HOLY FAMILY NURSING AND MIDWIFERY TRAINING COLLEGE

BEREKUM

A CLIENT/FAMILY CENTERED MATERNITY CARE STUDY ON

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BY

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PREFACE

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

The family centered maternity care study also gives the student midwife an opportunity to use her knowledge and skills acquired both practically and theoretically during her period of training to care for a pregnant woman throughout pregnancy, labour and puerperium.

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

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

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

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

Again, I wish to express my gratitude and heartfelt appreciation to all the staffs in Kenyasi Health Centre, now (Asutifi North District Hospital), Kenyasi most especially the midwife in-charge, Mrs. Rubamatu Kassim and all the other staffs for their maximum support given to me throughout my care study.

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

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

INTRODUCTION

This Client and Family Centred Maternity care study was on Madam Amoako Lydia a 29years old, Gravida 2 Para 1 and her family who live at Kenyasi in the Asutifi North District in the Ahafo Region. Client was first met on 15th November, 2022 at 36weeks of gestation and in good health. She went through pregnancy, labour and puerperium successfully and delivered a healthy Female baby on the 3rd December, 2022. Mother together with her baby was discharged on the 4th December, 2022. To maintain confidentiality, she will be called Madam Lydia throughout the study. The client was visited at home on several occasions and the entire family as well were included in the care. This study is made up of four chapters namely, chapter one, chapter two, chapter three and chapter four.

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

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

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

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

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

LITERATURE REVIEW

PREGNANCY

Henderson (2009) stated that, pregnancy may be suspected by the woman based on the knowledge on her menstrual cycle, sexual activity and the signs and symptoms of pregnancy. They are; amenorrhea, nausea and vomiting, breast changes, enlargement of the uterus, frequent micturition, skin changes and quickening. These signs and symptoms of pregnancy may be considered as presumptive, probable, and positive. They become obvious to the woman as her pregnancy advances. Women may confirm their pregnancy using home pregnancy test. Confirmation of pregnancy may also be sought from the midwife or doctor. This is established by a detail history and relevant clinic examination based on the signs and symptoms of pregnancy.

According to King et al, (2014), pregnancy is a profound anatomic and physiologic change in a woman's body. In addition to the reproduction organs all maternal physiologic system make adaptations needed to support the developing fetus and at the same time, maintain maternal homeostasis. Pregnancy lasts approximately Two Hundred and Sixty, Six days (266 days) or thirty, Eight weeks (38 weeks) from ovulation. The prenatal period covers the time from the first day of the last normal menstrual period to the start of labour, which marks the beginning of the intrapartum period. The prenatal period is divided into trimesters, first trimester is considered to be week(s) 1 to 12 because organogenesis is complete at the end of twelve weeks and the end. Historically, the second trimester was considered to be weeks 13 to 28 because prior to the introduction of modern neonatal intensive care technique, 28 weeks was limit of viability. The third trimester extends from weeks 28 to 40. The term post - date or post term is typically used to describe a pregnancy beyond forty weeks (40).

Konar (2013), during pregnancy, there is progressive anatomical physiological and biochemical change not only confined to genital organs but also to all systems of the body. This is principally a phenomenon of maternal adaption to the increasing demand of the growing foetus. Unless understood, this physiological adaptation to normal pregnancy can be misinterpreted as pathological. There is enormous growth of the foetus during pregnancy. The uterus which in non – pregnant state weighs about 60g. These occur under the influence of the hormones; oestrogen and progesterone limited to the half year of pregnancy, pronounced up to twelve weeks (12). Three (3) distinct layer of muscle fibres are evidenced, outer longitudinal; inner – circular and intermediate. Normal ante-verted position is exaggerated up to eight (8weeks). Thus, the enlarged uterus may lie on the bladder rendering it incapable of filling, clinically evident by frequent micturition. Increased frequency of micturition is noticed at 6 – 8 weeks of pregnancy which subsides after 12 weeks. It may be due to resetting of osmoregulation causing increased water intake and polyuria. In late pregnancy, frequency of micturition once more reappears due to pressure on the bladder as the presenting part descends down the pelvis. Stress incontinence may be observed in late pregnancy due to urethral sphincter weakness.

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

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

visits should be made according to the following schedule. First Visit: From onset of pregnancy up to sixteen weeks (16) gestation. Second visit: From the 24th to 28th week of pregnancy. Third Visit: at 32nd week of pregnancy and Fourth Visit: at 36th week of pregnancy.

Marie Elizabeth (2013) defines pregnancy as when the woman's egg and a man's sperm cell unit to form zygote. The duration of pregnancy has traditionally been calculated by the clinicians in terms of 10 lunar months or 9 months and 7 days or 280 days or 40 weeks, calculated from the first day of the last menstrual period. This is called menstrual or gestational age. It is divided into 3 trimesters, first trimester is considered to be 1 to 12 weeks because organogenesis is completed at the end of twelve weeks, second trimester is from 13 to 28 weeks and the third trimester start from 29 to 40 weeks. General check-up is done at interval of 4 weeks up to 28 weeks; at interval of two weeks up to 36 weeks and thereafter weekly till the expected date of delivery. Ideally this should be more flexible depending on the need, and the convenience of the patient.

Myles (2009), states that as soon as pregnancy is confirmed, many physiological changes takes place in the body and return to its non-pregnant state during puerperium due to the effect of certain hormones namely progesterone and oestrogen. These hormones are responsible for the major change that takes place during pregnancy. Even though these hormones have their own effects by causing the minor disorders that occurs during pregnancy, they are one way or the other an advantage for the mother and growing foetus since the foetus depends solely on the mother for survival when in utero. Variety of care that are rendered to expectant mothers and their entire families include history taking, physical examination (head to toe examination and abdominal examination i.e inspection, palpation and auscultation), laboratory investigation (urine, blood and stool), administration of routine drugs (folic acid, ferrous sulphate and multivitamins). The anatomical and physiological changes in the uterus play an essential role in pregnancy by

protecting and supporting the fetus, placenta and amniotic fluid. At the same time of labour, it is able to contrast regularly and forcibly to expel the fetus to its unique properties of contractility and elasticity.

LABOUR

Myles (2006) state that, labour purely in physical sense may be described as a process by which the foetus, placenta and membrane are expelled through the birth canal. Labour has four stages. First stage comprises of latent and active phase. The latent stage may take 6-8 hours in primigravida. This begins when the cervix is 3-4cm dilated and in the presence of rhythmic contraction is complete when the cervix is fully dilated (10). The transitional phase is the stage of labour when the cervix is from 8centimetres dilated until it is fully dilated. The second stage is that of expulsion of the foetus. It begins when the cervix is fully dilated and the woman feels the urge to expel the baby. It is completed when the baby is born. The third stage is that of separation and expulsion of placenta and membranes are expelled. It also involves the control of bleeding. It lasts from birth of the baby until placenta and membranes are expelled. The partograph has been widely accept as an effective means of recording the progress of labour. It is a chart on which the salient features of labour are entered in a graphic form and therefore provide opportunity for early identification of deviations from normal. The charts are usually designed to allow for recording 30minutes intervals and include; fetal heart rate, strength of contractions, frequency of contractions in terms of the number in 10minutes, 4hours interval which decent, maternal temperature, pulse, blood pressure, details of vaginal examination, fluid balance, urine analysis and drug administered. Konar (2013) conventionally, events of labour are divided into four stages. First stage starts from the onset of true labour pains and ends with full dilatation of the cervix. It is in other words, "Cervical stage" of labour. Its average duration is twelve hours (12) in primigravida and six hours

(6) in multipara. Second stage starts from the full dilation of the cervix and ends with expulsion of the foetus from the birth canal. It has got two phases, thus the Propulsion phase starts from full dilatation up to the descent of the presenting part of the pelvic floor and the Expulsion phase is distinguished by maternal bearing down efforts and ends with delivery of the baby. in primigravida and thirty minutes (30) in multipara. Third stage begins after expulsion of the foetus and ends with expulsion of the placenta and membranes (after-births). It average duration is about fifteen minutes (15) in both primigravida and multipara. The duration is reduced to five minutes (5) in active management. Fourth stage is the stage of observation for at least thirty minutes after expulsion of the (after birth). During this period, general condition of the client and the behaviour of the uterus are to be carefully monitored. Under bladder care, client is encouraged to pass urine by herself as full bladder often inhibits uterine contraction and may lead to infection. If the women cannot go to the toilet, she is given a bed pan. Privacy must be maintained and comfort must be ensured. If the client fails to pass urine especially in late first stage, catheterization is to be done with strict septic precautions. Under rest and ambulation, if the membranes are intact, the client is allowed to walk about. This attitude prevents vena cava compression and encourages descent of the head. Ambulation can reduce the duration of labour, need of analgesia and improves maternal comfort if, however, labour is monitored electronically or analgesic drug (epidural analgesia) is given, she should be in bed. Assessment of progress of labour and partograph recording are also done. Partographs are tools that allow labour progress to be graphically recorded and visually assessed. They aid in the early detection of abnormal labour progress and are credited by some for decreasing rated of prolonged labour, oxytocin use, caesarean section and intrapartum morbidity/mortality as compared to usual care. Use of partograph is initiated during presumed active labour.

Marshall and Raynor (2014) Labour, purely in the physical sense, may be described as the process by which the foetus, placenta and membranes are expelled through the birth canal; however, labour is much more than a purely physical event. What happens during labour can affect the relationship between the mother and the baby and can influence the likelihood and / or experience of future pregnancies. Human pregnancy is considered to last approximately 40 weeks. Complex physiology and psychological changes occur during the last few weeks of pregnancy and also during the onset of labour that prepare the woman for the process of labour and birth. Traditionally, three stages of labour are described, the first, second and third stage, but this is a rather pedantic view, as labour is obviously a continuous process. It has also been acknowledged that, there are three phases of labour, namely, the latent, active and transitional phases and these not only encompass specific physical changes but should also account for the emotional effect observed in women during this time. The onset of labour is a process, not an event; therefore, it is very difficult to identify exactly when the painless (Sometimes painful) contractions of pre labour develop into progressive rhythmic contractions of established labour. Diagnosing the onset of labour is extremely important, since it is on the basis of this finding that decision are made that will affect the intrapartum care and support subsequently provided. Under bath or shower, immersion in a warm bath or birthing pool can be an effective form of a pain relief for labouring women that facilitates increased mobility with no increased incidence of adverse outcome for the woman or foetus. The midwife should invite the woman who is mobile to have a bath or shower whenever she wishes during labour. Active management of the third stage of labour (AMTSL): An active management policy usually includes the routine prophylactic administration of an uterotonic agent, either intravenously, intramuscularly or (Occasionally) orally, as a precautionary measure aimed at reducing the risk of post-partum haemorrhage. It is applied regardless of the assessed obstetric risk

status of the woman, and is usually undertaken in conjunction with clamping of the umbilical cord shortly after birth for the birth and delivery of the placenta by the use of controlled cord traction.

King et al, (2014) labour is classically defined as the occurrence of regular painful contraction that promotes dilation of the cervix. Contractions that occur at regular intervals with increasing frequency, duration and intensity are the hallmark of labour. The onset of spontaneous labour cannot be reliably predicted, although many pregnant women experience premonitory signs or symptoms of impending labour. Common signs and symptoms suggestive of physiologic progress towards labour include descent of the foetus, cervical changes, increase in uncoordinated uterine contractions, rupture of membranes, bloody show or increased mucus discharge from the vagina, maternal perception of increased energy, gastrointestinal distress. Labour is the process by which childbirth occurs, requiring uterine contractions of sufficient frequency, duration and intensity to cause demonstrable effacement and dilatation of cervix.

Physiologic adaptations during labour are required to support the unique demands imposed on both the woman giving birth and her foetus. Traditionally, the processes involved in labour and birth have been conceptualized as those that affect the power (uterus), the passenger (foetus) and the passage (pelvis). The term fourth stage of labour refers to six hours following placental expulsion.

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Henderson (2009) stated that normal labour naturally follows a sequential pattern that involves painful regular uterine contractions stimulating progressive effacement and dilatation of the cervix and decent of the foetus through the pelvis, culminating in the spontaneous vaginal birth of the baby, followed by the expulsion of the placenta and membranes. The aims of midwifery care in

labour are to achieve a safe labour and birth for mother and baby, and a pleasurable, fulfilling experience of child birth for the mother and her partner. In order to give women centred care, the midwife should: Assess the needs and expectations of each individual woman regarding labour and birth. Plan care with each woman in labour that is tailored to meet her specific needs and expectations. Put the care plan into practice and evaluate the care given to measure its effectiveness. Under emotional and psychological care, it is important for the midwife to have a good understanding of women's feelings in labour. Attitudes and reactions to childbirth vary considerably and are influenced by differing social, cultural and religious factors. Many women anticipate labour with mixed feelings of fear and excitement. Throughout labour, there should be a free flow of information between the women and her partner and the midwife, particularly in relation to examinations and their findings. Being fully informed and involved in decision making helps the women to retain a sense of autonomy and control. The midwife should be aware that not all individuals may feel sufficiently secure or able to express fear or anxiety during labour.

PUERPERIUM

Myles (2008) states that, following the birth of the baby and expulsion of the placenta, the mother enters a period of physiological and psychological recuperation. Puerperium starts immediately after the delivery of the placenta and membranes continue for six weeks. The overall expectation is that by the six weeks after birth of the baby, all the body systems will have recovered from the effects of pregnancy and return to their non-pregnant state. Between exercise and healthy activity verse rest, relaxation and sleep, exploring each person's level of activity will encouraged in relation to appropriate exercise and by association, nutritional intake and rest or relaxation and sleep. Undertaken regular pelvic floor exercise is of benefit the woman's long term health.

According to Henderson (2009), the postnatal period or Puerperium is traditionally defined as the time from immediately after the end of labour until the reproductive organs have returned as nearly as possible to their pre gravid condition, a period estimated to be around 6-8 weeks. The changes in the urinary tract include a marked diuresis after delivery which lasts for 2-3 days. This is due to the reduction in blood volume occurring in the immediate postnatal period. The falling levels of progesterone affect the alimentary tract. The smooth muscle tone gradually improves throughout the body and symptoms of heartburn the women may have experienced should resolve. Constipation may however remain a common problem during the postnatal period.

According to Konar (2013), involution is the process whereby the genital organs revert back approximately to the state as they were before pregnancy. The woman is termed as puerperal. Puerperium is the period following child birth in which the body tissues, especially the pelvic organs revert back approximately to the pre – pregnant state both anatomically and physiologically. During Puerperium the following physiological changes take place in all women as the body returns to its pre-pregnant state: Involution of the uterus and other soft parts of the genital tract. Commencement of lactate. Physiological changes in other systems of the body. It is important that the midwife is familiar with these to ensure that appropriate care and advice are given. Puerperium begins as soon as the placenta is expelled and lasts for approximately 6 weeks when the uterus becomes regressed almost to the non-pregnant size. The period is arbitrarily divided into immediate-- within 24 hours; early – up to 7 days and remote – up to 6 weeks. Lochia is the vaginal discharge for the first fortnight during Puerperium. The discharge originates from the uterine body, cervix and vagina. Depending upon the variation of the colour of the discharge, it is named as: Lochia rubra: red, 1-4 days. Lochia serosa: 5-9 days, the colour is yellowish or pink or pale brownish. Lochia Alba: 10-15 days, pale white. The average amount of discharge for the

first 5-6 days is estimated to be 250mls. Normal duration may extend up to 3 weeks. Prolactin from the anterior pituitary gland initiates lactation. Once lactation commences, it is maintained by the baby suckling. This provides the natural stimulus for the release of prolactin.

Marie Elizabeth (2013) describes puerperium as the period following childbirth during which the body tissues, especially the pelvic organs revert back approximately to the pre-pregnant state both anatomically and physiologically. The period is divided into; Immediate –within 24 hours, early- up to 7 days, remote –up to 6 weeks, immediately following delivery, the uterus becomes firmer and retracted with alternatively hardening and softening. At the end of 6 weeks, its measurement is almost similar to that of the non-pregnant state and it weighs 60 grams. The lower uterine segment becomes thin, flabby and collapsed structure. The cervix contracts slowly; the external os admits to fingers for the few days but by the end of the first week, narrows down to admit the tip of a finger only. The external os never revert back to the nulliparous state. During puerperium the number of muscle fibers is not decreased but there is substantial reduction in the myometrial cell size. The arteries are constricted by contraction of its wall and thickening of the intimae followed by thrombosis. New blood cells grow in the thrombi. Soon after birth it takes a long time (4 to 8 days) for the vagina to involutes. The vaginal discharge for the first fortnight during puerperium is the lochia. The lochia originates from the uterine body, cervix and vagina. Depending upon the variation of the colour of the discharge it is named as: Lochia rubra (red) 1 -4 days, lochia serosa (yellowish or pink or pale brownish) 5- 9 days, lochia alba (pale white) 10 -15 days. The average amount of discharge, for the first 5-6 days is estimated to be 250 ml.

Marshall and Raynor (2014) puerperium starts immediately after the delivery of the placenta membrane and continues for six (6) weeks. In many cultures around the world, 40 days for recuperation is a time- honored 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 effects of the pregnancy and recovered to their non-pregnancy state.

WHY CLIENT WAS CHOOSEN

On 15th, November, 2022, Madam Lydia was met at the facility. Her routine labs confirmed Malaria as positive (+). Client was informed about the interest to take her as client and she agreed. The midwife in- charge was also informed and she gave the go ahead. This made me choose her as my client for the care study.

CHAPTER ONE

CLIENT'S PARTICULARS

1.0 INTRODUCTION

This chapter deals with assessment of the client. It gives information about Madam Lydia, the client used for the study, her social history, daily habits, and surgical, menstrual, obstetric and family histories. Information was acquired through observation, interview and antenatal care.

1.1 PERSONAL AND SOCIAL HISTORY

Madam Lydia is 29years of age comes from SEWEA in the Ashanti Region of Ghana but stays at Kenyasi No.1 specifically bypass in the Ahafo region with her family. She speaks only Twi. She is a Catholic, where she worships at Asueti. She is dark in complexion and is 154cm tall and weighs 53kg at booking. Her level of education ended at Senior high school. Client is a seamstress, she also have her own working shop where she sells pastries and she is married to Mr Alfred Antwi Boasiako who is a Mason. They have been married for four (4) years now. Mr. Antwi is 35years of age and lives in Sawea. He speaks English and Twi. He comes from Sawea in the Ashanti region.

Madam Lydia intention is to deliver at Kenyasi Health Centre at Kenyasi; Client has one female. Her first daughter is three years old. Madam Lydia's next of kin is her Mother. Client does not smoke and does not take alcohol.

1.2 FAMILY HISTORY

Opanin Amponsah and Madam Sakyiwaa Alice are the parents of Madam Lydia Amoah. Madam Lydia is the sixth born among eight children of her parents. According to her, all her parents are alive. Madam Lydia said there are no known hereditary conditions such as sickle cell disease, hypertension, mental disorder, epilepsy, diabetes and asthma in her family. She further stated that there is no history of multiple pregnancies in her family. According to her death in her family was natural.

1.3 MEDICAL HISTORY

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

1.4 SURGICAL HISTORY

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

1.5 MENSTRUAL HISTORY

According to client, she has a twenty-eight (28) days menstrual cycle and bleed for five days. She had her menarche at the age of fourteen (14) and since had a regular menstrual flow with no dysmenorrhea. She uses sanitary pad during her menstruation and she changes it at least twice a day.

1.6 CLIENT'S LIFESTYLE AND HOBBIES

Madam Lydia wakes-up around 6am and goes to bed around 9pm. She washes her face and brushed her teeth with toothbrush and toothpaste and sometimes uses tooth stick as well. She then sweeps her compound and bath her child. Client then takes her bath and prepares breakfast for the family, before she goes to the store. Madam Lydia closes from shop around 4pm and goes back home and prepare supper for her family around 5pm. She eats thrice daily and empties her bowel at least once a day, she neither smokes cigarette nor takes in alcoholic drinks

On Saturdays client sweeps and cleans her compound, her dirty clothes as well as that of her husband and her daughter are washed and dried in the sun. Madam Lydia's favourite food is Fufu with light soup. She enjoys conversing and uses her leisure time mostly to sleep. On Sundays client goes to church with her family and closes around 12:00pm. Client goes to the market every Thursday (which is a market day) to buy foodstuff in bulk and shops for the items that she would need in the upkeep of the house. She then comes home and prepares food for the family.

1.7 PAST OBSTETRIC HISTORY

Pregnancy; Madam Lydia G2P1, has no history of abortion. She went through her pregnancy without any complications such as antepartum haemorrhage, severe anaemia and gestational

diabetes but sometimes suffers from minor disorders such as heartburn, abdominal pain and had term pregnancy. Her pregnancy was up to term. The interval band between her previous and the current pregnancy is three years. She said she has had four doses of Tetanol toxoid injection during her first and second pregnancy and had all the doses of Sulphadoxine Pyrimethamine as prophylaxis against malaria. She was a regular attendant to antenatal care until she delivers.

Labour; She had spontaneous vaginal delivery. The baby cried as soon as she was delivered. She weighed 3.0kg at birth. She did not labour more than 18hours for the first child. She delivered her first child at Kenyasi Health Centre. The third stage was actively and properly managed within five (5) to fifteen (15) minutes without any complications, she further mentioned that she had no history of retained placenta and the perineum was always intact and on examination, there was no scar of episiotomy or any degree tear. In the fourth stage, the condition of the mother and the baby were good. She had no postpartum haemorrhage according to her.

Puerperium; Madam Lydia's puerperal period according to her was normal. She had no puerperal psychosis, sub-involution and she visited the postnatal clinic as scheduled. She and her baby were healthy throughout. She practiced exclusive breastfeeding for six (6) months and combine supplementary feed like corn dough porridge while she continues with the breastfeeding till the child was two years old. According to Madam Lydia, her child received the immunization against childhood preventable diseases. According to client, she had never practiced any family planning method and her child has been healthy since birth.

1.8 PRESENT OBSTETRIC HISTORY

Madam Lydia G2P1 visited the antenatal Kenyasi Health Centre at Kenyasi. According to her, she cannot remember her last menstrual period and her expected date of delivery was 12th December 2022. (According to scan). On Madam Lydia's first antenatal clinic visit, her history was taken

and recorded which included personal, family, medical, surgical and obstetrical histories. Laboratory investigations were also taken and physical assessment was done and recorded. Results of investigations which were carried out are as follows; Haemoglobin Level : 11.7g/dl, Sickling Test Negative, Blood group B, Rhesus factor :Positive ,G6PD :No defect, VDRL; Negative ,HIV status; Not reactive, Urine R/E ;No abnormalities detected, Stool R/E; No abnormalities detected.

The following observation were made and recorded; Temperature; 36.5^{0}C, Pulse ;75bpm, Respiration ;19cpm, Blood Pressure ;110/70mmHg, Hepatitis B status ;Negative, Weight 62kg, Height ;155cm

Records on Madam Lydia's antenatal card indicated that she was examined from head to toe and no abnormalities were detected. On abdominal examination, no abnormalities were detected and symphysio-fundal height was palpable and measured 19cm and gestational age was 20weeks. She had no complaints, therefore she was served with the following routine drugs.

Tablet folic acid - 5mg (1 daily) for 30days

Tablet ferrous sulphate - 200mg (1 daily) for 30days

Tablet multivite - 200mg (1daily) for 30days.

She was scheduled for the next visit which she followed correctly and carried out all the laboratory investigation requested until she was met. She had attended ANC 6 times before she was met. She had taken four doses of sulphadoxine pyrimethamine and the 4th dose of tetanol toxoid injection.

CHAPTER TWO

ANTENATAL CARE

2.0 INTRODUCTION

This chapter deals with the care that was given to client during her antenatal period. It include first contact with the client, home visits during antenatal period, subsequent visit to the hospitals and the care plans written to solve problems confronted by client.

2.1 FIRST CONTACT WITH CLIENT

Madam Lydia was met on the 15th November, 2022 at Kenyasi Health Centre during the antenatal day when she was 36 weeks pregnant. It was her fourth visit to the hospital. Client was brought to the facility on account of Malaria by her mother. Client was then taken to a confidential room and education was given on the effect of Malaria on her and her unborn child. This woman was approachable and ready to share any information. Introduction was made as Adjei Kopri Evelyn, a student midwife from Holy family nursing and Midwifery Training College Berekum on placement for Family Centred Maternity Care Study. She was afterwards sent to the vital signs table where her vitals were taken and recorded in the antenatal book. Her antenatal book was collected and it was found out that she fell within the criteria for care study. Madam Lydia was informed that, she would be monitored closely from pregnancy through labour to Puerperium as she has been chosen for care study. Client humbly agreed. She was thanked for her understanding and co-operation. She was also assured of confidentiality. The in-charge was also informed about the selection and she agreed to it. She was then taken through the general examination when it got to her turn with procedure explained. She was encouraged to asked questions. Below is the results recorded on first contact.

Temperature;36.5^{o}C, Pulse 76bpm Respiration 22cpm Blood pressure - 106/70mmHg, Weight 60 kg Height 155cm, Urine for protein and sugar; Negative, Haemoglobin level;12.8g/dl. Before the examination was carried out, client was informed and she gave her approval for the procedures to be carried out. She was reassured that all findings will be communicated to her and she was asked to void and was assisted to lie on the bed. Soap and water were used in washing of the hands after which they were dried with a clean towel and privacy was ensured. Head to toe examination was performed thoroughly.

2.2 PHYSICAL EXAMINATION

After checking for her cleanliness of the hair, there were also no dandruff, lice, ringworm, loss of hair, scalp infection and no abnormalities were detected. Client was congratulated for keeping the hair clean and was encouraged to keep it up. The face was inspected for Chloasma, oedema and rashes but no abnormality was detected. The ears were inspected and there were no discharges. The eyes were inspected for jaundice of the sclera, pallor of the conjunctiva, alignment with the ears and discharges but nothing abnormal was detected. Also client lips were inspected for pallor, dryness, lesions, sores and mouth for tooth decay, loss of teeth and halitosis but no abnormality was detected. Madam Lydia's neck was also checked and palpated. But there was no enlarged thyroid gland, lymph nodes and not distended neck vein or lumps.

During breast examination, both breasts were exposed to check for size, shape, dimpling, nipple retraction and condition of the skin. One breast was covered and she was asked to put hand of the part to be examined under her head. The breast was systematically palpated in a circular manner using the inner aspect of the fingers starting from the axillary tail of Spence. No abnormality was found. There were no masses, lumps, cracked or sore nipple and enlarge axillary lymph nodes. Client nipple was squeezed gently to see if there is any abnormal discharge clean with swab. Accordingly, the fluid was examined and no abnormality was found. The same was done for the other breast and no abnormality was found. Client was also taught self-examination of the breast. The condition of the skin was also good. Client was assisted to redress and findings communicated to her. Client was thanked for her co-operation. Hands were washed and dried and findings recorded. She was educated on the need to wear well-fitting brassieres and how to perform self-breast examination.

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

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

Abdominal Examination and Palpation

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

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

Measurement of symphysio-fundal height: Hands were warmed, the upper symphysio-fundal height measured 35cm and gestational age was 36weeks.

Fundal palpation was carried to find out the lie and presentation of the feotus. Facing Madam Lydia, palms were rubbed together to provide warmth and to prevent inducing contractions. To

determine what is found at the fundus of the client, the palm was placed on the abdomen below the xiphisternum and was gently moved downwards until the fundus was felt.

Lateral palpation assesses the main body of the uterus to confirm the lie and identify the foetal position. This was done with palms on both sides of the uterus midway between the symphysis pubis and the fundus; the uterus was stabilized with a hand. Also, palpation was done through the entire midline to the lateral side of the abdomen to locate the foetal back in a rotary manner. The other hand was also used to stabilize the uterus and the procedure was repeated for the other half of the abdomen.

The right lateral palpation was done at the right side of the woman and a smooth part was felt, which indicated the foetal back, which will help to position the fetal stethoscope to listen to the foetal heart rate and the foetal limbs. Lastly, rough part was located on the left side of the mother. The position was right occipito anterior.

Pelvic palpation is used to identify the presentation, which is the part of the foetus lying in the lower pole of the uterus and over the pelvic brim. This examination was done facing Madam Lydia’s feet. She was asked to flex the knee slightly and helped to relax by guiding her to breathe out slowly. Both hands were used in the process. One hand is placed on the either side of the presentation and pressure is applied with the other hand. Accordingly, a hard mass was felt at the lower pole indicating the head of the foetus. The lie was longitudinal and presentation was cephalic.

Descent of the head; Location of the anterior shoulder was made and two fingers were placed on it. The symphysis pubis was located and the right ulna border was placed just above the symphysis pubis and the anterior shoulder. Five fingers occupied the space indicating decent of 5/5.

On auscultation, the feotal stethoscope was warmed by rubbing in the palm and placed at the area where the foetal back was located to listen to the foetal heart rate. With one hand at the maternal radius to ensure that it is not the maternal pulse being listened to, the foetal heart rate was checked for one minute and recorded as 138 beats per minute.

Permission was sought to inspect the vulva and it was granted. A pillow was placed under her head and she was draped to provide privacy and modesty. Hands were washed with soap and clean running water and dried with clean towel. Sterile gloves were worn on both hands and the vulva and perineum were examined for abnormal discharges, rashes, genital wart, ulcers, scars and varicose vein. The labia majora was examined for same size and shape, redness, swelling and tenderness and nothing abnormal was detected. The client was asked to lie laterally and sit up before getting out of the couch. Madam Lydia was thanked for her cooperation and findings were communicated to her. All items were decontaminated appropriately. The gloves were removed and discarded. Hands were washed with soap under running water and dried with clean towel and all findings recorded in her antennal record book. Client was asked of any complains and questions. Client complains of waist pain. She was educated that, the pain was due to the weight of the gravid uterus. Client was encouraged to sit on seats with back rest and also taught how to perform exercise in pregnancy such as pelvic rock which helps to relieve back and waist ache, head and shoulder lift which helps to strengthen abdominal muscles and kegel exercise which helps to strengthen the pelvic floor muscles that makes delivery easier. She was also encouraged to take her drugs as prescribed.

Health education was given on birth preparedness, labour and delivery. She was also informed on home visits which she agreed. Her phone number with directions to her house was taken. The day

for the first visit was scheduled on the 17th November, 2022. She was thanked for her cooperation and the following drugs were given to her:

Tablet of Ferrous sulphate 200mg daily for 30days.

Tablet of folic acid 5mg daily for 30days.

Tablet of multivitamin 200mg daily for 30days.

Client was informed of her next visit which was on 22nd November, 2022. Client was also encouraged to report any problem like severe headache, vaginal bleeding and swelling of the lower limbs, severe abdominal pains and excessive vomiting immediately. All activities carried out and findings were recorded and reported.

2.3 FIRST ANTENATAL HOME VISIT

First home visit to Madam Lydia's house was on the 17th November, 2022 at 4:00pm. The main aim was to know where she lives, check how she was coping with pregnancy, meet members of her family, observe her physical environment, listen to her complains and address the needs of her family. The journey was made by an okada because the client's house is quite far from the clinic per directions given by her. It is located at Kenyasi Bypass road near the slaughter house. A seat was offered, a cup of water was offered after which interaction with client started. Introduction was made to the family. She was very glad for the visit. Her daughter was around on a play ground with her friends. And client was there with her mother preparing food for the family. Client lived in a boys quarters house. Layette was brought for inspection and it was complete. She was congratulated for purchasing all the items and was advised to add her National Health Insurance card, ANC card and a purse of money. Education was also given on the need to sleep under treated mosquito net to prevent contracting malaria. As advise that, malaria infection can result in complication in pregnancy. Client was educated on the signs of labour, and the progress of labour.

Then she complained of difficulty emptying her bowls. Client was encourage to take enough water, eat fruits like oranges, water melon and any fruit of her choice to help prevent constipation and She was also educated on the intake of a well-balanced diet, the importance of having enough sleep and rest, lifting of light loads and wearing of loose cloths and low heel shoes. She was again encouraged to keep up on her environmental hygiene. She was informed of the next visit, permission was sought to leave, she was very grateful. She was thanked for her cooperation and willingness to heed to the advice.

2.4 PSYCHOSOCIAL LIFESTYLE

The house was built with blocks and roofed with aluminium sheet. There were six bedrooms, toilet and bath are out the house. Outside the house was not painted but plastered with cement while inside of the room was painted with blue and white colour. Client and her daughter use one room, her mother also in one room and two rooms are also for tenant while, one other room is for her brother and the remaining one is not completed. Their surroundings were neat and not bushy. She uses plastic container with lid to collect her refuse and empties bin every morning. The used water from the bathroom drains through a pipe into a gutter. They have a pipe from which they fetch water and electricity as a source of light. They use pipe-born water as their drinking water. Water use for other purposes such as cooking, bathing, washing is stored in a blue coloured barrel covered with a lid.

2.5 SECOND ANTENATAL HOME VISIT

On the 19th November, 2022 at 4:30pm Madam Lydia was paid a visit as promised. A hospitable welcome was given by client. Client's husband was met, they were all happy after exchange of pleasantries, she complained of heart burns. Client was educated on the low intake of fatty and

spicy foods; she was thought to use more pillows to prop herself. Client was reassured and the physiological change in pregnancy was explained to her that, they will subside and disappear after delivery. Client was reminded on the true signs of labour. She also complained of feeling fatigue. We then discussed about postpartum family planning and her husband said they were interested in it

2.6 SUBSEQUENT VISIT TO THE CLINIC BY THE CLIENT

Madam Lydia reported to the hospital on the 22nd November, 2022. As scheduled. Client was asked of her previous complains and she confess that she can now pass stool freely. She was helped through the normal routine procedures and her vital signs were checked and recorded as follows; Temperature 36.2, Pulse 78bpm, Respiration 20cpm, Blood pressure 120/73mmHg, Other investigations were recorded as follows; Haemoglobin 12.8g/dl Weight 63kg. Client was asked to empty her bladder, midstream urine sample was tested for protein and sugar and it was negative.

Privacy was ensured and Madam Lydia was helped to change into gown and onto the examination couch. General examination was carried out under the supervision of the midwife in-charge and no abnormalities were found. On abdominal examination the symphysio-fundal height was 36cm and her gestational age was 37weeks. On lateral palpation the position was right occipito- anterior. On auscultation, the foetal heart rate was 134bpm with regular rhythm and good volume.

All findings were communicated to her and recorded in her antenatal card. Routine haematinics were given and she was advised to take them regularly as prescribed and reports after a week.

PROBLEMS IDENTIFIED DURING ANTENATAL CARE

1. Constipation
2. Heartburns
3. Fatigue

4. Lower abdominal pains

SHORT TERM OBJECTIVES

1. Client will be able to empty her bowl at least once within 48hours.
2. Client's heartburns will be reduced and cope with it till the end of pregnancy.
3. Client's fatigue will be reduced and cope with it throughout pregnancy.
4. Client will be able to cope with lower abdominal pains throughout pregnancy

LONG TERM OBJECTIVES

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

ANTENATAL CARE PLAN

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
22/11/22 7:00am	Constipation related to progesterone causing decrease peristaltic movement of the bowls and relaxation of the smooth muscles of the intestine.	Client will be able to empty her bowl at least once within 48hours as evidenced by; Client verbalizing that she is able to empty her bowels.	1. Reassure client to allay fear and anxiety. 2.Explain the physiology behind constipation 3. Educate client on the intake of food rich in fibre 4. Encourage client to take a lot of fluids every day. 5. Encourage the client to engage in tolerable exercises such as walking.	1. Client was reassured to allay fear and anxiety. 2. The cause was explained to client that it is as a result of smooth muscle relaxation by progesterone during pregnancy. 3. Client took food rich in fibre like oranges, banana. 4. Client drank eight glasses of water per day. 5. Client understood the health benefits of exercising and engage herself in walking.	24/11/22 7:00am	Goal fully met. Madam Lydia told midwife she was able to empty her bowls.	

ANTENATAL CARE PLAN

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
24/11/22 9:00am	Heart burns related to effect of progesterone causing relaxation of the cardiac sphincter during pregnancy.	Client's heartburns will be reduced and cope with it till the end of pregnancy as evidence by; Client verbalising that her heartburns has reduced.	1. Reassure client that her heart burns will be relieved. 2. Educate client on the physiology of heart burns. 3. Encourage client to reduce the intake of oily and spicy food. 4. Encourage client not to go to bed immediately after meals. 5. Educate client to use more pillows when sleeping to raise the head and shoulders.	1. Client was reassured that her heart burns would be relieved 2. The physiology was explained to client that the heart burn was as a result of relaxation of the cardiac sphincter by progesterone. 3. Client reduced intake of oily and spicy food. 4. Client spent 2hours before going to bed after meals 5. Client used more pillows when sleeping to raise the head and shoulders.	03/12/22 9:50pm	Goal partially met. Madam Lydia told midwife her heartburns has reduced.	

ANTENATAL CARE PLAN

DATE/ TIME	NURSING DIAGNOSIS	OUTCOME OBJECTIVE CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
26/11/22 7:30am	Fatigue related to weight of the growing foetus and stress from work	Madam Lydia fatigue will reduced and cope with it throughout pregnancy as evidence by; Client verbalising ability to cope with weight of product of conception and reduced stress of work.	1. Reassure client that her fatigue will reduce. 2. Encourage family members to help with household chores. 3. Teach client energy conservation techniques such as sitting rather than squatting or standing whiles working. 4. Encourage client to have adequate rest and exercise during the day. 5. Encourage client to engage herself in mild exercise to help relieve her from some stress in pregnancy.	1. Client was reassured that her fatigue will reduce. 2. Family members assisted in household chores. 3. Client was seen sitting rather than squatting or standing whiles working. 4. Client rested for at least 30minutes during daily activities. 5. Client engaged in deep breathing exercise which helped relieved her from the stress in pregnancy.	03/12/22 9:50am	Goal fully met. Client verbalising ability to cope with weight of product of conception and reduced stress of work.	

ANTENATAL CARE PLAN

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
28/11/22 4:30pm	Lower abdominal pain related to descent of the feotal head.	Client will be able to cope with lower abdominal pains throughout pregnancy evidenced by; Client verbalising that lower abdominal pain has reduced.	1. Reassure client to allay fears and anxiety. 2. Explain the physiology of lower abdominal pains to client. 3. Encourage client to wear low heel shoes. 4. Encourage client to have adequate rest and sleep. 5. Serve client with prescribed analgesic (Paracetamol).	1. Client was reassured to allay fears and anxiety 2. Lower abdominal pain was explained to client that it was due to the descent of the fetal head. 3. Client wore low heeled shoes throughout pregnancy. 4. Client was encouraged to have at least 2hours rest and sleep during the day and 6hours in the night. 5.Client was served with 1G of Paracetamol.	03/12/22 9:50pm	Goal fully met. Client verbalizing that lower abdominal pain has reduced.	

CHAPTER THREE

LABOUR

3.0 INTRODUCTION

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

3.1 ADMISSION AND MANAGEMENT OF LABOUR

ADMISSION

On 3rd December, 2022 at 3:30pm, Madam Lydia arrived at Kenyasi Health Centre with her Mother per ambulatory. They were warmly welcomed and seats offered to them. She complained of severe lower abdominal pains, painful uterine contractions and client said she had noticed some mucoid blood stain vaginal discharge (show) before coming. Madam Lydia was taken to the delivery room and her mother was given a chair to sit outside at the visitors lunge. At the delivery room, client was oriented and wash room shown to her, she was offered a bed. Procedures to be done were explained to client and her consent was given. Her vital signs were checked and recorded as follows; Temperature 36.2^0 C, Pulse rate 87 beats per minute, Respiration rate 20cpm, Blood Pressure 110/60mmHg

Client was served with a bedpan to empty her bladder and a specimen bottle for mid-stream urine. The mid-stream urine taken tested negative for protein and glucose using the urine reagent strip. The amount of urine produced was 150mls. She was assisted unto the couch; after

changing to gown, hands were washed and dried with a clean dry towel. Client was examined from head to toe and no abnormalities were detected.

Inspection: Client abdomen was ovoid in shape and medium in size. Striae gravidarium, linear nigra and foetal movement were present but no scar was found.

Palpation: The abdomen was palpated, symphysio fundal height was 37cm, and gestational age was 39weeks+1day the lie was longitudinal, presentation was cephalic and descent was $3/5^{th}$ palpable abdominally. Contraction was 3 in 10minutes lasting thirty (30) seconds.

Auscultation: The foetal heart rate was 140beat per minute with good volume and regular in rhythm.

Vagina Examination

Permission was sought from Madam Lydia for vaginal examination which she agreed. . Hands were washed with soap under running water and dried with a clean dry towel. A tray was set containing sterile gloves, a receiver for the used swabs, clean perineal pad and two sterile gallipots with one containing sterile cotton while the other contained savlon lotion was sent to the bed side. Client was assisted to assume a dorsal position with the knees flexed and a mackintosh and towel placed under client. Hands were washed a pair of sterile gloves were worn and client was draped afterwards. She was asked to expose her vulva. The vulva was inspected for oedema, scars and varicose veins but there was none present. Five (5) sterile cotton wool swabs were used for the examination. The dominant hand was used to pick the cotton wool and dipped into savlon solution; swab was dropped from the dominant hand into the non-dominant hand and swabbed per stroke from upwards-downwards starting with the labia majora.

The labia majora was swabbed from upwards-downwards and the used swab was disposed off into a receiver. The labia minora was swabbed also from upwards-downwards and the used swab was disposed into a receiver. The vestibule was patted and cleaned using the non-dominant hand. A swab was used to wipe the vestibule from upwards-down; the used swab was disposed into the receiver. Permission was sought from client for vagina examination which she agreed. Using the dominant hand, the middle and index fingers were inserted gently into the vagina pressing firmly downwards. This caused the relaxation of the vaginal walls and muscles. The condition of the vagina was warm and moist and the cervix was soft, thin and well applied to the presenting part. The cervix was effaced and dilatation was four (4) centimetres. Ischia spines were blunt and pubic arch was wide, sacral promontory was not reached at 9 centimetres. Membranes were intact and there was no moulding (0). The inserted fingers were withdrawn and observed but nothing abnormal was seen. A clean perineal pad was applied on the vulva and client was asked to lie on her left side to prevent supine hypotension syndrome. Client was tidied up neatly and placed in a comfortable position. All findings and the progress of labour was explained to client. The dilatation board was used to explain the cervical dilatation and the progress of labour to her. She was thanked for her cooperation and made comfortable in bed. The tray was discarded, hands were washed under running water with soap, dried with a clean dry towel and all information gathered was recorded on a partograph sheet around 3:00 am.

3.2 PREPARATION FOR BIRTH

In preparing for birth, a helper was identified, that was skilled and unskilled helpers. The skilled helper was the Midwife-In-Charge who would supervise labour and delivery as well as the care of the baby and mother. A second skilled helper was a ward assistant. The ward assistant who would assist in times of need. The emergency plan was reviewed. The contact numbers of the referral hospital were active when checked as well as the ambulance. Madam Lydia was informed that after delivery baby would be placed on her chest for skin to skin contact for one hour of which she responded positively. She was asked to wash her hands, chest and abdomen to prepare for skin to skin care prior to the second stage of labour.

The area for delivery was also prepared. Client was told that, the windows and doors will be closed, curtains were drawn down and fan will be turned off when delivery is eminent to provide warmth for the baby and also privacy.

Hands were washed thoroughly with soap and water to prevent the spread of infection. A dry, flat resuscitation area was prepared in case the baby will need any ventilation. The equipment to help babies breathe were assembled in the area for ventilation and their functions tested especially the ventilation bag and mask. The delivery trolley was set and the entire instruments needed for the delivery were assembled, a cot was prepared for the baby.

MANAGEMENT OF FIRST STAGE OF LABOUR

Client was put on partograph on admission because labour has established foetal heart rate, contractions and pulse was checked every 30 minutes and vaginal examination, descent, blood pressure and temperature was done 4hourly. On observation client was anxious. Client was

reassured of normal labour with a healthy baby without any complications after delivery. She was educated not to reuse pad when it falls. Client was complaining of waist pains and the sacral region was massaged to relieve the pain and she was encouraged that the pain will stop after delivery. She was encouraged to do deep breathing exercise when contractions comes and also to avoid pushing during contractions since the cervix will be oedematous and to prevent risk. Bedpan was provided for her to empty the bladder frequently to enhance effective contractions and descent of the foetal head since full bladder could slow down the progress of labour.

Client was educated on the importance of changing the perineal pad when soiled and not to be touching the perineal area. She was encouraged to ambulate**.** At 7:30 pm, client's vital signs were checked and recorded as follows: Temperature 36.9^0C, Pulse 80 bpm, Respiration 20 cpm, Blood Pressure 110/70mmHg. Descent was $1/5^{th}$ above the pelvic brim, foetal heart rate was 142 beat per minute with good volume. Contractions were 4:10, 5:10 and 4:10 lasting 40 seconds and 45 seconds respectively. She passed 100ml of urine and sample was tested for protein and glucose, which was negative. The vagina was warm and moist, the cervix was 8 centimetres (cm) dilated and well applied to the presenting part with membranes still intact. There was no moulding (0). Hands were washed with soap under running water and dried with a clean dry towel. All findings were plotted on the partograph. The delivery trolley which contains the following items was made ready:

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

Lower Shelf A jug for measuring the amount of blood loss, Receiver for placenta, Container with syringes and needles, Fethoscope, Antiseptic lotion (savlon), Sterile gloves, Extra perineal pad, Small cup containing water and bulb syringe, Cord clamp, Bed pan, Identification band ,Examination gloves, Mackintosh, Cot sheets, Drum containing gauze and cotton wool, Cheatle forceps in its container. At 10:40 am, membranes ruptured arteficially and liquor was clear. Vaginal examination done to rule out cord prolapse, moulding was two (++), the cervical os was also fully dilated that is 10cm and descent was $0/5^{th}$. The Midwife in- charge was informed about the progress of labour and also asked to confirm the findings and she said Madam Lydia's cervix was fully dilated. Findings were recorded on the partograph sheet and client was informed of full dilatation of the cervix. Madam Lydia was reminded again that the baby would be delivered onto her abdomen for skin to skin contact as well as to establish bonding. This marked the beginning of the second stage.

3.3 MANAGEMENT OF THE SECOND STAGE OF LABOUR

A chart was shown to client to select the position which she would like to assume in the delivery of the baby and client selected the lithotomy position. She was assisted to assume the lithotomy position with a pillow supporting the back and her legs well supported on the bed. After putting on the protective clothing, hands were washed thoroughly with soap and water and dried with a clean sterile towel. The already prepared delivery trolley containing the needed items was pulled nearer to the delivery bedside and the sterile towel covering the top shelf of the trolley removed. Delivery pack was opened by an assistant and a pair of sterile gloves was worn. The vulva was cleaned with savlon solution as well as the upper thighs. Client's abdomen and thighs were draped with a sterile dry towel. She was again encouraged to push with contractions, rest

in between contractions and adhere to instructions at this stage. Client complained of excessive sweating and a dump towel was used to mop her face and also encourage to drink cold malt. A clean perineal pad was then applied to the perineum to prevent faecal matter from contaminating the baby's face. As the foetal head was advancing, the index and middle fingers were placed on the foetal head to aid flexion and to allow the smallest diameter of the foetal head to distend the vulva. This was done to prevent perineal tear. The head crowned and client complains of fatigue and she was asked to breathe through her mouth, the sinciput, face and chin swept the perineum and the head was delivered by extension. One finger was quickly used to feel for cord around neck but there was none. The baby's eyes, mouth and nose were wiped off gently with sterile gauze as well and the airway was cleared with a penguin. Restitution and external rotation of the head took place which indicated internal rotation of the shoulders to lie in the anterio posterior diameter. The head of the foetus was held in both palms on each side of the biparietal bones and a downward traction was applied to allow the anterior shoulder to be slipped under the pubic bone. The posterior shoulder was delivered by an upward traction towards the mother's abdomen by lateral flexion, the trunk and the rest of the body were delivered onto the mother's abdomen as explained to her. This was to help in skin to skin contact as well as providing warmth and bonding between the mother and the baby. The Midwife-In-Charge who was supervising the delivery noted the time of delivery as 9:50pm. A healthy baby girl was delivered and sex confirmed by the mother. She was congratulated for her effort and co-operation.

3.4 IMMEDIATE CARE OF THE BABY AT BIRTH

Immediately the head was delivered, sterile gauze was used to clean baby's face, eyes, mouth and nose. The baby was delivered onto the mother's abdomen. Thorough cleaning of the baby was done quickly as possible to prevent heat loss and hypothermia. The baby was kept warmly wiping off the liquor thoroughly and was covered with a clean dry cot sheet on the mother's chest. The baby was not suctioned because the airway was clear and baby cried immediately. The Apgar score at the end of the first minute of birth was quickly assessed as 8/10.

The first minute APGAR score; colour-2, Breath-2, pulse-2, Tone-1, Reflex-1(8/10) and The fifth minute APGAR score; colour-2, Breath-2, Pulse-2, Tone-2, Reflex-1(9/10). The cord was then measured 2 finger beneath the baby's abdomen and clamped with the cord clamp and measuring 2 finger breath above the cord, the cord was cut. The baby was made warm by covering it with a warm dry sheet and was left on the mother's abdomen and skin to skin to prevent heat loss. Identification band was placed on the baby's wrist with the mother's name, sex, date and time of delivery and breastfeeding was initiated. The condition of the baby was very good as she was actively crying and responding to stimuli.

3.5 MANAGEMENT OF THE THIRD STAGE OF LABOUR

Client still in the lithotomy position, a gentle palpation was done on the uterus to exclude undiagnosed foetus but there was none. Ten (10) units of oxytocin was given intramuscularly on the thigh to aid in the contraction of the uterus, the cord was clamped near the perineum with the artery forceps with a receiver placed in between the mothers thighs to receive the placenta. The clamped cord was held with the dominant hand whiles the non-dominant hand

was placed above the fundus to feel for contractions. When a uterine contraction was felt, the non-dominant left hand was placed on the lower abdomen in the supra pubic area just above the symphysis pubis and counter traction applied to support the uterus to prevent uterine inversion whiles controlled cord traction was used in delivering the placenta until it was visible at the introitus. The non-dominant hand was released and both hands were used in receiving the placenta and gentle twisting movement was made to ease pressure on the membranes till fully. The placenta and its membranes were delivered at 9:57pm. The placenta was placed in the palms and quick examination was done to detect any retained product of conception but none was detected. It was then placed in a receiver to be properly examined in the sluice room. The uterus was massaged immediately after the delivery of the placenta to aid uterine contraction, arresting haemorrhage as well as expelling clots. Gauze was wrapped around the index and middle fingers to inspect the cervix, vagina and perineum to exclude tears and lacerations. The cervix and the vaginal wall were inspected using the clockwise method and the perineum was intact. There were no tears found in the cervix, the vaginal wall, the vulva nor the perineum. Client was cleaned and made comfortable by applying a clean perineal pad to the perineum to absorb lochia drainage. The mother and baby were covered with a piece of cloth to ensure an hour effective skin to skin contact.

Madam Lydia was encouraged to empty her bladder whenever she had the urge for the uterus to contract well and she was also taught how to massage the uterus herself and report any changes quickly. She was made comfortable in bed and congratulated for the effort made. All findings were recorded on the partograph.

3.6 EXAMINATION OF THE PLACENTA AND MEMBRANES

The placenta was dip in 0.5 chlorine and removed immediately. The placenta was examined under a good source of light and on a flat surface. The placenta was held by the cord and the length measured was 48centimeters long. The foetal surface was greyish blue with firm amniotic membranes and cord was in the centre of the placenta. The maternal surface was dark red in colour. It was covered with chorion which was opaque. The membranes, lobes and cotyledons were inspected and they were intact. No infarct and oedema were seen on the maternal surface, the cord was thick with Wharton's jelly. The tip of the cord was wiped with a dry cloth for inspection. It had two arteries and one big vein. The placenta was placed in 0.5% chlorine solution in the sluice room for decontamination and discarded in the placenta pit. The delivery instruments and equipment used were soaked in 0.5% chlorine solution, gloves were removed and hands were washed. After 10 minutes, instruments were removed with utility gloves, washed in soapy water and rinsed in clean water and was then air dried and packed for sterilization. Estimated blood loss was 150 millilitres. Madam Martha was informed about the findings and necessary documentations were made.

3.7 MANAGEMENT OF THE FOURTH STAGE OF LABOUR

Client and her baby were transferred into the lying in ward after putting the baby skin to skin for an hour. Monitoring of client and baby continued strictly for six (6) hours after a successful completion of the third stage of labour.

During this stage, the mother and the baby were assessed every 15 minutes for 2 hours, 30 minutes for an hour and one hourly for three (3) hours and recorded on the post-delivery observation chart and it fell within the normal ranges.

The uterus was massaged to enhance contractions. Blood clots were expelled and blood loss was 150 millilitres and the Symphysio- fundal height was 18 centimetres. At the end of the 6 hours monitoring, all findings were recorded in the post-delivery chart. Lochia was red in colour (rubra), moderate in quantity. Madam Lydia was educated on the need to micturate frequently and changing of perineal pads when soaked. Also how to fix baby to breast was demonstrated to client. The importance of exclusive breastfeeding for the first 6 months and to feed the baby on demand. She was also encouraged to wash hands thoroughly with soap and water before breastfeeding and after changing perineal pad. Client's mother was allowed to see her and she was served with porridge and bread to restore energy. General condition of client was go

3.8 PREVENTION OF DISEASES

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

3.9 EXAMINATION OF THE NEWBORN

Procedure was explained vividly to client, examination gloves were worn and baby was examined from head to toe to see if there is any deviation from normal. Baby was put on a flat surface, undressed and covered with cloth. Baby was exposed and the general condition,

respiration and skin colour was noted and the baby was covered again to be examined from head to toe.

Head and neck: On examination of the head, the index and middle fingers were run through the suture line to check for any bulging fontanelles but no abnormality was detected. There was no laceration on the scalp and no caput succedaneum. The ears were examined for size, shape, patency, position, softness of the cartilage but no abnormality was detected. The eyes were in alignment with the ears and presence of an eyeball. There was no redness of the conjunctiva or jaundice on the sclera. The nose was examined for shape, size, patency to rule out deviated septum and discharges but everything was normal. The mouth was examined for the presence of false teeth, cleft palate and tongue tie but there was none. Rooting, suckling and swallowing reflexes were present. There were no rigidity, congenital goitre and swelling of the neck.

Chest and abdomen: On the chest, respiratory movement was normal, and on breast examination there was no engorgement of the breast, had no masses on palpation and the nipple was inspected for position, extra nipple and everything was normal. There was no exomphalous, distention of the abdomen, and on palpation there were no enlarged spleen or liver as well as bleeding of the cord. There were three blood vessels that ran through the cord which indicated two arterial cord vessels and a cord vein, abnormalities such as omphalocele and gastrochisis were absent. The skin was examined for skin color, vernix caseosa, and lanugo, peeling of the skin, rashes and birth mark but no abnormality detected.

Limbs: The upper extremities were equal with no extra digits. There were palmer creases and, no webbed fingers. Grasping and Moro reflexes were present. Hands and arms were inspected for movement, paralysis, nail beds were checked for capillary refill and everything were normal. The lower extremities were examined for equality, extra or missing digits, clubbed feet

but no abnormality was detected. Congenital hips dislocation was checked using the ortolani's test. There was no dislocation since a 'clunk' was not heard.

Back: Baby was turn to the left side and on inspection there were no rashes, discolouration and hairy patches, the back was also palpated with the thumb to rule out spinal bifida or a missing vertebra but there was none.

Genitalia: The vulva was well formed, urethra and anal orifices were patent and there were no abnormalities noticed. Baby passed meconium and urinated soon after birth indicating the patency of the anus and urethra. Baby's weight was 2.9 kilogram; measurements of the head circumference (33), length of baby (50) were done. Gloves were removed and disposed aseptically before washing and drying hands. Findings were documented and communicated to client.

The baby was warmly wrapped in with a clean dry sheet and placed beside her mother. Mother was asked to observe the baby continuously and report any abnormality.

SUMMARY OF LABOUR

Client had a spontaneous vaginal delivery to a live female baby on 3rd December, 2022 at 9:50pm with birth weight 3.0kg with APGAR score 8/10 and 9/10. Placenta and membranes were completely delivered at 9:57pm by controlled cord traction. Estimated blood loss was 150mls. Condition of mother and baby was satisfactory and they were made comfortable in bed.

3.10 CONDITION OF BABY AT BIRTH

The general examination of baby was done and no abnormalities detected.

Temperature: 36.8^{0}C, Respiration: 40cpm, Apex beat: 128bpm, Weight: 3.0kg, Length: 50cm, Head circumference: 33cm, Sex: Female, APGAR score for the first and fifth minute of birth was 8/10 and 9/10 respectively. Meconium Passed, Urine: Passed, General Condition: Very Good, Abnormalities: None detected

3.11 CONDITION OF MOTHER AFTER BIRTH

Client was made comfortable in bed and was helped to fix baby to the breast. Uterus was well contracted and her condition was good. Client's initial vital signs were checked and recorded as well as other examinations done as;

Temperature 36.2 degree Celsius, Pulse 78 beats per minute, Respiration

20 cycles per minute, Blood pressure 110/60 millilitres of mercury, Symphysio-fundal height 17 centimetres, Blood loss 150 millilitres

3.12 CARE PLAN DURING LABOUR

Problems Identified During Labour:

1. Lower abdominal pain

2. Anxiety

3. Fatigue

4 Waist pain

SHORT TERM OBJECTIVES

1. Client will cope with lower abdominal pains throughout labour

2. Client will be relieved of anxiety within 30 minutes after delivery
3. Client will be relieved of fatigue within 48 hours after delivery.
4. Client will cope with waist pain throughout labour.

LONG TERM OBJECTIVES

Client and baby will go through all the stages of labour and puerperium successfully without any complication to both mother and baby.

LABOUR CARE PLAN

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
03/12/22 3:30pm	Lower abdominal pains related to painful uterine contractions and descent of foetal head	Client will cope with lower abdominal pains during labour as evidenced by; client verbalizing that she can cope with pain	1. Reassure client to ally fear and anxiety 2. Encourage client to practice deep breathing exercise. 3. Explain the physiology of pain to her in simple terms 4. Massage client sacral region 5. Encourage client to perform mild exercise such as walking	1. Client was reassured to ally fear and anxiety. 2. Deep breathing exercise was performed by client. 3. Physiology of pain was explained to her in simple terms. 4. Client sacral region was gently massaged as thought to promote comfort. 5. Exercise such as walking was performed by client as mild exercise.	03/12/22 10:00pm	Goal fully met. client verbalizing that she can cope with pain.	

LABOUR CARE PLAN CONTINUED

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
03/12/22 4:00pm	Anxiety related to unknown outcome of labour.	. Client will be relieved of anxiety within 30minutes after delivery as evidenced by Client verbalizing that she is no longer anxious.	1. Reassure client to allay her fears and anxiety. 2. Establish and maintain good interpersonal relationship with client. 3. Explain to client about the progress of labour and clarify all misconception 4. Encourage deep breathing exercise. 5. Encourage client to ask questions and answer them tactfully.	1. Client was reassured to allay fear and anxiety. 2. Good interpersonal relationship with client was established and maintained 3. Progress of labour and clarifications of all misconception was explained to client 4. Deep breathing exercise was performed by client. 5. Client was allowed to ask questions and express her worries and explanations were given accordingly.	03/12/22 7:00pm	Goal fully met. Client verbalized that she was no more anxious.	

LABOUR CARE PLAN CONTINUED

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATIO N	SIGN
03/12/22 7:30pm	Physical exhaustion (fatigue) Related to strain and stress of labour.	Client will be relieved of fatigue within 48 hours after delivery. as evidenced by client verbalizing that she is no more tired after delivery.	1. Reassure client she will be relieved of fatigue after delivery 2. Encourage client to rest in between uterine contractions 3. Encourage client to practice deep breathing exercise. 4. Serve client with energy drinks 5. Give client oral fluid to rehydrate her.	1. Client was reassured that she will be relieved of fatigue. 2. Client rested in between uterine contractions 3. Deep breathing exercise was done. 4. Client was served with malt. 5. Oral fluid (fruit juice) was given to client to rehydrate her.	05/12/2 2 11:40a m	Goal fully met. Client verbalizing that she is no more tired after delivery.	

LABOUR CARE PLAN CONTINUED

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES	NURSING ORDERS	NURSING INTERVENTIONS	DATE/ TIME	EVALUATION	SIGN
03/12/22 9:00pmam	Waist pain related to pressure of the descending foetus on the sacral nerves	Client will cope with waist pain throughout labour as evidenced by client verbalizing that she is no more tired.	1. Reassure client that she would be relieved of her waist pains. 2. Explain the physiological changes behind waist pains during labour to client. 3. Massage the client's sacral region to relieve her of waist pain 4. Engage client in a diversional therapy(conversation) 5. Encourage and assist client to adopt a comfortable position.	1. Client was reassured that she would be relieved of her waist pains. 2. The physiology behind waist pain during labour was explained to client. 3. Sacral massage was performed on client to relieve her of waist pains. 4. Client husband was allowed to talk to her to relieve her mind off the pains. 5. Client adopts a left lateral position.	03/12/22 10:00pm	Goal fully met as client verbalized that she is no more tired.	

CHAPTER FOUR

PUERPERIUM

4.0 INTRODUCTION

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

4.1 DAY OF DELIVERY

After delivery of the placenta and membranes, Madam Lydia and her baby were transferred to the lying-in ward at 1:30am after postpartum check when her condition and that of the baby was stable. She was given bread and porridge to eat for energy. She was encouraged to empty her bladder frequently to avoid postpartum haemorrhage as well as breastfeeding baby frequently to help the uterus to contract. The vital signs were monitored for every 15 minutes for the first 2 hours, every 30 minutes for the next 1 hour and hourly for the last three hours.

Her vital signs were checked and recorded as follows: Temperature 36.2 degree Celsius, Pulse 78 beats per minute, Respiration 20 cycles per minute, Blood pressure 110/60 mmHg, Her Symphysio- fundal height measured 17 centimetres. The uterus was checked for involution and the perineum was also checked for any active bleeding at this time. Lochia was bright red in colour (rubra) and the flow was normal. Client was encouraged to change perineal

pad frequently when soiled to avoid infection as well as wash her hands with soap and water after changing the pad. She was taught how to massage the uterus by rubbing the palm on the fundus to help in the involution of the uterus and arrest haemorrhage. She was also educated on exclusive breastfeeding for 6 months and on demand as this would help the baby to grow well. Client was also taught to perform pelvic floor muscles and abdominal exercises to strengthen the muscles and also to aid involution. Head to toe examination was done on the mother and no abnormality was detected. She complained of fatigue and was encouraged to have enough rest. Later, she was assisted to the bathroom to take her bath. She felt good and refreshed after bathing.

4.2 SUBSEQUENT CARE OF THE BABY

After six (6) hours of observation, baby was given warm bath and her cord dressed with methylated spirit and cotton wool swabs. Head to toe examination was also done and no abnormality was detected. The baby was wrapped in a warm dry sheet to maintain body temperature and he was also placed beside his mother to breastfeed. The mother was advised not to apply anything at the injection site. The vital signs and other measurements were taken and recorded as follows: Temperature 36.1 degree Celsius, Apex beat 124 beats per minute, Respiration 40 cycles per minute, Weight 3.0 kilograms, Length 47 centimetres, Head circumference 32 centimetres. All findings were communicated to Madam Lydia and recorded.

BABY BATH AND CORD DRESSING

REQUIREMENTS; Soap, Sponge, Surgical gloves, Cream/powder, Sterile cotton wool swabs and gauze in a gallipot, Towels, 1 big towel and 3 small towels, Cot sheets 2, Plastic apron**,** A clean baby dress, cap and socks, 2 jugs containing hot, and cold water each, Two receptacles for used water and dirty linens.

Procedure

All procedures were explained to the mother and she consented. She was also asked to observe how the procedure was done. A plastic apron was worn. The hands were washed with soap and water under running water and dried with a clean dry towel. Both cold water and hot water were missed together and the temperature of the water was checked using the elbow where client also confirmed. Examination gloves were worn and the baby was taken from his mother. The baby was put on a flat surface and the mother was given a seat to observe the procedure. The baby was undressed and quick observation was made before baby was wrapped with a cot sheet. His eyes were cleaned with cotton wool swab soaked in sterile water from the inner canthus to the outer canthus of each eye using separate cotton wool swabs. His face was cleaned with a damp face towel and dried. The nape of the neck was supported with one hand. The baby's ears were plugged with the middle finger and thumb to prevent water from entering into the ears. The head was washed with soapy sponge, the baby was lifted off the flat surface with the body resting in the elbow and still supporting the nape, the washed head was rinsed with clean water and was then dried. The baby was placed on the flat surface with the body been exposed. The neck, arms and front of trunk were bathed paying attention to the skin folds. The back was turned with one arm supporting the chest and the other hand bathing the back down to the feet, paying attention to the

skin folds. The baby's body was supported firmly and was immersed into the warm water with the head supported above the level of the water. The body was rinsed thoroughly. The baby was removed from the water onto the working surface and was covered with clean dry cot sheet. The wet cot sheet was removed and a clean dry towel was used to dry the baby paying attention to skin folds. Baby oil was smeared on the body and the baby was dressed up. The gloves were removed and hands were washed with soap under running water and dried with a clean dry towel.

Cord Dressing Sterile gloves were worn and the cord was exposed and was inspected for bleeding and looseness but there was none. Five (5) cotton wool swabs were soak in methylated spirit. The tip of the cord was held with sterile cotton wool swab, the base of the cord was then cleaned with separate cotton wool swab. The whole cord was cleaned from the base upwards and lastly the tip was also cleaned with separate cotton wool swab. The cord was left exposed to air dry. Gloves were removed and Hands were washed with soap under running water and dried with a clean dry towel. Baby was dressed and wrapped with clean dry cot sheet to maintain his temperature and was given to his mother. Client was thanked for her co-operation and she was accompanied to the bedside. Her things were packed and used items were discarded. The working surface and the instruments used were decontaminated with 0.5% chlorine solution for 10 minutes. Hands were washed with soap under running water and dried with a clean dry towel. Findings were communicated to the mother and were documented. The mother was encouraged not to touch or apply anything to the cord. She was taught and encouraged only to dress the cord with clean cotton wool swabs and methylated spirit. She was also encouraged to breastfeed the baby anytime baby wants to feed and allow him to empty one breast completely before he takes the other.

4.3 FIRST DAY POST DELIVERY (DAY OF DISCHARGE)

4th December, 2022 happens to be the first day after delivery. Madam Lydia and baby were in good health. She woke up around 6:30am and brushed her teeth. The baby was being breastfed and he was suckling well. Permission was sought later to examine the baby. Hands were washed with soap under running water and dried with a clean dry towel. On general examination, there was nothing abnormal detected. The baby was top and tailed, dressed and wrapped nicely in the presence of the mother and her husband. The cord was dressed with sterile cotton wool swabs soaked in methylated spirit. The baby passed urine and meconium which was normal. The mother was educated not to apply hot compress on the fontanelles with the intention that it is a wound and with the hot compress it would heal. It was explained to the family that the fontanelles would close by themselves. That is the anterior fontanelles will close by 18 months and the posterior fontanelles will also close by 6 weeks. Client was encouraged to keep the cord clean and to prevent using local herbs. She was also educated on the provision of warmth, maintaining temperature and prevention of infection. Vital signs and weight were checked and recorded as follows: Temperature 36.0^{0}c, Apex beat 132bpm, Respiration 43cpm, Weight 2.9kg, Mother's vital signs were checked and recorded as: Temperature 36.7 ^{0}c, Pulse 76bpm, Respiration 20cpm, Blood pressure 100/60mmHg.

Procedures to be done were explained to madam Lydia constant and she consented. Head to toe examination was done and nothing abnormal was detected. Her breasts were lactating and nothing abnormal was observed. The vulva and perineal pad were inspected after permission was sought and lochia was red (Rubra), flow was small and not offensive. She was reminded on changing of

perineal pad frequently especially when soiled to prevent ascending infection to the uterus. Client then complained of after pain. She was reassured and educated that it was as a result of involution of the uterus. She was then encouraged to practice good personal hygiene and do warm sit bath to help reduce the pain. On palpation, the uterus was well contracted and Symphysio- fundal height was 16 centimetres.

Madam Lydia took fufu with light soup as her breakfast. She was educated to practice exclusive breastfeeding on demand especially in the night. Every two to four hours or at least 8 to 12 times per day, the baby should be breastfed. Client was educated on the importance of breast milk to both mother and baby such as to aid in bonding as well as exclusive at night to serve as a family planning method. Education on proper personal and environmental hygiene to prevent infections was reinforced. Client was also encouraged to take in a balance diets.

She was encouraged to take enough rest, perform postnatal exercises and ambulate to help her abdominal muscles and pelvic floor muscles gain their tone. She was also reminded on how to perform self-breast examination and educated on its importance. The in-charge was informed about the procedures and findings, client and baby were reassessed for confirmation. She was informed of her discharge and was helped to pack her things. Routine drugs were prescribed according to the protocol of the facility. She was told to come for one week postnatal care on the 29th December, 2022. She was informed about the continuity of care and that she would be visited at home for seven days to check on her condition and that of the baby. Her mother was encouraged to take good care of her and also provide her with physical, emotional, psychological and financial support. She was again educated on the prescribed drugs, its route, dosage and effects and

encouraged to register the baby at the births and deaths registry. Client was asked if she had any other complaints or questions and she said no. She was discharged at 4:00pm on the 4th December, 2022.

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

Madam Lydia and her baby were visited on 5th December, 2022 in the evening at 5:00 pm. Both mother and baby looked healthy on arrival to their house. Greetings were exchanged with warm welcoming. She was informed of the procedures to be carried out. Hands were washed and dried. The baby was top and tailed after head to toe examination was done and no abnormality was detected. Baby passed meconium and urine during the procedure. The cord was also dressed with sterile cotton wool swabs and methylated spirit using aseptic technique, it was clean, dry and not offensive. The baby was dressed, wrapped and given to the client's mother. Madam Lydia emptied her bladder and head to toe examination was done. The conjunctiva was examined and there was no pallor. The breasts were soft and lactating well. The uterus was well contracted and Symphysio-fundal height was 14 centimetres. The perineum was clean, dry and intact, lochia was small, red and not offensive. Mother's vital signs were checked and recorded as follows Temperature; 36.50C, Pulse; 80bpm, Respiration; 20cpm, Blood pressure; 107/75mmHg

The baby's vital signs and weight were also recorded as follows: Temperature; 36.80C, Apex heart rate; 138bpm, Respiration; 46cpm, weight; 2.8kg. Baby was given to mother to breastfeed and baby was able to suckle well. Client was asked if she had any question or problem and she complained of not being able to sleeps. She was reassured, encouraged to take naps in the afternoon

and sleep whenever baby is asleep or whenever possible. Madam Martha was educated on danger signs of the newborn such as breathing difficulties, cyanosis, persistent vomiting, fever, crying weakly, refusal of baby to feed and yellowing of the palms of the hands and soles of the feet. Client and family were congratulated and permission was sought to leave. She was informed of the next home visit the next day.

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

On 6th December, 2022 at 7:00 am and 5:00 pm, Madam Lydia was visited twice to assess her and her baby. On observation, the general condition of the family was good. The procedures to be carried out were explained to her. The symphysio fundal height was 12centimeters.

The perineum was inspected and it was clean, dry and intact with small bright red lochia which was not offensive. Her vital signs were checked and recorded as follows: Morning: temperature; 36.3^0C, pulse; 76bpm, Respiration: 18cpm, Blood pressure: 100/60mmHg. Evening: Temperature: 36.80C, pulse: 80bpm, Respiration; 20cpm, Blood pressure: 110/60mmHg. Permission was sought to top and tail and dress baby's cord but before that, head to toe. Baby was top and tailed and cord was dressed and left to dry. Baby was wrapped in a cot sheet and given to mother for breastfeeding. Baby's vital signs and weight were checked and recorded as follows: Morning: temperature: 36.8^0C, Apex heart beat: 130bpm, Respiration: 38cpm, weight: 2.7kg. Evening: Temperature; 36.9^0C, apex heart rate: 132bpm, Respiration: 40cpm, weight; 2.7kg.

During head to toe examination no abnormality was detected but on breast examination, client's breast was full on inspection and the breast was tender to touch on palpation. She was reassured

and she was educated to breastfeed baby on demand to reduce the breast pain and can also lie on bed to breastfeed effectively. She was also educated on other positions that can be used during breastfeeding such as lying on her side. Client and family were for thanked their cooperation and permission was sought to leave and return the following day.

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

Madam Lydia was visited at home twice to check on how she and the baby were faring on 7th December, 2022 at 7:00am and 5:00pm respectively. Greetings were exchanged and permission was sought to inspect her perineal pad. Her lochia was pink serosa and not offensive. Client said the lower abdominal pain has stopped when asked. Client complained of nappy rashes on the baby and she was encouraged to continuously changed baby's diaper when soiled. And also used cotton diapers. She also said she was able to have enough sleep now. Head to toe examination was conducted and everything was normal. The uterus was firmly contracted and symphysio-fundal height measured 10centimetres. Vital signs were checked and recorded as: Morning: Temperature; 36.50C, Pulse; 88bpm, Respiration; 18cpm, Blood pressure; 11/60mmHg. Evening: Temperature; 36.7^{0}C, Pulse; 78bpm, Respiration; 19cpm, Blood pressure; 110/60mmHg. Mother was asked to top and tail the baby under supervision which she did very well with few lapses. Head to toe examination was done and everything was normal. Baby's cord was dressed with six cotton wool swabs and methylated spirit and left to dry. The cord was not offensive and the baby passed stools and urine in which stools were brownish yellow in colour. The baby's vital signs and weight were checked and recorded as follows: temperature: 36.5^{0}c, Apex heart rate: 134bpm, Respiration:

46cpm, Weight: 2.6kg. Evening**:** Temperature: 36.8^{0}c, Apex heart rate: 130bpm, Respiration: 47cpm, Weight: 2.6kg**.**

Client was thanked for her cooperation and support. She was asked to take her routine drugs and permission was sought to leave.

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

Madam Martha was visited again on 8th December, 2022 at 7:00am. Mother, baby and family looked healthy on arrival. Client said she was relieved of her lower abdominal pain when she was asked about it. Head to toe examination of the baby was done and no abnormality was detected.

Baby's cord was dressed with methylated spirit, it was dry and non- offensive and the stump was almost off. Head to toe examination was carried out on the mother and result was healthy afterwards. On palpation, the uterus was well contracted and the Symphysio- fundal height was 8centimetres, perineum was inspected for Lochia and the colour was pink (serosa) and the flow was small not offensive. The breast was lactating well. Her vital signs were checked and recorded as follows: Blood pressure: 110/ 60mmHg, Temperature: 37.1^{0}c, Pulse: 76bpm, Respiration: 18cpm. The baby's vital signs and weight were checked and recorded as follows:

Temperature: 36.8^{0}c, Apex heart beat: 130bpm, Respiration: 47cpm Weight: 2.6kg. Client was asked of complaints and she responded she is doing very well. Mother was encouraged to ask questions. All findings were communicated to her and the necessary documentations were done. Client was thanked and permission was sought to leave.

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

On the 9th December, 2022, Madam Lydia was visited at 7:00am. Mother and baby looked healthy on arrival. Baby was bathed, head to toe examination was done and no abnormality was detected. The cord was off and the stump was dressed with cotton wool swab and methylated spirit, it was dry and not offensive. Madam Martha was also examined from head to toe and no abnormality was detected. On palpation, symphysio fundal height was 6cm. Perineum was clean and lochia was small and serosa in colour and not offensive when inspected. Madam Lydia's vital signs were checked and recorded as: Blood pressure; 100/60mmHg, Temperature; 36.9^{0}c, Pulse; 72bpm, Respiration; 21cpm. Baby's vital signs were checked and recorded as: Temperature; 36.8^{0}c, Apex heart rate; 138bmp, Respiration; 40cpm Weight; 2.7kg. Baby was given to mother to breastfeed and baby's suckling was good. Mother was encouraged to continue with breastfeeding. Client was thanked and permission was sought to leave.

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

On 10th December, 2022, Client and baby were visited at 5:00pm. Mother and baby looked happy on arrival and the whole family was doing well. Procedures to be done were explained to Madam Lydia. Her permission was sought and she consented. Head to toe examination was done for the baby and the mother and no abnormality was detected. Her symphysio fundal height was measured and it was 4cm. The perineal pad was inspected and lochia was pink (serosa) and the flow was small no foul smell. Her vital signs were checked and recorded as follows; Blood pressure; 110/70mmHg, Temperature; 36.5^{0}c, Pulse; 78bpm, Respiration; 19cpm. The baby was top and

tailed and the umbilical stump was cleaned with cotton wool swabs and methylated spirit. The cord stump was clean and dry with no offensive odour. The baby looked healthy and active. Her vital signs were checked and recorded as: Temperature; 36.5^{0}c, Apex heart rate; 130bpm, Respiration; 38cpm, Weight; 2.8kg. Madam Lydia was asked if she had any problem and she said no. Client was informed about the termination of visits on the seventh day and permission was sought to leave after a short interaction.

4.10 SEVENTH DAY POSTNATAL HOME VISIT (8TH DAY POST DELIVERY)

On the 11th December, 2022, at about 5:00pm, client was visited for the last time. Greetings were exchanged and a seat was offered. Baby and mother were doing well. Madam Lydia's mother bathed the baby under supervision and she did it perfectly after head to toe examination was done on both mother and baby and no abnormality was detected. The baby passed urine and stools during the bath. The colour of the stool was bright-yellow. The uterus was no more palpable on palpation. The perineal pad was inspected and the lochia was scanty and brownish red in colour. The cord stump was dressed with six cotton wool swabs and methylated spirit by Madam Lydia under supervision and she did it well. The cord stump was clean, dry and healed. Mother's vital signs were checked and recorded as follows: temperature: 36.1C, Pulse: 76bpm, Respiration: 18cpm and Blood pressure: 110/60mmHg, Symphysio- fundal height: 2cm. The baby's vital signs were: temperature; 36.7^{0}C, apex heart beat: 134bpm, respiration; 40cpm and weight: 2.9kg. Madam Lydia was encouraged to continue exclusive breastfeeding for six months, ensure personal and environmental hygiene as she always does. The importance of immunizing the baby against

the preventable childhood diseases was also explained to her. She was reminded of her visit to the clinic on the following day. Madam Lydia and her family expressed their heartf elt gratitude. They were thanked for their cooperation and also making the work easier. Permission was sought to leave.

4.11 FIRST POST NATAL VISIT TO THE CLINIC

On 29th December, 2022, Madam Lydia and her baby came to the Clinic at 8:00 am. They were welcomed and offered a seat. Client and baby were looking healthy and they were nicely dressed in all white. The purpose of this visit was to maintain the physical, and medical wellbeing of mother and baby and also to do further investigations to know the state of health of both mother and baby. Client was asked how she and her family were doing and she said they were fine. General observations were made on her mood and attitude towards baby and all were okay. All procedures to be carried out were explained to her and her consent was sought. She was asked to empty her bladder and a sample of urine was taken to test for glucose and protein and all tested negative. Her vital signs and haemoglobin level were checked and recorded as: Temperature: 36.30C, pulse: 72bpm, Respiration: 18cpm, Blood pressure; 100/60mmHg and **Haemoglobin; 12.8g/dl.** Privacy was provided and Madam Lydia was helped to undress and lie on the examination bed. Hands were washed with soap under running water and dried with a clean dry towel. Head to toe examination was done on her. On the head, the hair was very neat, well combed and clipped with white ribbon and free from lice and dirt. The conjunctiva was pink; there were no discharges from the eyes, nose and ears. There was no abnormality detected in the mouth and there was the absence

of enlarged lymph nodes around the neck. The breast was lactating well; there were no sore or cracked nipple and breast engorgement. The abdomen was firm; there was no tenderness, no scars, enlarged liver or spleen on examination. The uterus was not palpable. There was no oedema, varicosities and tenderness in the calf muscle. The perineum was intact and there was no offensive vaginal discharge. The lochia was small and the colour was alba. She was thanked for her cooperation and helped to dress up. The baby was also examined from head to toe and no abnormality was detected. The umbilical stump was inspected and it was healed. The baby looked healthy and active. The baby's vital signs were checked and recorded as follows: Temperature: 36.6^0c, Apex heart rate: 138bpm, Respiration: 38cpm, Weight: 3.1kg. Mother was encouraged to ask questions but she said there was none. Client was educated on exclusive breastfeeding and the importance of attending child welfare clinic. All findings were recorded and communicated to client.

4.12 CARE PLAN DURING PUERPERIUM

Problems Identified

1. After pain (lower abdominal pain)
2. Sleeplessness
3. Breast engorgement
4. Fatigue
5. Skin rashes on baby

Short Term Objectives

1. Client will be relieved of after pain within 48 hours
2. Client will be able to sleep for 3 hours within 24 hours
3. Client will be relieved of breast engorgement within 72 hours
4. Client will be relieved of fatigue within 48 hours
5. Client's baby's will be relieved of skin rashes within 72 hours

LONG TERM OBJECTIVES

Madam Lydia and her baby will have a safe and normal puerperium without any complications.

TABLE C: CARE PLAN DURING PUERPERIUM

DATE/ TIME	NURSING DIAGNOSIS	OBJECTIVE/ OUTCOME CRITERIA	NURSING ORDER	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
07/12/22 7:00am	After pain related to involution of the uterus.	Client's after pain will reduce within 48 hours as evidenced by Client verbalizing that her after pain has reduced	1. Reassure client to allay fears and anxiety. 2. Explain the physiology of after pain to the client. 3. Advice client to breastfeed on demand 4.Ecourage client to empty her bladder frequently 5.Administer prescribed analgesic to reduce client after pain	1. Client was reassured to allay fears and anxiety. 2. Physiology of after pain was explained to the client. 3. Client breastfed baby at least eight times a day. 4. Client emptied her bladder frequently whenever she has the urge to. 5. 1g of paracetamol was administered to reduce client after pain.	10/12/22 7:00am	Goals fully met as 1. Client verbalized that her after pain has reduced.	

TABLE C: CARE PLAN DURING PUERPERIUM CONTINUE

DATE/ TIME	NURSING DIAGNOSIS	OBJECTIVE/ OUTCOME CRITERIA	NURSING ORDER	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
10/12/21 8:00am	Inadequate sleep related to demand of feeding of baby at night.	Madam Martha will be able to sleep for 3 hours in a day as evidenced by client reporting that she can now sleep well.	1. Reassure client that she will be able to have adequate sleep. 2. Encourage client's relatives to help her in the care of the baby during the day. 3. Encourage client to limit her time spent with visitors. 4. Encourage client to sleep in a noise free environment. 5. Encourage client to sleep whenever baby sleeps. 6. Encourage client to breastfeed baby well before going to sleep.	1. Client was reassured to take a warm bath to help her have adequate sleep. 2. Client's relatives were involved in daily activities to help client in the care of the baby for her to sleep during the day. 3. Time spent on visitors was limited for client to have enough rest. 4. Client was able to sleep well in a noise free environment. 5. Client was encouraged to sleep whenever baby sleeps. 6. Client was encouraged to breastfeed baby well before going to sleep.	11/12/22 10:00am	Goal fully met. Client reporting to midwife that she can now sleep well.	

TABLE C: CARE PLAN DURING PUERPERIUM CONTINUE

DATE & TIME	NURSING DIAGNOSIS	NURSING OBJECTIVE/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTIONS	DATE & TIME	EVALUATION	SIGN
13/12/22 10:00am	Breast engorgement related to inadequate emptying of the breast.	Client breast engorgement will be relieved within 72 hours as evidenced by Client verbalizing that the breast is no more tender to touch	1. Reassure client to allay fear and anxiety. 2. Teach client on how to fix baby correctly to the breast. 3. Teach client how to correctly position herself when breastfeeding 4. Encourage client to do manual expression of breast milk when not feeding. 5. Encourage client to continue exclusive breastfeeding. 6. Encourage client to apply cold and warm compress to the breast.	1. Client was reassured to alley fear and anxiety. 2. Baby was fixed correctly to breast. 3. Demonstration was done to client on how to position baby during breastfeeding 4. Client expressed her breast milk manually. 5. Client continued exclusive breastfeeding. 6. Client applied cold and warm compress to the breast.	15/12/22 10: 00am	Goal fully met. Client reported that her breast is no tenderer to touch.	

PUERPERIUM CARE PLAN CONTINUED

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVE/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
16/12/22 7:35pm	Fatigue related to stresses of labour.	Client will be relieved of fatigue within 48 hours as evidenced by; Client verbalize she is relieved of fatigue.	1. Reassure client that her condition is temporal and can be managed. 2. Encourage client to rest 3. Advise client to ensure noise free environment. 4. Advise client to have a warm bath before resting. 5. Encourage client support person to help with the house hold chores.	1. Client was reassured that the fatigue is temporal and would be managed. 2. Client took rest when baby was asleep. 3.Client slept in a noise-free environment 4. Client took warm bath before resting. 5. Support person helped client with house hold chores.	18/12/22 7:35pm	Goal fully met. client reported that, she was relieved of body discomfort.	

TABLE C: CARE PLAN DURING PUERPERIUM CONTINUE

DATE AND TIME	NURSING DIAGNOSIS	OBJECTIVES/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE AND TIME	EVALUATION	SIGN
20/12/22 7:30am	Nappy rash related to prolong use of diaper	Baby's nappy rashes will disappear within 72 hours as evidenced by: Client verbalizing that baby nappy rashes have resolved.	1. Reassure client that the rashes will disappear. 2. Educate client on the need to change diaper when soiled. 3. Encourage client to use cotton diapers 4. Educate client not to scratch the rashes. 5. Teach client how to use prescribed powder. 6. Encourage mother to use carbolic soaps when bathing baby.	1. Client was reassured that the rashes would disappear. 2. Client changed diaper when soiled. 3. Cotton diapers were used on baby. 4. Mother did not scratch the rashes as it would cause more pain and infection. 5. Prescribe powder was used by client example Vaseline, Shea-butter and Listerine powder. 6. Mother used baby soaps when bathing baby.	23/12/22 7:30am	Goal fully met Client verbalized that nappy rashes on baby had been resolved.	

SUMMARY AND CONCLUSION

The Patient/Family Care Study has given an account of how the midwifery nursing process approach was used in nursing Madam Amoah Lydia throughout pregnancy and after birth. Client is a native of Sewea in the Ashanti Region. A 29 years old gravida 2 para 1, who was an attendant at Asutifi North District Hospital, Kenyasi for antenatal care, was chosen among the lot because she fell within the criteria for clients to be chosen for the care study. Friendship was then established to render effective care throughout pregnancy, labour and puerperium.

Home visit were done and the minor problems that were encountered during the period of pregnancy, labour and puerperium were all managed using the nursing process. Her successful antenatal care, labour and puerperium were due to the early assessment and analysis of her problems, proper counselling and education. She had a spontaneous vaginal delivery to a live female child on the 3rd of December, 2022 at 9:50pm without any complications. The appropriate cares were rendered to her and the baby. She was also educated appropriately.

She had intensive puerperal care and all visits and examinations were carried out on her as required and hence she had a normal and safe puerperium. The baby also received all appropriate immunizations required at birth for the prevention of any diseases or complications. She was finally handed over to the midwife in charge for the continuity of care. There was proper and accurate documentation of all activities and procedures carried out on her and the baby for proper and easy reference. The Client / Family Centered Care Study has enabled me to understand the unique essence of the case study and the midwifery profession as well as the managerial tool and

step for managing any pregnant woman through antenatal, labour and puerperium and therefore sustained.

TERMINATION OF CARE

On 29th December, 2022, it was explained to Madam Lydia that the care being given to her by me has come to an end since the period of study was over. She was handed over to the midwife in charge for the continuity of care. It was made known to her that update on her will be received from the midwife -in-charge and she will be called if the need arises for any information, and she gladly said she will be available any time needed. She and her entire family were thanked for availing themselves and helping me to achieve this study. Madam Lydia expressed her gratitude for the care given to her. She and the family were bid farewell

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APPENDIX 1

DATE	WEIGHT (KG)	BLOOD PRESSUE	URINE FOR PROTEIN/ SUGAR	GESTATIONAL AGE IN WEEKS	FUNDAL HEIGHT (CM)	PRESENTATION	DESCENT OF FETAL HEAD	FETAL HEART RATE(FH)	TREATMENT GIVEN	COMPLAIN	SIGN
10/05/22	53kg	90/60mmHg	Negative / Negative	10+1d	-	-	-	-	Routine drugs	No complain	C.N
09/06/22	58kg	100/60mmHg	Negative / Negative	14weeks		-	-	-	Routine drugs	No complain	C.N
02/08/22	55kg	90/60mmHg	Negative / Negative	21weeks	20cm	-	-	-	Routine drugs	No complain	C.N
10/10/22	59kg	100/60mmHg	Negative / Negative	31weeks+ 2d	35cm	-	-	135bpm	Routine drugs	Feels well	B.C
26/10/22	61kg	114/72mmHg	Negative / Negative	36weeks	35cm	-	-	140bpm	Routine drugs 1G of paracetamol tid X7	Waist pain	B.C

MOTHER'S ANTENATAL

DATE	WEIGHT (KG)	BLOOD PRESSUR	URINE FOR PROTEIN/ SUGAR	GESTATIONAL AGE IN WEEKS	FUNDAL HEIGHT (CM)	PRESENTATION	DESCENT OF FETAL HEAD	FETAL HEART RATE (FH)	TREATMENT GIVEN	COMPLAIN	SIGN
07/11/22	60kg	100/70mmHg	Negative / Negative	36weeks	35cm	Cephalic	$5/5^{th}$	140bpm	Routine drugs	Feels well	B.C
15/11/22	62kg	106/68mmHg	Negative / Negative	37weeks+1d	37cm	Cephalic	$5/5^{th}$	140bpm	Routine drugs	Feels well	
17/11/22	63kg	126/73mmHg	Negative Negative	36Weeks+5d	35cm	Cephalic	5/5	138bpm	Continue treatment	Healthy	A.K. E
24/11/22	65kg	100/70mmHg	Negative Negative	37Weeks	36cm	Cephalic	5/5	140bpm	Continue Care	No complains	A.K. E
01/12/22	63kg	124/72mmHg	Negative / Negative	38weeks+5d	38cm	Cephalic	$5/5^{th}$	137bpm	Continue treament 1G of paracetamol tid X7	Lower abdominal pains	

APPENDIX II: COMPLETED DIAGNOSTIC INVESTIGATIONS

ANTENATAL

DATE	SPECIMEN	INVESTIGATION	NORMAL VALUES	FINDINGS	REMARKS
20/ 11/ 2021	Blood	Haemoglobin level	12g/dl-16g/dl	11.7g/dl	Normal
		Sickling status	Negative	Negative	Normal
		Grouping and Rhesus	A, B, AB, and O	B	Normal
		factor	Positive and Negative	Positive	Normal
		HIV status	None reactive	Negative	Normal
	Urine	VDRL	None reactive	Non-defect	Normal
		Hepatitis status	Negative	Negative	Normal
		G6PD status	None reactive	Non-defect	Normal
		Sugar	Negative	Negative	Normal
		Protein	Negative	Negative	Normal

COMPLETE DIAGNOSTIC INVESTIGATION

DATE	SPECIMEN	INVESTIGATION	NORMAL VALUES	FINDINGS	REMARKS
14/04/22	Urine	Sugar Protein	Negative Negative	Negative Negative	Normal Normal
25/05/22	Urine	Sugar Protein	Negative Negative	Negative Negative	Normal Normal
28/06/22	Urine	Sugar Protein	Negative Negative	Negative Negative	Normal Normal
04/08/22	Urine Blood	Sugar Protein Haemoglobin Level	Negative Negative 12g/dl-16g/dl	Negative Negative 12.8g/dl	Normal Normal Normal
07/09/22	Urine	Sugar Protein	Negative Negative	Negative Negative	Normal Normal
26/10/22	Urine	Sugar Protein	Negative Negative	Negative Negative	Normal Normal
02/11/22	1 Urine	Sugar Protein	Negative Negative	Negative Negative	Normal

DATE	SPECIMEN	INVESTIGATION	NORMAL VALUES	FINDINGS	REMARKS
09/11/22	Urine	Sugar	Negative	Negative	Normal
		Protein	Negative	Negative	Normal
	Blood	Haemoglobin	12g/dl-16g/dl	12.9g/dl	Normal
16/11/22	Urine	Sugar	Negative	Negative	Normal
		Protein	Negative	Negative	Normal
	Blood	Haemoglobin	12g/dl-16g/dl	12.8g/dl	Normal

APPENDIX III

PHARMACOLOGICAL DRUGS FOR MOTHER

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

PHARMACOLOGICAL DRUGS FOR MOTHER CONT'D

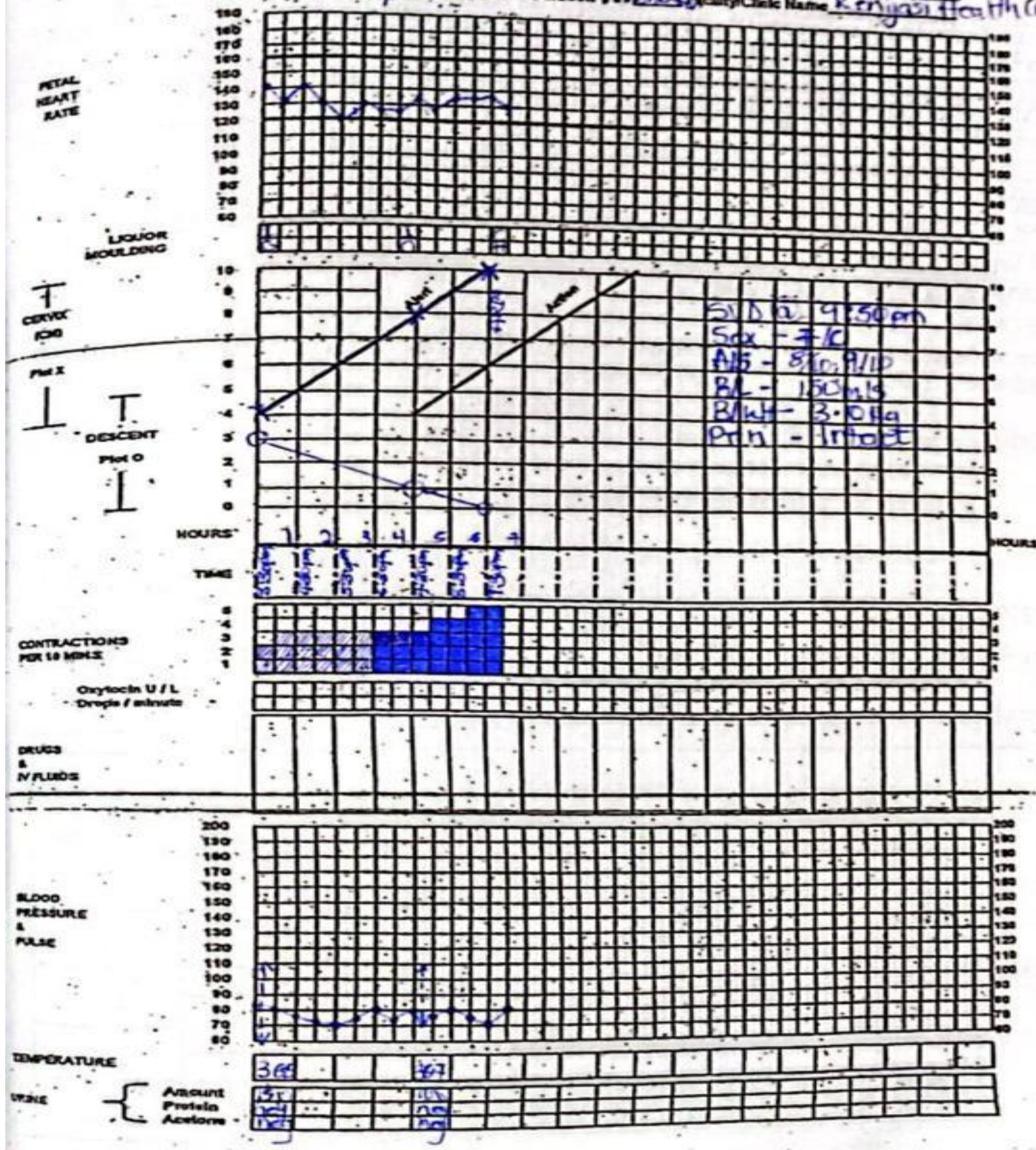
NAME OF DRUG	CLASSIFICATION	DOSAGE	ROUTE	USE AND ACTION	ACTUAL EFFECT	SIDE EFFECT	SIDE EFFECT EXPERIENCED
Tablet Metronidazole	Antibiotic	400 mg 3 times daily	Orally	Fights against bacterial infection	Fights against bacterial infection	Stomach pain, dizziness, dry mouth, cough, sore tongue	No side effect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

PHARMACOLOGICAL DRUGS FOR MOTHER CONT'D

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

PHARMACOLOGICAL DRUGS FOR BABY

NAME OF DRUG	CLASSIFICATION	DOSAGE	ROUTE	USE AND ACTION	ACTUAL EFFECT	SIDE EFFECT	SIDE EFFECT EXPERIENCED
Injection vitamin k	Coagulant (Group K Vitamins)	1.0mg	Intramuscular	Production of prothrombin which aids in clotting.	No bleeding	Risk of haemolysis in people with G6PD deficiency.	No side effects observed.
Chloramphenicol eye drop	Antibiotic	2 drops	Instillation	To prevent eye infection.	Eye infection was prevented.	Transient stinging	No side effect observed.
Oral polio vaccine	Antigen vaccine	2 drops	Orally	Production of antibodies to prevent poliomyelitis	Under observation	Diarrhoea Fever	observed.
Capsule vitamin A	Group A vitamin supplement	200,000 units for 2 days	Orally	Growth, development and proper sight	Normal vision and healthy skin.	Vomiting	No side effect observed.
Injection Bacillus Calmette Guerin (BCG)	Antigen vaccine	0.05 milligrams	Intradermal injection	Production of antibodies against tuberculosis	Under observation	Blister formation and fever	Blister observed



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LABOR NOTES

Client (12P1), with gestational age of 39weeks to came to the facility accompanied by mother per ambulation, she had spontaneous vaginal delivery at 9:50pm to a live female baby with APGAR Score 8/10, 9/10. IM Oxytocin 10 unit was given to her within one minute after delivery. fundus palpated to rule out second twin but wasn't diagnosed. third stage completed successfully. IM Vitamin K was administered, eye care and cord dressing done. Head to toe examination done with no abnormality detected. Client and baby were cleaned and put comfortably in bed and under close monitoring.

Please circle or write responses.

DELIVERY

DATE: 3/12/202[illegible] TIME: 9:50pm METHOD: Spontaneous / Vacuum Extraction / C/S / Other

PERINEUM: **Intact** / Episiotomy / Laceration

ANESTHESIA: **None** / Local / General

THIRD STAGE

Active Management: **Yes** / No Medication: Time 9:52pm Type/Dose Oxytocin - 10units Cytotec - 600mg

PLACENTA: TIME: **Complete** / Incomplete

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

BABY

Weight: 3.0kg

Sex: **Male** / Female

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

APGAR

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

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

FOURTH STAGE MONITORING

Frequency	Time	B/P.	Pulse	Fundus	Bleeding	Bladder
Every 15 minutes first 2 hours	10:00pm	110/60mmHg	72	Contracted	No active bleeding	200mls
	10:15pm	115/65mmHg	78	"	"	Nil
	10:30pm	120/70mmHg	81	"	"	Nil
	10:45pm	105/70mmHg	84	"	"	Nil
	11:00pm	100/60mmHg	76	"	"	Nil
	11:15pm	110/60mmHg	89	"	"	150mls
	11:30pm	120/70mmHg	72	"	"	Nil
	11:45pm	110/60mmHg	83	"	"	Nil
Every 30 minutes For 1 hour	12:15pm	120/80mmHg	75	"	"	Nil
	12:45pm	110/60mmHg	88	"	"	250mls

Birth Attendant Adjei Kopn Evelyn assisted by Loretha Wilson (Senior Midwife) Date 3/12/2022

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MATERNITY CHART

NAME: Lydia Amoah

AGE: 29years WARD: Lying – In

IP NO.: 640/22 BED NO.: 2

Date	03/10/22	04/10/22	05/10/22	06/10/22	07/10/22	08/10/22	09/10/22	10/10/22	11/10/22
Days in Hospital	D0	D1	D2	D3	D4	D5	D6	D7	D8
Days P. OS FH	18	16	14	12	10	8	6	4	2
Hour am		7:00	8:00	7:30	8:00	9:00	9:00	9:30	8:30
Hour pm	8:00	5:00	4:00	5:00	4:00	4:50	4:00	3:30	4:00

Temperature

Temp	FH
41·0	18
40·5	16
39·5	14
39·0	12
38·5	10
38·0	8
37·5	6
37·0	4
36·5	2
36·0	
35·5	
35·0	

	D0	D1	D2	D3	D4	D5	D6	D7	D8
Pulse	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Resp.	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
B.M.									
Urine	Passed	Passed	Passed	Passed	Passed	Passed	Passed	Passed	Passed
B. P. am		100/60	101/75	100/60	110/60	110/60	100/60	110/70	110/70
B. P. pm	110/60	110/70	110/50	110/60	100/60	110/85	100/70	112/65	110/60

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NEW BORN EXAMINATION FORM

ame: Baby Ama Lydia Date of Assessment: 3/12/22 Time: 9:59pm
ate of Birth: 3/12/22 Time of Birth: 9:50pm Sex: [ ] M [x] F . Age at time of Assessment (days/hrs) ______
estational Age [ ] 39wks [ ] Mode of Delivery: [x] Vaginal Assisted Vaginal C-Section
PGAR: 1min [8] 5min [9] Birth Weight: [ ] 3.0kg [ ] Length 47 cm Head Circumference: 32 cm
emperature at time of Assessment: 36.1 °C Urine passed: Yes No Meconium passed: Yes No
ame of Assessor (Midwife/Doctor): Adjei Kopri Evelyn

Respiration
ate
[ ] Rate < 30 b/m *
[ ] Rate < 60 b/m *
[ ] 30-60 b/m
[ ] Retractions *
[ ] Grunting *
[ ] Stridor *

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

Tone
[x] Normal
[ ] Floppy *
[ ] Increased *

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

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

Cry
[ ] 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*
[ ] Scaphoid*
[ ] 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
[ ] Undescended testes
[ ] Abnormal meatus
[ ] Hernia
[ ] Other: ______

Female Genitalia
[x] Normal
[ ] Fistula(meconium/urine through abnormal opening in vagina) *
[ ] Large clitoris *
[ ] 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 [x] Polio Immunization
[ ] Antibiotics in mother
[ ] Antenatal corticosteroids

*May indicate severe disease that requires urgent referral
iagnoses (if known) ______
lassification: (Overall assessment) [x] Normal [ ] Baby with a Problem [ ] Danger Sign/ <1500g/ severe Jaundice
lan: [x] Routine Care [ ] Problem. Continue supportive in-patient care [ ] Urgent Referral / Advanced Care [ ] Discharge

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NEW BORN EXAMINATION FORM

Date of Assessment: 04/12/22 Time: 4.00pm

Name: Baby Ama Lydia. Sex: [ ] M [x] F . Age at time of Assessment (days/hrs)

Date of Birth: 3/12/22 Time of Birth: 9.50pm

Astational Age [ ] [ ] Mode of Delivery: [x] Vaginal Assisted Vaginal C-Section

APGAR: 1min 8 [ ] 5min [ ] 9/10 Birth Weight: [ ] 2.9 kg [ ] Length 47 cm Head Circumference: 32 cm

Temperature at time of Assessment: 36.7 °C Urine passed: Yes No Meconium passed: Yes No

Name of Assessor (Midwife/Doctor): Adjei Kopii Evelyn.

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
- [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
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25. Resuscitation provided
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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 [x] Polio Immunization
- [ ] Antibiotics in mother
- [ ] Antenatal corticosteroids

*May indicate severe disease that requires urgent referral

Diagnoses (if known)

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

Plan: [x] Routine Care[ ]Problem. Continue supportive in-patient care [ ]

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NEW BORN CHART

Name: Baby Ama Lydia. No: .... Birth Weight: 3.0 kg.

Sex: Female Mother's No: 660/22 Length: 47cm

Nature of Delivery: Spontaneous Vaginal delivery. Diagnosis: Term Baby.

Date of Birth: 03/12/2022 Time: 9:50pm Date of Discharge: 04/12/22

Date	3/12/22		4/12/22		5/12/22		6/12/22		7/12/22		8/12/22		9/12/22		10/12/22		11/12/22					
No. of Days	DD		D1		D2		D3		D4		D5		D6		D7		D8					
Weight	3.0kg		2.9kg		2.8kg		2.7kg		2.6kg		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		36.1°C	36.0°C			36.8°C	36.8°C	36.9°C	36.5°C	36.8°C	36.8°C		36.8°C			36.5°C		36.7°C				
Stools		Passed	Passed			Passed	Passed	Passed	Passed	Passed	Passed		Passed			Passed		Passed				
Urine		Passed	Passed			Passed	Passed	Passed	Passed	Passed	Passed		Passed			Passed		Passed				

Remarks: Trunk, Limbs, Abdomen, Neck — No Abnormalities detected

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TEMPERATURE CHART

NAME: Baby Ama Lydia

AGE: New born WARD: Lying-In

IP NO.: BED NO.: 2

Date	3/12/22	4/12/22	5/12/22	6/12/22	7/12/22	8/12/22	9/12/22	10/12/22	11/12/22					
Days in Hospital	D0	D1	D2	D3	D4	D5	D6	D7	D8					
Days P.O.	3.0	2.9	2.8	2.7	2.6	2.6	2.9	2.8	2.9					
Hour		36.6	36.7	36.2	36.5	36.6	36.8	36.8	36.5					
	36.1	36.5	36.8	36.9	36.8	36.7								

Temperature

C	F
41.5	302°
41.0	301°
39.5	300°
39.0	299°
38.5	298°
38.0	297°
37.5	296°
37.0	295
36.5	294
36.0	293
35.5	56°
35.0	55°

Pulse	124	132 / 133	138 / 137	130 / 132	134 / 130	130	138 / 136	130 / 132	134 / 143
Resp.	40	43 / 45	46 / 46	38 / 40	46 / 45	41	40 / 42	38 / 40	40 / 34
B.M.									
Urine	passed	passed	passed	passed	passed	passed	passed	passed	passed
B.P. A.M. / P.M.									

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SIGNATORIES

THE STUDENT

NAME: ADJEI KOPRI RVELYN

SIGNATURE................................

DATE.......17/07/23.......................

THE MIDWIFE IN-CHARGE (KENYASI HEALTH CENTRE)

NAME: MRS. RUBAMATU KASSIM

SIGNATURE.......................(for)

DATE.......17/07/23.......................

THE SUPERVISOR

NAME: MS MARTHA KYEREMAA

SIGNATURE.......................................

DATE.......17/07/23..................................

PRINCIPAL

NAME: MS MONICA NKRUMAH

SIGNATURE.................................

DATE.......17/07/23..........................

ACADEMIC CO-ORDINATOR - NURSING ... MIDWIFERY ... COLLEGE, BEREKUM

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