HOLY FAMILY NURSING AND MIDWIFERY TRAINING COLLEGE, BEREKUM

A CLIENT/FAMILY CENTERED MATERNITY CARE STUDY ON MADAM OFORIWAA EMMANUELLA

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PREFACE

A family centered maternity care is a tool that allow the midwife to put into practice the skills and acknowledge which has been acquired during her training to provide services to mother and baby and as part of the Nursing and Midwifery Councils of Ghana's requirement for awarding midwifery students a certificate, every student Midwife is required to undertake this care study to be qualified for the certificate. Students therefore receive training in midwifery as a basic course for three years within which theoretical and practical knowledge is impacted into them and also acquire skills needed in providing holistic care for a woman and her family in pregnancy, labour and puerperium. This care study gives the student midwife the opportunity to utilize the knowledge and skills she has acquired during her training to give quality care to all her clients including her chosen client.

For quality care and prevention of complications, student midwife is made to understand the concept properly for prompt intervention to help identify and manage problems early enough in pregnancy, labour and puerperium. The Client/Family Centered Maternity Care Study is a systematic and thoughtful approach designed to provide accurate and holistic obstetric care to an expectant mother and her family based on the understanding of the knowledge of the client as a unique individual with specific problems and needs throughout the period of pregnancy, labour, delivery and puerperium with the use of the nursing process. This care study helps the student midwife to gain client's confidence without any fear or doubt.

The focus of this booklet is therefore on the selection of a client and also to appreciate her as a unique individual with special needs peculiar to herself and the family. During these interactions, the client gets the opportunity to express herself in order to gain quality care to her satisfaction and to allay her anxiety and fears.

The care study enables the student midwife to use the new trends in midwifery like the use of partograph to monitor labouring mothers during labour.

This partograph is a tool developed by World Health Organization (WHO), which when used correctly helps reduces the menace of maternal death in the country. The active management of third stage of labour was introduced to limit the occurrences of postpartum hemorrhage.

As qualified midwives and students render quality care through establishment of rapport, health education, counseling and notifying deviations from normal during pregnancy till end of puerperium, maternal and infant mortality could be reduced.

ACKNOWLEDGEMENT

I would like to acknowledge the immense contribution of the following people towards the success of this care study. My profound gratitude goes to the Almighty God for seeing me through this great exercise by providing me wisdom, knowledge and strength.

My sincere gratitude goes to the Principal of the college, Ms. Monica Nkrumah for guidance, kindness and patience that she granted to me during this study. I wish to express my sincere gratitude to all the teaching and non- teaching staff of The Holy Family Nursing and Midwifery Training College, Berekum in Bono Region of Ghana for their encouragement. I would also like to express my sincere gratitude to my supervisor Ms. Ernestina Mensah for the editing, construction, critics and contributions towards the success of this care study.

My sincere appreciation goes to the midwife in-charge, Mrs. Ophelia Asantewaa the midwife in charge at Wenchi Methodist Hospital in the Bono Region and other supportive staff members who co-operated with me so much in the course of this exercise.

I am also very grateful to my client Madam Oforiwaa Emmanuella and her family, for offering me the necessary information to recounting and understanding this script.

I am particularly indebted to my dear lovely parents Mr. and Mrs. Manu-Gyan and my siblings for their support and love for me, who offered me a peace of mind throughout this my care study period by providing me with both financial and psychological support and my friends especially Nana Asuman who help me in one way or the other to finish this script. May God richly bless them and give them long life to reap what they had sown.

Finally, the authors and publishers of the various books used as references cannot be left out, I am grateful.

INTRODUCTION

This client centered care study is the details of the care rendered to Madam Oforiwaa a 33year old married woman who is Gravida 3 Para 2 all alive as of the time of first contact. She visited the Antenatal clinic on the 11th November 2022. After glancing through her card, the records indicated that she could be used for the study, so permission was sought from her and she agreed. She was cared for during the antenatal period and was visited home to assess her environment and community in which she lives.

Madam Oforiwaa's problems identified throughout the period were managed. Throughout the period of pregnancy, labour and puerperium however, a comprehensive approach of considering her physical, psychological, social and economic status was used in caring for her. The information gathered from her Antenatal records, herself, and family helped to render an individualized and appropriate care. In this script however, is compelled into four main chapters.

Chapter one contains information on client`s particulars thus histories and lifestyles which helped to get more information about the client and be able to take care of her appropriately, as well as ensuring individuality and uniqueness of the client.

Chapter two also deals with the Antenatal care of the client from the day of first visit up to the time labour began. It also contains the care plan problems identified during this period.

The third chapter deals with the time labour began, the management of the various stages of labour as well as immediate care of the newborn and at the end also contain care plan managed during that period.

The last chapter, being chapter four also gives information about the puerperium, the care given to the client and the new born baby up to forty days.

In addition to these, are the various care plans for the client at each stage of physiological and psychological process of pregnancy, labour and puerperium, followed by summary and

conclusion, bibliography, appendix, complete diagnostic investigation, pharmacology of drugs for the mother and the baby, Antenatal records, labour records, postnatal records and signatories.

LITERATURE REVIEW

PREGNANCY

According to Tiran, D. (2012) pregnancy is from conception to delivery of the fetus; normal duration is 280 days (40 weeks or 9 months and 7 days), counting from the first day of the last to delivery or 265 days from conception to delivery.

According to Marshall and Raynor (2014) pregnancy is divided into three trimesters. The first trimester is from conception until 12 weeks of gestation. The phase is associated with changes such as breast tenderness and feeling nauseated. The second trimester starts from 13 weeks to 25 weeks where pregnancy is noticed physically as the woman's body make-up changes to adjust to the pregnancy. The third trimester is from 26 weeks to 40 weeks, a period when the fetus continuous to grow and become matured for delivery. Care must therefore be taken once pregnancy has been confirmed so that the woman carries the pregnancy to term successfully.

According to Weller (2014), pregnancy is being with a child, the condition from conception to expulsion of the foetus. The normal period is 280 days or 40 weeks counted from the first day of the last menstrual period.

Myles (2014) describes pregnancy as a unique experience for every woman and each pregnancy the woman experiences will be new and uniquely different, nausea and vomiting, constipation, heartburns, headache, leg cram are minor disorders of pregnancy. Changes in the urinary system during pregnancy occur as a result of enlarging uterus affecting all the parts of the urinary tract at various times with the hormones of pregnancy having an even greater influence than mechanical effects. Progesterone relaxes the walls of the ureters, and allows dilatation and kinking. In some women this can result in stasis of urine resulting in marked infection

King (2014) states that, the prenatal period covers the time from the first day of the last menstrual period to the start of true labour, which marks the beginning of the intrapartum

period. Prenatal period is divided into trimesters, the first trimester is 1to 12 weeks because organogenesis is completed at the end of twelve weeks (12) and the risk for spontaneous abortion is significantly reduced at this time. Second trimester is 13 to 28 weeks, third trimester extends from weeks 28 to 40. The term 'post- date' is typically used to describe a pregnancy beyond forty weeks (40)

According to Oduro-Kwarteng (2015), pregnancy is the condition of having a developing embryo or foetus in the uterus as a result of the union of an ovum and spermatozoa. Pregnancy can occur any time after a female begins to menstruate (menarche) in conjunction with ovulation until she reaches menopause where ovulation ceases.

LABOUR

According to Jacob (2013), labour is the process that involves a series of integrated uterine contractions that occur over time, and work to propel the product of conception (foetus, placenta and amniotic fluid) out of the uterus through the birth canal.

Konar (2013) states that, labour is the process by which the fetus, placenta and membranes are expelled through the birth canal. The events of labour are divided into four stages: First stage starts from the onset of true labour pains and ends with full dilation of the cervix. It is in other words the 'cervical stage' of labour. Its average duration is twelve hours (12) in prim gravida and (6) in multipara. Second stage starts from dilation of the cervix (not from the rupture of membranes) and ends with expulsion of the fetus from the birth canal. It mostly last up to 30 minutes in multiparous and 60 minutes in nulliparous women. Third stage begins after delivery after delivery of the fetus and ends with the expulsion of the placenta and membranes. Its average duration is about 15 minutes in both primigravida and multipara. Fourth is the stage of observation for at least one (1) hour after expulsion of product of conception. During this

period, general condition of the patient and the behavior of the uterus are to be carefully monitored.

Marshall& Raynor (2014) stated that labour in the physical sense as the process by which the fetus, placenta and membranes are expelled through the birth canal. Normal labour occurs between 37 to 40 weeks of gestation. Labour begins when there are regular, painful contractions and with cervical dilatation. Signs and symptoms of labour are painful regular contractions, show, progressive dilation of the cervix, and sometimes ruptured membranes. First stage of labour begins with cervical dilatation which begins with rhythmic contractions until the cervix is fully dilated. This stage is in two phases, the latent phase is 0 - 3cm and the active phase starting from 4cm – 10cm when the cervix is fully dilated with both phases lasting from 8-12hours. Second stage of labour begins with the expulsion of the foetus from the birth canal. It begins when the cervix is fully dilated and the woman feels the urge to expel the foetus. It is however complete when the baby is born. This last from 30 minutes to 1 hour. The third stage is the separation and the expulsion of the placenta and its membranes as well as arrest of haemorrhage. From the above, it can be deduced that labour is a physiological phenomenon which can be managed by the midwife with the use of partograph, aseptic delivery process and active management of third stage of labour (control cord traction).

Myles (2014) describes labour as the process by which the fetus, placenta and membranes are expelled through the birth canal. It also explained that the first stage of labour can be divide into 3 stages namely;

- The latent phase which is prior to the active phase of first stage of labour and may last for 6-8hours in primigravida when the cervix dilates from 1cm to 3cm and to cervical canal shortens from 3cm long to less than 0.5cm long.

- The active phase which is the time the cervix undergoes more rapid dilations. This begins when the cervix is 4cm dilated and the presence of rhythmic contractions, is completed when the cervix is fully dilated (10cm).
- The transitional phase which is the stage of labour when the cervix is from around 8cm dilated until it is fully dilated or the until the expulsive contractions of second stage are felt by the woman. There is often a brief lull in the intensity of uterine activity at this time.

According to Tiran (2015), normal labour occurs spontaneously after 37 weeks' gestation with vertex presentation of single foetus, completed within 24 hours without maternal and foetal trauma; physiology depends on interaction between uterus, maternal pelvis and foetus.

PUERPERIUM

According to Jacob (2013), puerperium is a period following childbirth during which the body tissues especially the pelvic organs reverse back approximately to the pre-pregnant state both anatomically and physiologically, he further explained that, the post-partum period is divided in immediate puerperium that is the first 24 hours early puerperium from the end of all 24 hours up to 7 days. Remove 8 from the end of 7 days up to 6 weeks.

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

- ❖ Lochia rubra; red, 1-4 days
- ❖ Lochia serosa; pink or pale brownish, 5-6 days
- ❖ Lochia alba; pale white, 10-15 days

Konar (2013) also added that, the average amount of discharge for the first 5-6 days is estimated to be 250ml, normal duration extends up to 3 weeks.

American Academy of paediatrics (2014) cited in their provider guide: Essential Care for Every Baby that all babies must be given eye care by instillation of tetracycline/chloramphenicol eye drop/ointment to prevent eye infection and also administering of vitamin K injection to prevent haemorrhage disease of the new born as well as cord dressing.

Marshall and Raynor (2014) stated that puerperium starts immediately after the delivery of the placenta membrane and continues for six weeks. In many cultures around the world, 40 days for recuperation is a time-honoured practice. The general expectation is that by six weeks after birth all the systems in a woman's body will have recovered sufficiently from the efforts of the pregnancy and recovered to their non-pregnant state.

Oduro-kwarteng (2015), defines puerperium as a period that start immediately after delivery of the placenta to 6-8 weeks. This period is characterized by a lot of physiological changes, some of which include the following; lactation is well established, the productive organs return to the non-pregnant state.

According to Tiran (2015) puerperium is a period of six to eight weeks following childbirth during which the uterus and other organ structures return to their non-pregnant state.

Myles (2014) stated that 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. Myles strikes the difference between exercise and healthy activity verses rest, relaxation and sleep. Exploring each person's level activity will encourage advice in relation to appropriate exercise and by association, nutritional intake and rest or relaxation and sleep. Undertaking regular pelvic floor exercise is of benefit to the woman's long-term health. Myles mentioned that, regardless of

whether women are breastfeeding, they may experience tightening, and enlargement of their breast towards the 3rd or 4th day. Hormonal influences encourage the breast to produce milk. For women who are breastfeeding the general advice is to feed the baby and avoid excessive handling of the breast. Simple analgesics may be required to reduce the discomfort.

WHY CLIENT WAS CHOSEN

Madam Oforiwaa G3P2A was chosen as a client on 11th November, 2022 at the Methodist Hospital, Wenchi in the Bono East region, during one of her usual antenatal visits. She was 36 weeks pregnant. During interaction, client was worried of having severe waist pains. Upon her complains decision was made to educate the client on the cause of waist pains in late pregnancy. Knowing that is one of the physiological changes in late pregnancy decision was made to take her as a client in order to support her. Introduction was made as a student from Holy Family Nursing and Midwifery Training College, Berekum and was at the hospital for practical experience. Permission was sought from her to be taken as a client for the care study which she accepted. Client was shown to the in charge and approval was given to use her for the case study. All the necessary particulars were collected. Appointment for home visit was booked, direction to her house was given and phone numbers were exchanged. Client was thanked and she left.

CHAPTER ONE

CLIENT PARTICULARS

1.0 INTRODUCTION

This chapter gives an overview about the client and the family. It comprises personal, social, family, medical, surgical, menstrual, client lifestyle, past and presents obstetrical histories.

1.1 SOCIAL HISTORY

Madam Oforiwaa, a 33-year-old Gravida 3 Para 2^{AA} woman lives in Wenchi in Bono region. She stays with her husband and her two children (two males) at her husband's residence. Client is fair in complexion, 155 centimeters in height with average weight of 72kilograms. Her highest form of education is the Senior High School and she is a trader. She is a Christian. Her parents, husband and her siblings are all Christians.

She is married to Mr. Ansah for eleven years now, who is a driver. Madam Oforiwaa's favorite food is banku and okra stew. She speaks Bono Twi. According to Madam Oforiwaa her next of kin is her elder's son. She does not smoke nor take alcohol.

1.2 FAMILY HISTORY

Madam Oforiwaa is the seventh born among the 10 children of Mr. Ofori and Madam Grace. Out of the ten children nine are alive. After an extensive conversation with the client, it was noticed that her family does not have any known history of inherited condition such as heart diseases, hypertension, sickle cell disease, diabetes, asthma, mental illness and also no congenital abnormalities like cleft lip and palate, missing digits or extra digits has yet been noticed. She said there is no history of multiple pregnancies in her family as well. And also added that deaths in the family to the best of her knowledge has always been natural.

1.3 MEDICAL HISTORY

According to Madam Oforiwaa, she has no known medical condition like heart disease, Hypertension, tuberculosis, epilepsy, asthma, diabetes etc., and that she has never been hospitalized. Client said she occasionally suffers from mild headache, general body pains and malaria for which she takes it to the hospital for medical treatment. She has no known allergy to any drug or food.

1.4 SURGICAL HISTORY

Madam Oforiwaa has never undergone any kind of surgical operation. According to client, she had never been involved in accident of any kind which could affect her pelvis. Client has never been transfused, neither has she donated blood.

1.5 MENSTRUAL HISTORY

According to Madam Oforiwaa, she attained her menarche at the age of sixteen (16) years and has a regular menstrual cycle of twenty-eight days. Client`s menstrual flow is moderate and lasts for five days with no dysmenorrhea. Madam Oforiwaa had never experienced any menstrual disorder.

1.6 CLIENT'S LIFESTYLE/HOBBIES

Madam Oforiwaa wakes up around 5:30am and returns to bed at 9:30pm. When client wakes up in the morning, she prays, after which client sweeps her compound and then fetches water at nearby pipe and brushes her teeth with toothbrush and toothpaste (pepsodent). Client prepares breakfast for the family. Client takes her evening bath at 6:00pm and goes to bed around 9:30pm. Madam Emmanuella likes to socialize a lot. Client said she urinates frequently and empties her bowel twice a day. She likes Banku and okra stew.

Client also said she eats at least three times a day. Every evening after meals, she always washes the utensils and baths her children.

According to her, she attends evening church service on Wednesdays and Fridays and Mass on Sunday. As part of her favorite hobbies, client likes listening to gospel music and according to her mother, client likes talking too much. Madam Emmanuella is sociable and likes laughing all the time. Madam Emmanuella is in good terms with everybody in her house and the neighborhood. Client dislikes gossips, liars, alcoholics and smokers.

1.7 PAST OBSTETRICAL HISTORY

PREGNANCY

Madam Oforiwaa G3P2^{A} has never experience any abortion before being it spontaneous or induce and added that, she carried both the first and second pregnancies to term. According to client, she has never experienced any complications in pregnancy such as gestational diabetes, pregnancy induced hypertension, eclampsia, anaemia etc. but she experienced some minor disorders such as, mild vomiting, headache and frequency of micturition which subsided after delivery. She had no danger signs of pregnancy such as severe abdominal pains, severe anaemia, and bleeding, severe frontal headache, severe vomiting too and added that she eats well during all her pregnancies. Client said she attended antenatal clinic during her previous pregnancies till labour was due. Client said in her first pregnancy, she received five doses of sulphadoxine pyrimethamine (SP) but in the second pregnancy she remembers she took SP till delivery and received three doses in all for of tetanus immunization during her previous pregnancies. Client said the intervals between her first child and her second child is four years.

LABOUR

According to client all her labour started spontaneously at night in the house before she was sent to the hospital.

She said all her babies were delivered at the hospital spontaneously when labour was due with no complications such as retained placenta and postpartum hemorrhage. Client said she did not labour for a long time because, she usually delivers shortly after their arrival at the hospital.

When asked, she said that it does not also take long for the placenta too to be delivered in both the first and second deliveries and the amount of blood loss was small in both deliveries. Her babies cried immediately after delivery.

PUERPERIUM

According to madam Oforiwaa, her babies cried immediately they were delivered. She said she had her first born on the 20th May, 2013 and it is a male with birth weight of 2.8 kilograms. The second born was delivered on the 14th June, 2017 with the birth weight of 3.1 kilograms and that is a male. Client said she breastfed her babies exclusively for six (6) months after that she introduce them to complementary feeds and finally weaned them at the ages of 2years. All her babies were immunized against the childhood preventable diseases at the Wenchi Methodist Hospital. Client went through puerperium successfully without any complications such as breast abscess, depression and puerperal psychosis.

Client's babies also went through puerperium successfully without any complications. Client was asked if she had any knowledge about family planning during her previous pregnancies and she answered positively but she has never used any before. Client was then educated that breastfeeding is another form of family planning method since client said she breastfeeds exclusively for six months. Client said her sweet mother Grace and her husband has been her support over the years in the postnatal period.

1.8 PRESENT OBSTETRICAL HISTORY

Madam Oforiwaa's first visit to the Hospital was on the 24nd of June, 2022 when she was in her 16th weeks of gestation. Her last menstrual period was 8th March 2022, and her EDD was calculated as 15th December 2022 but her first ultrasound scan gave expected date of delivery as 10th December, 2022. She said she noticed the movement of the fetus (quickening) at the 16th week of gestation and the movement became stronger as the pregnancy advanced. According to the client she experienced minor disorders of pregnancy like nausea and

vomiting, excessive salivation, pica and frequency of micturition which are normal physiological changes in pregnancy. She was educated on exercise, personal and environmental hygiene, malaria and nutrition. Her vital signs and other assessments were recorded as follows;

Temperature	-	36.2oC,
Pulse	-	73bpm,
Respiration	-	19cpm,
Blood Pressure	-	107/73mmHg,
Weight	-	64kg,
Height	-	155cm
fetal heart rate	–	142bpm,
Heamoglobin	–	13.8g/dl,
Rhesus factor	–	Positive,
Blood Grouping	-	AB,
Sickling	–	Negative,
Human Immune Virus (HIV)	–	Negative,
Syphilis	-	negative
6Glucose 6Phosphate Dehydrogenase	-	No defect,
Stool Test	-	No abnormalities detected,
Urine Albumin and Glucose	–	Negative,

Hair to toe examination was carried out with no abnormalities detected

Symphysio-fundal height measured 38cm. Client complained of backache and she was educated on sleep, rest and exercise. She was given the following treatment;

Tablet ferrous sulphate (fersolate): 200mg daily x 30 days, to treat low blood level of iron, which may lead to complications such as preterm delivery, low birth weight and infant mortality.

Tablet multivitamin: 200mg daily x 30 days, for the health of the mother and good health of the baby.

Tablet folic acid 5mg: daily x 30 30 days, it helps prevent neural tube defects such as spinal bifida and also reduce the risk of other birth defects such as cleft lip, cleft palate and heart defects,

Tetanus diphtheria immunization 1st dose was given on 8/07/22 and the 2nd dose was on 5/08/20. Sulfadoxine pyrimethamine (SP) 1st dose was given to her on the 19th August, 2022, when she was 24weeks of gestation because She was told that (SP) wasn't available during her previous visits, second dose was given to her on the 16th of September, 2022, when she was 28 weeks of gestation, the third dose was given on 14th of October, 2022 when she was 32 weeks of gestation, to protect her and the foetus against malaria.

CHAPTER TWO

ANTENATAL CARE

2.0 INTRODUCTION

This chapter describes the first contact with client, home visits, monitoring and education given to the client, problems identified and the nursing care plan used to address those problems identified during the antenatal period.

2.1 FIRST CONTACT WITH CLIENT

The first contact with Madam Ofoiriwaa was on the 11th November 2022 at Methodist Hospital Wenchi around 10:50am. She was welcomed and a seat was provided to her and her Antenatal card was taken to flip through. Her gestation was 36 weeks and she had visited the clinic for five (5) times. Client was worried of having severe waist pain.

Introduction was made as a student midwife on clinical field from Holy Family Nursing and Midwifery Training College, Berekum and would like to take her as a client to support her physically and psychologically through this later part of pregnancy, labour and puerperium. She readily agreed and asked whether she was going to get the attention she needed and she was assured of maximum attention. She was thanked and assured of confidentiality. She was also encouraged to share every problem of hers. Client was then introduced to the midwife in-charge for her approval and she consented to it. The procedures to be carried out on her were explained to her to gain her cooperation. Weight was 72kilograms and the following vital signs were taken and recorded as;

Temperature	36.7 degree Celsius,
Pulse	82 beats per minute,
Respiration	20 cycles per minute and
Blood pressure	110/60 millimeters of mercury.

Haemoglobin	12.7g/dl

Urine was taken to test for protein and glucose and it all tested negative. The findings were explained to her afterwards, it was documented.

PHYSICAL EXAMINATION

The procedure for head-to-toe examination was explained to her and she was asked to empty her bladder in preparation for the examination if she has the urge. She was assisted onto the examination couch whiles privacy was provided. Hand washing was done and dried with a clean dry towel. Hands were then rubbed together to provide warmth. The examination proceeded systematically from head to toe.

The head was examined first for lice, dandruff and other infections of the scalp and also to detect hair loss or breakages but none was detected. Client was then encouraged to continue keeping her hair clean and neat. The face was also examined for the presence of oedema. The eyes were examined for pallor, jaundice and discharges. The mouth for cracked lips, sore and also pallor, halitosis, tooth decay and tongue also for pallor. The ears were examined for pain, discharges and its alignment. The nose was examined for discharges and none was detected.

The neck was also examined for enlarged thyroid gland, distended neck veins and enlarged lymph nodes. Everything was in good health and nothing abnormal was detected. As the examination was going on, she was engaged in conversation to avoid boredom.

On breast examination, the breasts were first exposed and observe the colour, alignment, size and abnormality of the nipple. Then one breast was covered and Madam Martha was asked to put her hand under her head to examine her breast for presence of lumps and any abnormal discharge by palpation but no abnormality was detected. She was educated on how to examine her breast a week after menstruation, so as to detect any abnormality early enough for appropriate action to be taken. Cotton wool was put on the nipple and the areolar was squeezed to check for any abnormal discharge which was absent.

The upper extremities were examined for equality and alignment with the body and whether there is any oedema present but no abnormality was detected. The fingers were checked for over grown nails, dirt and pallor of her palms, then her nail bed capillary refill but all these were absent and she was encouraged to continue her cleanliness.

The lower extremities were examined for varicose veins, oedema, and tenderness in the calf muscles and varicose veins were noticed and were explained to her to be normal during pregnancy and it resolving gradually possibly after delivery. She was asked to turn her back for inspection and palpation but no sacral oedema was palpated. The hands were washed and dried.

Abdominal examination

On abdominal inspection, the shape and size of the abdomen was oval and medium. There was no scar except for some very few traces of straie gravidarum and linea nigra. Fetal movement was also observed.

During measurement of the symphysio-fundal height, the upper border of the symphysis pubis and the fundus were located and the zero mark of the tape measure was placed on the fundus and extended along the contour of the abdomen along the midline to the upper border of the symphysis pubis. The symphysio-fundal height measured 38centimeters and gestation was 36weeks**.**

On fundal palpation, whilst standing at the client's right side and facing the head end of client, each palm was placed on either side of the fundus. The fingers were curved around the top of the fundus to determine what was in the fundus. A soft mass was felt which indicated the buttocks.

During lateral palpation, each palm was placed on each side of the uterus at the level of the umbilicus. One hand was used to stabilize the uterus using a rotatory movement of the other

hand to map out the back which was smooth at the mother's right side, the same movement was done to reveal the limbs which were rough on the left side of the mother.

On pelvic palpation, upon facing the woman's feet, she was asked to bend her knees slightly and also to breathe through her mouth slowly to help her relax the abdominal muscles. Each palm was placed on either side of the uterus, just below the umbilicus, hands directing towards the symphysis pubis as the thumbs were almost meeting, a hard mass was felt indicating the head of the foetus.

During the assessment of descent, location of the anterior shoulder was done and two fingers were placed on it which was 2cm below and away of the umbilicus. The upper border of the symphysis pubis was also located and with the ulna border of the right hand placed on the upper boarder of the symphysis pubis. Five fingers were accommodated between the symphysis pubis and the anterior shoulder, indicating a descent of 5/5 above the pelvic brim. The lie was longitudinal, presentation was cephalic, and the position was right occipito anterior.

On auscultation, fetal stethoscope was rubbed in the palm to make it warm. It was placed at the area where fetal back was located. The ear was placed against the fetal stethoscope to listen for fetal heart beat for a minute as it was being compared with maternal pulse. The fetal heart rate was144 beats per minute.

Vulva Examination, permission was sought to inspect the genital area and she agreed. Hand washing was done with soap under running water and cleaned with a clean towel. She was then asked to bend her knee and open the thighs. The mons pubis was well shaved; there were no scars, oedema, genital warts, clitorectomy and no abnormal discharges from the vagina. All findings were communicated to her and she was thanked for her cooperation. Client was encouraged to continue keeping the vulva clean and dry, change panties after bathing, wear cotton panties and avoid douching. Madam Oforiwaa was helped to get off the examination

bed, as she turned to her left side, sit up before getting out of the bed. She was encouraged to ask any questions bothering her mind and she smile and said no question.

She had no complained aside the waist pain. Client was reassured and educated that it was all due to the pregnancy. She has some slight pedal oedema so she was encouraged to stand for short periods, elevate her legs when sitting or sleeping and to do active exercise like walking to prevent circulatory stasis in the lower extremities as well as strengthen the muscles during pregnancy and delivery. She was also educated to lie on her left side when sleeping to prevent supine hypotensive syndrome and also encouraged to wear low heels to reduce the waist pains. She was however congratulated and the following tablets were given to her.

- Tablets multivitamins 200mg daily for 7 days
- Tablet folic acid 5mg daily for 7 days
- Tablet ferrous Sulphate 200mg daily for 7 days
- Tablet paracetamol 1000mg 3 times daily for 7 days.

The next visit on 18st November, 2022 was made known to her and also to report to the hospital when there was any problem even if her next visit was not due. Appointment for home visit was also booked with her and she gave the direction to her house and her phone number was collected. Finally, she was goodbye at the hospital gate.

2.2 FIRST ANTENATAL HOME VISITS

The first visit to Madam Oforiwaa home was on the 14th November, 2020 at 4:30pm. The main purpose for the visit was to assess the physical environment in which the client lives.

The environment was inspected before entering the house. On arrival, greetings were exchanged and seat was offered by client.

Client introduced me to her mother and husband. The whole family was very happy.

The house is built with blocks and roofed with aluminum sheets. The house has two bed rooms, a hall, bathroom and a toilet facility. Client lives with her nuclear family. Client and her husband occupy one room and the other is being occupied by her two children.

She was asked of her preparedness towards labour and delivery and she said she would have no problem with transportation to the hospital since her father own's 'okada'. Her delivery items were well packed on inspection except her health insurance. Client was educated on the important of adding her health to the items earlier to prevent forgetfulness.

PHYSICAL

Client's room was well ventilated and her source of light was electricity. Client's windows were lined with louvers and mosquito proof net. She sleeps under insecticide treated net every day. The entire house was neat and client had a cordial relationship with the family. They have a nice toilet and bath which was well cemented and neatly kept. The refuse container was lined with polyethylene bag and well covered so she was congratulated to maintain it. There was a kitchen also attached to the building. They use fire wood in preparing their food

PSYCHOSOCIAL

Madam Oforiwaa and her family have a cordial relationship with each other. She has a warm and friendly relationship with her neighbours. Her friends most at times visit her and also visit them at her leisure time. She has respect for humans and likes to make new friends. She attends social gathering like funeral and wedding ceremony at all times. She introduced me to her neighbours and friends.

. She was educated on sibling rivalry and client was informed that she should start telling the children about the arrival of the new baby. Good communication with the children was also encouraged and she was also educated on danger signs of pregnancy such as vagina bleeding, early rupture of membranes and severe vomiting. She was asked to report immediately if any of the danger signs was experienced. Client was also asked of any complaints of which she

complained of insomnia. She was assured and educated on measures to adopt to cope with the complaints such as drinking less water before bed, urinating before bed, taking warm baths before bed and resting during the day. The next visit was made known to her and permission was sought to leave.

2.3 SECOND ANTENATAL HOME VISITS

The second antenatal home visit was on the 20th November, 2022 at 5:10pm. Greetings were exchanged and seat was offered. The aim of the visit was to check on the improvement on the previous advice given during the first visit. Education was reinforced on rest and sleep, birth preparedness and complication readiness such as transportation readiness, arrangement of donors and support person. She was also educated on true labour signs such as painful rhythmic uterine contractions and show. Client was congratulated for taking the advice. Client`s mother and husband were educated to help her psychologically and physically. She was reminded of her next visit to the clinic.

2.4 CLIENT'S SUBSEQUENT VISIT TO THE CLINIC

Madam Oforiwaa visited the clinic on the 18st November, 2022 at 9:45am. She was welcomed and seat was offered to her to rest for a while. Enquiries were made on her health and that of the entire family and she said all was well. The Antenatal card was glanced through and her vital signs and other assessments checked and recorded as follows:

Temperature 36.8 degree Celsius,

Pulse 84 beat per minute,

Respiration 20 cycles per minute,

Blood pressure 116/74 millimeters of mercury,

Weight 78kilograms

Urine for glucose and protein was negative.

She was told to empty her bladder and every procedure to be carried out was explained to her and privacy was provided. Physical examination was done on her. All findings were communicated to the client. She complained of backache and headache. She was reassured and educated on the physiological changes that occur during pregnancy. It was also explained to her that, she should ben from the knees and try to avoid stressful situations and was reassured.

Madam Emmanuella medications were as follows:

Tablet folic acid 5mg daily for 7 days

Tablet Ferrous Sulphate 200mg daily for 7 days

Tablet multivitamins 200mg daily for 7 days

2.5 NURSING CARE PLAN DURING ANTENATAL CARE

PROBLEMS IDENTIFIED ON

On 11th November, 2022 client complained of;

1. fatigue

On 14th November, 2022 Client complained of;

2. increase vaginal discharges

On 18st November 2022, client complained;

3. of heart burns

On 20th November, 2022 Client complained of;

4. body discomfort

On the 25th November, 2022, client complained of

5. interrupted sleep

SHORT TERM OBJECTIVES:

1. Client will be relieved of fatigue within 72 hours
2. Client will be relieved of increased vaginal discharge within 24 hours

3. Client will be relieved of heart burns within 24 hours
4. Client will be relieved of body discomfort (backache) after delivery
5. Client will be relieved of interrupted sleep within 24 hours

LONG TERM OBJECTIVE:

Madam Oforiwaa will carry the pregnancy to term, go through labour and puerperium with all the support needed to prevent complications to herself and the foetus.

NURSING CARE PLAN DURING ANTENATAL CARE

TIME	DIAGNOSIS	NURSING OBJECTIVE/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTIONS	DATE/ TIME	EVALUATION	SIGN
11/11/22 9:00am	fatigue related to advance stage of pregnancy	Client's fatigue will reduce within 48hours as evidenced by client verbalizing that she feels strong	1.reassure client that she is in safe and in competent hands 2.encourage client to rest at least 2hours during the day. 3.encourage client to limit activities at home. 4.encourage client to eat energy giving foods to boost her energy and reduce fatigue 5.encourage client to get support during her pregnancy.	1.client was reassured that she will feel strong after delivery 2.client rested in between activities 3.client limited her activities at home 4.client was taking adequate carbohydrate foods to gain energy. 5.client was supported by her spouse in her daily activities	13/11/22 8:50am	Goal fully met as client verbalize that she feels strong.	

ANTENATAL CARE PLAN CONTINUED

DATE/ TIME	NURSING DIAGONOSIS	NURSING OBJECTIVES/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/T IME	EVALUATION	SIGN
14/11/22 9:15am	Increased vaginal discharge related to physiological change in pregnancy.	Client will be able to cope with increase in vaginal discharge throughout pregnancy as evidence by client verbalizing that she is coping	1. Reassure client that the situation is temporal. 2. Explain the importance of keeping her perineum clean. 3. Educate the client to wipe the anus from anterior to posterior after defecation. 4. Educate client to bath at least twice a day to keep the perineum clean. 5. Educate client to wear loose cotton underwear with panty liners.	1. Client was assured that it will subside after delivery 2. She has been educated on the importance of keeping her perineum clean. 3. Client has been educated to wipe the anus from front to back. 4. Client has been educated to have her bath at least twice a day. 5. Client was wearing cotton underwear with panty liner.	14/11/22 10:15am	Goals fully met as Madam Oforiwaa verbalized that she is coping with increased vaginal discharge.	

ANTENATAL CARE PLAN CONTINUED

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTIONS	DATE/ TIME	EVALUATION	SIGN
18/11/22 9:00am	Heartburns related to relaxation of the cardiac sphincter of the GIT due to the effects of progesterone	Client's heartburns will resolve within 24 hours as evidenced by 1. Client verbalizing that she is relieved of the burning sensation in her chest. 2. Midwife visualizing that client expressed no sign of burning sensation.	1. Educate client on the physiology of heartburns. 2. Encourage client to relax for some time before lying down to sleep after eating. 3. Encourage client to reduce intake of oily, spicy and fatty foods. 4. Educate client to eat early. 5. Serve antacid as prescribed	1. Client was told it was caused by relaxation of the cardiac sphincter of the GIT due to the effects of progesterone. 2. Client relaxed for at least two hours after eating before lying down to sleep. 3. Client reduced the intake of oily, spicy and fatty foods. 4. Client was encouraged to eat at least two hours earlier than she used to. 5. Magnesium tricilicate was served as prescribed.	19/11/22 11:00am	Goals fully met as client was relieved of burning sensations in the chest.	

ANTENATAL CARE PLAN CONTINUED

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
20/11/22 9:50am	Backache related to structural a change that occurs as pregnancy advances.	Client's backache will be subside and client will be able to cope with backache throughout pregnancy as evidence by client verbalizing that the pain has subside.	1. Reassure client. 2. Explain the physiology of backache to the client. 3. Educate client to have rest and sleep. 4. Encourage client to perform manageable exercise. 5. Encourage client to sit with her back supported with pillow.	1. Client was reassured of relieved of pain. 2. The physiology of backache was explained to the client. 3. Client had 2 hours rest and sleep daily. 4. Client performed manageable exercise such as squatting and walking. 5. Client always sat with her back supported with pillow.	20/11/22 8:25pm	Goal was fully met as client Verbalized that she was relieved after delivery	

ANTENATAL CARE PLAN CONTINUED

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
25/11/22 9:50am	Insomnia related to frequency micturition at night	Client will be able to sleep within 72hours for at least an hour during the day and 3 hours a night throughout pregnancy as evidenced by client verbalizing that she is able to take a nap in the day and slept for 3 hours during night	1. reassure client 2. explain the physiology of frequent micturition to client. 3. educate client to take warm baths before going to bed to aid in easy falling asleep 4. encourage client to reduce the intake of fluid prior to bed time.	1. client was reassured that she will be able to sleep at nights 2. client is enlightened on physiology of frequent micturition in pregnancy as a reduction in bladder capacity by descending fetal head. 3. client took a warm bath to promote relaxation and aid in easy falling asleep 4. client reduce the intake of water and other liquids prior to bed time	28/11/22 9:50am	Goal was fully met as client verbalizing that she is able to take a nap in the day and sleep for 3 hours in the night	

CHAPTER THREE

LABOUR

3.0 INTRODUCTION

This chapter deals with the management of client during the first, second, third, fourth stages of labour. the immediate care of the new born and care plan for problems identified.

3.1 ADMISSION AND MANAGEMENT OF FIRST STAGE

Madam Oforiwaa came to the hospital on 9th December, 2022 at 4:59am accompanied by her husband and mother. They were welcomed and offered seats. Madam Oforiwaa complained of lower abdominal pains and painful uterine contractions which she said started at around 2:00am. Her answers to questions asked indicated that client had seen blood-stained mucus (Show) but membranes have not ruptured. Client's appearance indicated that she was truly in labour pains and her gait indicated that she had no abnormalities on her pelvis. During history taking, Madam Oforiwaa expressed some level of anxiety as to what the outcome of labour would be. Client's antenatal book was glanced through for previous histories and also to confirm client expected date of delivery and her gestation was 39 weeks +6 days. Client, her husband and her mother were then orientated to the ward and they were introduced to other colleague midwives on the ward and she was reassured of a successful outcome. Then at the delivery room, client was assisted to undress, changed into a gown and onto a delivery bed. Madam Oforiwaa was reassured and procedures to be done were explained to her for which she gave her consent. Her hemoglobin level was 12.9grams per deciliter; then client's vital signs were checked and recorded as:

Temperature 36.4 degree Celsius,

Pulse 82 beat per minute,

Respiration 20 cycles per minute

Blood pressure 120/80 millimeter of mercury.

Client was served with a bed pan to empty her bladder. The midstream urine was taken with a clean specimen bottle and the testing strip dipped into the urine. The strip was tapped at the edge of the bottle, compared with colours on the container and urine tested negative for protein, glucose and acetone. After Madam Oforiwaa was admitted, she was informed about the general and abdominal examination that was to be done on her. Hand washing was done and dried with a clean dry towel. The hands were then rubbed together to provide warmth. The examination proceeded systematically from head to toe. The head was examined first for lice, dandruff and also to detect hair loss or breakages but no abnormality was detected. The face was also examined for the presence of oedema. The eyes were examined for pallor, discharges and jaundice. Mouth for cracks, sore, halitosis and tooth decay. The ears were observed for discharges and felt for pain. The neck was also examined for enlarged thyroid gland, distended neck veins and enlarged lymph nodes or goiter. Everything was in good shape and nothing abnormal was detected. The upper extremities were examined for equality and both were equal and the fingers for dirt, extra digits and grown nails, palm for pallor and all were absent. Madam Emmanuella was asked to put her hand at the part to be examined under her head as the breast was examined for size, shape, presence of lumps and sore nipple and armpits for enlarged lymph nodes but none of this abnormality was found. Cotton wool was put on the nipple and the areolar was squeezed to examine for any abnormal discharge. The lower extremities were examined for varicose veins, oedema and tenderness in the calf muscles and they were all absent except varicose veins which was still

present. She was asked to turn her back for inspection and palpation but no lesions, scoliosis or kyphosis were found.

On abdominal inspection there was no scar except for some few traces of straie gravidarum and linea nigra. The shape and size of the abdomen were globular and medium respectively. She felt the fetal movement according to her. The fundus was located and the zero mark of the tape measure was placed there. The tape was extended along the contour of the abdomen along the midline to the upper border of the symphysis pubis. The symphysio-fundal height measured 38 centimeters.

On palpation, upon facing the head of the client, each palm was placed on either side of the fundus. The fingers were curved around the top of the fundus to determine what occupied the upper pole of the fundus. A soft mass was felt which indicated the buttock of the foetus. During lateral palpation, each palm was placed on each side of the uterus, midway between symphysis pubis and fundus. One hand was used to stabilize the uterus and the palm of the other was used to examine. Fetal back (smooth part) was located at the right-hand side of the woman's abdomen and the fetal limb (rough part) on the left side.

On pelvic palpation, upon facing the woman's feet, she was asked to bend her knees slightly and also to breathe out slowly to help relaxation of the abdominal muscles. Each palm was placed on either side of the uterus, just below the umbilicus, hands directing towards the symphysis pubis as the thumbs were almost meeting, a hard mass was felt indicating the head of the foetus. Then location of the anterior shoulder was done and two fingers were placed on it which was 2cm below and away of the umbilicus. The upper border of the symphysis pubis was also located and with the ulna border of the right hand placed on the upper boarder of the symphysis pubis. Five fingers were accommodated between the symphysis pubis and the anterior shoulder, indicating a descent

of 3/5 above the pelvic brim. The lie was longitudinal, presentation was cephalic, and the position was right occipito anterior.

On auscultation, fetal stethoscope was rubbed in the palm to make it warm. It was placed at the area where fetal back was located. The ear was placed against the fetal stethoscope to listen for fetal heart beat for one minute as it was being compared with maternal pulse. The fetal heart rate was 142 beats per minute. After the auscultation, hands were warmed by rubbing, in order to check for contractions after sitting comfortably by her. There were three (3) contractions in ten (10) minutes lasting for 26,32,35 seconds. Also, there was presence of fetal movement.

Vaginal examination

Permission was sought from Madam Emmanuella for vaginal examination around.5:15am. A tray which was set containing; sterile swabs in a gallipot with savlon solution, sterile cotton wool swab and a pair of sterile gloves and a receiver were drawn closer to the bedside. Hands were washed with soap under running water and dried with clean dry towel. A pair of sterile gloves was worn and client was asked to flex her knees.

On inspection, there were no sore, scars, abnormal discharges, varicose veins, genital warts or oedema. The vulva was swabbed from the labia majora to the minora and then finally the vestibule using sterile cotton soaked in savlon solution, a swab at each time from top to down. Client's permission was sought and the index and the middle finger of the right hand were gently inserted into the vagina. The vagina was warm, moist and roomy. The cervix was soft, thin and the presenting part was well applied it. The membranes were intact with no moulding. The cervical dilatation was 4cm. The Midwife in-charge, congratulated client and said, she is very cooperative. Client was thanked and made comfortable by wiping all discharges and a clean perineal pad was applied. Gloved hands were dipped into 0.5% chlorine solution before removing. Gloves were

removed by turning them inside out and were disposed into plastic container. Hands were thoroughly washed with soap and under running water and dried with a clean dry towel. She was informed about the progress of labour using the dilatation board and encouraged to take a walk to help hasten up the dilatation. The findings were documented.

Preparation for birth

Identification of helpers was done that is, a skilled helper and unskilled helper. The skilled helper was the sister Siata Musah a staff midwife who could help to assist in the care of the baby. The unskilled helper was the mother and was also informed about her role to run errand including helping to call another helper. The area for delivery was also prepared. The source of light was checked. Mother was informed that the windows and doors would be closed and curtains would also be drawn down when the baby is about to be delivered to provide warmth and prevent the baby from losing heat. Hand washing and aseptic technique were observed to prevent infection. Madam Oforiwaa was informed that her hands and chest would be washed for skin- to -skin contact prior to second stage of labour. The resuscitation table was made clean and the equipment was checked to be adequate and functioning properly. Madam Oforiwaa and her mother were informed about the importance of such preparation. The emergency drugs and equipment for delivery were checked and made available.

3.2 MANAGEMENT OF FIRST STAGE OF LABOUR

This stage includes monitoring the client until the second stage is due. The fetal heart rate, contraction and maternal pulse were monitored every 1 hour but temperature, blood pressure, dilation of the cervix and descent of the fetal head were checked every four (4) hours and recorded on the partograph.

Madam Oforiwaa was advised to lie on her left side to prevent supine hypotension syndrome. She was educated on some of possible outcome of labour such as safe delivery without complication. Client complained of waist pains so sacral massage was done and then the physiology behind the pains was explained to her. She was encouraged to perform deep breathing exercise during contractions to minimize the pains. Water was served frequently to prevent dehydration and also, she was given malt as an energy drink to enable her get energy. She was encouraged to empty the bladder whenever she has the urge to allow descent of the fetal head and prevent prolonged labour. The dilatation board was used to explain the cervical dilation and progress of labour to Madam Oforiwaa. Client was then reassured of normal delivery without any complications. Client was encouraged to breathe through her mouth when there was contraction and also avoid pushing during contraction since the cervix is not fully dilated so as to prevent edematous cervix and also to rest in-between contraction to prevent exhaustion. Client was educated on the importance of changing the pad when soiled and not to be touching the perineal area and to stop mishandling the perineal pad. Client was thanked for her cooperation. She was encouraged to assume any of the positions used during labour as the various methods were demonstrated to her after confirmation of full dilatation. At 9:15am, contractions were four (4) in ten (10) minutes all lasting 45seconds, fetal heart rate was 145beats per minute, maternal pulse was 84 beat per minute. On vaginal examination, the vagina was warm and moist, the cervix was eight (8) centimeters dilated, membranes were intact and the presenting part was well applied with descent $1/5^{th}$.Vital signs were checked and recorded as; Temperature 36.3 degree Celsius, Respiration 20 cycles per minute, Blood Pressure 120/90 millimeter of mercury, Pulse 79beat per minute. The amount of urine emptied was 150 milliliters. Urine tested negative for glucose, protein and acetone. Client was made comfortable in bed by cleaning all discharges and a new perineal pad applied.

The delivery trolley was then set-in with the following items;

TOP SHELF

1. A delivery pack containing;

- ❖ Sterile cord scissors
- ❖ 2 sterile artery forceps
- ❖ Sterile sheets
- ❖ Gallipot containing sterile gauze/cotton
- ❖ Sterile receiver for placenta
- ❖ Sterile cot sheet
- ❖ Episiotomy scissors
- ❖ Xylocaine as an anaesthetic agent
- ❖ Suturing forceps
- ❖ Bulb syringe

BOTTOM SHELF

1. Cot sheet
2. Cord clamp
3. Oxytocin
4. Perineal pad
5. Identification band
6. Sterile gloves
7. Examination gloves
8. Savlon

9. Bed pan

10. Measuring jug

Madam Oforiwaa was anxious about the outcome of the labour and was reassured that she is in the hands of competent midwives. Client complained of having the urge to bear down and immediately membranes ruptured so another vaginal examination was done at 10:09am and the cervix was fully dilated (ten centimeters), there was no cord prolapse, descent was 0/5, moulding was (++). The midwife in- charge also confirmed the full dilatation and she agreed that the findings should be documented on a partograph sheet. Client started vomiting so a vomitus bowl was served, after which she was informed of the full dilatation of the cervix. All observations made were plotted on the partograph.

3.3 MANAGEMENT OF SECOND STAGE OF LABOUR

Madam Oforiwaa was told that, she had successfully passed the first stage and was encouraged to push well with contraction and rest in- between contractions. The aseptically prepared trolley was taken to the bedside. The client was asked to breathe through the mouth. The midwife in-charge confirmed the findings and preparations were made. Client was reminded that the baby would be delivered onto the abdomen to establish bonding and warmth. Procedure to be carried out was explained to her. She was then reassured and her hands and chest were washed as already explained to her. Madam Oforiwaa was encouraged to assume lithotomy position as she preferred and her head was supported with pillows. After wearing the protective clothing; face mask, plastic apron, goggles and boots, a thorough hand washing was done. Sterile gloves were worn and the delivery pack was opened by the in-charge whiles standing on client`s right side. The perineum, pubis and upper thighs were swabbed with a sterile cotton wool soaked in savlon solution. A sterile towel was placed on the abdomen and another under the buttocks. A perineal pad was kept at the

perineum to prevent feaces from contaminating baby's eyes. Client was encouraged to push only when she has the urge. As the fetal head was advancing, the index and middle fingers were placed on the fetal head to aid flexion to allow the smallest diameter to distend the perineum, [sub occipito bregmatic] this was done to prevent perineal tear and intra cranial hemorrhage. When the head crowned, client was asked to stop pushing but pant and blow. This was done to deliver the head slowly in order to prevent perineal tear. The head was delivered by extension, thus allowing the sinciput, face and mentum to sweep the perineum. During the resting phase before the next contraction and client was asked not to push again. Cord around neck was checked but was not felt and sterile gauze was used to clean the eyes from inside to the outside.

After restitution, there was external rotation of the head which meant that shoulders have rotated internally and that they are ready to be delivered. So, the fetal head was held in-between the palms on each side of the parietal bones. With the next contraction, the fetal head was flexed downwards and the anterior shoulder escaped the symphysis pubis. Gently, the fetal head was moved upwards in a direction towards mother`s abdomen to deliver the posterior shoulders. Then with lateral flexion the rest of the body was delivered onto the mother`s abdomen at 10:18am. A female child was born and she cried at birth. Client was congratulated for good work done.

3.4 IMMEDIATE CARE OF THE BABY

Immediately the head was delivered, the eyes were cleaned with sterile gauze from inside contour out. The baby was then delivered onto mother's abdomen and the baby cried immediately after birth. Liquor was dried off the baby with a dry cot sheet to keep baby warm and the wet sheet was removed. Baby was then placed skin to skin on mother's abdomen and covered with a warm dry sheet for warmth and bonding. Then the first minute Apgar score was assessed to be 8/10. The cord was clamped with cord clamps at two places and cut in between them to separate baby from

mother, two finger breaths from baby's abdomen was measured, a cord clamp was applied and then three finger breaths above the clamp after which it was cut short on the part of the baby and the mothers end together with the artery forceps was place in the sterile receiver between the mother's thigh. The fifth minute Apgar was also assessed to be 9/10. An identification band with the name of the mother, sex of the baby, date and time was placed on the baby's wrist.

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

3.5 MANAGEMENT OF THIRD STAGE OF LABOUR

The procedure was explained to Madam Oforiwaa to gain her usual cooperation. Immediately after delivery, the uterus was palpated through the abdomen to exclude the presence of a undiagnosed twin and there was none, 10 units of oxytocin was given in the thigh by the in-charge who supervised the delivery, within a minute after the birth of the baby to enhance the contraction of the uterus which contribute to the expulsion of the placenta and its membranes as well as controlling of bleeding. The cut end of the cord which was in the receiver and in between the mother's thigh was taken and the cord was re-clamped closer to the perineum and a kidney dish was placed in-between her thighs. The left hand (non- dominant hand) was placed on the fundus to feel for contractions. As soon as there were contractions, the left hand was removed and placed at the supra pubic area with the palm facing the mother`s abdomen to provide counter pressure. At the same time, the clamped cord was held with the right (dominant hand) and a steady traction was applied (controlled cord traction). The controlled cord traction and counter traction was maintained until the placenta became visible at the vulva. Then hands were released from the abdomen and

clamped cord to receive the placenta at the introitus with both hands. The placenta was gently twisted to tease the membranes to become rope-like till it was delivered at 10:22am. The placenta was quickly examined and placed in the receiver. The uterus was massaged through the abdomen until it contracted and blood clots were expelled. The birth canal was examined; there were no tears or lacerations at cervix, vagina and the perineum. Client was encouraged to void when the urge comes to prevent postpartum hemorrhage. Blood and liquor stains were wiped from her body and a clean perineal pad was applied. She was covered with a piece of cloth. Client was taught on how to massage the uterus by herself to expelled any retained blood and was asked to feel for the contracted uterus immediately. Client was asked to report any bleeding from the vagina. Client's husband and mother was informed that she had delivered a bouncing baby boy. Client was informed about the findings and necessary documentations were done. Client was congratulated for her effort.

3.6 EXAMINATION OF PLACENTA

The placenta was sent to the sluice room for proper examination. The placenta was immersed into 0.5% chlorine solution to reduce the spread of infection and then removed and held by the cord and the cord was seen to be medially inserted in the fetal surface. The cut end of the umbilical cord was wiped off with cotton swab and one vein and two arteries were seen with no true or false knot in the cord. The fetal surface was observed for smoothness and the colour was grey. By lifting the cord and holding the placenta up, the membranes were inspected for completeness. The placenta was then returned to the surface and the membranes were spread out to look for extra vessels, lobes or holes but none was identified. The amnion was pulled back towards the cord and the membranes for proper visualization of the chorion which was intact. The maternal surface appeared to be complete with no missing lobes or cotyledons. Blood loss was 96mls.The placenta was discarded

per the clinic's protocol. The instruments used were soaked in 0.5% chlorine solution for 10 minutes using utility gloves, the instruments were washed, rinsed and dried, ready for sterilization. The gloved hands were dipped in the 0.5% chlorine solution and the gloves were removed from inside out.

3.7 MANAGEMENT OF THE FOURTH STAGE OF LABOUR

During the fourth stage of labour, close observation of the mother and baby is made for six hours following the expulsion of the placenta, membranes and the subsequent arrest of hemorrhage. Mother and baby were then transferred to the lying-in after the one-hour skin to skin of the baby. Continuous monitoring was done for five hours since an hour has already been done. The mother and baby were assessed every 15 minutes for two hours and 30minutes for the next one hour.

PREVENTION OF DISEASES

This was done within the 90 minutes after birth. The lower lid of the eyes was instilled with 2 drops of tetracycline eye drop as prophylaxis against infections of the eyes such as opthalmia neonatarum. The cord was dressed with sterile cotton wool soaked in methylated spirit to prevent cord infection such as tetanus and no bleeding was noticed. The mother was educated not to apply anything to the cord, like herbs, animal dung or other substances, unless a treatment was recommended by the in-charge.

Client was informed that her baby would be injected with one (1) mg of vitamin K intramuscularly in the front, outside of the mid-thigh after the head-to-toe examination. This would help to prevent hemorrhagic disorders of the baby such as cord bleeding. Madam Oforiwaa was again informed that, her baby would be given Polio O Vaccine and Bacillus Calmette Guerin (BCG) 0.05mls intradermal the next day to protect her against tuberculosis. She was educated not to apply anything on the injected site.

EXAMINATION OF THE NEWBORN

This examination was done to exclude any abnormalities of the newborn. Hands were washed with soap and water and the procedure was explained to the understanding of the client. Disposable gloves were worn and the baby was examined in the presence of the mother in a clean, warm environment. The baby was put on a covered flat surface and only the part to be examined was exposed. Head to toe examination was carried out to detect any abnormalities; the head was examined for depressed skull bone, bulging of the fontanelles, oedematous swelling, laceration on the skull but no abnormality was detected. The head circumference was measured by encircling the head with a tape measure from the occipital protuberance to the supra-orbital region and it measured 32cm and full length to be 49cm. The ears were examined for shape, size, patency and the cartilage in the pinna was checked for its softness. The eyes were also examined for the colour; red spot, jaundice and conjunctival hemorrhage but no abnormality was found. The nose was inspected for size and shape and also for deviated septum but the septum was normal. The nostrils were inspected for patency and mucosa for colour. With the examination of the mouth, the little finger was use to feel the palate for any cleft palate, the gum was checked for presence of false teeth and the tongue for torn tie, but no abnormality was detected. Sucking, rooting and swallowing reflexes were checked and were found to be present when the baby was put to breast.

The neck was examined for congenital goiter, swelling, growth and rigidity of neck but no abnormality was detected. The chest was inspected for shape and the chest wall for abnormal rise and fall and expansion which was normal with respiration rate of 48 cycles per minute. The breast was inspected for false milk. Examination of the upper extremities was done and the hands were inspected for clubbing, extra or missing digit, nails and webbing. Hands and arms were inspected for symmetry, movement and paralysis, and the palm for palmer creases. Shape and colour of nail

and nail bed were inspected and reflexes (grasping and Moro) checked and everything was normal. The abdomen was examined and the shape and size of the abdomen were normal. The cord was inspected for bleeding and the number of vessels, the liver, the spleen, the kidney and the bladder were palpated for size, tenderness and masses but no abnormality was detected.

The genitalia were examined, the urethral and anus were examined for patency and they were patent as the baby passed meconium and urine. The genitalia were developed with a normal labia major and minora. The lower extremities were inspected for extra digits, webbing, symmetry, movement, clubbed feet, paralysis and hip dislocation but none was detected. The baby was turned on her back with the head turned on one side and the spine were checked for swelling, dimples or hairy patches, spinal bifida and for missing vertebra but none was detected. The skin was inspected and no abnormality was detected. The baby's weight was taken. A scale was cleaned with methylated spirit to prevent infection. A fresh cloth was put on the scale and the weight was then adjusted to 0kg. Hand washing was done and mother was asked to unwrap the baby. The baby was quickly wrap with the weighed cloth and placed on the scale and the weight was taken as 2.6kg. The baby was then taken out.

Baby's temperature was also measured to detect any abnormality. A thermometer was cleaned. The baby was positioned on the side and the tip of the thermometer was put high in the armpit. The arm was held against the side for the recommended time. Temperature recorded was 36.6^{0}C. One (1) mg of vitamin K 1ml was administered. Baby was classified as normal and routine care continued. Baby was wrapped to maintain his temperature after the examination and made comfortable and was given to her mother to breastfeed. Gloves were removed and discarded Hands were washed and dried with a clean towel and all findings were recorded and communicated to the mother. Baby's vital signs were checked and recorded as below; Temperature 37.0-degree Celsius

Apex beat 148 beats per minutes, Respiration 48 cycles per minutes. The measurements done on the baby were recorded as follows: Head circumference 32 centimeters, Length of baby 49 centimeters

MANAGEMENT OF THE MOTHER

Madam Oforiwaa's fundus was massaged to facilitate contraction and mother was taught how to massage her uterus. The mother's initial vital signs were checked and recorded as follows; Temperature 36.8 degree Celsius, Pulse 90 beats per minute, Respiration 20 cycles per minutes, Blood pressure 120/80 milliliter of mercury. She was encouraged to empty her bladder and also change perineal pad when soiled. Baby was put to breast to promote breastfeeding and initiate bonding. Client was taught to place the baby with the head and body in a straight line, the abdomen touching hers, the face opposite the nipple, chin touching the breast and the neck not flexed and that the whole body should be supported. She was told to notice good attachment when the mouth is open wide, the lower lip is turned downward, the chin is touching the breast and most of the dark portion of the nipple is in the baby's mouth. It was explained to her that, breastfeeding soon after birth would help her provide enough milk. Also, it would help the uterus contract to reduce maternal bleeding.

Lochia was red in colour, [Lochia rubra] small in quantity and had no foul smell. Client was educated on frequent of micturition and changing of perineal pads when wet, how to fix baby to breast, the importance of exclusive breastfeeding for the first six months, feeding on demand and feeding the baby not less than eight (8) times a day. Client's mother was allowed to see her and she was served with malt and porridge to restore energy. General condition of client was satisfactory as well as the baby and all labour notes were recorded on the partograph sheet. The

symphysio-fundal height was 17 centimeters. At the end of the fourth stage, the amount of urine passed was 115 milliliters and total blood loss was estimated to 96 milliliters.

3.7 CONDITION OF BABY AT BIRTH

Head to toe examination	No abnormalities were detected
Baby's weight	2.6 kilograms
Head circumference	32 centimeters
Length of baby	49 centimeters
Meconium	Passed
Urine	Passed
Temperature	36.5 degree Celsius
Apex heart beat	148beats per minute
Respiration	48cycles per minutes
First minute APGAR	8/10
Fifth minute APGAR	9/10
Sex	female
General Condition of baby	Very good

3.8 CONDITION OF MOTHER

Temperature	-	36.8 degree Celsius
Pulse	-	74 beats per minute
Respiration	-	20cycles per minute
Blood pressure	-	120/80 millimeters of mercury
Symphysio-fundal height	-	17 centimeters
General condition		Very good

3.9 NURSING CARE PLAN DURING LABOUR

PROBLEMS IDENTIFIED

On the 09/12/22, client complained of;

1. client complained of anxiety
2. client complained of excessive sweating
3. client complained of labour pains
4. client complained of vomiting
5. client complained of lower abdominal pains

SHORT TERM OBJECTIVES

1. Client will be relieved of anxiety at the end of labour.
2. Client will be relieved of excessively sweating within 2 hours
3. Madam Oforiwaa will cope with the labour pains throughout the period of labour
4. Client will be relieved of vomiting within 20 minutes
5. Client's lower abdominal pain will subside and client will cope with lower abdominal pain throughout labour.

LONG TERM OBJECTIVES

Madam Oforiwaa will go through labour and puerperium successfully and deliver a healthy baby without any complications.

LABOUR CARE PLAN FOR MADAM MARTHA

DATE /TIME	NURSING DIAGNOSIS	NURSING OBJECTIVE/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE /TIME	EVALUATION	SIGN
09/12/22 at 7:00am	Anxiety related to unknown outcome of labour.	Client will be allayed of anxiety within 30 minutes as evidenced by 1. Client delivering a healthy baby without any complication 2. Midwife observing that client is comfortable	1. Reassure client that labour will end safely with the help of competent staffs on duty. 2. Explain every procedure to be carried on client. 3. Encourage her to ask questions and answer tactfully 4. Update client with progress of labour	1. Reassure client that she is in competent hands and labour will end safely. 2. Each procedure to be carried out on her was explain to her. 3. Client concerns were addressed. 4. Client was updated about progress of labour	09/12/22 at 7:30am	Goal fully met as Client observed to be relaxed in bed	

LABOUR CARE PLAN FOR MADAM MARTHA

DATE /TIME	NURSING DIAGNOSIS	NURSING OBJECTIVE/OUT COME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE /TIME	EVALUATION	SIGN
09/12/22 at 5:30am	Excessive sweating related to stress of labour.	Client will remain hydrated within 20minutes and to the end of labour as evidenced by midwife observing that client is not dehydrated and with minimal sweating	1. Reassure client of competent care to promote comfort. 2. Encourage client to continue deep breathing exercise. 3. Clean face and body of client with wet towel. 4. Provide fresh air.	1. Client was reassured of competent care to promote comfort. 2. Client continued deep breathing exercise. 3. Client face and body were cleaned with wet towel 4. Client was provided with fresh air by opening windows and switching on fans.	09/12/22 at 5:50am	Goals met as the Midwife observed that client was not sweating and was comfortable. 2.Client verbalizing that she is not sweating again	

LABOUR CARE PLAN FOR MADAM MARTHA

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES /OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTIONS	DATE/ TIME	EVALUATION	SIGN
09/12/22 02;00am	Labour pains related to contractions and descent of the fetal head.	Madam Oforiwaa will cope with labour pains throughout labour as evidenced by client verbalizing.	1.Reassure client 2.Educate client on the cause of labour pains 3. Encourage client to walk around to enhance descent of foetus. 4. Give client sacral massage. 5. Encourage client to practice deep breathing exercise.	1.Client was reassured of relieved of pain after delivery. 2. Client was educated that uterine contraction and descent is the cause of the labour pain. 3. Client walked around to enhance descent of foetus. 4. Client was given a sacral massage. 5. Client preformed deep breathing exercise during contractions to relieve pain.	09/12/22 10:18am	Goal met as Madam Oforiwaa was able cope with the labour pains.	

LABOUR CARE PLAN CONTINUED

DATE / TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES	NURSING ORDERS	NURSING INTERVENTIONS	DATE / TIME	EVALUATION	SIGN
09/12/22 7:00am	Vomiting related to the hormonal fluctuation in labour.	Client will be relieved of vomiting within 2 hours as evidenced by; Client verbalizing.	1. Reassure client. 2.Assist client to rinse her mouth after vomiting. 3. Hydrate the client with IV fluids. 4. Keep all nauseating items away from client 5. Encourage client to put something dry in her mouth.	1. Client was assured that she can be relieved of vomiting. 2. Client was given water to rinse her mouth after vomiting. 3. Client was given IV fluids to replace fluid loss. 4. Keep away all nauseated items. 5. Client kept chewing stick in her mouth.	029/12/22 9:00am	Goal fully met as Madam Oforiwaa verbalized that she is no more vomiting.	

LABOUR CARE PLAN CONTINUED

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES/OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTIONS	DATE/ TIME	EVALUATION	SIGN
9/12/22 5:10am	Lower abdominal pains related to painful uterine contractions in labor.	Client's lower abdominal pain will subside after delivery and client will cope with lower abdominal pain throughout labor as evidenced by; 1. Client verbalizing that the pain has subsided.	1.Reassure client. 2.Explain the physiology behind lower abdominal pain to her. 3. Encourage deep breathing exercise. 4. Encourage client to walk around. 5. Allow client to assume a comfortable but harmless position.	1.Client was reassured that her condition can be managed. 2.Cause of pain was explained to her. 3. She was encouraged to perform deep breathing exercise during contractions. 4.client was assisted to walk around slowly to relieve pain. 5. Client lied left lateral with pillows supporting her back and abdomen.	09/12/22 10:18am	Goal was met as client verbalized that the pain has subsided.	

CHAPTER FOUR

4.0 INTRODUCTION TO PUERPERIUM

This chapter talks about how Madam Oforiwaa and baby were managed and cared for during the period of puerperium. It also throws more light on the subsequent care of the baby, preparation towards discharge, subsequent post- delivery assessment, home visits, postnatal review and the nursing care plan drawn for the management of problem encountered during puerperium.

4.1 DAY OF DELIVERY

Madam Oforiwaa and her baby´s general condition after delivery were assessed before they were transferred to the lying- in room for continuous observation. A bed was made for mother and baby. She was educated and demonstrated how to fix baby to breast and was encouraged on breastfeeding on demands. Hand washing with soap and water after visiting the toilet and changing perineal pads was stressed on to prevent cross infection from the mother to child. Her vital signs were checked and recorded as follows;

Temperature	36.8^0C
Pulse	74 beats per minute
Respiration	20 cycle per minute
Blood pressure	120/80 millimeters mercury

Lochia was small in amount of flow and red in colour with no clots and she was told to report any abnormal bleeding. She was served with milo beverage and bread after which she was made comfortable in bed with baby placed by her side.

4.2 SUBSEQUENT CARE OF THE BABY

After six hours of birth, a brief physical examination was done to check for obvious signs and the baby was seen healthy and the baby was supposed to be bathed for the first time but due to the cold weather condition it was postponed to the next day. On the laps of the mother, the baby's skin was assessed, the chest was also checked for fast or slow breathing and any wheezing sound from the nostrils but everything was normal. Vital signs of the baby were checked and recorded as follows; Temperature 36.2 degree Celsius, Apex beat 143 beats per minute, Respiration 44 cycles per minute. Vitals of client was checked and recorded as; temperature 36.7, pulse of 75bpm, respiration of 22cpm, BP was 120/80. Client was educated on how to fix baby to breast and to feed the baby frequently and on demand not less than 8 to 12 times a day was stressed as well. She was also educated on exclusive breastfeeding for the first 6 months and completes emptying of one breast before the other. Emphasis was also made on hand washing after visiting the toilet, removing baby's soiled napkins, before and after handling the baby to prevent infection.

4.3 FIRST DAY POST DELIVERY AND DISCHARGED

10th December 2022, was Oforiwaaa's first day post– delivery. Around 8:30am. Client woke up healthy with a cheerful look. All procedure to be carried out on both mother and baby were explained to her. Permission was sought from client and head to toe examination was done but no abnormality was detected. The breasts had no abnormality that will interfere with breastfeeding just that it was not lactating well, abdomen was soft on palpation, uterus was well contracted and the symphysio-fundal height was 16 centimeters, vulva was clean on inspection, The Perineal pad was inspected for the flow of lochia which was small and red (rubra) in colour with no smell. Post-delivery hemoglobin level also recorded 11.9gld. Client vital signs were checked and recorded as, Temperature 36.8 degree Celsius, Pulse 68 beats per minute. Respiration 20 cycles per minute,

Blood Pressure 120/70mmHg. Client complained painful micturition and after pain. The physiology of painful micturition and after pain as the result of laceration, stretching of the perineal muscles during labour and the involution of the uterus respectively. Client was encouraged to breastfeed baby frequently. Mother then took a warm bath and was served with porridge and bread.

The First Bath of the New Born

REQUIREMENTS

- Soap
- Sponge
- Cream/ powder
- Sterile cotton in a gallipot or wrapped
- Basin
- Towels: 1 big towel and 3 small ones
- Cot sheets 2
- Apron
- Gloves
- A clean baby dress, cap and socks(if available)
- Mackintosh
- 2 jugs containing hot and cold water each
- Two receptacles for used water and dirty linen
- A receiver for used swab

Permission was asked from the mother to bath the baby. Baby's cord was checked for bleeding before bath but no bleeding was detected. Items to be used were: Plastic apron, soap and water, sponge, small towel, bath towel, basin, flat surface, gloves, cot sheets, warm water, cotton wool

swabs, methylated spirit, baby oil, powder, diaper and baby dress. Water was mixed and the elbow was used to test for the temperature. Plastic apron was put on, hands were washed with soap and water and dried with clean dry towel. Gloves were worn and the baby was put on a protected flat surface and was undressed. Baby was then wrapped with a cot sheet with the head exposed for bath. The eyes were cleaned with clean cotton wool swabs soaked in clean water from the inner cantus to the outer cantus. The face cleaned with damp face towel and dried. The nape of the baby's neck was supported and ears plugged with two fingers of the hand supporting baby's head. The head was then washed with soapy sponge. Baby was then lifted off flat surface, supporting the nape of the neck and the body resting in the elbow, to the edge of the basin, soap was rinsed off baby's hair and dry. Baby was then put on protected flat surface and exposed. Arms were washed to the trunk with much attention on the skin folds. Baby's back was turned with one arm supporting the chest and the back washed to the feet. Baby was supported firmly and immersed in a bath of warm water, with head above and rinsed thoroughly. Baby was then placed on the flat surface covered with bath towel and dried with a small towel whiles paying attention to the skin folds. Baby was oiled and then dressed nicely up exposing her umbilical area.

CORD DRESSING

Sterile gloves were worn. Sterile cotton wool swap were dipped in methylated spirit and used to dress the cord. The umbilical was swapped with the cotton wool swaps followed by the stem, the tip of the cord then the clamp until they were all clean. Cord was exposed to dry. Baby was well rapped in clean cot sheet to provide warm and then baby was given to the mother. The baby's vital signs were checked and recorded as; Temperature 36.8 degree Celsius, Apex beat 147 beats per minute Respiration 42 cycles per minute. Baby weighed 2.5 kilogram. The baby was then given his first immunizations which were Bacillus Calmette Guerin (BCG) vaccine 0.05ml intradermal

at the right upper arm and oral polio vaccine O (OPV) two drops at the back of the tongue by the community health nurse. Client was advice not to apply anything at the injection site or massage it. She was also reminded that additional doses of the immunizations would be required later. Immunizations against other diseases would also be needed later and so she should follow the recommendation of the health authority. It was explained to her that, these immunizations will help prevent the child from serious childhood illnesses. Client was told that there could be a tissue reaction over the area and a scar formation later indicating that the child was immunized against tuberculosis effectively.

The baby was then wrapped in a clean and warm cot sheet and handed over to the mother for breastfeeding. She was educated on breastfeeding problems such as cracked nipples, sore nipple, and breast engorgement, among others. The position and attachment to the breast was encouraged. Client was reminded on the intake of nutritious diet, fruit and frequent breastfeeding of the baby. Education was given on the change of perineal pad when soiled and the need to wash her hands after removal and also before breastfeeding the baby to prevent infections. Client was also educated on postnatal exercises such as Kegel, ambulation and also family planning as well as exclusive breastfeeding, changing of napkins frequently when soiled. Washing of baby's clothes, drying them in sun and keeping the baby warm always were also made known to her.

Before discharge, Client was assessed on her readiness for home care and also on breastfeeding of which she was able to position baby correctly to the breast. The baby was re-assessed without any abnormality. Most importantly, the umbilicus was thoroughly inspected because of risk of bleeding. As part of preparing parents for home care, breastfeeding exclusively for six (6) months at a frequency of 8 to 12 times a day and recognizing signs of successful breastfeeding, recognizing and managing common breastfeeding problems such as breast engorgement, hand washing,

dressing cord with cotton wool and methylated spirit, complete scheduled immunizations, recognizing danger signs of the baby such as fever and cord bleeding and then to the mother; offensive vaginal discharge were reinforced. The vital signs of the baby were as follows: Temperature 36.7^0C, Apex beat 140 beat per minute, Respiration 45 cycle per minute. vital signs of mother were also checked and recorded as; temperature 3.7degree Celsius, pulse 70bpm, respiration 19cpm, BP 110/80mmHg.

Client was finally discharged at 6;30pm on the 10th December and she was helped to pack her belongings after serving medications. Madam Oforiwaa was given the following drugs;

Tablet folic acid	5mg tablet daily for 7 days
Tablet ferrous Sulphate	200mg tablet daily for 7 days
Tablet multivitamin	200mg tablet daily for 7 days
Tablet paracetamol	1g tid for 7days

Her bills were settled by the National Health Insurance Scheme. Client was accompanied home and she was informed that she would be visited daily for seven (7) days. Client was congratulated.

4.4 FIRST POSTNATAL HOME VISIT

On the 11st December 2022, at 7:00am, Madam Oforiwaa and family were visited as promised. Client was at home with the family. General health condition of mother and baby was good. Explanation was given to her that she and her baby were going to be examined from head to toe to determine any abnormality for prompt treatment. Client was examined from head to toe and nothing abnormal was detected. Breast was firm and has started lactating small, abdomen was soft on palpation, uterus was well contracted and the symphysio-fundal height was 15 centimeters., vulva was clean on inspection, lochia was bright red and the flow was small with no offensive odour. Client was also advised to keep the baby warm always and not to expose the baby to cold

weather. Client after pain and painful micturation had subsided when enquiries was made but she complained of interrupted sleep. Client was advice to make the room conducive for good sleep and also bath warm water before sleep. The surrounding was neat and she was congratulated and encouraged to keep it up Observations and vital signs checked and recorded were; Temperature 36.6 degree Celsius, Pulse 72 beats per minute, Respiration 19 cycles per minute and Blood pressure 120/80 mmHg.

Hands were washed with soap and water and dried. Baby was examined from head to toe. Baby´s general condition was good and she was active. The cord was inspected for bleeding and infection and was noticed that an unprescribed medication was applied to the cord. Baby was top and tailed with cord cleaned and dressed with the methylated spirit. Baby was given to mother to breastfeed. Hands were washed and dried. Mother was reminded not to apply any hot compress on the fontanels and emphasis was made on her not applying any unprescribed medications on the cord in order to prevent infections. Baby's vital signs and other findings were recorded as follows;

Temperature	36.7^0 C
Apex beat	136 bpm
Respiration	44cpm
Weight	2.4kg
Suckling	Good
Skin	Pink
Cord	Dry and clean
Stool	Meconium

The family members were encouraged to continue supporting her so that she can have enough rest and strength to take care of the baby. After interacting with her for some time, permission was

sought to leave. Madam oforiwaa and her family was visited in the evening too. Her vital signs were checked and recorded; temperature 35.9 degree Celsius, pulse 75 beat per minute, respiration 20 cycles per minute, BP 100/80mmHg. And baby was observed and checked; temperature 36.4degree Celsius, respiration 39cycle per minute, apex heart beat 139 beats per minute.

4.5 SECOND POSTNATAL HOME VISIT

On the 12st December 2022, at 8:00am, Madam Oforiwaa and family were visited as promised. Client was at home with mother. Client was asked about the condition of the children and she said they are all doing well. General health condition of mother and baby was good. Explanation was given to her that she and her baby were going to be examined from head to toe to determine any abnormality for prompt treatment. Client was examined from head to toe and detected that some herp was applied on the cord was but no bleeding but baby is unable to suck well leading to breast engorged of the mother.

Mother's breast was painful to touch. Mother and family was educated on the risk of putting herps on the cord and the need to express the breastmilk manually if baby is not sucking to avoid breast engorgement. Mother was still not able sleep due to the painful breast engorgement. On palpation, the uterus was well contracted and the symphysio-fundal height was 14 centimeters. lochia was rubra and the flow was small with no offensive odour on examining the perineal pad. Observations and vital signs checked and recorded were; Temperature 36.7 degree Celsius, Pulse 71beats per minute, Respiration 21 cycles per minute, Blood pressure 120/70 mmHg and Lochia was Bright red.

Head and toe examination was done paying attention to skin folds around 8:30am. permission was sought and the herp was removed, then cord was dressed with sterile cotton wool soaked in methylated spirit. He passed meconium and urine during the top and tail. The baby was weighed

and wrapped nicely before feeding. The baby's vital signs and observations were checked and recorded as; Temperature 36.7degree Celsius, Apex beat 143 beats per minute Respiration 49 cycles per minute, Cord Clean, Colour Pink, Stool Meconium and Weight 2.3kg.

In the evening at 5;20pm client was visited and findings were temperature 36.7degree Celsius, pulse 76 beats per minute, respiration 22cycle per minute, BP 130/90mmHg. And baby was checked and recorded as temperature 36.5 degree Celsius, respiration 37cycle per minute, apex heart beat 138 beats per minute. Client was also advised to keep the baby warm always and not to expose the baby to cold weather. Client was able to eat half of the meal served. The surrounding was neat and she was congratulated and encouraged to keep it up. Another day was scheduled for the next visit and permission was sought to leave.

4.6 THIRD POSTNATAL HOME VISIT

On 13th December 2022, Madam Oforiwaa was visited in the morning around 8:20am as promised. Everybody in the house was in good health and every procedure to be carried out was explained to her. Head to toe examination was carried out without any abnormality such as anaemia was detected. The breast engorgement has subsided and now able to sleep small because baby has started suckling again. Mother expressed the rest of the breast milk as thought. The breast was lactating well, uterus was well contracted on palpation and the symphysio-fundal height was 13 centimeters. The perineal pad was inspected before she took her bath and the flow of lochia was small and bright red in colour (rubra) which was not offensive. Observations and vital signs were checked and recorded as follows; Temperature 36.8 degree Celsius, Pulse 75 beats per minute Respiration 21 cycles per minute, Blood pressure 110/80 mmHg and Breast was Lactating.

The baby was examined from head to toe and there was no abnormality. Baby was put to breast in front of me and she was suckling well. The cord was clean and free from herp and seen to be drying

up and was dressed with sterile cotton wool soaked in methylated spirit. It had no signs of infection. Baby's weight was 2.3kilogram. The baby's vital signs and other observations were checked and recorded as; Temperature 36.6 degree Celsius, Apex heart beat 136 beats per minute, Respiration 39 cycles per minute ,Colour Pink and Cord Clean.

The baby was wrapped in a warm cot sheet and was given to the mother for breastfeeding.

Client was regaining her appetite. Client was once again visited in the evening and findings were temperature 36.6deree Celsius, respiration 19 cycle per minute, pulse 70 beat per minute, BP 120/70mmHg. Baby vitals were also as follows; temperature 36.5 degree Celsius, Apex heart beat 132 beats per minute, respiration 37 cycle per minute. Mother and baby were healthy. Client was reminded of the next visit; she was thankful and permission was sought to leave.

4.7 FOURTH POSTNATAL HOME VISITS

Madam Oforiwaa was visited again on the 14th December 2022, at 7:30am. Greetings were exchanged and a seat was offered. On observation, the general condition was good. Clients had relieve from breast engorged when asked. Client said she was able to sleep better than the previous night. Uterus was contracted with symphysio-fundal height of 12 centimetres. Perineal pad was inspected and the flow of lochia was small, and pink (serosa) in colour with no offensive odour. Assessment was made on mother and the results were recorded as; Blood Pressure-110/70mmHg, Temperature 36.6 degree Celsius, Pulse 69 beats per minute, Respiration 20 cycles per minute, Lochia Serosa and Breast was lactating well.

The baby was top and tailed and the cord was also dressed as usual and cord was dry almost falling off without offensive odour. Baby's weight was 2.4kilogram. Baby's vital signs and other

observations were recorded as below; Temperature 36.5 degree Celsius, Apex heart beat 138 beats per minute, Respiration 36 cycles per minute, Cord Clean and dry.

4.8 FIFTH POSTNATAL HOME VISIT

On the 14th December 2022 at 7:50am the next home visit was made to the client's house. They were found in good health and the family was congratulated for taking good care of the baby. Client said fullness of breast was better and had no complaints. Client was advised to continue sleeping during the day time and also the need to take in nutritious diet. During examination, it was realized that the cord had fallen off and the mother confirmed that it fell during the night. Baby was bathed in the presence of Madam Oforiwaa and her mother as they were told to observe and the cord stump was dressed and the area was clean and dry. Baby passed urine and yellowish stool. Baby's weight was 2.5 kilograms. Head to toe examination was done and her breast was lactating very well. On palpation abdomen was soft and uterus was well contracted with symphysio-fundal height of 11centimeters.Client lochia was pink in colour (serosa) with scanty flow and not offensive. Observations and vital signs of the mother were checked and recorded as; Temperature 36.7 degree Celsius, Pulse 78 beat per minute, Respiration 19 cycles per minute, Blood pressure 110/80 millimetres of mercury and Breast was lactating. The vitals signs and other observations of the baby were checked and recorded as; Temperature 36.7 degree Celsius, Apex heart beat 129 beat per minute and Respiration 32cycles per minute.

4.9 SIXTH POST NATAL HOME VISIT

On the 16th December 2022 at 4:30pm, Madam Oforiwaa and her family were visited again as scheduled. They were all doing well and were congratulated for their support towards the care of the new born when she confirmed the maximum support being rendered by the Mother and family and they were encouraged to continue supporting her. On arrival, client mother was with the baby.

Water was placed on fire in preparation for the baby to be bathed. The baby was bathed as usual, dressing of the stump of the cord was done. Enquiries were made about client sleeping patterns and she always had a good sleep during day and nights. Client's conjunctiva was inspected for pallor. The breast was also observed lactating well. Uterus was well contracted on palpation with symphysio-fundal height of 10 centimeters. On perineal pad examination, the lochia was pink (serosa), minimal flow without any offensive odour. She was thanked and was reminded of the next day's visit being the last home visit after which home care will be terminated. In fact, this information did not go down well with the family so they were all sad but were reassured of continuity of care as the mother will be handed over to another staff whom they can contact whenever there is a problem.

Vital signs and other observations of the mother were checked and recorded as; Temperature 36.9 degree Celsius, Pulse 76 beats per minute, Respiration 19 cycles per minute, Blood pressure 120/70 millimetres of mercury, Lochia Serosa, Breast Lactation very well. Observations on baby were recorded as; Temperature 36.6 degree Celsius, Apex heart rate 127 beats per minute, Respiration 35 cycles per minute, Stool Brownish –Yellow and Weight 2.6kg. Permission to leave was requested and granted.

4.10 SEVENTH POSTNATAL HOME VISIT

On 17th December 2022, at 8:30am was the last visit to Madam Oforiwaa's house. Client was doing well with baby and the entire family. All procedures to be carried out were explained. Hands were washed and examination from head to toe was done but no abnormality was detected. Lochia was inspected and it was pink in colour (serosa) with no odour. The symphysio-fundal height was 4cm.The breast was soft and was lactating very well. Vital signs and other observations a were checked and recorded as, Temperature 36.8 degree Celsius, Pulse 72 beat per minute, Respiration

21 cycles per minute, Blood pressure 110/80 millimeter of mercury, Lochia Serosa and Breast well Lactating. The baby was examined and Madam Oforiwaa's mother was supervised to bath and dress the stump of the cord which was done perfectly. The wound had healed. Baby's weight was 2.9kilograms. The baby's vital signs and other observations were checked recorded as; Temperature 36.4degree Celsius, Apex heart beat 136 beat per minute, Respiration 39cycle per minute, Stool Yellow and Weight 2.7kg. The baby was dressed and handed over to the mother for breastfeeding. Emphasis was made on her perineal care and the intake of nutritious diets as well as avoiding the use of hot application on the fontanels. Client was encouraged to continue exclusive breastfeeding for 6 months. It was further explained that, exclusive breastfeeding could serve as a family planning method. Mother was reminded of the 1st postnatal visit to the clinic on 8th January and its importance and also the need to immunize the baby against the childhood preventable diseases. Client was told to report to the hospital when there was any problem as soon as possible and also made her aware that, the day was the last visit to her house, Madam Oforiwaa together with the entire family was thanked for their cooperation. Client and her family also expressed their heartfelt gratitude.

4.11 FIRST POSTNATAL VISIT TO THE CLINIC

On the 18th December 2022, Madam Oforiwaa came to the clinic for the first postnatal examination. Both mother and baby were doing well. Every procedure to be carried on client was explained to her. Vital signs and Hb were checked and recorded as follows; Temperature 36.5 degree Celsius, Pulse 76 beat per minute, Respiration 19 cycles per minute, Blood pressure 110/70 millimeters mercury, Haemoglobin level was 12.5 gram per deciliter.

Client weighed 87 kilograms. Madam Oforiwaa was given a specimen bottle to collect midstream urine to test for protein and glucose and they tested negative. Client was asked to lie on the couch

for head-to-toe examination. On the head, the hair was neatly dressed. The eyes were free from discharges and the conjunctiva was not pale and no jaundice was noted. The ears were also free from discharges. The neck veins were not distended and no lymph nodes palpated. The breast was examined and there were no mass, engorgement or sore nipple. There was no tenderness, enlarged liver or spleen. The fundus was not palpable. The upper extremities were also inspected and no abnormalities were detected. The baby was taken from the client's relative with permission and examined from head to toe and nothing abnormal was detected. Baby weighed 2.9 kilogram.

The baby's vital signs were taken and recorded as follows; Temperature 36.8 degree Celsius, Pulse 134 beats per minute, Respiration 46 cycles per minute.

After the examination, she was also educated on various types of family planning methods which would be appropriate for her and also emphasized on the need to feed the baby exclusively. Madam Oforiwaa was told about the intake of well-balanced diet to improve her health and also provide more breast milk for the baby. Again, she was encouraged to maintain her personal hygiene and to continue the pelvic and abdominal exercises and also attend the six weeks postnatal care. Madam Oforiwaa was educated to register the baby at the birth and deaths registry of which she agreed. Client was thanked for her co-operation throughout the care and then informed of termination of care and that the midwife in charge would continue with her care.

The client was left in the hands of the midwife in-charge at the Wenchi Methodist Hospital for continuity of care. She was served with Multivitamin one (1) tab twice daily. She was very delighted and expressed her gratitude for the care rendered to her. She was thanked and she was seen off at the facility gate.

4.1SECOND POSTNATAL VISIT TO THE CLINIC

The six weeks postnatal visit was made on 23rd January 2023. According to the midwife in-charge, client visited the hospital. The baby's weight was increased and normal according to the weight chart. All immunization were given per the weeks. Baby was looking healthy and active. Client was then handed over to the public health nurse for continuity of care. The midwife in-charge was really appreciated for her co-operation.

4.13 CARE PLAN DURING PUERPERIUM

PROBLEMS IDENTIFIED DURING PUERPERIUM

ON 10TH DECEMBER, 2022

1. Painful micturition
2. After pain

ON 11TH DECEMBER, 2022

3. Interrupted sleep

ON 12TH DECEMBER,2022

4. Risk of umbilical cord infection
5. Breast engorgement

SHORT TERM OBJECTIVES

1. Madam Oforiwaa's painful micturition will resolve within 48 hours.
2. Madam Oforiwaa will be relieved of after pains within 48 hours.
3. Madam Oforiwaa will have a good sleep within 72 hours
4. Baby will not develop umbilical cord infection within 24 hours of puerperium
5. Client would be relieved of breast engorgement within 48 hours.

LONG TERM OBJECTIVES

Madam Oforiwaa will go through puerperium without complication to her and baby.

PUERPERIUM CARE PLAN

DATE AND TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES/OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE AND TIME	EVALUATION	SIGN
10/12/22 at 8:30am	painful micturition related to perineal lacerations during the second stage of labour	Client's burning sensation on micturition will resolve within 48hours as evidence by 1.Client verbalizing that she is no longer having the burning sensation 2. Midwife observing a relaxed facial expression.	1. Reassure client. 2. Explain to client the physiology of the burning sensation. 3. Encourage client to empty her bladder frequently 4. Encourage client to have warm sitz bath. 5. Serve client prescribed medications	1. Client was reassured that the condition will resolve after few days. 2. Client was taught that it was as result of urine in contact in the lacerations. 3. Client emptied her bladder more whenever she feels the urge. 4. Client have warm sits bath at least twice daily. 5. Client was served with tablet Paracetamol 1000mg.	12/12/22 at 8:30am	Goal fully met as client said she was coping with the pain.	

PUERPERIUM CARE PLAN CONTINUED

DATE / TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE / TIME	EVALUATION	SIGN
10/12/22 at 10:30am	After pains related to involution of the uterus due to release of oxytocin during breastfeeding	Client will be relieved of after pain within 48hours as evidence by 1. Client verbalizing that the pain has relieved. 2. Midwife visualize client is relieved of after pains as client do not complain anymore	1. Reassure client. 2. Explain the physiology of after pains to the client. 3. Educate and assist client to do postnatal exercises. 4. Encourage client to apply pressure to the lower abdomen. 5. Serve prescribed analgesics.	1. Client was reassured that the condition will resolve after few days. 2. Client was told pain was due to contraction of the uterus after delivery. 3. Client ambulating and performing pelvic floor exercise. 4. Client lie face down .with pillow under her abdomen to minimize pain. 5. Client was served with tablet Paracetamol 1000mg.	12/12/22 at 11:30am	Goal fully met as client verbalized that the pain had relieved	

PUERPERIUM CARE PLAN CONTINUED

DAT/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVE/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
11/12/22 9:30pm	sleep interrupted related to painful breast engorgement	client will have a good sleep within 72hours as evidence by client verbalize she easily fall asleep without any difficulties, midwife visualize client sleeping well.	1. Encourage to apply warm compress on the breast to relieve pains 2. Encourage to bath warm water before bed to induce sleeping 3. Encourage family to support her in terms of caring of the baby for her to have nap in the afternoon 4. Encourage client to make the room conducive for sleeping 5. Serve prescribe analgesics to relieve breast pains	1.Warm compress was applied on the breast 2.client bathed warm water 3. family support client for her to have a nap in the afternoon 4.Room and environment was made conducive 5. prescribed analgesics was served	14/12/22 09:30pm	Goal fully met as client said She has better sleep than previous nights.	

PUERPERIUM CARE PLAN CONTINUED

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES/OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
12/12/22 5:00pm	Risk for umbilical cord infection related to application of unprescribed medication on cord.	Baby will not develop umbilical cord infection within 72 hours of puerperium as evidenced by; 1. Baby showing no sign of infection and maintaining vital signs within the normal ranges.	1. Educate client on management of the cord. 2. Dress cord daily with prescribed medications. 3. Encourage client on proper hygiene 4. Encourage client to apply prescribed medications on the cord given to her at the facility	1. Client was educated that cord will separate early when kept clean and dry. 2. Cord was dressed daily with clean cotton wool and methylated spirit. 3. Client wash and dry hands before dressing the cord. 4. Client used cotton wool and methylated spirit on the cord.	13/12/22 5:00pm	Goals fully met as baby show no sign of cord infection.	

PUERPERIUM CARE PLAN CONTINUED

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES/OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION
12/12/22 at 9:00am	Breast engorgement related to inadequate empting of the breast.	Client will be relieved of within 72 hours as evidenced 1. Client verbalizing that she feels comfortable in her breast and the Midwife visualizing that the fullness is reduced.	1. Reassure client that she will be relieved of breast engorgement. 2. Teach client how to fix the baby to breast correctly. 3. Encourage client to apply cold compress to the breast. 4. Encourage client to do gentle expression of the breast milk. 5. Encourage client to continue exclusive breast feeding.	1. Client was reassured that she will be relieved of breast engorgement. 2 Client understood and demonstrated well how to fix baby to breast correctly. 3. Client applied cold compress to the breast. 4. Client expressed milk into a cup. 5. Madam Angelina breastfed baby exclusively.	14/12/22 at 9:00am	Goal was fully met as client reported that she has been relieved of breast engorgement.

SUMMARY AND CONCLUSION

The Client and Family Centered Maternity Care Study was conducted on Madam Oforiwaa, a 33-year-old Gravida 3 Para 2 all alive and her entire family through pregnancy, labour and puerperium safely without any complications.

Madam Oforiwaa was met as a regular attendant to the Wenchi Methodist Hospital who was in her 36th week at the time she was met. Arrangements were made for her to be used as client and she accepted willingly. Various histories were taken and she was visited to render midwifery care to her entire family in her house. Madam Oforiwaa was assisted throughout her late pregnancy, labour and puerperium safely without any complication. During the care, she encountered some minor disorders and was managed appropriately through the use of the nursing process. She was also educated on personal hygiene; danger signs in pregnancy and nutrition, importance of exclusive breastfeeding, postnatal exercise among others were all discussed until she delivered.

Madam Oforiwaa delivered spontaneously on 9th December 2022 to an alive and healthy female baby with a birth weight of 2.6kg at 10:18am.Placenta and membranes were delivered by the active management of the third stage cord. Client went through normal puerperium without any complications as of the time she was discharged home on the 10th December 2022. Postnatal care was well rendered to her and the baby and all problems during the period were addressed promptly. Visits were made to her house to give daily routine care; problems like Loss of appetite and after pains were found and solved. She was visited till the 7th day after delivery and she later reported to the hospital for the first week and was handed over to the midwife in charge and the child welfare clinic for continuity of care and client reported to the hospital for the sixth week postnatal examination.

In conclusion, client family centered maternity care study equipped me with the skills to deal with challenges of pregnant, laboring and puerperal women. It also created good interpersonal relationship between the midwives and the family.

Again, care study encourages learning by doing, the development of analytical and decision-making skills as well as reporting skills. Being base on the nursing process, the students become familiar with the use of nursing process as a basic for practice thereby encouraging evidence-based nursing care, as it provides a systematic way of collecting data, analyzing information and reporting the results of nursing care.it gives an in-depth description and explanation of how a patient's response to a specified disease condition is diagnosed and given intervention. The study also broadened students' knowledge on issues concerning pregnancy, labour and puerperium. With this experience gained, standard care will be rendered to all clients that will come my way irrespective of their social status and the environment in order to reduce maternal and infant morbidity and mortality.

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APPENDIX I

ANTENATAL RECORDS

DATE	SPECIMEN	INVESTIGATION	NORMAL RANGE	FINDINGS	REMARKS
24th June, 22	Urine Blood	Protein Glucose Hemoglobin level PMTCT Syphilis Rhesus factor Grouping Sickling Test HIV Antibody G6PD BF for Malaria	Negative Negative 11.4g/dl - 16g/dl Negative Non -Reactive Negative/Positive A, B, AB, O Negative Negative No Defect / Full Defect /Partial Defect Negative	Negative Negative 13.8g/dl Negative Non- Reactive Positive AB Negative Negative No Defect Negative	Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal
22/07/2022	Urine	Protein Glucose	Negative Negative	Negative Negative	Normal Normal
19/08/2022	Urine	Protein Glucose	Negative Negative	Negative Negative	Normal Normal
16/09/2022	Urine Blood	Protein Glucose Haemoglobin level	Negative Negative 11.4g/dl - 16g/dl	Negative Negative 12.1g/dl	Normal Normal Normal
14/10/2022	Urine	Protein Glucose	Negative Negative	Negative Negative	Normal Normal

COMPLETE DIAGNOSTIC INVESTIGATION ANTENATAL CONTINUED

DATE	SPECIMEN	INVESTIGATION	NORMAL RANGE	FINDINGS	REMARKS
11/11/2022	Urine	Protein	Negative	Negative	Normal
		Glucose	Negative	Negative	Normal
	Blood	Haemoglobin level	11.4g/dl - 16g/dl	12.7g/dl	Normal
18/11/2022	Urine	Protein	Negative	Negative	Normal
		Glucose	Negative	Negative	Normal
25/11/2022	Urine	Protein	Negative	Negative	Normal
		Glucose	Negative	Negative	Normal
02/12/2022	Urine	Protein	Negative	Negative	Normal
		Glucose	Negative	Negative	Normal
	Blood	Haemoglobin level	11.4g/dl - 16g/dl	12.4g/dl	Normal

LABOUR

DATE	SPECIMEN	INVESTIGATION	NORMAL RANGE	FINDINGS	REMARKS
09/12/22	Blood	Haemoglobin	11.4g/dl- 16g/dl	12.9g/dl	Normal
	Urine	Protein	Negative	Negative	Normal
		Glucose	Negative	Negative	Normal
		Acetone	Negative	Negative	Normal

PUERPERIUM

DATE	SPECIMEN	INVESTIGATION	NORMAL RANGE	FINDINGS	REMARKS
16/12/22	Blood	Haemoglobin	11.4g/dl- 16g/dl	13.0g/dl	Normal
	Urine	Protein	Negative	Negative	Normal
		Glucose	Negative	Negative	Normal
27/12/22	Blood	Haemoglobin	11.4g/dl-16g/dl	13.3g/dl	Normal
	Urine	Protein	Negative	Negative	Normal
		Glucose	Negative	Negative	Normal

APPENDIX II

PHARMACOLOGY OF DRUGS FOR THE MOTHER

NAME OF DRUG	CLASSIFI-CATION	DOSAGE	ROUTE	ACTION/ USES	ACTUAL EFFECT	SIDE EFFECT	SIDE EFFECT EXPERIENCED
Vitamin K	Coagulant	1milligram	Intramuscula-rly	Production of prothrombin	No bleeding	None	None observed
Chloranphenicol eye drop	Prophylaxis antibiotic	2-3 drops	Instillation	Prevents eye infection	Infection was prevented	Nephroxicity	None observed
Polio vaccine	Antigen	2 drops	Orally	Production of antibodies against poliomyelitis	Polio was prevented	There may be diarrhea	None observed
Injection Bacillus Calmette Guerin (BGC)	Antigen	0.05 Milligram	Intradermal	Vaccinates neonates against tuberculosis	Tuberculosis prevention	Blister formation	None observed

PHARMACOLOGY OF DRUGS FOR THE MOTHER

Pnuemo coccal	Antigen	0.5 milligram	Intramuscula-rly	Vaccinates neonates against pneumonia	Pneumonia prevention	Redness at the side of injection and fever	None observed
5 in 1 vaccine (Pentavalent)	Antigen	0.5 milligram	Intramuscula-rly	Vaccinates neonates against diphtheria, pertusis (whooping` cough), tetanus, hepatitis B, heamophilus influenza type B	Prevention of childhood preventable diseases	Low grade fever	None observed
Rota virus	Antigen	1.5 millligrams (2 drops)	Orally	Prevention of gastroenteritis	Gastroenteritis prevention	None	None observed

APPENDIX III

ANTENANTAL RECORDS

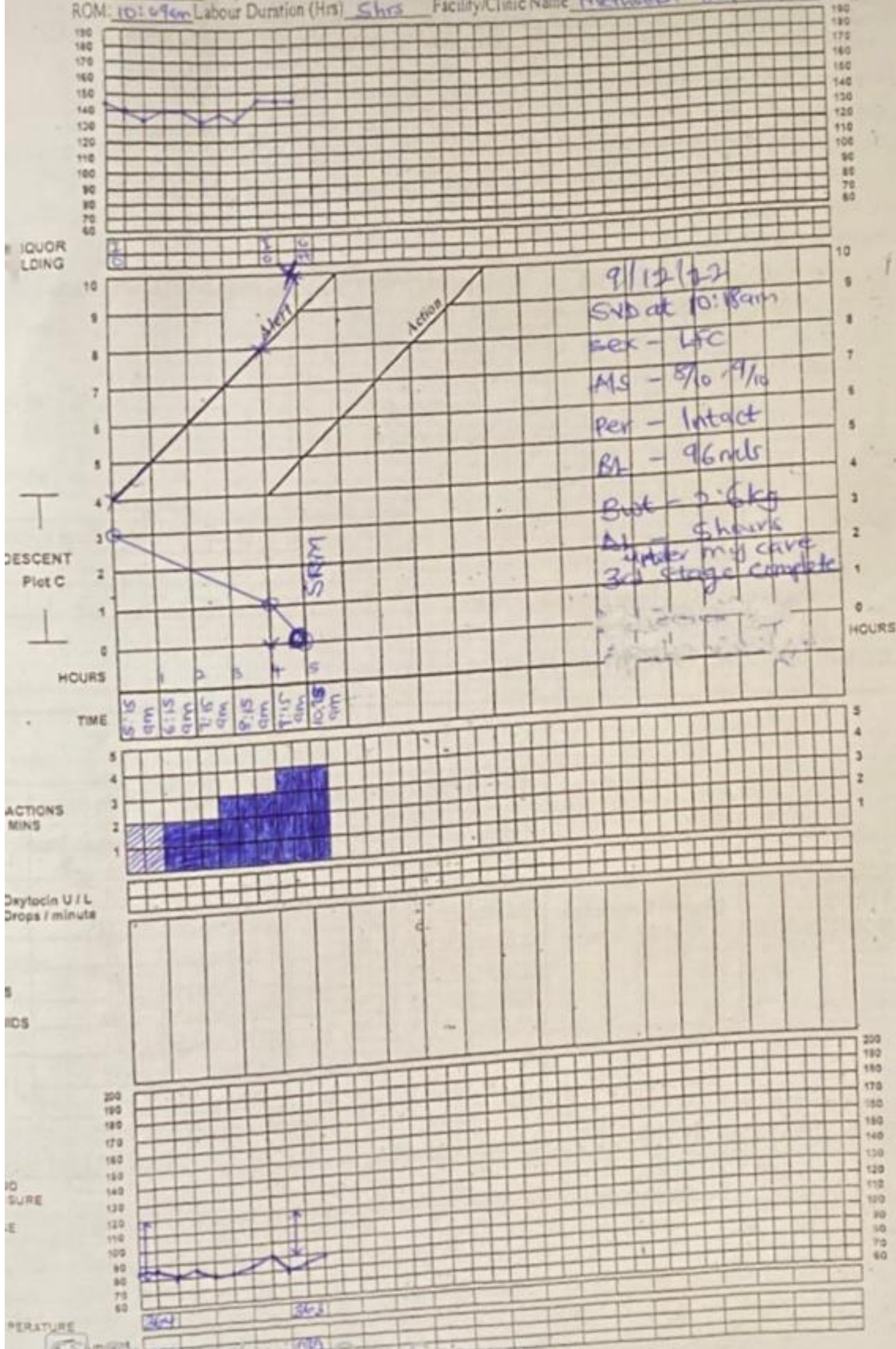
DATE	WT	VITAL SIGNS (BP/TPR)	URINE/ PROTEIN/ SUGAR	HB (GDL)	GESTATION IN WEEKS	FUNDAL HEIG-HT	PRESENTATION	DESCENT	FETAL HEART RATE	COMPLAINS	TREATMENT	REMARKS
24/06/22	72kg	107/73mmHg 36.2°c 73bpm 19cpm	Negative	13.8g/dl	16weeks	17cm	_	_	142bpm	Backache	Routine drugs	Well
22/07/22	73kg	100/60mmHg 36.1°c 80bpm 20cpm	Negative	_	20 WeekS	22cm	_	_	130bpm	No complains	Routine drugs	Well
19/08/22	74kg	100/60mmHg 36.8°c 80bpm 20cpm	Negative	_	24 Weeks	26cm	Cephalic	5/5th	128bpm	Headache	Routine drugs and First SP	Well
16/9/22	75kg	100/60mmHg 36.7°c 78bpm 20cpm	Negative		28 Weeks	29cm	Cephalic	5/5th	134bpm	No complains	Routine drugs and Second SP	Well

ANTENANTAL RECORDS

DATE	WT	VITAL SIGNS (BP/TPR)	URINE/ PROTEIN/ SUGAR	HB (GDL)	GESTA TION IN WEEKS	FUNDAL HEIG-HT	PRESENTA TION	DES CENT	FETAL HEART RATE	COMP LAINS	TREAT MENT	REM ARKS
14/10/22	**75kg**	100/60 36.5^{o}c 74bpm 20cpm	Negative	-	32 Weeks	34cm	cephalic	5/5th	131bpm	No complains	Routine drugs and Third SP	Well
11/11/22	76kg	110/60mmHg 36.5^{0}c 74bpm 20cpm	Negative	12.7g/dl	36 Weeks	38cm	Cephalic	5/5th	132bpm	No complains	Routine drugs and Fourth SP	Well
18/11/22	78kg	100/70mmHg 36.6^{o}c 72bpm 18cpm	Negative	_	37 Weeks	39cm	Cephalic	5/5th	137bpm	Waist pains	Routine drugs	Well
25/11/22	78.5kg	110/70mmHg 36.4^{o}c 75bpm 19cpm	Negative	_	38 Weeks	39cm	Cephalic	5/5th	140bpm	No complains	Routine drugs	Well
2/12/22	79Kg	110/72mmHg 36.4^{o}c 79bpm 21cpm	Negative	12.4g/dl	39 Weeks	40cm	Cephalic	5/5th	135bpm	Constipation-on Waist pain	Routine drugs	Well

WHO Modified Partograph

Registration No. AAAC15230 Name(Last, First) Oforinjia Emmanuella Age: 33
Date: 9/12/22 Parity/Gravida 2/3 LMP 8/03/22 EDD 15/12/22 Gestation(wks) 39+6 days
ROM: 10:09am Labour Duration (Hrs) 5hrs Facility/Clinic Name methodist hospital, Wenchi



LABOR NOTES

Client had SVD at 10:18am to a live female neonate with APGAR score of 8/10 and 9/10 at the 1st and 5th minute respectively. Birth weight of 2.6kg, full length of 49cm and head circumference of 32cm. Inj oxytocin 10 unit given per IM into left thigh after ruling out undiagnosed twin. Placenta and all membranes delivered at 10:22am. Perineum intact on inspection. Cord clamped and cut to seperate baby from mother. Baby dried and all essential baby care done. Baby wrapped warmly and put to breast. Both mother and baby are doing well and under close monitori[ng]

Please circle or write responses.

DELIVERY

DATE: 09/12/2022 TIME: 10:18am METHOD: (Spontaneous) / Vacuum Extraction / C/S / Other

PERINEUM: (Intact) / Episiotomy / Laceration

ANESTHESIA: (None) / Local / General

THIRD STAGE

Active Management: (Yes) / No · Medication: Time 10:20am Type/Dose Oxytocin, 10units

PLACENTA: TIME: 10:22am (Complete) / Incomplete

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

BABY

Weight: 2.6 kg

Sex: Male / (Female)

Baby Position: (Vertex) / Breech / Other

APGAR

Time	Color	Breath	Heart	Tone	Reflex	TOTAL
1min	2	2	2	1	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	10:30	120/80	84	well contracted	no active bleeding	120mls
	10:45am	123/81	87	17cm	"	
	11:00am	119/82	85	well contracted	"	emptied
	1:15am	126/86	80	well contracted	"	
	11:30am	121/80	83	well contracted	"	90mls
	11:45am	127/80	82	well contracted	"	
	12:00pm	120/81	79	well contracted	"	emptied
	12:15pm	121/89	86	well contracted	"	
Every 30 minutes For 1 hour	12:45pm	120/85	81	17cm	"	105mls
	1:15pm	117/81	75	well contracted	"	

Birth Attendant Afrah Evelyn Date 09/12/2022

CS Scanned with CamScanner

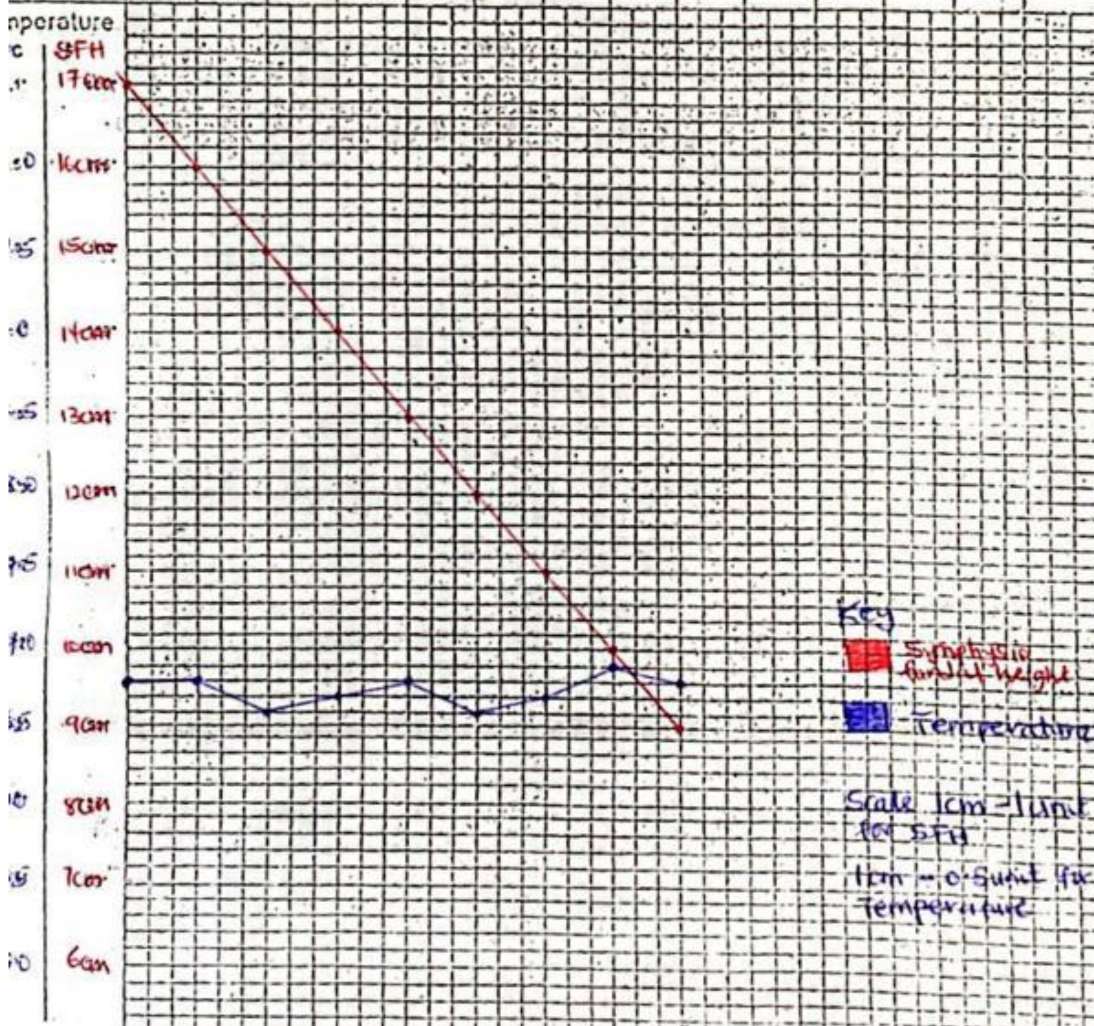
MATERNITY CHART

E: OFORIWAA EMMANUELLA

: 33 YEARS WARD: LYING - IN

D.: AAAG5230 BED NO.: 2

ate	9/12/22	10/12/22	11/12/22	12/12/22	13/12/22	14/12/22	15/12/22	16/12/22	17/12/22					
s in Hospital	Date of birth	Date of disch	D1	D2	D3	D4	D5	D6	D7					
ys P. O.														
our Am	10:18	8:30	7:00	8:00	8:20	7:50	7:50		8:30					
Pm	6:00	6:00	4:30	5:20	4:50			4:30						



Pulse	74 75	65 70	72 75	71 76	75 80	69	78	76	72					
D.	19 21	20 19	17 18	21 22	21 19	20	19	18	21					
.	Passed	Passed	Passed	Passed	Passed	Passed	Passed	Passed	Passed					
ne	Passed	Passed	Passed	Passed	Passed	Passed	Passed	Passed	Passed					
P. AM	120/80	120/70	120/80	120/70	110/80	110/70	110/80		110/80					
	120/80	110/80	110/80	130/70	120/70			130/70						

CS Scanned with CamScanner

NEW BORN EXAMINATION FORM

Baby Oforiwaa Emmanuella Date of Assessment: 9/12/22 Time: 11:00am

f Birth: 09/12/22 Time of Birth: 10:18am Sex: [ ] M [x] F Age at time of Assessment (days/hrs) New

nal Age 37+6days Mode of Delivery: [x] Vaginal Assisted Vaginal C-Section

R: 1min 8/10 5min 9/10 Birth Weight: 2.6 kg [ ] Length: 49 cm Head Circumference: 32 cm

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

f Assessor (Midwife/Doctor): Afrah Evelyn (Student Midwife)

---

iration

- < 30 b/m *
- < 60 b/m *
-) b/m
- ctions *
- ting *
- or *

ity/Movemnet

- aneous symmetric ments
- ed/Absent Movement in nb *
- ovement

- l
- y *
- sed *

- r
- ll over
- ody but blue hands/feet
- l over *

- ed *

- ining pus
- g

7. Suck

- [x] Good
- [ ] Weak
- [ ] Absent

8. Head swelling

- [ ] Caput succedaneum
- [ ] Cephalhaematoma
- [ ] Subgaleal hemorrhage
- [x] No swelling

9. Sutures

- [x] Normal
- [ ] Overlapping
- [ ] Fused
- [ ] Widely Separated *

10. Fontanel

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

11. Eyes

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

12. Ears

- [x] Normal (size / shape/position)
- [ ] Abnormal: ____________

13. Mouth

- [x] Normal
- [ ] Cleft palate
- [ ] Cleft Lip
- [ ] Other: ____________

15. Neck

- [x] Normal
- [ ] Swelling
- [ ] Webbed
- [ ] Other: ________

16. Clavicle

- [x] Normal
- [ ] Swelling/Fracture

17. Chest

- [x] Normal (Shape/movement)
- [ ] Abnormal ____________

18. Heart rate

Rate: ____________

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

19. Femoral pulse

- [x] Present
- [ ] Not palpable*

20. Abdomen

- [x] Normal
- [ ] Distended*
- [ ] Scarphoid*
- [ ] Abdominal defect*
- [ ] Maases: ____________
- [ ] Other ____________

21. Back (spine)

- [x] Normal
- [ ] Abnormal Swelling *
- [ ] Hairly patch over spine
- [ ] Abnormal dimple
- [ ] Abnormal curvature

22. Limbs

- [x] Normal
- [ ] Abnormal ____________

23. Genitalia

Male Genitalia

- [x] Normal
- [ ] Undescended testes
- [ ] Abnormal meatus
- [ ] Hernia
- [ ] Other: ____________

Female Genitalia

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

24. Anus

- [x] Patent
- [ ] Imperforate*

25. Resuscitation provided

- [ ] One
- [x] Suction/stimulation
- [ ] Bag and mask
- [ ] Endotracheal Tube
- [ ] Ventilator/CPAP

26. Services provided

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

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icate severe disease that requires urgent referral

(if known) Spontaneous Vaginal delivery

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

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

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NEW BORN EXAMINATION FORM

Name: Baby Oforiwaa Emmanuella   Date of Assessment: 9/12/22   Time: 11:00am

Date of Birth: 9/12/22   Time of Birth: 10:18am   Sex: [ ] M [x] F   Age at time of Assessment (days/hrs): New

Astational Age: 39+6days   Mode of Delivery: [x] Vaginal   Assisted Vaginal   C-Section

APGAR: 1min 8/10 5min 9/10   Birth Weight: 2.6 kg [ ]   Length: 49 cm   Head Circumference: 32 cm

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

Name of Assessor (Midwife/Doctor): Afrah Evelyn (Student Midwife)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

23. Genitalia

Male Genitalia
- [ ] Normal
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- [ ] Abnormal meatus
- [ ] Hernia
- [ ] Other: ______

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

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

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

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

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

Diagnoses (if known) Spontanous Vaginal delivery (Term baby)

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

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

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Name: Baby Uforiwaa Emmanuella No: AAAG1397/22 Birth Weight: 2.6kg

Sex: Female Mother's No: AAAG5230 Length: 49 centimetres

Nature of Delivery: Spontaneous Vaginal Delivery Diagnosis: Term Baby

Date of Birth: 09/11/2022 Time: 10:18am Date of Discharge: 10/12/2022

Date	9/12/22		10/12/22		11/12/22		12/12/22		13/12/22		14/12/22		15/12/22		16/12/22		17/12/22					
No. of Days	Day of Birth		Day of Discharge		D1		D2		D3		D4		D5		D6		D7					
Weight	2.6kg		2.5kg		2.4kg		2.4kg		2.45kg		2.6kg		2.7kg		2.8kg		2.9kg					
	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM
Temperature	36.5°C	36.2°C	36.8°C	36.7°C	36.7°C	36.4°C	36.7°C	36.5°C	36.6°C	36.7°C	36.5°C		36.7°C			36.6°C	36.4°C					
Stools	Passed	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	Passed					

Remarks:

Head
Neck
Upper extremeties
Trunk
Genitals
Lower extremeties

NAD

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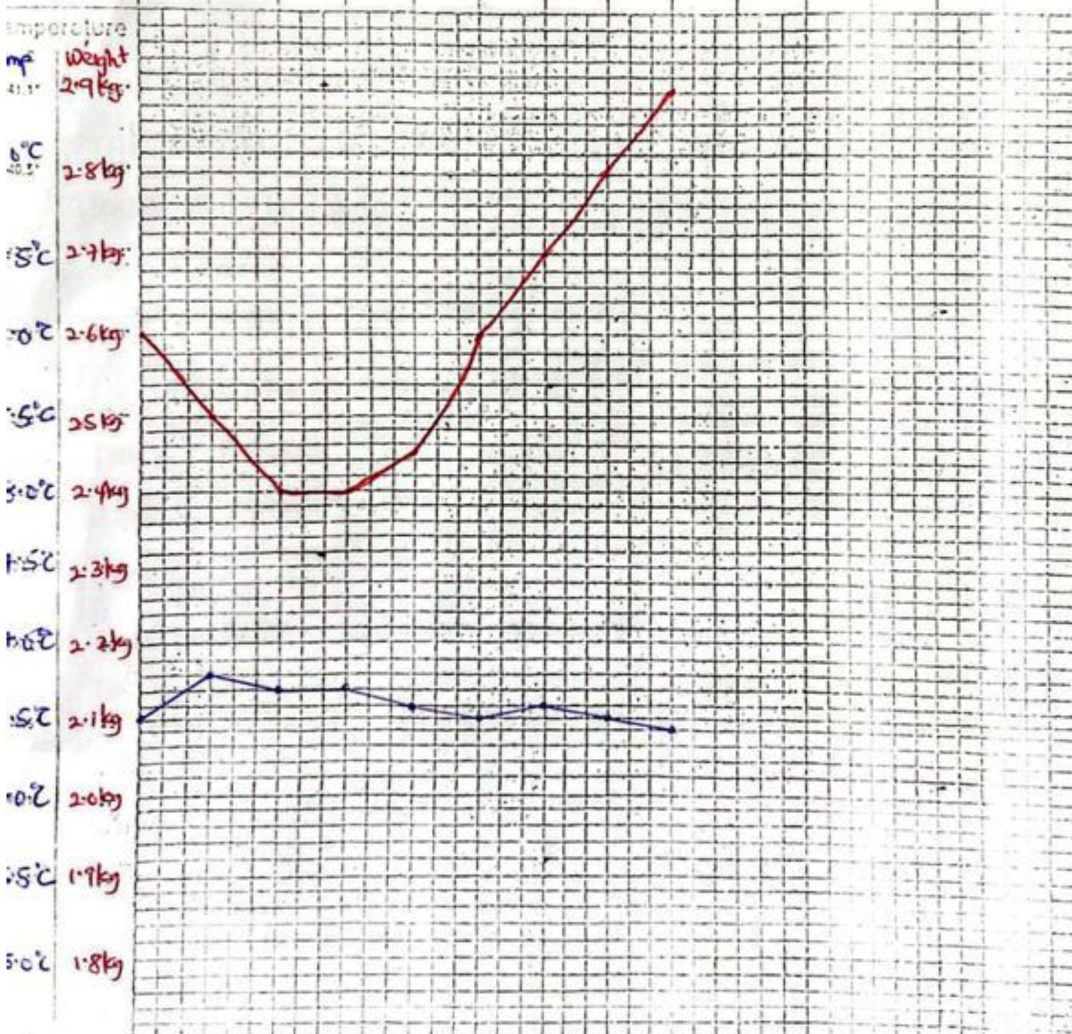
TEMPERATURE CHART

NAME: Baby Oforiwaa Emmanuella

E: New   WARD: Lying-In

IO: AAA G1397/22   BED NO.: Cot 2

Date	9/12/22	10/12/22	11/12/22	12/12/22	13/12/22	14/12/22	15/12/22	16/12/22	17/12/22
Days in Hospital	DOB	DOD	D1	D2	D3	D4	D5	D6	D7
Days P. O.									
Hour AM	10:18	8:30	7:00	8:00	8:20	7:30	7:50		8:30
Hour PM	6:00	6:00	4:30	5:20	4:50			4:30	



	9/12/22		10/12/22		11/12/22		12/12/22		13/12/22		14/12/22	15/12/22	16/12/22	17/12/22
	143	148	147	140	136	139	143	138	136	132	138	129	127	132
	44	48	42	45	44	37	49	37	39	37	36	32	35	39

	9/12/22	10/12/22	11/12/22	12/12/22	13/12/22	14/12/22	15/12/22	16/12/22	17/12/22
Stool	Passed	Passed	Passed	Passed	Passed	Passed	Passed	Passed	Passed
	Passed	Passed	Passed	Passed	Passed	Passed	Passed	Passed	Passed

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SIGNATORIES

THE STUDENT MIDWIFE

NAME: AFRAH EVELYN

SIGNATURE: ....

DATE: 22nd June, 2023

THE MIDWIFE IN CHARGE

NAME: MS. OPHELIA ASANTEWAA

SIGNATURE: ....(for)

DATE: 7/07/2023

THE SUPERVISOR

NAME: MS ERNESTINA MENSAH

SIGNATURE: ....

DATE: 23 - 06 - 2023

THE PRINCIPAL

NAME: MONICA NKRUMAH

SIGNATURE: .... (R)

DATE 17/07/2023

STAMP........................

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