Lower abdominal pains	Tablet (folic acid, ferrous sulphate, multivitamin and paracetamol)	Health
29/08/23	36.6	87	100/80	Negative	39	36	cephalic	5/5th	135 beat per minute	Lower abdominal pains	Tablet (folic acid, ferrous sulphate, multivitamin and paracetamol)	Health
22/08/23	36.7	85	100/80	Negative	38	36	cephalic	5/5th	130 beat per minute	Lower abdominal pains	Tablet (folic acid, ferrous sulphate, multivitamin and paracetamol)	Health
29/08/23	36.6	87	100/80	Negative	39	36	cephalic	5/5th	135 beat per minute	Lower abdominal pains	Tablet (folic acid, ferrous sulphate, multivitamin and paracetamol)	Health

.0

WHO Modified Partograph

Registration No. 857/22 Name (Last, First) Abena Mabel Age 24
Date 26/8/23 Parity/Gravida 2 / 2 LMP 26/11/22 EDD 3/8/23 Gestation (wks) 37
ROM (Time, Date) 6:30/ 26/8/23 Labour Durable (Hrs) 6 Facility/Clinic Name Kaken Health centre.



LABOR NOTES

On 30th August, 2023 at 6:20am, Madam Mabel Akoso had a spontaneous vaginal Delivery to a live female child. Injection of oxytocin 10 unit was given. Apgar score of first minute was 8/10, fifth minute 9/10 at 6:25am, the placenta and its membrane completely delivered with perineum intact, estimated blood loss was 120mls.

Please circle or write responses.

DELIVERY

DATE: 30/8/2023 TIME: 6:20am METHOD: (Spontaneous) / Vacuum Extraction / C/S / Other

PERINEUM: (Intact) / Episiotomy / Laceration

ANESTHESIA: (None) / Local / General

THIRD STAGE

Active Management: (Yes) / No Medication: Time 6:20am Type/Dose 10 unit oxytocin.

PLACENTA: TIME: 6:25am (Complete) / Incomplete

BLOOD LOSS AMOUNT: 120mls (Small (Less than 250 cc)) Moderate (250-499 cc) Large (more than 500 cc) Significant for mother

BABY

Weight: 2.7kg

Sex: Male / (Female)

Baby Position: (Vertex) / Breech / Other

APGAR

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

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

FOURTH STAGE MONITORING

Frequency	Time	B/P.	Pulse	Fundus	Bleeding	Bladder
Every 15 minutes first 2 hours	6:20am	130/75	86	17cm	100mls	120mls
	6:25am	130/75	85	Contracted	No active	—
	6:30am	130/75	86	~	~	—
	7:5am	120/75	86	~	~	—
	7:20am	130/80	86	~	~	60mls
	7:05am	130/75	85	~	~	—
	7:30am	130/75	85	~	~	—
	8:00am	130/75	86	~	~	—
Every 30 minutes For 1 hour	8:30am	120/75	86	~	~	—
	9:05am	120/75	85	~	~	50mls

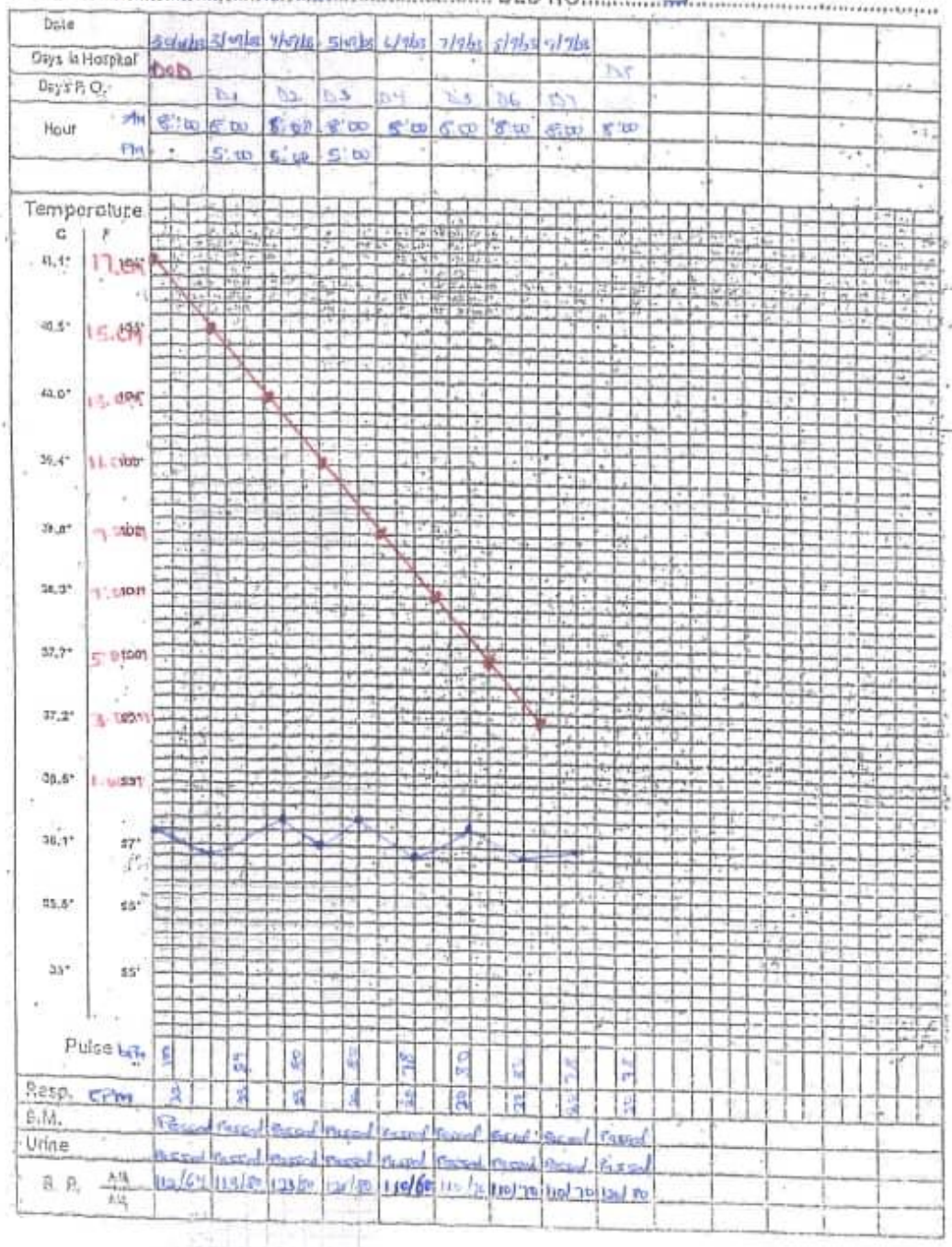
Birth Attendant Akuoko Abigail (student midwife) Date 30/08/23

MATERNITY CHART

NAME: Madam. Abena Adobel

AGE: 24 years WARD: Lying in ward

IP NO.: KHC 80723 BED NO.: 3



NEW BORN CHART

Name:.....Baby Of ABENA MABEL.....No:.....Birth Weight:.....2.9kg.....

Sex:.....FEMALE.....Mother's No:.....5071/23.....Length:.....47cm.....

Nature of Delivery:..SPONTANEOUS VAGINAL DELIVERY.....Diagnosis:.....TERM BABY.....

Date of Birth:.....30th AUGUST 2023.....Time:.....6:20AM.....Date of Discharge:..2ND SEPTEMBER 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	DOD		D1		D2		D3		D4		D5		D6		D7		D8					
Weight	2.9kg		2.85kg		2.80kg		2.75kg		2.70kg		2.70kg		2.75kg		2.80kg.		2.85kg					
Temperature	AM 36.6°C	PM 36.4°C	AM 36.5°C	PM 36.7°C	AM 36.7°C	PM 36.2°C	AM 36.4°C	PM 36.2°C	AM 36.8°C	PM	AM 36.7°C	PM	AM 36.6°C	PM	AM 36.7°C	PM	AM 36.5°C	PM	AM	PM	AM	PM
Stools	Passed	Passed	Passed	Passed	Passed	Passed	Passed	Passed	Passed		Passed		Passed		Passed		Passed					
Urine	Passed	Passed	Passed	Passed	Passed	Passed	Passed	Passed	Passed		Passed		Passed		Passed		Passed					
Remarks	Neck Head Trunk Genitals Limbs — No Abnormalities Detected.																					

NEW BORN EXAMINATION FORM

e: Baby of Abena Mabel. Date of Assessment: 2/09/23 Time: 5pm

s of Birth: 26/8/23 Time of Birth: 5:20am Sex: ☐ M ☑ F Age at time of Assessment (days/hrs) 11 hrs

stional Age ☐ 37 ☐ Mode of Delivery: ☑ Vaginal Assisted Vaginal C-Section

GAR: 1min 8 5min 9 Birth Weight: ☐ 2.9 kg ☐ Lenght ____ cm Head Circumference: 36 cm

nperature at time of Assessment: 36.1 °C Urine passed: Yes No Meconium passed: (Yes) N

me of Assessor (Midwife/Doctor): Akuoko Abigail.

Respiration

p 45
Rate <30 b/m *
Rate <60 b/m *
30-60 b/m
Retractions *
Grunting *
Stridor *

ctivity/Movemnet

pontaneous symmetric
ovements
educed/Absent Movement in
1 limb *
o Movement

ne

rmal
ppy *
reased *

lour

k all over
k body but blue hands/feet
d all over *
*
ndiced *

rd

rmal
d. draining pus
eeding

rmal
rill *
sent *

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: 135
☐ Normal (100-160)
☐ <100 *
☐ >160*

19. Femoral pulse
☐ Present
☐ Not palpable*

20. Abdomen
☑ Normal
☐ Distended*
☐ Scarphoid*
☐ Abdominal defect*
☐ Maases: ____
☐ Other ____

21. Back (spine)
☑ Normal
☐ Abnormal Swelling *
☐ Hairly patch over spine
☐ Abnormal dimple
☐ Abnormal curvature

22. Limbs
☑ Normal
☐ Abnormal ____

23. Genitalia

Male Genitalia
☐ Normal
☐ Undescended testes
☐ Abnormal meatus
☐ Hernia
☐ Other: ____

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

24. Anus
☑ Patent
☐ Imperforate*

25. Resuscitation provided
☐ One
☑ Suction/stimulation
☐ Bag and mask
☐ Endotracheal Tube
☐ Ventilator/CPAP

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

y indicate severe disease that requires urgent referral

oses (if known) ____

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

NEW BORN EXAMINATION FORM

Name: Baby of Abena Mabel Date of Assessment: 30/08/23 Time: 7:15pm
Date of Birth: 30/8/23 Time of Birth: 6:30am Sex: ☐ M ☑ F Age at time of Assessment (days/hrs) 1 hour
Gestational Age 37 ☐ Mode of Delivery: ☑ Vaginal Assisted Vaginal C-Section
APGAR: 1min 7 5min 9 Birth Weight: 2.9kg ☐ Length: 47 cm Head Circumference: 36 cm
Temperature at time of Assessment: 36.6 °C Urine passed: Yes No Meconium passed: Yes No
Name of Assessor (Midwife/Doctor): AKUOKO ABIGAIL supervised by Augustina

1. Respiration
Rate 45
☐ 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: 135bpm
☑ Normal (100-160)
☐ <100 *
☐ >160*

19. Femoral pulse
☑ Present
☐ Not palpable*

20. Abdomen
☑ Normal
☐ Distended*
☐ Scaphoid*
☐ Abdominal defect*
☐ Masses: _____
☐ 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) _____

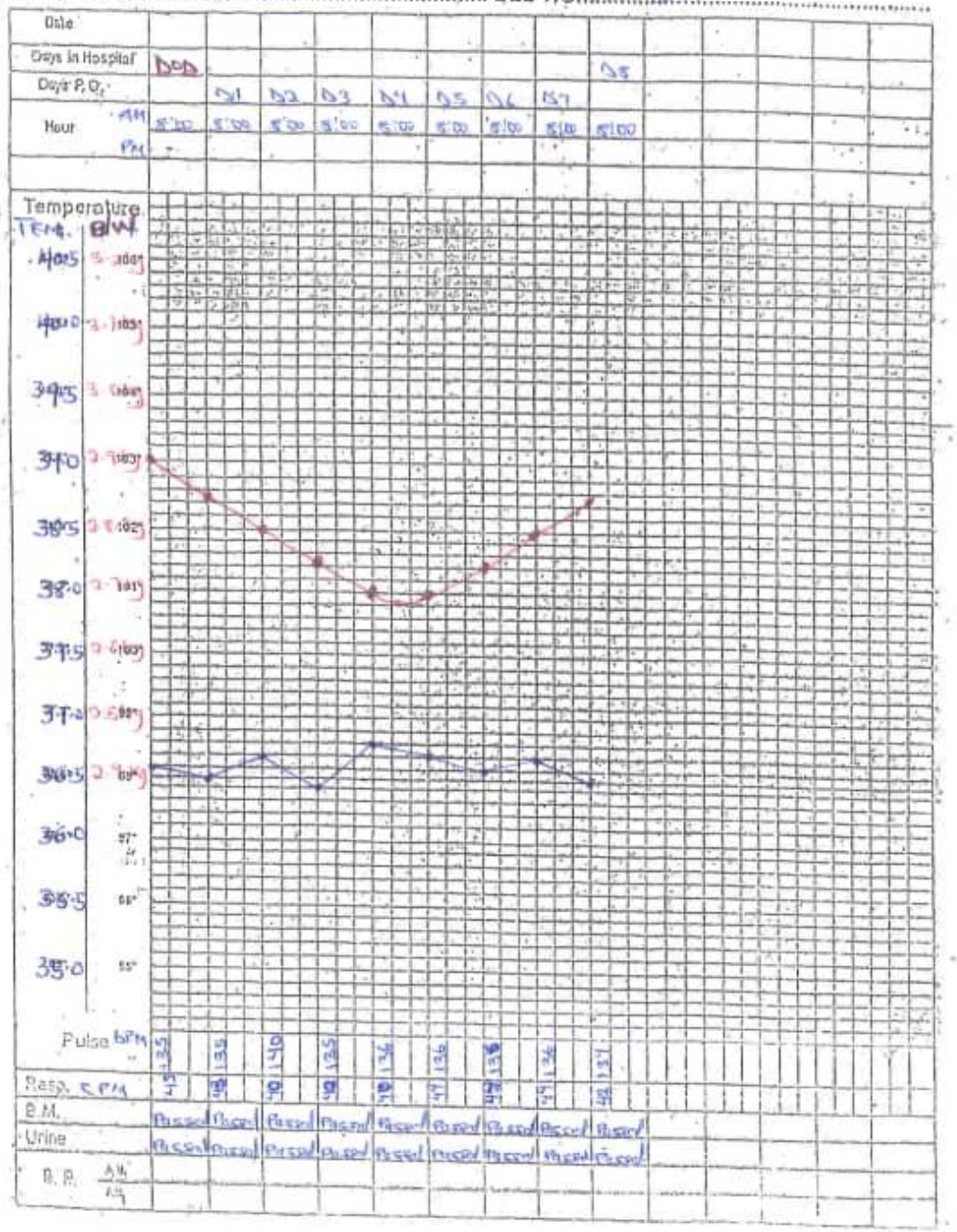
Classification: (Overall assessment) [ ] Normal [ ] Baby with a Problem [ ] Danger Sign/ <1500g/ severe Jaundice
Plan: [ ] Routine Care[ ]Problem, Continue supportive in-patient care [ ] Urgent Referral / Advanced Care[ ] Discharge

TEMPERATURE CHART

NAME: Baby of Atena Mabel

AGE: New Born WARD: Lying In Ward

IP NO.: 8571/22 BED NO.: 3



SIGNATORIES

STUDENT

NAME: AKUOKO ABIGAIL

SIGNATURE: .....

DATE: .....7th June, 2024.....

MIDWIFE IN-CHARGE: (KOKOA HEALTH CENTRE)

NAME: ` MRS.BOAHEN FRANCISCA

SIGNATURE.....(for)

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

SUPERVISOR:

NAME: MARTHA KYEREMAA

SIGNATURE: .....

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

PRINCIPAL

NAME: MONICA NKRUMAH

SIGNATURE.....

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

PRINCIPAL
HOLY FAMILY NURSING AND
MIDWIFERY TRAINING COLLEGE
BEREKUM