HOLY FAMILY NURSING AND MIDWIFERY TRAINING COLLEGE

BEREKUM

A CLIENT / FAMILY CENTRED MATERNITY CARE STUDY ON

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BY

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SUBMITTED TO THE NURSING AND MIDWIFERY COUNCIL OF GHANA IN PARTIAL FULFILMENT TOWARDS THE AWARD OF LICENCE TO PRACTISE AS A PROFESSIONAL REGISTERED MIDWIFERY

AUGUST 2024

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PREFACE

A family centered maternity care is the sum total and systematic care given to a pregnant woman and her family during pregnancy, labour and puerperium, taking into consideration their individual problems.

The family centered care study is an academic work that gives the student midwife the greatest opportunity to practise all the knowledge and skills acquired during the period of training in providing comprehensive and quality nursing care to client and family. This care is extended to the community in which the client lives. The care study also serves as a learning tool for the student to collect relevant data, analyse the data, plan and implement nursing interventions and evaluate the care to ascertain whether set goals have been achieved or not.

The study offers new ways of providing care for women and their families that integrate during pregnancy, childbirth and postpartum by helping the families make informed choices for their care. The study will also help the student midwife to give the necessary supervision, care, and advice to women during pregnancy, labour and postpartum including preventable measures and detection of abnormal conditions on both mother and the newborn that was learnt in class.

Some of the current trends in midwifery is the introduction of partograph which helps in monitoring labour and to see when labour is prolonged so that possible interventions can be done. Another current trend is technological advancement, for example foetal monitoring has progressed from the use of fetoscope to electronic foetal monitors. In addition, we also have family centered care as a current trend in midwifery, thus integration and bonding take high priority and much anticipatory counselling is offered.

The study consists of all information of the client and the family which enables the student to recognize the client as an individual who has a specific problem and needs to render good nursing care.

The family centered maternity care study further forms part of the requirement by the Nurses and Midwives Council of Ghana in awarding a diploma certificate at the end of program

ACKNOWLEDGEMENT

I thank the Almighty God for giving me the strength, guidance and wisdom in writing this care study.

I wish to express my sincere gratitude to the entire staff of Holy Family Nursing and Midwifery Training College, Berekum especially my supervisor, Mrs. Celestina Ahiaworn , the Principal of the college, Ms. Monica Nkrumah for their support and motivation during the period of writing this care study.

I am also grateful to the staff of Emil Memorial Hospital especially the staff at the Maternity Unit for their support and encouragement during the period of my clinical experience.

Special thanks and appreciation also go to Mrs. Elizabeth Adu and her family for their cooperation during my study on them. Without them, this would not have been a success. I honour my parents Mr. and Mrs. Adu and all my brothers and sisters for their general support throughout my education.

Finally, I would like to acknowledge the Authors of the books I used as references and also all persons who in diverse ways contributed in making the writing of this care study successful.

INTRODUCTION

The family centered maternity care study is a systematic approach used in the care of an expectant mother and her family. The expectant mother is properly and successfully managed throughout her pregnancy, labour and puerperium to carry out a successful outcome without complications.

The study gives the student midwife the chance to give effective nursing care to the pregnant woman in her own home and environment as a whole. This helps the pregnant woman to openly share some of her confidential problems like financial difficulties since she is in her own environment and feels more comfortable

The student gains more experience which will help her care for pregnant women in future. She is able to identify individual problems, analyse them and find solutions to them.

This family centered maternity care study is about Madam Elizabeth Adu, gravida 3 para 2^{AA}, 30 years old whom I took care of during pregnancy, labour and puerperium. Madam Elizabeth Adu was met on 14th August, 2023 during ANC visit at Emil memorial hospital and my interaction with her ended on 8th September, 2023 which was on her 10th day postnatal visit to the clinic where she was handed over to the public health nurse for continuity of care. She was taken as a client because based on our conversation it was realized she has less knowledge on the benefits of practising family planning.

The family centered maternity care study is made up of four chapters.

Chapter one talks about the assessment of the client and her family which includes: personal and social history, habits of daily living, family, medical, surgical, menstrual, past and present obstetric history.

Chapter two involves antenatal care given which includes the first contact with client, first antenatal home visit, second antenatal home visit and client's subsequent visit to the clinic.

Chapter three involves admission of client during labour, management of first stage, second stage, and third stage, fourth stage of labour and summary of labour notes.

Chapter four entails management of the puerperium, subsequent care of the baby, preparations towards discharge, first to seventh day postnatal home visit and first postnatal visit to the clinic. It also includes summary and conclusions, appendices, bibliography and signatures.

LITERATURE REVIEW

Literature review is a summary of the writings/ reports/findings of studies already conducted by recognized authorities, authors on the problems under investigation. It is also a research proposal aimed to convince the reader of the significance and worthiness of the research project.

PREGNANCY

It is a period of having a developing embryo in the uterus and it is a time when women and their partners are especially open to reflecting on their lifestyles and healthcare options. Pregnancy is defined as the period between conception and delivery of the foetus. Normal duration is 280day (40 weeks) counting from the first day of the last normal menstrual period to delivery (Tiran, 2015)

Marshall and Raynor (2014) stated that as soon as pregnancy is confirmed, many physiological changes take place in the body and return to its pre-pregnant state during the period due to the effects of hormones, oestrogen and progesterone. These hormones are responsible for the major changes that take place during pregnancy. Even though these hormones have their own effects by causing the minor disorders that occur during pregnancy, there are some advantages for the mother and the growing foetus depends solely on the mother for survival when in utero.

Variety of care that are rendered to the expectant mothers and their entire families includes 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, multivitamin, ferrous sulphate , sulphadoxine pyrimethamine in malaria prophylaxis and tetanus toxoid, education on minor disorders, rest and sleep, danger signs of pregnancy, diet , travelling , exercise, personal and environmental hygiene, birth preparedness and complication readiness.

Focus antenatal care is a comprehensive and client centered care given to pregnant women to ensure no risk throughout pregnancy. This care includes thorough physical examination and monitoring of client's wellbeing.

The hormone oestrogen is produced in higher quantities during the first twelve weeks cyesis and takes responsibilities of the growth of the uterus and duct system systems of the breast, nipples and the lining of the vagina.

The hormone progesterone is also responsible for the development of thick vascular decidua for the embedding of the fertilised ovum and keeps the decidua throughout the gestational period and also relax plain or smooth muscles and allows the decidua to enlarge to accommodate the growing foetus and placenta.

Antenatal care is the care given to pregnant women from the time conception is confirmed until the beginning of labour (Marshall & Rayor, 2016).

The national safe motherhood protocol (2017) also stated that antenatal care is the health care and education given to pregnant women at the time conception is confirmed till labour begins which is important to prevent complications and promote health care.

However, pregnancy is divided into three (3) divisions (trimester) which is first, second and third trimester. The first trimester starts from the conception to the third month (12 weeks) of pregnancy. The second trimester also starts from the fourth month and ends at the sixth month. Whiles the third trimester also starts from the seventh month and ends at the ninth month. It is the responsibility of the midwife to conduct the following activities to ensure a positive outcome of the pregnancy. The activities are;

Examining and monitoring pregnant women

Assessing care requirements and writing care plans

Undertaking antenatal care in hospitals and homes

carrying out screening tests

Providing information, emotional support and reassurance to women and their partners.

Taking patient samples, pulses, temperatures and blood pressures.

LABOUR

Myles (2020) labour purely in physical sense may be described as the process by which the fetus, placenta and membranes are expelled through the birth canal. Labour has four stages. Stage one comprises of latent phase and may last 6 to 8 hours in primigravida. LATENT This begins when the cervix is 4cm dilated and in the presence of rhythmic contractions, progressively dilates to 10cm or full dilatation. Second stage of labour is the expulsion of the foetus. It begins when the cervix is fully dilated and the woman has the urge to expel the baby. There is stretching of the clitoris, gaping of the anus and bulging of the perineum. Labour completes when baby is born. In multigravida women, it last 15-30 minutes. Third stage begins after the expulsion of foetus and ends with the expulsion of the placenta and membranes (afterbirth). The fourth stage is a period of careful observation of the mother made to assess excessive bleeding and the firmness of the contracting uterus immediately after the third stage of labour and it last for six hours after delivery of the placenta.

Marshall and Raynor (2014) also define labour as the process by which the foetus, placenta and its membranes are expelled through the birth canal.

In this physiological process, the foetus, placenta and membranes are expelled through the birth canal. Normal labour starts spontaneously at term that is within 37 weeks to 42 weeks of pregnancy, the foetus presenting by vertex completing spontaneously within 10 hours with no complications to mother and baby.

Although labour is a continuous process, it is divided into four (4) stages so that caregivers can provide specific care at certain periods during the process. On Average, it lasts for 12 hours.

The first stage starts with a regular painful rhythmic contraction accompanied by taking up of the cervix (effacement) and the dilatation of the cervix ends when the cervical os is fully opened (10cm). Show remains the first sign of true labour in most cases of labour (Marshall & Raynor, 2014). This lasts from 6-8 hours.

The second stage of labour commences from the full dilatation of the cervix to the expulsion of the baby. This stage lasts for about 1 hour in primigravidae and 30 minutes for multiparous women (Marshall & Raynor, 2014).

The third stage begins immediately after the delivery of the baby until placenta and membranes as well as controlling bleeding (haemorrhage) (Marshall & Raynor, 2014).

The fourth stage of labour is the first six hours after delivery where the mother and baby are critically observed to detect any complications that may occur. The midwife is also responsible in conducting the following activities during labour;

Caring for and assisting women in labour

Monitoring and administering medication, injections and intravenous infusions during labour

Monitoring the foetus during labour

PUERPERIUM

National safe motherhood service protocol (2017) states that, the postnatal period is the period that starts from the end of delivery of the placenta and membranes and control of haemorrhage up to six weeks after delivery.

Fraser, Cooper and Myles (2016) also state that puerperium is a period of 6-8 weeks which begins as soon as the placenta is expelled. The major causes of death in this period are infections, hypertensive complications, haemorrhages and thromboembolism.

During this period, lactation is established under the care of the midwife. Specialised care and protection are provided to baby and mother against infections and lactation is also established by the help of the midwife. Babies and mothers are prone to infections, so they need

specialised care to protect them against such infections. The principles of early postnatal period is to promote the physical and psychological wellbeing of the mother, her baby and the family unit, to identify any deviation from normal and to promote breastfeeding and family planning.

Puerperium on the other hand is the period of six (6) to eight (8) weeks following childbirth during which the uterus and the other organs and structures that took part during pregnancy returned to their non – pregnant state. In Bailliere's Midwives' Dictionary 2008, Aims of postnatal care are;

Promote rest and sleep

Promote lactation

Prevent complications

Family planning education and motivation.

In this period, the mother' fundal height, lochia, vital signs, and general health is monitored for any deviation or abnormality. The baby's cord, weight, breastfeeding pattern and general health are also monitored. Some of the changes that occur during puerperium are;

The reproductive organs return to their non- pregnant state and traumatised tissue or area of the genitals tract heals.

Other physiological changes which occurred during pregnancy are reversed.

Lactation is established.

The foundation of the relationship between the infant and the parents are laid down.

The mother recovers from the stress of pregnancy and delivery, and assumes responsibility for the care and nurture of the infant.

Responsibilities of the midwife during this period are;

Encourage sound methods of infant feeding and promote the development of good maternal-child relationships.

Henderson (2015) 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 pregravid condition, a period estimated to be around 6-8 weeks. Puerperium is a time of major physiological change and a time of major emotional and personal upheaval. An early postnatal check includes: maternal haemoglobin and assessment of the baby and the mother looking particularly for tiredness and depression. Further states that, the falling progesterone levels affect the alimentary tract. The smooth muscle tone gradually improves throughout the body, and symptoms of heartburn the woman may have experienced should resolve. Constipation may however remain a common problem during the postnatal period.

Konar (2022), puerperium is the period following child birth in which the bodies tissue, especially the pelvic organs revert back approximately to the pre-pregnant state both anatomically and physiologically. During puerperium the following physiological changes take place in all women as the body returns to its pre-pregnant state; Involution of the uterus and other soft parts of the genital tract, commencement of lactation. Physiological changes in other systems of the body. It is important that the midwife is familiar with these to ensure that appropriate care and advice are given. 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 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 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

WHY CLIENT WAS CHOSEN

On the 14th August,2023, Madam Elizabeth was seen at Emil Hospital Wenchi as a client on one of her usual antennal visits to the hospital. On our first contact, she was seen vomiting at the client's washroom. An approach was made to ask her how she was doing and what caused her to vomit. She replied she was fine but took in something that made her feel nauseated and the reason for throwing up. She was educated to stay away from food or items that make her nauseated more often. On further interaction with her, it was noticed that she was ever ready to listen to any advice given to her. Rapport was established and was advised to adhere to all that was given to her in order to have a safe pregnancy and delivery as well. Her antenatal booklet was then taken for a glance. After glancing through her antenatal booklet, it was realised that she was a regular attendant and had a good obstetric history and qualified to be used for the care study. It was noticed that she has been complaining of backache mostly throughout her previous antenatal visits. She was asked if she had any issue and this began our conversation. She said that she has a backache whenever she sits or bends down. Upon hearing this complaint, a decision and an opportunity was taken to introduce self to her as a student midwife from Holy Family Nursing and Midwifery Training College, Berekum, who is on clinical practice and the interest to select her for the study. She agreed to be used for the study and was glad.

CHAPTER ONE

ASSESSMENT OF CLIENT AND FAMILY

1.0 INTRODUCTION

This chapter gives insight of the client profile, lifestyle, family history, medical and surgical history, present and past obstetric history.

1.1 CLIENT'S PROFILE/SOCIAL HISTORY

Madam Elizabeth Adu, gravida3 para 2^{AA}, 30 years old, stays at Nwoase a suburb of Wenchi within Bono Region of Ghana with her husband and her children. She works as a teacher and speaks Twi and English. She is dark in complexion, 165 cm tall and weighs 60 kg during her first antenatal visit. She is a Christian and worships with the Roman Catholic Church at Nwoase with her husband and children. She is married to Mr. Charles Gyamfi who is also a teacher at Nwoase . Their first son is 6 years old and their second son is also 4 years old. Her next of kin is her husband. She doesn't smoke neither does she drink alcohol, she also said she is not allergic to any food or drug

1.2 HOBBIES/HABIT OF DAILY LIVING

Madam Elizabeth wakes up around 6:00 am to eliminate her bowel and urinate when she has the edge to do so, brush her teeth with pepsodent tooth paste and brush every morning and takes her bath twice daily. She takes care of the household chores and prepares her children for school. She takes her breakfast at 7:00 am, that is porridge and bread and at times she takes Milo and bread, then she goes to work. She normally takes gari and beans with fried plantain and sometimes rice and kontomire stew for lunch at 12:30 pm. She closes from work

around 4 pm and she rests for an hour and thereafter prepares supper for her family. She usually takes her supper at 6pm and then spends the rest of the evening watching television and preparing her lesson notes for the next day at school. She goes to bed around 8:00 pm. The food she likes best is yam and garden eggs stew. On Saturdays, she wakes up at 5:30 am. She performs her house chores, takes her breakfast and on Sundays she goes to church. Her hobbies are reading storybooks and listening to music.

1.3 MEDICAL HISTORY

Madam Elizabeth has never been admitted to the hospital except during labour. She had no hereditary condition such as epilepsy, asthma, hypertension, diabetes mellitus, sickle cell disease, glucose 6 phosphate dehydrogenase deficiency (G6PD). She has not suffered from any lower respiratory tract infection like pneumonia and tuberculosis. She was tested negative for HIV. She has no known allergies to food and drugs.

1.4 SURGICAL HISTORY

Madam Elizabeth has not had any accident involving her pelvis, spine or lower extremities neither has she undergone any obstetrical operation such as caesarian section, myomectomy and has not been transfused with blood before. She has not undergone any other general operation like appendectomy or laparotomy

1.5 FAMILY HISTORY

Madam Elizabeth is the first child of two children to Mr. Adu Kwabena and Madam Martha Gyamfuaa who are both farmers and lives in Western North (Sefwi Awiaso). Her siblings are all alive including her parents and none of her siblings depend on her for a living. According to her, there is a history of multiple pregnancies in the family from her mother’s side. There is no history of congenital malformation like Down syndrome, cleft lip, cleft palate, extra

digit. There are also no hereditary diseases such as sickle cell disease, asthma, diabetes, hypertension, mental illness such as schizophrenia in her family. There is however a history of twin gestation in their family. They are not allergic to any food or drugs. The husband provides money in the house and she sometimes support. There is no history of drug addiction and alcoholism in her family. The family is at peace with each other.

1.6 MENSTRUAL HISTORY

According to Madam Elizabeth had her menarche at the age of (15) fifteen. She has (28) twenty-eight day's cycle and she bleeds moderately for (7) seven days and she change her pad twice a day. According to her, she does experience dysmenorrhea during the first day of her menstrual cycle but she takes no drugs to relieve the pain. Her last menstrual date was 18th November, 2022 and her expected date of delivery (EDD) was calculated as 25th August, 2023.

1.6 PAST OBSTETRICAL HISTORY

Pregnancy

Madam Elizabeth G3P2^{AA}, has had three pregnancies in her lifetime with no abortion. She carried her first and second pregnancies to term without any complication like antepartum haemorrhage and the interval between the first and second pregnancies is three years, second and third pregnancies is two years. She however complained of constipation and backache which was managed by the midwife. She said she attended ANC when she was 3 months pregnant. She took sulphadoxine pyrimethamine four times and tetanus toxoid immunisation two times during her first and second pregnancies. She took two scans before she delivered.

She delivered her first and second children spontaneously per vagina at Email Memorial hospital Wenchi without any complications.

Labour

According to her, labour lasted for about 12 -13hrs in both deliveries. She said Placenta and its membranes were also delivered a few minutes after delivery of the babies with slight bleeding. Blood loss was 150mls in her first delivery and 200mls in her second delivery. Her first and second babies cried immediately after delivery without any complication like asphyxia. They also did not have any congenital abnormalities like cleft lip or cleft palate. She delivered live male babies who weighed 3.2 kg and 3.0 kg respectively. She was supported by her mother-in-law before, during and after delivery.

Puerperium

During puerperium, she did not suffer any ill health conditions like breast engorgement, urinary tract infection and genital tract infection. Lochia flowed for about 10 days. Her babies were healthy without any congenital malformation and they were not affected with any disease such as ophthalmia neonatorum . She breastfed her babies exclusively for six months after which she introduced complementary feed such as corn porridge, mashed kenkey and water alongside the breast feeding. She weaned them at 1 year and 6 months. According to her, she immunised her first and second babies against all the childhood diseases at the health Centre after birth. And her mother and sister supported her. According to her, she used oral contraceptives for three years after getting pregnant.

1.7 PRESENT OBSTETRICAL HISTORY

Madam Elizabeth gravida 3 para2^{AA} visited the clinic for the first time on the 3rd March, 2023 at her early stage of pregnancy. According to her, her last normal menstrual period was on 18th November, 2022 and her EDD was calculated to be 25th August, 2023. Her expected date of delivery by ultrasound scan was 11th August, 2023 and 8th September, 2023 as first and second scan respectively.

She complained of backache, lower abdominal pain, insomnia, and headache. She was advised to take in enough fluid and light diets and should always stay away from nauseated items. Procedure to be performed on her during the antenatal clinic was explained to her including head to toe examination to detect any abnormalities which can be treated on time, laboratory investigation and health education about pregnancy were given. Vital signs were checked and recorded as follows;

Temperature	36.2ºc
Pulse	76 bpm
Respiration	20 cpm
Blood Pressure	107/60 mmHg
Weight	60 kg
Height	165 cm

Privacy was provided and Madam Elizabeth was assisted to undress. She was helped onto the examination couch in the dorsal position and was examined from head to toe without detecting any abnormalities. The findings were communicated to her and documented. She was assisted to dress up and helped out of the couch. The urine she passed was tested for protein and sugar and it was found to be negative. Laboratory investigation was requested and done with the results as follows;

Haemoglobin	11.6gldl
Sickling	Negative
Blood group	AB
Rhesus factor	Positive
Venereal Disease Research Laboratory	Non-reactive
HBsAg	Negative
Stool routine examination	No ova, cyst, larvae or protozoa seen

Urine Protein/sugar Negative

Routine drugs served were;

Ferrous sulphate 200 mg daily x 30 days

Folic acid 5 mg daily x 30 days.

Tab multivitamin 200 mg daily x 30 days

She was educated on personal and environmental hygiene and danger signs of pregnancy like oedema , bleeding, severe lower abdominal pain and she was told to report immediately if she sees any of the danger signs, she was also educated on her nutrition.

She received her first dose of Sulphadoxine Pyrimethamine (SP) on the 27th March, 2023 at 17+2 weeks gestation and the fourth dose of tetanol toxoid injection on 4th October, 2022.

She received her 2nd dose of sulphadoxine pyrimethamine on 28th April 2023 at 21+2 weeks, 3rd on 26th May 2023 at 25+2 weeks, 4th dose on 26th June 2023 at 29+2 weeks and fifth dose on 31st July 2023 at 36 weeks gestation. She had her hemoglobin level checked on 3rd March, 2023 (12.4gdl), 28th April, 2023 (12.5g/dl) and 26th May 2023(12.8g/dl). She was advised to have enough rest and take all her drugs as prescribed by the midwife. All physical examinations carried out on her showed no abnormalities. Madam Elizabeth was asked to report every one month. From her records at each visit, everything was normal. Insecticide Treatment Net was given to her on 3rd March, 2023.

CHAPTER TWO

ANTENATAL CARE

2.0 INTRODUCTION

This chapter deals with the care given to the client during her antenatal visit. It consists of first contact with the client, first antenatal home visit, subsequent visits to the hospital, subsequent home visits and nursing care plan for the client during antenatal.

2.1 FIRST CONTACT WITH CLIENT

Madam Elizabeth on the 14th August, 2023, at Emil Hospital Wenchi on her 8th antenatal visit at gestational age of 37+2 weeks. She was very co-operative and willing to do whatever she was told to do provided she understands it well. On further interaction with her, it was noticed that she was ever ready to listen to any advice given to her. Rapport was established and was advised to adhere to all that was given to her in order to have a safe pregnancy and delivery as well. Her antenatal booklet was then taken for a glance. After glancing through her antenatal booklet, it was realised that she was a regular attendant and had a good obstetric history. It was noticed that has been complaining of backache mostly throughout her previous antenatal visits. Vital signs were checked and recorded. She was asked if she had any issue and this began our conversation. She said that she has a backache whenever she sits or bends down. Upon hearing this complaint, it was decided to take her as a client and help educate her. The physiology behind her backache and also minor disorders in pregnancy were explained to her. Some time was taken to educate her on backache. She was told that backache is one of the minor disorders in pregnancy and it is as a result of relaxation of ligament by the activity of the hormones relaxin and progesterone and it can occur as a result of the growing uterus causing a change in posture (making the woman tend to put shoulders

backward to support the uterus and keep her balance). She was encouraged to assume a proper position when sitting or lifting an object. She was also encouraged to do regular mild exercises like walking and also should have enough rest. With a good past obstetric history, she was taken as a client for the care study. Self-introduction was made as a student midwife from Holy Family Nursing and midwifery Training College Berekum. Opportunity was used to explain to her the intentions of taking her as my client for the care study and taking care of her during the remaining antenatal visit, throughout labour and puerperium. The importance of the care study was explained to her and the relatives she came with. They were told that this helps to promote quality of care for the mother, her baby and the family at large. She was sent to the consulting room and assured her of quality of care throughout pregnancy, labour and puerperium. General observation was done on her and recorded as follow;

Blood pressure - 100/60 mmHg

Temperature - 36.2^{o}c.

Pulse - 70 bpm

Respiration - 20 bpm

Weight - 69 kg

Height - 165 cm

Laboratory investigations done included;

Urine analysis reveals;

Protein - negative

Sugar - negative.

Physical examination was the next examination to be conducted on her. All procedures were also explained to her to seek her consent. The importance of the examination was also explained as it will help to detect abnormalities for early management and also to monitor the progress of her state.

HEAD TO TOE EXAMINATION

With madam Elizabeth's consent sought to perform general head to toe examination, she was asked to empty her bladder because full bladder interrupts with abdominal examination. The colour , odour of the urine was noted and samples taken for laboratory investigation. Privacy was provided and assisted her into the examination gown and helped her onto the examination couch. She was asked to lie in a lateral position while hands were washed with soap and water and dried with a clean towel. Palms were rubbed together in order to make them warm. A head-to-toe examination was conducted under the supervision of the midwife in-charge.

HEAD AND NECK

The hair was examined for dandruff, and alopecia and none was detected. The eyes were examined for pallor, discharges and discoloration and none was detected. The ears and nose were examined for discharges and also the mouth was examined for offensive odour, crack lips, pallor of the mucous membranes, bleeding gum but none was detected. The neck was examined for growth like goitre, enlarged lymph nodes but none was detected. The upper extremities were also examined for alignment, swelling and oedema of the hands, fingers for capillary refill and overgrown fingernails but none was detected.

BREAST EXAMINATION

The breast was exposed and inspected for size, shape, signs of pregnancy, dimpling and nipple retraction, and condition of the skin and no abnormality were detected. One breast was covered and she was asked to put the hand of the part to be examined under her head. The breast was palpated systematically in a circular manner using the inner aspect of the fingers and client was taught self-examination and no abnormality detected. Nipples were squeezed gently with cotton wool for fluid (colostrum) and were examined for odour or blood and colour. The same was done for the other breast and no abnormality was noted. Breastfeeding

history was asked and her desire to breastfeed was positive as her child was breastfed. Client was encouraged to wear a well-fitting brazier to support the breast and enhance comfort.

ABDOMINAL EXAMINATION

Hands were rubbed together in order to help prevent premature induction of contraction. Permission was asked to expose her abdomen for inspection and palpation while lying on her back. The abdomen was examined to detect any deviation from normal. Items used for the examination were shown to her to allay fear.

Abdominal Inspection

The shape of the abdomen was ovoid upon inspecting. The abdomen was inspected for scars, striae gravidarum and linea nigra and all of these, except scars were present. There was no evidence of foetal movement.

Measuring of symphysio- fundal height

The symphysio fundal height was checked and it measured 37cm. The abdomen was palpated and it was noted that the gestational age was 38 weeks. On fundal palpation, the foetal buttocks occupied the upper pole of the uterus denoting a longitudinal lie.

ABDOMINAL PALPATION

On abdominal palpation, hands were rubbed to generate warmth. The palms were placed on either side of the fundus for fundal palpation. The fingers were curved around the fundus to determine what lies in the upper pole. The abdomen was palpated for tenderness, masses, enlarged spleen and liver, suprapubic tenderness but none was present. She was asked if there is pain and she replied negatively.

LATERAL PALPATION

On lateral palpation, hands were placed on each side of the uterus, midway between the symphysis pubis and the fundus, the uterus was stabilised with one hand and examined with the other and palpated the entire area from the abdominal midline to the lateral side and from

the symphysis pubis to the fundus in a rotatory manner. A smooth curve was felt which indicated the back at the right side of the abdomen, the process was then repeated on the left side of the abdomen and an irregular mass and movement were felt which indicated the limbs. This helps to locate where to place the stethoscope to listen to the foetal heart sound. The position was therefore left occipito anterior.

PELVIC PALPATION

Position was changed to face the feet of client. She was asked to bend the knees slightly and breathe in slowly. Palms were placed on either side of the uterus with palms just below the level of the umbilicus and the fingers directed inwards towards the symphysis pubis with thumbs almost meeting. The head was palpated as hard mass occupying the lower pole. The presentation was cephalic.

DESCENT

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

ON AUSCULTATION

A fetoscope was rubbed in the palms to make it warm and was placed at the area where the back was located to listen to the foetal heartbeat. While listening to the heart beat, one hand was placed at the maternal radial pulse to ensure that it is not the maternal pulse being listened to. As soon as the maternal pulse was heard, client's hand was left. The foetal heart rate was checked for one minute noting the volume and rhythm and was recorded as 132 beats per minute.

From the above abdominal examination, lie was longitudinal, Descent was 5/5th and presentation was cephalic.

EXTREMITIES

Client's upper extremities were inspected for equality, edema of the finger and pallor of the palms and no abnormality was detected. The lower extremities were also inspected for edema, equality, size, tenderness in the calf muscle and varicose veins but none was detected and no extra digits. The thighs were examined for deep vein thrombosis and swelling at the groin.

BACK

The back was examined for spinal or vertebrae abnormalities such as scoliosis, kyphosis and costo-vertebral angle for tenderness and swelling, and oedema of the sacral region but none was detected.

VULVA EXAMINATION

Permission was sought to inspect the genital area and she agreed. Hands were washed with soap and water and dried with a clean towel. Examination gloves were worn. The vulva was inspected for edema, scar, clitoridectomy (FGM), rashes, ulcer of the vulva, discharges, offensive odour, genital warts, swellings, varicocele and over grown pubic but none was present. The mons pubis was well shaved. Client was encouraged to continue practising good vulva hygiene. Client was asked to assume lateral position and sit up before getting out of bed. Hand washing was done and dried with a clean towel.

Madam Elizabeth was thanked for her cooperation and was helped out of the examination couch and assisted to dress up. She was made comfortable in a chair and all findings were explained to her that everything was normal and no abnormalities were detected and that her pregnancy is progressing normally. She was allowed to ask questions and tell anything that worried her. She complained of backache and lower abdominal pains. She was encouraged to do some mild exercise. She was also advised to have enough rest and sleep.

She was again advised on the need to have a support person who will help her with some of her chores so that she can rest in between activities. Her normal routine drugs were also served.

Tablet folic acid 5 mg daily ×30 days

Tablet Fersolate 200 mg tds × 30 day

Tablet multivitamin 200 mg daily x 30 days

Client was thanked for her cooperation and also thanked her for allowing me to use her as a client for my care study. Appointment for home visit was scheduled for on 16th August, 2023. Direction to her house was given and contact numbers were exchanged. She was escorted to the gate and bid her goodbye.

2.2 FIRST ANTENATAL HOME VISIT

Madam Elizabeth was visited in her house around 2:30pm on the 16th August, 2023 as arranged with her previously. The purpose of the visit was to inquire about the complaints she made during the previous antenatal visit, to assess the health status, interact with her and her family to know the problems she might be facing at home and the best way of solving them, and also to observe the home environment.

On arrival, tenants met outside the compound were greeted and asked of my client's door. Upon knocking at her door, she came out and was invited to her room, a warm welcome was given and a seat offered. Madam Elizabeth was asked of her family, to which she replied that her husband has gone to a meeting and her mother-in-law was in the kitchen and her children have gone to school. Upon observation, she lives in a compound house with her family and they relate with each other very well in the house.

PHYSICAL ENVIRONMENT

The house is made up of 5 bedrooms, 5 kitchens, 1 toilet and bath. Each room has one kitchen, but they all share the same toilet and bath together. The rooms are spacious and the windows of each room is covered with net to help prevent mosquitoes from entering. Madam Elizabeth, her husband and children occupy one room which has mosquito nets on the bed. She has a good lighting system. She shares the toilet and bath with other tenants. Pipe is her source of water. The drainage system is good and there are gutters situated at vantage points to drain water from the house. She stores her water in a barrel and covers it with a well-fitting lid and also has a kitchen where she cooks and also uses it as a storage room for her food stuff. Her environment was clean and hygienic and her refuse is disposed of at the refuse dump every morning. Education on personal and environmental hygiene was made and how best she and her family can protect themselves from being infected with malaria and other diseases. She was advised to always keep the environment clean especially where the dustbin is situated to prevent breeding of mosquitoes. Client was also advised that she should always make sure she and her family sleep under the treated mosquito net and they should not stay out too long in the evening to prevent themselves from being infected with malaria.

Introduction was made by madam Elizabeth to her mother-in-law at the kitchen who was the one acting as her support person and some of her tenants who were around. They were asked to take good care of her so that she can deliver safely. Their toilet and bath were cleaned by her mother-in-law since she is pregnant and cannot bend to clean the toilet and bath. She was asked whether she had a problem with where she was staying and she said no and that she feels comfortable with where she stays and everyone is good to her. Madam Elizabeth said, she is ever ready to receive her new baby and that everything which will be needed for the delivery and after delivery has been bought. She brought them out from a suitcase which she had packed neatly and was checked out and everything was in order and well prepared. She

was encouraged on the importance of exercise and good positioning to help relieve her backache. She was also advised to take in fibre diets, roughages and fluids which will improve her intestinal motility to prevent constipation.

After one hour, her husband came home from the meeting and was introduced to him. Intentions of taking care of Madam Elizabeth throughout pregnancy, labour and puerperium was explained to him. He showed his gratitude and appreciation. Later her children came home and they were all healthy-looking children. After one and half hours staying with client, permission to leave was sought. She was reminded of her next appointment to the ANC and encouraged to report whenever she was not feeling well and the next visit was scheduled and were bid goodbye and left.

PSYCHOSOCIAL ENVIRONMENT

According to madam Elizabeth, her husband and family have a good and friendly relationship with each other. She has a warm relationship with her fellow tenants and other relatives as well as neighbours who stay in her area. Client said she has quite a number of friends but does not visit them usually but does visit when she has some leisure time to chat for a while and they also do the same sometimes. She also added that she really likes attending social gatherings like weddings, funerals and naming ceremonies. Madam Elizabeth is very approachable, friendly and finds it easy to make new friends. She also said she believes in love and respect for every human either old or young.

2.3 SUBSEQUENT ANTENATAL HOME VISIT

On the 18th August 2023, client was visited for the second time around 2:00pm. Madam Elizabeth and her mother-in-law were met with a warm welcome and a seat was offered. They were all looking fine and healthy. She said she was fit but complained of a slight

headache so she was advised to have a nap and take 1 gram of paracetamol. She was also taught deep breathing exercises which will help reduce the pain.

The purpose of the visit was to educate her on signs of labour such as severe lower abdominal pain, seeing of show and expulsive uterine contractions. She was also educated on birth preparedness and complications readiness by talking about support during labour, transportation system in case labour set in at night but her husband said he had already discussed it with a taxi driver who stays next to their house. Her husband was told to get a standby donor in case the need arises for blood transfusion. Madam Elizabeth also educated her on breastfeeding. She was encouraged on the need to practise exclusive breastfeeding when she gives birth and its importance was explained to her, which she said she now understands the reasons for exclusive breastfeeding and agreed to practise. They bid goodbye and left the place.

2.4 SUBSEQUENT VISIT TO THE CLINIC

On the 21st August 2023, Madam Elizabeth visited the clinic at 9:00am. She was welcomed and offered her a seat. Madam Elizabeth complained of insomnia and fatigue. She was reassured that everything is going to be well and was explained to her that it is as a result of the gravid uterus and because she is heading towards labour that is why she is experiencing such symptoms.

Permission was sought to conduct physical examination in order to detect any deviation from the normal about her and the foetus. The vital signs were checked and recorded as follows.

Temperature - 36.0^{o}c

Pulse - 76 bpm

Respiration - 22 cpm

Blood Pressure - 110/60 mmHg

Weight - 68 kg

Privacy was provided and hands were washed with soap and running water and dried with a clean towel. On abdominal examination the maturity was 39weeks + 2 days and the symphysio fundal height was 39cm. On palpation the lie was longitudinal, position was left occipito anterior, presentation was cephalic and descent was 5/5th above the pelvic brim. On auscultation, the foetal heart rate 148bpm. Madam Elizabeth was assisted to dress up and get out of the couch. She was educated on early signs of labour, personal and environmental hygiene in order to prevent infection. It was also stressed on the need for her and her family to continue sleeping under the mosquito net to prevent malaria. Her next visit was scheduled but was told to report to the facility if she saw any sign of labour.

2.5 NURSING CARE PLAN ON ANTENATAL CARE

PROBLEMS IDENTIFIED

1. 14/08/2023. Client complained of vomiting.
2. 14/08/2023. Client complained of backache.
3. 14/08/2023. Client complained of lower abdominal pain.
4. 18/08/2023 Client complained of headache.
5. 21/08/2023. Client complained of difficulty in sleeping (Insomnia).
6. 21/08/2023. Client complained of body weakness (Fatigue).

SHORT TERM OBJECTIVES

1. Client's vomiting will be subsided throughout pregnancy.
2. Client will cope with the backache within 24 hours and throughout pregnancy
3. Client will cope with lower abdominal pain within 48 hours and throughout pregnancy.
4. Client will be relieved of headaches within 24 hours.

5. Client will be able to sleep during the day and at night within 48 hours.
6. Client will be relieved of fatigue within 24 hours.

LONG TERM OBJECTIVES

Client will go through the pregnancy successfully without any complications to her and her baby.

ANTENATAL CARE PLAN CONTINUED

Table 1

Date and Time	**Nursing Diagnosis**	**Objective/Outcome Criteria**	**Nursing orders**	**Nursing Interventions**	**Date and Time**	**Evaluation**	**Sign**
14/08/23 at 09:00 am	Risk for fluid and electrolyte deficit	Client's vomiting will be subsided throughout pregnancy.	1. Assess for signs of dehydration. 2. Assess blood pressure (BP) 4 hourly. 3. Educate and encourage relatives on the need to give the patient fluid frequently. 4. Serve well-nourished diet.	1. Patient was assessed and it was observed that, patient had good skin turgor, mucus membrane and did not complain of thirst which indicates there was no sign of dehydration. 2. Patient's BP was checked and read 4hourly as 127/56mmHg indicating normal hydration status. 3. Patient's relatives were educated on the need to give the patient oral fluids and they served her with orange juice and copious amount of water every day. 4. Patient took 1L of water.	29/08/2023 at 9:00am	Goal fully met as client's vomiting reduced.	F.G

Table 2 ANTENATAL CARE PLAN CONTINUED

Date and Time	**Nursing Diagnosis**	**Objective/Outcome Criteria**	**Nursing orders**	**Nursing Interventions**	**Date and Time**	**Evaluation**	**Sign**
14/08/23 at 09:00 am	Backache related to pressure on the sacral nerves from the weight of gravid uterus and relaxation of the joints	Client will cope with backache within 24 hours and throughout pregnancy as evidence by 1. Client verbalizing that she can cope with the pain. 2. Client's relatives reporting that client coped with the pain	1. Reassure the client that the condition will be well managed. 2. Explain the physiology of backache to the client. 3. Encourage client to wear low heel shoes. 4. Encourage client to sleep on a firm mattress 5. Encourage client to push heavy objects instead of lifting.	1. Client was reassured that the condition will be managed 2. The physiology of backache was explained to client as pressure of the sacral nerves from the weight of the gravid uterus. 3. Client wore low heeled shoes to reduce the pain. 4. Client was slept on a firm mattress to reduce the pain 5. Client was pushed heavy objects to help reduce the pain.	15/08/2023 at 9:00am	Goal fully met as client expressed her ability to cope with the backache	F.G

Table 3 ANTENATAL CARE PLAN CONTINUED

Date and Time	Nursing Diagnosis	Objective/Outcome Criteria	Nursing orders	Nursing Interventions	Date and Time	Evaluation	Sign
14/08/23 at 9:15 am	Lower abdominal pain related to descent of fetal head into lower abdomen	Client will cope with pain within 48 hours and throughout pregnancy as evidenced by 1. client verbalizing that she is able to cope with pain 2. Client's mother reporting that she is coping with lower abdominal pain	1. Reassure client to allay anxiety and that her condition is manageable 2. Explain the physiology behind the lower abdominal pain to client as a result of descent of fetal head into lower abdomen 3. Advise client to have enough rest during the day. 4. Advise client to adopt a comfortable position to help subside pain. 5. Encourage client to reduce strenuous activities and rest in bed after daily activities.	1. Client was reassured to allay anxiety and that her condition is manageable. 2. The physiology behind lower abdominal pain was explained to the client as a result of descent of the fetal head into the lower abdomen. 3. Client had enough rest during the day. 4. Client sat with her back supported to help subside pain. 5. Client reduced strenuous activities such as lifting heavy objects and rested in bed after daily activities.	16/08/2023 at 9: 15 am	Goal fully met as client verbalized that she was able to cope with lower abdominal pain.	F.G

Table 4 ANTENATAL CARE PLAN CONTINUED

Date and Time	Nursing Diagnosis	Objective/Outcome Criteria	Nursing orders	Nursing Interventions	Date and Time	Evaluation	Sign
18/08/23 at 2:30 pm	Headache related to stress in late pregnancy	Client will be relieved of headache within 24 hours as evidenced by 1. Client verbalizing that pain has been relieved. 2. Client's mother-in-law verbalizing that client no more complains of headache.	1.Reassure client that headache will subside within 24 hours 2. Advise client to have enough bed rest. 3. Encourage client to take in more fluids. 4. Encourage client to add more fruits and vegetables in her diet. 5.Administer 1 gram of paracetamol to relieve pain	1.Client was reassured that headache will subside within 24 hours 2. Client had enough bed rest. 3. Client took in more at least 7 glasses of water 4. Client added more fluids and vegetables in her diet. 5. 1 gram of paracetamol was administered to relieve pain	19/08/23 at 10:30am	Goal fully met as client verbalizing that she has been relieved of headache.	F.G

Table 5 ANTENATAL CARE PLAN CONTINUED

Date and Time	Nursing Diagnosis	Objective/Outcome Criteria	Nursing orders	Nursing Interventions	Date and Time	Evaluation	Sign
21/08/23 at 9:05 am	Insomnia is related to the advanced stage of pregnancy.	Client will be able to sleep within 48 hours as evidenced by 1. Client verbalizing that she is able to sleep at least 8 hours during the night. 2. Client's husband testifying that, client is able to sleep	1. Reassure client 2. Educate client to take less fluid at night 3. Explain the physiology behind frequency of micturition in pregnancy to client. 4. Encourage client to empty bladder before going to bed 5.Educate client on sleeping measures	1. Client was reassured that she will be able to sleep well to allay anxiety. 2. Client was educated to take less fluid at night to prevent frequency of micturition. 3. Physiology behind frequency of micturition in pregnancy was explained to client 4. Client emptied her bladder before going to bed to enable her to sleep adequately. 5. Client was educated on sleeping measures such as sleeping in a quiet environment as well as a ventilated room to enable her to sleep adequately.	23/08/23 at 9:05 am	Goal fully met as client was able to sleep for 8 hours in the night without interruption.	F. G

Table 6 ANTENATAL CARE PLAN CONTINUED

Date and Time	Nursing Diagnosis	Objective/Outcome Criteria	Nursing orders	Nursing Interventions	Date and Time	Evaluation	Sign
21/08/23 at 9:20 am	Fatigue related to inadequate rest and sleep	Client will be relieved of tiredness within 24 hours as evidenced by 1. Client verbalizing that the tiredness has been relieved. 2. Relatives of client verbalize that she less complains of getting tired.	1. Reassure client that pregnancy can be stressful and that the fatigue could be managed to allay her anxiety. 2. Advise client to get a support person to assist her with the house chores. 3. Advise client to do away with any forms of stress such as noise so that she can rest. 4. Advise client to have enough rest during the day in between activities. 5. Encourage client to sleep in a well-ventilated room to induce sleep	1. Client was reassured that pregnancy can be stressful and that the fatigue could be managed to allay anxiety. 2. Support person assisted her with the house chores. 3. Client avoided all forms of stress so that she can rest. 4. Client had enough rest during the day in between activities. 5. Client slept in a well-ventilated room to induce sleep	22/08/23 9:20 am	Goal fully met as client was relieved of tiredness.	F. G

CHAPTER THREE

INTRAPARTUM CARE

3.0 INTRODUCTION

This chapter entails management of Madam Elizabeth Adu during her various stages of labour, care of the baby, examination of the placenta, summary of labour notes and nursing care plan.

3.1 ADMISSION AND MANAGEMENT OF FIRST STAGE OF LABOUR

Madam Elizabeth Adu reported at Emil Memorial Hospital at labour ward on 29th August, 2023 at 10:00am with the history of lower abdominal pains and waist pains which started at 8:00am. She was accompanied by her mother-in-law. They were welcomed and offered seats. She was oriented to the ward and was reassured that everything was going to be fine and that she was in competent hands. History of labour was taken after glancing through her ANC chart.

She felt foetal movement around 8:30 am, her last meal was Milo and bread at 7:00 am but was not able to eat it all. Show was seen around 8:45 am when she was emptying her bladder but no liquor was noticed. She was properly dressed and neat in appearance but her facial expression showed that she was in pain. Client was reassured and educated her on the lower abdominal and waist pain that the lower abdominal pain is as the result of the uterine contractions and the waist pains is as a result of the descent of the presenting part and also due to the relaxation of the perineal muscles to aid in the birth of the foetus. She was taught how to do the deep breathing exercise and was encouraged to do it. Her mother-in-law was

also taught on how to do the sacral massage and was also encouraged to do it for her from time to time to help subside the pain.

Madam Elizabeth was told that there will be the need to examine her in order to confirm and manage labour well. Procedures to be done were explained to her and consent was gained. Anaemia, jaundice and edema were not evidence as she was observed on her body. Privacy was provided, vital signs checked and recorded as follows;

Temperature - 36.3°c

Pulse - 86 bpm

Respiration - 1 23 cpm

Blood Pressure - 20/70 mmHg

She was taken to the examination room and asked to empty her bladder. She passed 150 mls of urine. The urine was tested for sugar and protein but none was present. She was helped to undress and assisted her to change into her maternity gown. Client was helped onto the couch; hands were thoroughly washed with soap under running water and dried with a clean towel. It was explained to client that the examination was done to check the position and presentation of the foetus, check the foetus condition and check if the foetus is descending into the pelvis. Consent was sought to examine her from head-to-toe.

ON ABDOMINAL EXAMINATION

INSPECTION: the abdomen was ovoid in shape and medium in size. Foetal movement was visible. On scars of previous caesarean section observed but there was linea nigra and striae gravidarum present on the abdomen.

MEASURING OF THE SYMPHYSIO-FUNDAL HEIGHT

Maturity was estimated at 39 +2 days old and symphysio fundal height was measured from the fundus to the symphysis pubis which measured 35 centimetres.

ABDOMINAL PALPATION

With clean and warm hands, the abdomen was palpated. The abdomen was not tender to touch as well as no enlarged spleen or liver could be identified.

ON FUNDAL PALPATION

Standing on the right-hand side of the client while facing her, palms were rubbed together and gently fundus was palpated. The upper pole of the uterus was occupied with the foetus buttocks.

ON LATERAL PALPATION

Foetus presented with limbs on the left-side and back at the right-side of the mother's abdomen.

ON PELVIC PALPATION

Facing the woman's feet and still on the right-side, pelvis palpation was done and the foetal head occupied the lower pole of the uterus. The lie was longitudinal and the presentation was cephalic.

DESCENT

The anterior shoulder was located using two fingers. Four fingers were admitted in-between the anterior and the upper border of the symphysis pubis indicating a descent of 4/5th above the pelvic brim.

ON AUSCULTATION

The fetoscope was warmed and placed on the abdomen where the back of the foetus was located and each heart beat was counted for a period of one minute and in all 130 beats per minute was recorded with regular and good volume. Contractions were time for ten minutes and recorded as 2 in 10 lasting 30 seconds.

The lie was longitudinal, presentation was cephalic and position was left occiput anterior.

VAGINAL EXAMINATION

At 10:30am, the procedure for a vaginal examination was explained to gain her consent. Hands were washed with soap under running water, dried them with a clean towel and wore sterile gloves. A sterile drape was used to cover both thighs. The vulva was quickly inspected to rule out edema, varicosities, warts but none was present. Vulva swabbing was done with cotton wool soaked in savlon solution and vaginal examination was performed. The middle and index finger were inserted into the vagina. The vagina was warm and moist. The cervix was soft and thin 4cm dilated, and well applied to the presenting part and the skull bones were touching each other. Maternal blood pressure, cervical dilation, descent and moulding were assessed four hourly.

Client was sent to the monitoring room and was admitted into a warm bed and made comfortable. Her items for delivery were arranged on her bedside locker. She was encouraged to walk around her bedside and rest when tired and also, she should adopt a position suitable for her. She was advised to change her pad when soiled and always wash her hands whenever she does that to prevent infection. Madam Elizabeth's mother-in-law was informed about the progress of labour and made to understand that her in-law would be discharged after delivery if mother and baby are in good condition.

Foetal heart rate, maternal pulse and uterine contractions were assessed half hourly. Temperature was checked twice an hour. Vaginal examination, descent and moulding were also checked every 4 hours. Urine was checked for protein and sugar every time she passed urine

She was encouraged to continue doing the deep breathing exercise since she complained of painful uterine contraction and also should try to sleep when contractions wear off. Madam Elizabeth Adu expressed her fears and anxiety of the outcome of labour and she was reassured that labour was progressing normally and that the outcome would be good.

At 2:30pm, contraction was 4 in 10 minutes lasting 45 seconds, foetal heart rate was 134 bpm, and maternal pulse was 94 bpm. She passed 100 mls of urine and was tested for protein and sugar which were all absent and temperature was 36.3oc. Membranes ruptured spontaneously and liquor was clear, vaginal examination was done to exclude cord prolapse, the cervical dilation was 8cm, foetal skull was overlapping each other and descent was 2/5th above the pelvic brim. Maternal blood pressure was 130/70mmH.

At 4:30 pm, contraction was 4 in 10 minutes lasting for 48 seconds, maternal pulse 90 bpm, and foetal heart rate 140 bpm, descent was 0/5, temperature was 36.6C and blood pressure was 120/80. All were recorded on the partograph. On vaginal examination, the presenting part was seen and the anus was gaped, cervix fully dilated, descent was zero fifth. When fingers were drawn a small amount of blood was seen on them. Fetal skulls was touching each other. Delivery trolley and resuscitation tray was prepared, containing delivery packs. The ischial spine was smooth and blunt with rounded edges indicating adequate pelvis. The cervical dilation was 10 centimetres. And she passed 200mls of urine and tested negative for both protein and acetone. She was reassured and taken to the delivery room for the second stage of labour and was informed that her baby would be delivered onto her abdomen. At 4:40pm, she complained of the urge to bear down.

3.2 PREPARATION FOR BIRTH

In preparation for birth, the Midwife-in-charge who would supervise labour and delivery and also assist in the care of the baby was identified as the skilled helper whereas the unskilled helper happened to be the client's mother - in- law, who accompanied her to the clinic and would run errands when the need arises. Emergency plan was reviewed, which includes communicating with the doctor and physician assistant to be alert and attend to any emergency when needed. Client's mother - in - law was asked to inform a taxi driver to be

alert in case of emergency. The delivery room area was cleaned and good source of light was ensured and an emergency portable light was present and functioning. Preparation of the area for ventilation and certain windows and doors were closed to provide privacy and warmth. A dry, flat and safe surface was prepared for receiving the new-born. The resuscitation tray was checked, cleaned and all equipment and instruments were assembled and tested for their function. Client's hand and abdomen was washed when the second stage was imminent to prepare skin-to-skin care to prevent infection to the new-born. The delivery pack and emergency drugs like magnesium sulphate, oxytocin and among others were made available.

3.3 MANAGEMENT OF FIRST STAGE OF LABOUR

At 2:30 pm vaginal examination was repeated and client was 8 cm dilated and was plotted on the partograph. With contractions becoming frequent and strong, breathing exercises through her mouth were taught during contractions and was encouraged to practise them and was also told not to push when she has not been asked, to prevent edematous cervix. Foetal heart rate, contractions and pulse were monitored every 30 minutes but vaginal examination, descent, blood pressure and temperature were checked every four hours.

Her vital signs were checked and recorded as follows.

Temperature - 36.2 degree Celsius

Pulse - 86 beats per minutes

Respiration - 22 cycles per minutes

Blood pressure - 110/70 millimetres of mercury

Foetal heart rate was 134 bpm, uterine contraction was 4 in 10 minutes lasting 45 seconds. Membranes ruptured spontaneously and liquor was clear, descent was 2/5th and the foetal skull was overlapping each other but could be pushed back indicating two ++. The amount of urine passed was 100 mls which was tested for acetone and the test result was negative.

Client was engaged in conversation which served as a form of diversional therapy in order to divert her attention from the pain and reduce her anxiety. She was encouraged to take in a light nutritious diet in order to prevent dehydration and also help her during the second stage of labour. All findings were recorded on the partograph and client was informed of progress of labour using the dilatation board, she was informed delivery was imminent and during that period she would have the urge to defecate and therefore should tell us. The delivery trolley was set up.

THE TOP SHELF

A. Cord scissors
B. Cord clamp
C. 2 artery forceps
D. 2 cot sheets
E. Episiotomy set
F. 4 drapes
G. 2 gallipots (one containing cotton swabs soaked in savlon solution and the other containing gauze)

BOTTOM SHELF

A. Measuring jug
B. Placenta bowl
C. Sucker in a bowl of water
D. Vitamin k injection
E. 10 units of oxytocin
F. Sterile gloves
G. Bed pan
H. Rubber mackintosh

I. Rubber apron

J. Examination gloves

K. Cot sheets

L. Perineal pads

M. Lidocaine

Client was helped to wash her hands and chest with soap and clean water and dried with a clean towel to prepare for skin-to-skin care. She complained about the frequency of micturition.

At 3:30 pm Madam Elizabeth verbalised having the urge to pass stools, vaginal examination was done to rule out cord prolapse. Cervical dilatation was 10cm, descent was 0/5th, contractions was 4 in 10 minutes lasting 45 seconds and foetal heart rate was 146 bpm, the perineum bulged and the anus gaped. The in-charge was called to come and assist the delivery. The first stage lasted for 6 hours 30 minutes,

3.4 MANAGEMENT OF THE SECOND STAGE OF LABOUR

With full dilatation of the cervix confirmed by the midwife on duty at 3:30 pm and client was asked to assume any comfortable position she wished and she opted for the lithotomy position after showing her various types during the first stage of labour. Madam Elizabeth Adu was then assisted to assume the position with her knees flexed. Windows were closed, curtains were well drawn and all fun was kept off. Protective clothing such as apron and face mask, goggles, boots and cap were worn. Hand washing done with soap under running water, wiped with a clean towel and then wore a sterile glove. Aseptically, the perineum, vulva, pubis and upper thighs were swabbed with a sterile cotton wool swab soaked in savlon solution. The abdomen and thighs were draped with sterile drapes. A perineal pad was placed at the anus to prevent contamination of the delivery field with faeces and was told to push

with each contraction and rest in between contractions. Foetal heart rate was checked after each contraction by the assistant. She was encouraged to push whenever she felt the urge to do so. With good uterine contraction and maternal effort, the head advanced and flexion was maintained till the head no longer receded between contractions and there was crowning.

She was asked to stop pushing and breathe through her mouth as the sinciput, the face and chin then swept through the perineum and foetal head was delivered by extension. The baby's eyes were cleaned from the inner canthus to the outer canthus with sterile cotton wool swab whilst the mouth and nose were cleaned with sterile gauze. Cord checked around neck but nothing was detected. Restitution occupied indicating internal rotation of the shoulder and external rotation of the head to take place to bring the shoulders into the anterior posterior diameter of the pelvic outlet. With the next contraction, a gentle push by the mother, delivered the anterior shoulder by gently moving the baby's head towards the mother's anus. The posterior shoulder was also delivered gently by moving the baby's head towards the mother's abdomen. The rest of the body was delivered by lateral flexion onto the mother's abdomen at 4:50pm. An alive female infant was delivered and cried immediately after birth. Baby was cleaned off liquor and placed on skin to skin on the mother. The cord was cleaned and cut and baby was showed to the mother to identify the sex. Mother was congratulated for her effort.

3.5 IMMEDIATE CARE OF THE NEWBORN

It is the care given to the baby soon after delivery. As soon as the baby was born, the baby's eyes were cleaned with a sterile gauze from the inner canthus to the outer. This was done to prevent the eye from becoming infected with organisms that might be present at the birth canal. The airway was cleared off liquor and mucus by a sterile gauze. Baby was placed on her mother's bare chest to help improve the baby's temperature and to create a bond with her,

head turned to her side to prevent aspiration. Baby's cord was clamped 3 cm from the umbilicus with a cord clamp and 2cm from the first clamp with artery forceps which was cut in between with cord scissors.

Baby's Apgar score in the 1st minute was 8/10 and 9/10 in the 5th minutes. The baby was put to breast within 30 minutes of delivery to initiate early breastfeeding. An identification band bearing the mother's name, baby's sex and weight were put on the baby's wrist.

3.6 MANAGEMENT OF THE THIRD STAGE OF LABOUR.

Madam Elizabeth was informed about the third stage and what is going to be done for her. The abdomen was palpated for the second twin but nothing was detected. 100 mls of urine was emptied from the bladder and oxytocin injection 10 units was given intramuscularly within one minute of birth. A sterile receiver was placed closer to the vulva. With uterine contraction, the forceps on the cord was removed and clamped close to the vulva ensuring that no external genitalia structure was clamped. The non-dominant hand was placed at the level of the symphysis pubis with the palm facing the umbilicus to stabilise the uterus. The uterus was hard and well contracted. With the dormant hand, the cord was held using the forceps and pulled steadily in a downward and outward direction to deliver the placenta by controlled cord traction. When the placenta appeared at the vulva, hands were cupped to ease pressure on the friable membrane. Twisting it gently to help bring out all membranes and increase the chance of delivering the placenta and membranes intact. The placenta and membranes were delivered at 4:55pm. A quick examination of the placenta on a flat surface was done to check for missing lobes and torn membranes. The uterus was rubbed for contractions and blood clots were also expelled from the uterus. The perineum and genital tracts were examined for tears and laceration and there was none. The uterus was massaged and it was well contracted. Blood lost was approximately 100 mls. Madam Elizabeth was

cleaned up and a perineal pad was placed at the vulva. She was taught how to massage the uterus to help it contract. Madam Elizabeth was asked whether she will take the placenta home and she said no, so the placenta was placed in the placenta bowl, and sent to the sluice room for further examination.

Examination of the placenta and membranes was done soon after delivery of the placenta before the client was sent to lying in ward. The end of the cord was examined for the number of blood vessels and it has two arteries and one vein. The cord was thick, strong and was covered with Wharton's jelly. It was inserted in the centre of the placenta. The foetal surface looked shiny and bluish grey in colour and blood vessels radiating from the cord to the edges of the placenta. The placenta was held by the cord and the membranes were allowed to hang on gloved hands and the membranes were complete and intact with the amnion covering the foetal surface. The chorion was thick, opaque, intact and continued with the edges of the placenta. The length of the cord was normal. The maternal surface looked dark red in colour, with lobes fitted together without any gap and with no infarct. Used instruments were immersed into 0.5% chlorine solution for 10 minutes, and were washed with soap and water and autoclaved for the next use. Placenta was put in a placenta bucket and discarded into a placenta pit.

3.7 MANAGEMENT OF THE FOURTH STAGE OF LABOUR

Madam Elizabeth was helped to get out of the delivery couch to the lying-in ward and made comfortable in a warm bed at 5:05pm. The mother and baby were closely monitored for a period of 6 hours following delivery. The postpartum vital signs were checked and recorded every 15 minutes for two hours, 30 minutes for 1 hour and hourly for the remaining 3 hours. Mother vital signs were checked and recorded as;

Temperature - 36.0^{o}c degree Celsius

Blood pressure	-	120/70 mmHg
Pulse	-	84 bpm
Respiration	-	18cpm

The uterus was well contracted and the fundal height measured 16 cm. She was encouraged to pass urine frequently to enhance uterine contraction and also to prevent excessive bleeding. She was taught how to massage the uterus to make sure it is well contracted. The lochia was red in colour and the flow was moderate with no clots. She was also advised to change her pad frequently when soiled and to wash her hands before and after the pad has been changed. She was served with rice and light soup as she ordered and ate half of it. Client took her bath and changed to a new dress. She later complained of tiredness and waist pains which was explained to her that the tiredness and waist pains is as a result of the stress and strains she went through during labour. She was then advised to have enough rest and sleep so that she can regain her strength.

The baby was also monitored for 6 hours and that was 15 minutes interval for the first 2 hours, 30 minutes interval for the next 1 hour and hourly for the next 3 hours and the condition was good. The skin was pink in colour, the airway was patent and the cord was not bleeding. The baby was given vitamin k injection intramuscularly and chloramphenicol eye drop was instilled on her eyes to prevent bleeding and eye infection. I supported the mother to breastfeed the baby to initiate breastfeeding. She was taught how to fix and attached the baby to the breast. This was to enhance the process of bonding and attachment between the mother and the baby.

3.8 SUMMARY OF LABOUR NOTES

Madam Elizabeth reported to the labour ward on 29th August, 2023 at 10:00 am. She had spontaneous vaginal delivery at 4:50 pm to an alive female infant. The placenta and membranes were delivered at 4:55 pm. The baby cried immediately after delivery.

First stage lasted - 6 hours, 30 minutes

Second stage lasted - 20 minutes

Third stage lasted - 5 minutes

Total duration of labour - 6 hours, 55 minutes

Condition of Baby at Birth

Sex	female
Weight	2.9 kilogram
Apgar score	8/10 and 9/10
Full length	52 centimeters
Head circumference	34 centimeters
General condition of the baby	Good

Apgar score for the first 1 minutes and 5 minutes was

APGAR	1ST MINUTE	5TH MINUTES
Appearance	1	2
Pulse	2	2
Grimace	2	2
Activity	1	1
Respiration	2	2
Total	8/10	9/10

Condition of the mother

Perineum	Intact
Estimated blood loss	100 milliliters
Temperature	36.0 degrees Celsius
Pulse	84 beats per minute
Respiration	18 cycle per minute
Blood pressure	120/70 millimeters of mercury
Fundal height	16 centimeters
General condition	Satisfactory

Condition of Placenta and Membranes

Umbilical cord and vessels	3 vessels (2 arteries and 1 vein)
Lobes and membranes	Intact
Cord insertion	Centrally
Maternal surface	Dark red in color
Fetal surface	Bluish grey in color

3.9 NURSING CARE PLAN FOR LABOUR

PROBLEMS IDENTIFIED

29th August, 2023

1. Client complained of Lower abdominal pains.
2. Client complaints of waist pains
3. Client was anxious.
4. Client complained of the frequency of micturition.

5. Client was exhausted.

SHORT TERM OBJECTIVE

1. Client will be able to cope with lower abdominal pains within 3 hours and throughout labour.
2. Client will be relieved of waist pain within 6 hours.
3. Client fears will be allayed within an hour.
4. Client will be able to cope with the frequency of micturition within 4 hours and throughout labour.
5. Client will be able to maintain her energy level within 4 hours.

LONG TERM OBJECTIVE

Client will have safe delivery to an alive healthy baby without any complications to herself and the baby

Table 6: Nursing Care Plan for Labor

Date and Time	Nursing Diagnosis	Objective/Outcome Criteria	Nursing orders	Nursing Interventions	Date and Time	Evaluation	Sign
29/08/23 at 10:00am	Lower abdominal pain related to descent of the foetal head into the pelvis	Client will be able to cope with lower abdominal pain within 3 hours throughout labour as evidenced by 1. Client verbalizing that she is coping with lower abdominal pain. 2. Midwife observing that client has adapt coping mechanism	1. Reassure client that lower abdominal pain is a normal physiology of labour. 2. Explain the physiology behind lower abdominal pain to client. 3. Encourage client to do deep breathing exercises during contractions. 4. Give sacral massage during contractions. 5. Advise client to adopt a comfortable position to help subside pain.	1. Client was reassured that lower abdominal pain is a normal physiology of labour. 2. The physiology behind the lower abdominal pain was explained to client as a result of descent of the foetal head into the pelvic cavity. 3. Deep breathing exercises were done by client during contractions. 4. Client was given sacral massage during contractions to reduce pain. 5. Client adopted a left lateral position to help subside pain.	29/08/23 at 1:00pm	Goal fully met as client verbalized that she is coping with lower abdominal pain.	F. G

Table 7: Nursing Care Plan for Labour

Date and Time	Nursing Diagnosis	Objective/Outcome Criteria	Nursing orders	Nursing Interventions	Date and Time	Evaluation	Sign
29/08/23 10:10am	Waist pain related to descent of the foetal head putting pressure on the sacral nerves	Client will be relieved of waist pain within 6 hours and throughout labour as evidenced by 1. Client verbalizing she has been relieved of waist pain. 2. Midwife observing client performing deep breathing exercise	1. Reassure client that the condition will be managed. 2. Encourage client to adapt a comfortable position 3. Encourage client to perform deep breathing exercise 4. Educate client on diversional therapy and its importance. 5. Teach client about sacral massage.	1. Client reassured that condition is manageable 2. Client adapt left lateral position to help reduced the pain 3. Client performed deep breathing exercises to help cope with the pains. 4. Client engaged in conversation as a means of diversional therapy. 5. Sacral massage was done for client to help alleviate pain.	29/08/2023 4:50pm	Goal fully met as client verbalized that pain has subsided.	F. G

Table 8: Nursing Care Plan for Labour

Date and Time	Nursing Diagnosis	Objective/Outcome Criteria	Nursing orders	Nursing Interventions	Date and Time	Evaluation	Sign
11/05/23 1:30 pm	Anxiety related to unknown outcome of labour	Client will be relieved of anxiety within hour as evidenced by 1. Client verbalizing that she is no more anxious 2. Midwife observing client is interacting with other clients	1. Reassure client that labour is a normal and physiological continuous process 2. Teach client the stages and process of labour 3. Orient client to the environment and delivery ward. 4. Encourage client to express her feelings. 5. Introduce client to someone who has gone through labour successfully.	1. Client reassured that labour is a normal and physiological continuous process 2. Client taught the stages and process of labour. 3. Orientation to the environment and delivery ward was done to reduce her anxiety 4. Client expressed her feelings and concerns and they were addressed appropriately. 5. Client introduced to someone who has gone through labour successfully.	29/08/2023 2:30 pm	Goal fully met as client verbalized that she was no more anxious.	F. G

Table 9: Nursing Care Plan for Labour

Date and Time	Nursing Diagnosis	Objective/Outcome Criteria	Nursing orders	Nursing Interventions	Date and Time	Evaluation	Sign
29/08/23 3:00 pm	Frequency of micturition related to physiology of labour and pressure of the presenting part on the bladder	Client will cope with frequency of micturition within 4 hours throughout labour as evidenced by 1. Client verbalizing she is able to cope with frequency of micturition.	1. Reassure client that frequency of micturition is a normal physiology of labour 2. Teach client the importance of bladder emptying during labour. 3. Teach client on complications of full bladder during delivery. 4. Serve client with a bedpan and provide privacy to enable her void frequently. 5. Encourage client to take in a lot of fluid to replace the fluid lost.	1. Client reassured that frequency of micturition is a physiology of normal labour. 2. Client taught the importance of bladder emptying during labour as it aids in descent of the foetal head. 3. Client taught about complications of the full bladder during delivery, as it can cause injury to the bladder. 4. Client served with a bedpan and privacy was provided for her. 5. Client served with a fruit juice to replace the fluid lost.	29/08/23 7:00 pm	Goal fully met as client voided at least every one hour and was able to cope with frequency of micturition.	F. G

Table 10: Nursing Care Plan for Labour

Date and Time	Nursing Diagnosis	Objective/Outcome Criteria	Nursing orders	Nursing Interventions	Date and Time	Evaluation	Sign
29/08/23 3:30pm	Maternal exhaustion related to stress during labour and delivery	Client will maintain her energy level within 4 hours throughout labour as evidenced by 1. Client verbalizing that the fatigue has resolved. 2. Midwife observing client coped throughout labour	1. Reassure client to allay anxiety 2. Teach client to do deep breathing exercise and relaxation during contraction 3. Instruct client to pant during contraction to avoid premature pushing 4. Encourage client to take a lot of fruit juice to maintain her energy. 5. Instruct client to rest in between contraction	1. Client reassured to allay anxiety 2. Client taught deep breathing exercises and relaxed during uterine contraction. 3. Client instructed to pants during contraction to avoid premature pushing 4. Client served with fruit juice to maintain her energy. 5. Client rested in between contractions to maintain her energy.	29/08//2023 7:30 pm	Goal was fully met as client went through labour successfully.	F. G

CHAPTER FOUR

PUERPERIUM

4.0 INTRODUCTION

This chapter deals with the care given to the mother and baby, baby's first bath, first day post-delivery care, preparation towards discharge, subsequent post-delivery, home visit problem identified, nursing care plan, short-term, long-term objectives on puerperium and termination of care.

4.1 DAY OF DELIVERY

On 29th August, 2023, Madam Elizabeth and her baby's conditions were assessed after the delivery of the placenta and membranes before transferring them into the lying-in ward and no abnormalities were detected.

The mother's temperature, pulse rate, respiration and blood pressure were observed and recorded quarter hourly for two hours, half hourly for one hour, hourly for three hours and four hourly till discharge. All findings were recorded on the post- delivery observation chart. A head-to-toe examination was performed on the mother and outcome was as follows; conjunctiva was red with no pallor, breast was examined and lactation confirmed as milk was expressed from the nipples, and the uterus well contracted, lochia was draining well without any clot and colour was red and with normal constituency. The calf was palpated for pain that is a sign of thrombosis but it was absent, no cramps were detected. Mother and baby were sent to the postnatal ward after some few hours of delivery. Madam Elizabeth's mother-in-law brought her fufu and groundnut soup and some soft drink. Her husband and some few neighbours came in to congratulate her. Mother was assisted to perform post-natal exercise

such as kegel exercise to restore pelvic tone. After the examination, all findings were communicated to her and helped her to dress up and then allowed her to rest. She was advised on early ambulation to enhance effective blood circulation and also facilitate drainage of lochia as well as emptying bladder frequently to enhance involution and prevent post- partum haemorrhage after which she was assisted to have a warm bath. Prescribed drugs as follows were collected from the pharmacy and client was taught how to take them.

Tablet Paracetamol - 1000 mg tds × 5 days

Tablet folic acid - 5 mg daily ×30 days

Tablet fersolate - 200mg tds × 30 days

Vitals were checked and recorded as follow:

Mother's Vitals

Temperature	36.0 degrees Celsius
Pulse	84 beats per minute
Respiration	22 cycle per minute
Blood pressure	120/70 millimetres of mercury

Baby's Vitals

Temperature	36.8 degree Celsius
Apex Heart Beat	136 beats per minute
Respiration	43 cycle per minute
Weight	2.9kg

4.2 SUBSEQUENT CARE OF THE BABY DURING PUERPERIUM

After six hours, Madam Elizabeth was informed about the need for a baby bath and general examination of the baby and she responded positively. Head to toe examination was done and no abnormality detected and all findings were communicated to her.

EXAMINATION OF THE BABY

All procedures to be done on the baby were explained to the mother that there was the need to examine the baby from head to toe to detect any abnormalities and to give prompt management if possible. Hands were washed with soap under running water and dried with a clean towel, put on a rubber apron and a pair of examination gloves, put baby on a warm sterile padded surface with only the part of the baby's body to be examined exposed at a time under a good source of light. The baby was exposed for quick observation of the colour which was pink and the body was covered with a small amount of vernix caseosa.

HEAD AND NECK

Baby's head circumference was measured as 34cm. The head was examined for size and shape, widened sutures, bulging or depressed fontanelle, edematous swelling; caput succedaneum, microcephaly, anencephaly and hydrocephalus but none was detected and the baby's hair was silky. The eyes normally situated without pallor or discharges or yellowish discoloration of the conjunctiva. The pinna of the ears was soft and there were no discharges from the ears. The nose was centrally placed with a normal septum, the bridge of the nose was well formed and nostrils were patent without any discharges. There were no abnormalities in the mouth. Sucking, moro and swallowing reflexes were present. The neck was palpated and no abnormalities were detected.

CHEST AND ABDOMEN

The breast was normal with no abnormalities detected and the respiratory rate was noticed by the upward and downward movement of the chest. The chest circumference was 32cm. The

abdomen was examined for shape and size, enlarged spleen and liver, bleeding from the umbilical cord and abnormalities such as omphalocele and gastroschisis, and among others were absent. The cord had three vessels, two arteries and a vein running through and there was no bleeding.

UPPER EXTREMITIES

The upper extremities were of equal length and size with no webbed or extra or missing digits, clubbing, nails overgrowth. Hands and arms were inspected for symmetry, movement and paralysis on the palm for palmar creases. Shape and colour of the nail bed was checked and grasping and Moro reflexes were checked. Everything was normal.

LOWER EXTREMITIES

The lower extremities were of equal length with no abnormalities like clubbed foot, webbed toes and extra digits and was flexed and abducted to exclude any congenital hip dislocation by using Ortolani's test and it was absent.

BACK

The baby was turned on her side, the thumb was used to run through the back to exclude abnormalities like, missing vertebrate and inspect for spina bifida, meningocele, swelling but none was found. The skin of the back was also examined for its colour and any hairy patches and none was seen.

GENITALIA AND ANUS

The genitalia were examined. The labia majora was covering the labia minora. Anus was assumed to be patent because the baby already passed meconium. Gloves were removed and disposed of aseptically before washing and drying hands with a clean towel. The length of the baby was 52cm on measurement. All findings were communicated to the mother and the midwife in-charge and documented.

BABY'S FIRST BATH AND CORD DRESSING

Baby bath requirements

TOP SHELF

- 2 gallipots (one with cotton and the other one with sterile water)
- Cord dressing tray

BOTTOM SHELF

- Soap
- Sponge
- Cream/powder
- Basin
- Towels (big towel and 3 small ones)
- Cot sheets (2)
- Gloves
- A clean baby dress, cap and socks if available
- Mackintosh
- 2 jugs containing hot and cold water
- A receiver for used cotton wool swabs
- Methylated spirit for cord dressing

Permission was sought from mother to bathe baby 24 hours after delivery. After examining the baby, the procedure was explained to mother and the needed things were collected. The items to be used were assembled, kept on a mackintosh apron, mixed the hot and cold water and tested the temperature of the water with my elbow, went for the baby, placed her on a warm flat surface, washed and dried my hands and put on examination gloves. Baby was undressed and covered with a cot sheet. Her eyes were cleaned with sterile cotton dipped into sterile water cleaning from inner cantus outwards. The face was cleaned with a damp face

towel. The sponge was lather with soap and baby's neck was supported with the left hand; thumb and index fingers were plugged into baby's ears to prevent water from entering the ears. The hair was washed in a circular motion with the soapy sponge, rinsed and dried with a dry towel and front of the trunk to the feet and turned the back down to the feet.

Baby's body was immersed in a bath of warm water and soap was rinsed. Baby was lifted gently from the water and put on a clean dry cot sheet and dried with a small towel and baby oil was applied to the skin, dressed up and put on a new cot sheet leaving the cord uncovered. Gloves were discarded, washed and dried hands.

The cord looked neat and with no signs of inflammation. The procedure was explained to mother. A set of tray containing sterile cotton wool swabs, receiver for used swabs, Methylated spirit, sterile gloves and plastic apron. Hands were washed with soap and water and dried and sterile gloves wore. The ligature was observed for looseness. Six pieces of sterile cotton wool swabs were dipped in the methylated spirit. The tip of the cord clump was held with soaked cotton wool swabs. The skin was swabbed 5 cm away from the base of the cord. The base of the cord was cleaned with a fresh cotton wool swab. The stem of the cord was swabbed from the base upwardly in strokes to the tip. The tip of the cord was cleaned with the last swab. The cord was exposed and baby was sent to mother. Hand washing was done and findings were communicated to the mother and made comfortable.

Baby was wrapped in a warm cot sheet and was sent to the mother to be breastfed and she was thanked. All linens belonging to the baby were given to the mother and the nursery was cleaned. I decontaminated the used articles in 0.5% of chlorine solution for 10 minutes, washed, rinsed, dried and sterilised. All procedures were documented and shown to the midwife in-charge.

4.3 FIRST DAY POST DELIVERY / DISCHARGE

On 30th August, 2023 Madam Elizabeth was looking healthy and refreshed. She had her bath, dressed up and was served with tea and bread in the morning and fufu with groundnut soup in the afternoon. She was asked how she was faring and she complained of after pain of which it was explained to her that it was due to the involution of the uterus and that it will subside within some few days. Client was encouraged to apply warm compress to her lower abdomen to relieve the pains. Her uterus was examined and was well contracted, lochia was examined to rule out other causes such as infection, she was encouraged to empty the bladder frequently to enhance involution and was given tablet Paracetamol 1g tid × 5 days to take to relieve pain. Her morning vital signs were checked and recorded.

Permission was sought and head to toe examination was carried out. She was assisted to lie on the couch. On inspection of the head; the hair was plaited with no dandruff, lice or ringworm. The eyes were normal with no pallor of the conjunctiva, the gum and tongue were normal with no sores, halitosis or tooth decay. The neck was palpated and there was no lymph node or goitre present. On breast inspection, the breast was of equal size, the nipple was a little erected and on palpation, there was no lump in the breast and colostrum was flowing freely and she was taught to practise breast self- examination at home. The upper limb was equal in length with pink palms with capillary refill on the fingernail bed and the fingernails were clean and short.

On abdominal palpation the uterus measures 16 cm and the uterus was well contracted. There was no edema at the back and sacral region. The lower extremities were equal in length with no varicose veins or rashes on inspection. There was neither pain nor edema in the calf muscle. Hands were washed and dried and gloves were kept on and was instructed to open her tights exposing the vulva. The perineal pad was removed noting the colour, smell and the quantity of the lochia rubra , odourless and moderate respectively). Gloves were removed and

washed, dried hands and assisted her to redress and made comfortable and communicated findings to her. She had not yet emptied her bowels but had emptied her bladder twice.

Procedure was explained to the mother to carry out an examination to detect any abnormalities. Before mother and baby were discharged, the procedure was explained to the mother to carry out an examination to detect any abnormalities on the baby and everything was normal. Baby passed (greenish) meconium once and had urinated and could suck well on the breast. Baby was top and tailed, the cord was dressed aseptically and wrapped in a warm cot sheet to enhance warmth. Baby was given 2 drops of oral polio vaccine against poliomyelitis and Bacillus Calmette Guerin (BCG) 0.05 ml at the right upper arm as her first immunisation against tuberculosis. Madam Elizabeth was encouraged to continue with the rest of the immunizations when the baby is six weeks old at the Child Welfare Clinic in order to be immunised against vaccine preventable disease and also to register her baby at the birth and death registry. She was also advised not to apply anything on the blister that will form later at the site of injection which is very significant.

Mothers Vitals;

Temperature	36.0℃
Pulse rate	82 bpm
Respiration rate	20cpm
Blood pressure	110/60 mmhg
Fundal height	16 cm

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

Temperature	36.5 degree Celsius
Apex Heart Beat	136 beats per minute
Respiration	45 cycles per minute

Weight	2.8kg

Mother was educated on personal hygiene and the importance of exclusive breastfeeding. She was advised to report to the clinic when she sees danger signs of puerperium such as offensive lochia, breast engorgement, cracked nipples, abscess and pyrexia. They were reminded not to put herbal preparations on the cord, and warm water to the fontanelles and sutures as told earlier in the morning. Also, she was advised not to expose the baby to cold weather or too much heat. She was then informed that, home visit will be done for the next seven days with the first three days done in morning and evening and the rest will be done daily. They were made to settle their bill with the health insurance card and were finally discharged at 10:00am, after which they bid goodbye with the promise of seeing them again. Mother was served with the following drugs on the day of delivery. She was educated on how to take the drugs as she will be taking it herself in the house.

Tablet paracetamol 1000 mg tds x 5 days

Tablet fersolate 200mg tds x 30 days

Tablet folic acid 5mg daily x 30 days

Madam Elizabeth was visited at 5:30 pm in the evening just to know how they were doing. Mother and baby were in a good condition. Head to toe examination was done on both mother and baby and no abnormalities were detected. Baby was topped and tailed and cord dressed. Mother was reminded to breastfeed baby on demand. Client's family was asked to support her in the household chores, so that she can have enough rest. Client however complained of lower abdominal pains. Education on the physiology of after pains during puerperium was given to her and also was encouraged to void frequently and empty her bowels, she was also told that it was as a result of the uterus contracting and was advised to apply warm compress and also the analgesic that was served.

Mother was advised against putting herbs on baby's cord and also not to apply warm compress on the fontanels. The dangers such as getting infections, high body temperature etc, associated with the above practice was explained to her. She was advised to take a nutritional diet to help repair worn out tissue and help in healing of placental sites. Client was educated on postnatal exercises to improve circulation and strengthen abdominal muscles and pelvic floor muscles. Both mother and baby's vital signs were checked and recorded as;

Mother's vitals;

Observation	**Evening**
Temperature	36.3
Pulse rate	80 bpm
Respiration rate	22 cpm
Blood pressure	110/60 mmHg

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

Observation	**Evening**
Temperature	36.6ºc
Apex Heart Beat	134 bpm
Respiration	44 cpm

4.4 FIRST DAY POSTNATAL HOME VISIT (SECOND DAY OF DELIVERY)

Madam Elizabeth was visited in the morning and evening at 8:00am and 4:30 pm respectively on the 31st August, 2023. On arrival, greetings were exchanged with a warm welcome, seat was offered and water served as tradition demands. Their health was inquired and she said they are all fine, just that she complained of difficulty in sleeping and she was advised to

sleep whenever her baby sleeps and also to restrict visitors. She was educated to feed the baby well before she goes to bed. Her fundal height was 16cm. General observation was made on mother after the procedure had been explained to her.

Baby's colour was pink and the cord was checked for bleeding and discharge but none was detected. Baby had passed meconium and urine twice. Mother was encouraged to take her drugs as prescribed, breastfeed the baby on demand, breastfeed exclusively for six months and also not to apply any herbs on the cord as this will lead to infection. She was educated on personal hygiene and the importance of sleeping under a treated mosquito net. The baby was topped and tailed paying attention to the skin folds and general examination was carried out and no abnormalities were present. The cord was orderly dressed with no abnormality detected on it and was getting dried. Permission sought to leave and promised to visit the next. Mother and baby's vitals were checked and recorded as;

OBSERVATION ON MOTHER

OBSERVATION	**MORNING**	**AFTERNOON**
Temperature	36.4^{o}C	36.7^{o}C
Pulse	80bpm	85bpm
Respiration	20cpm	21cpm
BP	100/60mmHg	100/65mmHg
Lochia	Rubra	Rubra
Fundal Height	16cm	16cm
Condition of Uterus	Contracted	Contracted

OBSERVATION ON BABY

OBSERVATION	**MORNING**	**AFTERNOON**
Temperature	36.0^0C	36.2^0C
Heart beat	140bpm	142bpm
Respiration	42cpm	43cpm
Skin Colour	Pink	Pink
Cord Bleeding	No	No
Cord	Shrinking	Shrinking
Weight	2.8kg	2.8kg
Stool Colour	Meconium	Meconium

4.5 SECOND DAY POSTNATAL HOME VISIT (THIRD DAY OF DELIVERY)

On the 1st September, 2023, the second visit was made to the client house at 7:00 am and 5:40 pm morning and evening respectively. Madam Elizabeth was greeted and welcomed me warmly and offered a seat. She was asked of her health and that of her family's as well. She said her condition had improved. Baby was doing well. Permission was sought to inspect her perineal pad. Perineal area was clean, the lochia was red (rubra), not offensive and the flow was moderate. Head to toe examination was also done and all findings were normal. The uterus was firm and well contracted and symphysis fundal height was 15 cm.

The baby was topped and tailed paying attention to the skin folds and general examination was carried out and no abnormalities were present. The cord was orderly dressed with no abnormality detected on it and was getting dried. The baby passed stools and urine that night,

according to the mother, baby's weight was 2.7 kilograms. Permission was sought to leave and they bid me farewell and showed appreciation.

Mother third day vitals

Observation	morning	Evening
Temperature	37.0℃	36.6℃
Pulse	80 bpm	76bpm
Respiration	20cpm	20cpm
Blood pressure	100/60mmhg	100/60mmhg
The Fundal height	15cm	15cm

Baby's third day vitals

Observation	**Morning**	**Afternoon**
Temperature	36.5℃	36.2℃
Apex beat	130bpm	132bpm
Respiration	52cpm	50cpm
Weight.	2.7kg	2.7kg
Cord	Shrinking	Shrinking
Skin Colour	Pink	Pink
Stool Colour	Meconium	Meconium
Suckling	Yes	Yes

4.6 THIRD POSTNATAL HOME VISIT (FOURTH DAY OF DELIVERY)

On the 2nd September, 2023, the third home visit was made to Madam Elizabeth's house at 8:00am and 4:40pm morning and evening respectively. Greetings were exchanged. Mother and baby were doing well as well as other members of the family. Permission was sought to

begin the examination and also the baby's bath. Her perianal and perineal pad was checked, the place was clean and lochia was rubra (red) with scanty flow without any offensive smell. Her breast was lactating well but she complained of backache and engorgement of breast. She was encouraged to breastfeed baby at least 8 times a day, wear a fitting brassiere to relieve pain and also support the back when sitting to breastfeed, feed on demand and she was reassured. Symphysio fundal height was 14cm when measured. Her vital signs were checked and recorded as

OBSERVATION ON MOTHER

OBSERVATION	**MORNING**	**EVENING**
Temperature	36.4℃	36.0℃
Pulse	82 bpm	80bpm
Respiration	20cpm	19cpm
Blood pressure	100/59mmHg	100/60 mmHg
Lochia	Rubra	Rubra
Fundal Height	14cm	14cm
Condition of Uterus	Contracted	Contracted
Breast	Lactating but engorged	Lactating but engorged

Baby had a good general condition with no rashes, jaundice absent, cord stump was healing with no bleeding. Baby was able to suckle well. The baby was top and tailed. The cord was neatly dressed. The baby also passed brownish yellow stools and urine. Permission was sought to leave and client was reminded of the next day's visit.

OBSERVATION ON THE BABY

OBSERVATION	MORNING	EVENING
Temperature	36.5℃	36.2℃
Apex Heart Beat	124 bpm	130bpm
Respiration	47cpm	40cpm
Skin Colour	Pink	Pink
Cord Bleeding	No	No
Cord	Shrinking	Shrinking
Suckling	Yes	Yes
Weight	2.7kg	2.7kg
Stool Colour	Brownish Yellow	Brownish Yellow

4.7. FOURTH POSTNATAL HOME VISIT (FIFTH DAY OF DELIVERY)

On the 3rd September, 2023, Madam Elizabeth and her baby were visited at their house at 7:00am to continue with the postnatal care. Their health status was required and was told they are all fine and she said the pain in her breast was subsiding. Lochia was pink (serosa) with scanty flow without any offensive odour on inspection of the perineal area. Head to toe examination was done and all findings were normal. Symphysiofundal height was measured and it was 13 cm. Madam Elizabeth was educated to continue breastfeeding on demand as she complained of heaviness in the breast which was as a result of fullness. She was also educated to apply warm compress on them to reduce pain and was to make sure one breast is emptied before the other and to wear a well-fitting brassier.

Baby was top and tailed paying attention to the skin folds and the general condition carried out with no abnormalities detected. The cord was orderly dressed with methylated spirit and no abnormality found. The baby had already passed stools and urine with stool colour of bright or mustard yellow. Her weight was 2.8 kg. Client educated on personal hygiene in order to prevent infection and also was advised to take fruits containing adequate roughage to prevent constipation and also eat a well-balanced diet.

OBSERVATION ON THE MOTHER

OBSERVATION	**MORNING**
Temperature	36.9℃
Pulse	79bpm
Respiration	21cpm
Blood pressure	109/80mmHg
Lochia	Serosa
Fundal Height	13cm
Condition of Uterus	Contracted
Breast	Lactating but slightly engorged

OBSERVATION ON BABY

OBSERVATION	**MORNING**
Temperature	36.6℃
Apex Heart Beat	135bpm
Respiration	45cpm
Skin Colour	Pink
Cord Bleeding	No
Cord	Shrinked
Suckling	Yes
Weight	2.8 kg
Stool Colour	Bright Yellow

4.8 FIFTH DAY POSTNATAL HOME VISIT (SIXTH DAY OF DELIVERY)

On 4th September, 2023 fifth postnatal home visit was at 5:30pm. Greetings were exchanged with client and her family after which a seat was offered in client's room. Mother and baby were both in a healthy condition on arrival. Head to toe examination was conducted on Madam Elizabeth and no abnormality was detected. Inspection of the lochia was done and the colour was pink (serosa) without any bad odour and flow was scanty. The perineum was clean and intact. On palpation, Symphysio fundal height was 12 centimetres. Madam Elizabeth vital signs were checked and recorded as follows:

OBSERVATION ON MOTHER

OBSERVATION	EVENING
Temperature	36.5℃
Pulse	86 bpm
Respiration	22 cpm
Blood pressure	110/70 mmHg
Lochia	Serosa
Fundal Height	12 cm
Condition of Uterus	Contracted
Breast	Lactating

Head to toe examination was done on the baby and no abnormalities detected. The cord was dry and showing signs of detachment. Baby was top and tailed after which the cord was clean with cotton wool swabs soaked in a methylated spirit. Baby passed urine and a yellowish stool. The weight was 2.9 kg. She was reminded of her seventh visit (one week visit) to the clinic of which she was told that she will make that visit on the 8th of September, 2023 instant of 5th September, 2023. The reason behind this was explained to her that the clinic's postnatal clinic is always held on Fridays. She was very grateful and permission was sought to leave.

OBSERVATION ON BABY

OBSERVATION	EVENING
Temperature	36.6℃
Apex Heart Beat	126 bpm
Respiration	50 cpm
Skin Colour	Pink
Cord Bleeding	No
Cord	Shrinked
Suckling	Yes
Weight	2.9 kg
OBSERVATION	EVENING

4.9 SIXTH POSTNATAL HOME VISIT (SEVENTH DAY OF DELIVERY)

The 6th day postnatal home visit was made on 5th September, 2023 at 7:00am. Greetings were exchanged with client and her family and a seat was offered. Mother and baby were both in a healthy condition and client said the fullness of breast has subsided except that the baby's cries a lot. She was reassured and encouraged to feed the baby well and change napkins before she sleeps and also educated to dress the baby according to the weather. Symphysio fundal height measured 11cm. Inspection of the lochia was done and the colour was serosa with no offensive smell. She was encouraged to continue keeping her perineum clean and change pad frequently to prevent infection and educated on family planning. After head-to-toe examination, no abnormality was detected.

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

OBSERVATION ON MOTHER

OBSERVATION	MORNING
Temperature	36.4℃
Pulse	80 bpm
Respiration	20 cpm
Blood pressure	110/70 mmHg
Lochia	Serosa
Fundal Height	11 cm
Condition of Uterus	Contracted

OBSERVATION ON BABY

OBSERVATION	**MORNING**
Temperature	37.0℃
Apex Heart Beat	120 bpm
Respiration	52 cpm
Skin Colour	Pink
Cord Bleeding	No
Cord Condition	Almost off
Suckling	Yes

Weight	3.0 kg
Stool Colour	Not seen

She was reminded that the seventh day will be my last visit. She was encouraged to breastfeed the baby frequently and ask questions if she has any. Permission to leave was sought after they bid me goodbye.

4.10 SEVENTH POSTNATAL HOME VISIT (EIGHTH DAY OF DELIVERY)

The last visit for the week was on 6th September, 2023 at 7:00am. Greetings were exchanged and was warmly welcomed. The condition of mother and baby was very good. Head to toe examination was done after explaining the procedure to her. Permission was sought and the perineal pad was inspected. Lochia was creamy white (Alba) but very little and not offensive. Nothing abnormal was detected. Symphysio fundal height was 9 centimetres when checked.

Baby was bathed by the client and cord stump dressed and it went on well, under supervision. Head to toe examination was done and no abnormality was found. Baby had passed urine and bowel movement was present. Weight was 3.1 kilograms.

All the findings were explained to client and she was educated on the importance of visiting the clinic for the first week postnatal and was reminded of the date as 8th September, 2023. The importance of immunising the baby fully was given to her. She was encouraged on the intake of more fluids and roughages to enhance bowel movement and was asked to maintain good personal hygiene. Madam Elizabeth was thanked for her support and cooperation and farewell was done.

OBSERVATION ON MOTHER

OBSERVATION	MORNING
Temperature	36.2oc
Pulse	84 bpm
Respiration	22 cpm
Blood pressure	100/60 mmHg
Lochia	Alba
Fundal height	9 cm
Condition of uterus	Contracted
Breast	Lactating

OBSERVATION ON BABY

OBSERVATION	MORNING
Temperature	36.5oc
Apex heart beat	140 bpm
Respiration	44 cm
Skin colour	Pink
Cord bleeding	No
Cord	Off
Weight	3.1 kg

Suckling	Yes
Stool colour	Dark Yellow

4.11 TENTH DAY POSTNATAL VISIT TO THE CLINIC

Madam Elizabeth came to the postnatal clinic on the 8th September, 2023, at 9:30am for a review in the company of her mother-in-law. She was warmly welcomed and offered a seat and asked how she was fairing and she said they are doing well. Every procedure to be done was explained to her to gain her consent. Mother and baby's vital signs were checked and recorded as follows:

Mother

Temperature	36.0℃
Pulse	78 bpm
Respiration	20cpm
Blood pressure	110 /60 mmhg
Weight	62kg
Haemoglobin	12.3g/dl

Baby

Temperature	37.0℃
Apex heart Beat	134 bpm
Respiration	44cpm
Baby's weight	3.3 kg
Cord Stamp	Healed

Baby was given to Madam Elizabeth's mother-in-law; privacy was provided while mother was asked to empty her bladder and a sample of the urine was tested for protein and sugar which were negative. She was assisted to undress, draped and lie on the couch. Hands were washed with soap and under running water and dried with a clean towel and conducted physical examination from head to toe. The hair was neatly braided with no dandruff or lice and the conjunctiva was pink in colour with clear sclera. The nose and ears were clear with no discharge. The mouth was neat with no halitosis and the neck was palpated and no enlarged lymph nodes, oedema and distended neck veins were detected. The breast was equal in size with the nipples prominent and was lactating, her upper and lower extremities were examined and no oedema or pallor was noticed and there was no pain in her calf muscles and the fundal height was not palpable. Her perineal pad was clean, vulva was inspected and no abnormality was detected, lochia was alba and without odour. She had emptied her bowel once and urinated twice. She weighed 62kg.

Hands were washed with soap and under running water and dried with a clean towel, sought permission from mother and baby's head to toe examination was also done. Baby was placed on a clean protected surface and undressed, baby's skin was pink in colour, the size and shape of the head was normal with sutures felt and fontanelles to be pulsating well without any abnormalities and there were no rashes on the face and body. Conjunctiva was pink and the sclera chosen any signs of jaundice nor eye discharges. The nose and ear were patent with no discharges. The mouth was clear and the neck was palpated but no abnormality was found. The chest and abdomen were normal and moved with respiration. The upper limbs were equal in size with no rashes and the umbilical cord was dry with no discharges. The genitals were examined. The labia majora was covering the labia minora. Anus was assumed to be patent because baby already passed meconium because mother verifies that she passed

meconium twice. The hips were examined and there was no dislocation and the lower limbs were equal in size with no abnormalities and she weighed 3kg.

All findings were communicated to her and recorded after washing hands. She was reminded to maintain personal and environmental hygiene and to avoid any application of herbal drugs onto the cord stamp as it will heal by itself. She was educated on the maintenance of adequate nutrition to keep her healthy and to prevent constipation. She was also educated on various topics including family planning, immunization of the baby, exclusive breastfeeding and the importance of attending child welfare clinic and was also told of registration of the baby at birth and death registry. She was informed of six weeks' postnatal visit which was on 20th October, 2023, she was also encouraged her to report to the clinic immediately if any abnormality is detected on either herself or the baby. Client and family were congratulated for their co-operation and time spent with throughout our encounter. Madam Elizabeth was taken to the public health nurse for continuity of care.

They expressed much joy for all that they were taught and help given to them. They were promised to pay them a visit from time to time whenever time permit. They were escorted out and bid them goodbye.

4.12 TERMINATION OF CARE

Madam Elizabeth and her family were previously told that our relationship will be temporal and it will end on the tenth day. The preparation of termination of care started on the first interaction that was on the 14th August 2023 at Emil Memorial Hospital Wenchi. She given the explanation on the need to be handed over to the midwife in-charge for continuity of care on the 8th September, 2023. The importance of drug compliance was explained to her and was encouraged to have enough rest and sleep to regain her strength, they were also reminded to register the baby at birth and death registry. And also, to complete baby's immunization

schedule. Condition of baby and mother were normal and she was encouraged to continue taking good care of herself and the baby. Client was handed over to the community health care nurses for continuity of care. She was then reminded that visits to them will be occasional.

4.13 SECOND POSTNATAL VISIT TO THE CLINIC

According to the midwife in charge, on the 20th October, 2023, Madam Elizabeth came to the clinic for six weeks visit. They were warmly welcome and they all looked very healthy. General examination was conducted on the client from head to toe as well as vital signs after her permission was sought. Madam Elizabeth was given a urine sample container to provide some urine to be sent to the laboratory for urine analysis to be performed. She was educated on the need and procedure to provide midstream urine for the examination. A sample of blood was also taken from Madam Elizabeth with her consent to be sent to the laboratory for her haemoglobin level to be tested. All findings were explained to her as follows;

OBSERVATION	**FINDINGS**
Temperature	36.4ºC
Pulse	82 bpm
Respiration	20cpm
Blood Pressure	100/80 mmHg
Haemoglobin	11.8 g/Dl
Urine protein	Negative
Glucose	Negative

Madam Elizabeth was sent to the palpation room where privacy was provided by drawing the curtains and closing doors and windows. She was helped to 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, hair was neat and well styled. The conjunctiva was pink and there were no discharges from the eyes, nose, ear, tongue and mouth were neither pale. No abnormality was found on the neck. On the breast, no abnormalities such as sore nipple, engorgement, cracked nipple and mastitis were detected and the breasts were lactating well. On examining the abdomen, no abnormality such as subinvolution, tenderness, enlargement of liver and spleen was detected and uterus was not palpable. Certain condition such as edema was looked out for at the lower extremities. It was detected that she showed no abnormality. Speculum examination revealed no bruises on the cervix but showed slit-like appearance. She had not resumed her menses when asked.

Her baby was also examined from head to toe to rule out for abnormalities. On the head, the anterior fontanelle was palpated for pulsation and it was normal. The posterior fontanelle had closed. There were no discharges from the eyes and nose. The skin was nice with no rashes. The chest, upper and lower extremities were normal. The findings on the baby were as follows:

OBSERVATION	FINDINGS
Temperature	36.2ºC
Respiration	34cpm
Apex heartbeat	134 bpm
Weight	5.5kg

Madam Elizabeth and baby were handed over to the child welfare clinic for continuity of care and for the six weeks' immunization against diphtheria, pertussis, tetanus, haemophilus influenza and hepatitis B. According to the midwife in charge she was encouraged to ask questions but she had none and no complaints either. She was reminded on exclusive

breastfeeding, rest and sleep, exercise and nutritious diet, which would help in lactation. She was finally referred to the public health nurse for continuity of care but to report to the facility anytime she encounters any health-related problem. She was thanked for her cooperation and understanding.

4.14 NURSING CARE PLAN DURING PUERPERIUM

PROBLEMS IDENTIFIED

1. 30/08/2023 client complained of after pains.
2. 31/08/2023 client complained of difficulty in sleeping.
3. 31/08/2023 client complained of leg cramps.
4. 02/09/2023 client complained of backache.
5. 02/09/2023 client complained of breast engorgement.

SHORT TERM OBJECTIVES

1. Client after pain will be relieved within 72 hours.
2. Client will have adequate rest and sleep within 24 hours
3. Client leg cramps will subside within 24 hours
4. Client backache will resolve within 24 hours
5. Client's breast engorgement will subside within 48 hours

LONG TERM OBJECTIVES

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

Table 11: Nursing Care Plan for Puerperium

Date and Time	Nursing Diagnosis	Objective/Outcome Criteria	Nursing orders	Nursing Interventions	Date and Time	Evaluation	Sign
30/08/23 9:30 am	After pains related to involution of the uterus.	Client's pain will be relieved within 72 hours as evidenced by 1. Client verbalizing that pain has been relieved. 2. Client's mother-in-law reporting that client after pain has been relieved.	1. Reassure client that her pains will subside. 2. Explain the physiology of the after pain as a result of involution of the uterus 3. Examine the lochia to rule out other causes such as infection. 4. Encourage micturition to help uterine involution. 5. Administer prescribed analgesic such as paracetamol	1. Client was reassured that the pains would subside. 2. Physiology of pains was explained to client as a sign of involution. 3. Lochia was examined to rule out other causes such as infection. 4. Client was encouraged to empty her bladder frequently. 5. Prescribed analgesics such as paracetamol 1g three times daily × 3 days was served	02/09/23 9:30 am	Goal fully met as client verbalized that the pains has been relieved.	F.G.

Table 12: Nursing Care Plan for Puerperium

Date and Time	Nursing Diagnosis	Objective/Outcome Criteria	Nursing orders	Nursing Interventions	Date and Time	Evaluation	Sign
31/08/23 At 8:30 am	Disturbed sleep pattern related to baby crying at night	Client's sleep will be restored within 24 hours as evidenced by 1. Client verbalizing that she can sleep. 2. Client mother-in-law confirming that, client was able to sleep	1. Reassure client that her sleep pattern will be improved. 2. Encourage client's relatives to assist her in the care of the baby during the day. 3. Encourage client to always ensure that baby is fed well before putting her to bed at night. 4. Counsel client to sleep when baby is asleep 5. Counsel client to make baby comfortable by changing baby's napkin when soaked before bed time.	1. Client was reassured that her sleeping pattern will be improved. 2. Client's relatives assisted her in the care of the baby during the day. 3. Client fed baby well before putting her to bed at night 4. Client slept while baby was asleep. 5. Client made baby comfortable by changing baby's napkin when soaked before bed time.	01/09/23 8:30am	Goal fully met as client verbalized, she has been able to sleep well	F.G.

Table 13: Nursing Care Plan for Puerperium

Date and Time	Nursing Diagnosis	Objective/Outcome Criteria	Nursing orders	Nursing Interventions	Date and Time	Evaluation	Sign
31/09/23 8:00am	Leg cramps related to hormonal changes during puerperium.	Client leg cramps will subside within 24 hours as evidenced by 1. Client verbalizing that pain has subsided. 2. Client's husband reporting that client leg cramp has subsided.	1. Reassure client that it will resolve with time. 2. Encourage client to apply warm towels on the cramped muscles. 3. Encourage client to do mild exercise 4. Educate client to avoid standing for a longer period of time 5. Asses for signs of deep vein thrombosis.	1. Client was reassured that it will resolve with time. 2. Client applied a warm towel on the cramped muscles. 3. Client preformed mild exercise 4. Client was educated to avoid standing for a longer period of time 5. Client was assessed to rule out sign of deep vein thrombosis	01/09/2023 8:00am	Goal fully met as client verbalized that pain has subsided.	F.G.

Table 14: Nursing Care Plan for Puerperium

Date and Time	Nursing Diagnosis	Objective/Outcome Criteria	Nursing orders	Nursing Interventions	Date and Time	Evaluation	Sign
2/09/23 8:30 am	Backache related to poor positioning and fixing of baby to breast.	Client backache will resolve within 24 hours as evidenced by 1. client verbalizing that the backache has resolved. 2. Client sister testifying that, client no longer complain of backache	1. Give emotional support to client that the pain will be relieved 2. Explain to client that it is due to poor positioning and fixing of baby to breast. 3. Encourage client to sit up with her back well supported to the chair or the wall during breastfeeding. 4. Assist client to adjust baby to a position that will enable her mouth to touch her breast. 5. Encourage client to sleep on a well firm mattress.	1. Emotional support was given to client that pain will be relieved. 2. Condition was explained to client that it is due to poor position and fixing of baby to breast. 3. Client supported her back with a chair or wall while breastfeeding. 4. Client was assisted to adopt a proper position that enabled the baby's mouth to touch her breast. 5. Client was encouraged to sleep on a firm mattress	03/09/23 8:30am	Goals fully met as client verbalized that she is relieved of backache.	F.G.

Table 15: Nursing Care Plan for Puerperium

Date and Time	Nursing Diagnosis	Objective/Outcome Criteria	Nursing orders	Nursing Interventions	Date and Time	Evaluation	Sign
02/09/23 4:40 pm	Breast engorgement related to poor attachment of the baby to breast or inadequate emptying of breast	Client' engorged breast will subside within 48 hours as evidence by the 1. Client verbalizing that she is relieved of breast engorgement.	1. Reassure client that her breast engorgement will subside. 2. Demonstrate to client on the correct attachment of the baby to the breast. 3. Educate and encourage client on gentle manual expression of breast milk and store it 4.Encourage her to continue breast feeding the baby. 5. Encourage client to apply warm and cold compress on both breasts.	1. Client was reassured that her engorged breast will subside 2. A demonstration was done on how to properly fix the baby to breast and store. 3. Client was educated and encouraged on a gentle manual expression of breast milk and its storage 4. Client was encouraged to continue breast feeding the baby on demand and frequently. 5.Client was encouraged to apply warm and cold compress on both breasts.	04/09/23 4:40 pm	Goal met as client reported that her breast engorgement has subsided.	F.G.

SUMMARY AND CONCLUSION

The family centred maternity care study was written on Madam Elizabeth Adu who is 30 years of age and Gravida 3 Para 2 ^{AA} and was a regular attendant at Emil Memorial Hospital Wenchi in the Bono Region. The interaction with her started on the 14th August 2023 during her 8th visit to the antenatal unit. She was 37+2 weeks pregnant at that time. Glancing through her antenatal book, it was realised that she has been complaining of having backache in most of her previous antenatal visit. Decision was then made to take her as a client which will help me to educate her on the minor disorders of pregnancy, the causes and the management so as to help her through the rest of her pregnancy through to labour and puerperium. Introduction was made to her and permission was sought to take her as a client for the study and she happily agreed. She was visited at home to know her family, assess her environment and the community in which she lives. She was given the required education, support and management throughout the study.

She went through pregnancy, labour and puerperium without any complication. She delivered a live and healthy female infant on 29th August, 2023 who weighed 2.9kg and cried lustily at birth. Her lactation was successfully established and she breastfed her exclusively. Client and baby were discharged the next day and on the 10th day she was handed over to the community health nurses at the Clinic for continuity of care. She was helped to identify and solve her problems. She and her baby were thoroughly examined and motivated on each visit to detect any abnormality. The baby received her immunisation on the day of delivery.

The Family centred maternity care study gave me the opportunity to apply my knowledge acquired in the classroom and the clinical field to give care to my client and her family because pregnancy is not just about carrying baby and giving birth but also involves the involvement of the family.

It is my desire that the knowledge and experience acquired during this period will enable me to render effective care to others throughout my practice.

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APPENDIX I

MATERNAL ANTENATAL RECORD

DATE	WEIGHT (KG)	BLOOD PRESSURE	URINE FOR PROTEIN/ SUGAR	GESTATIONAL AGE IN WEEKS	FUNDAL HEIGHT	PRESENTATION	DESCENT OF FOETAL HEAD	FOETAL HEART RATE (FH)	TREATMENT GIVEN	COMPLAIN
3/03/2023	60	107/60	Negative	13	EP	-	-	EP	Routine drugs	Headache
27/03/2023	63	123/70	Negative	17+2	NP	-	-	EP	Routine drugs	No complains
28/04/2023	65	110/70	Negative	21+2	14	-	-	143 bpm	Routine drugs	Headache
26/05/2023	69	107/60	Negative	25+2	23	Cephalic	-	125 bpm	Routine drugs	No complains
26/06/2023	72	101/65	Negative	29+2	25	Cephalic	5/5 th	130 bpm	Routine drugs	No complains
17/07/2023	77	107/60	Negative	33	29	Cephalic	5/5 th	146 bpm	Routine drugs	No complains
31/07/2023	80	109/60	Negative	36	33	Cephalic	5/5 th	133 bpm	Routine drugs	No complains
14/08/2023	80	107/60	Negative	37+2	35	Cephalic	5/5 th	149 bpm	Routine drugs	Lower abdominal pains
21/08/2023	81.5	123/65	Negative	38+2	36	Cephalic	5/5 th	135	Routine drugs	No complains

APPENDIX II

LABORATORY INVESTIGATIONS

DATE	SPECIMEN	INVESTIGATION	NORMAL VALUES	FINDINGS	REMARKS
03/03/2023	Blood	Haemoglobin	11g/dl-16g/dl	11.56g/dl	Normal
		PMTCT	Negative	Negative	Normal
		Blood Group	A, B, AB, O	AB	Normal
		Rhesus Factor	Positive, Negative	Positive	Normal
		Hepatitis B	Negative	Negative	Normal
		Sickling	Negative	Negative	Normal
		G6PD	Non-Reactive	Non-Reactive	Normal
		VDRL	Non-Reactive	Negative	Normal
		RDT	Negative	Negative	Normal
	Urine	Protein	Negative	Negative	Normal
		Glucose	Negative	Negative	Normal
	Stool	R/E	Negative	No abnormality detected	Normal

LABORATORY INVESTIGATIONS CONTINUED

DATE	SPECIMEN	INVESTIGATION	NORMAL RANGE	FINDINGS	REMARKS
27/03/2023	Urine	Protein	Negative	Negative	Normal
		Glucose	Negative	Negative	Normal
28/04/2023	Urine	Protein	Negative	Negative	Normal
		Glucose	Negative	Negative	Normal
	Blood	Haemoglobin level	11-16 gms/dl	12.5 gms/dl	Normal
26/05/2023	Urine	Protein	Negative	Negative	Normal
		Glucose	Negative	Negative	Normal
	Blood	Haemoglobin level	11-16 gms/dl	12.8 gms/dl	Normal
26/06/2023	Urine	Protein	Negative	Negative	Normal
		Glucose	Negative	Negative	Normal
17/07/2023	Urine	Protein	Negative	Negative	Normal
		Glucose	Negative	Negative	Normal

LABORATORY INVESTIGATIONS CONTINUED

DATE	SPECIMEN	INVESTIGATION	NORMAL RANGE	FINDINGS	REMARKS
31/07/2023	Urine	Protein Glucose	Negative Negative	Negative Negative	Normal Normal
14/08/2023	Urine Blood	Protein Glucose Haemoglobin level	Negative Negative 11-16 gms/dl	Negative Negative 12.0gms/dl	Normal Normal Normal
21/08/2023	Urine	Protein Glucose	Negative Negative	Negative Negative	Normal Normal

APPENDIX III

PHARMACOLOGY OF DRUGS FOR THE MOTHER

DRUG NAME	CLASSIFICATION OF DRUGS	DOSAGE OF DRUG	ROUTE OF ADMINISTRATION	ACTION AND USES	SIDE EFFECT OF DRUG	REMARKS
Tablet fersolate	Iron preparation	200mg tds × 30days	Oral	1.it helps in formation of red blood cells 2.supplement the iron requirement of the body in the treatment of iron deficiency anaemia	1.gastrointestinal disturbances like constipation and diarrhoea 2.dark stool	1.dark stool observed 2.haemoglobin level increased
Tablet folic acid	Vitamin preparation	5mg daily ×30 days	Oral	1.helps in the formation of red blood cells 2.prevention of neural tube defect	Gastrointestinal disturbances	None observed

PHARMACOLOGY OF DRUGS FOR THE MOTHER

DRUG NAME	CLASSIFICATION OF DRUGS	DOSAGE OF DRUG	ROUTE OF ADMINISTRATION	ACTION AND USES	SIDE EFFECT OF DRUG	REMARKS
Tablet multivitamin	Vitamin preparation	200mg tds × 30 days	Oral	1. Helps in the prevention and treatment of anaemia 2. Improve appetite	Nausea and vomiting Abdominal discomfort	None observed
Capsule vitamin A	Vitamin preparation	200,00 IU start and repeated after 24 hours	Oral	Prevent night blindness	1. Gastrointestinal upset 2. Nausea and vomiting 3. Liver damage will occur after prolonged use	None observed
Tablet paracetamol	Analgesic and antipyretic	1000mg tds x 5 days	Oral	To relieve pain to reduce body temperature	Overdose may lead to nausea, vomiting, abdominal pain and hepatotoxin	None observed

PHARMACOLOGY OF DRUGS FOR THE MOTHER

DRUG NAME	CLASSIFICATION OF DRUGS	DOSAGE OF DRUG	ROUTE OF ADMINISTRATION	ACTION AND USES	SIDE EFFECT OF DRUG	REMARKS
Capsule amoxicillin	Antibiotic	500mg tds× 5 days	Oral	Treatment and prevention of infection	1. Nausea and vomiting 2. Anorexia and abdominal pains	None observed
Tablet metronidazole	Antibiotic	400mg tds × 7 days	Oral	Treatment and prevention of infection	Nausea	None observed
Tablet Sulfadoxine-Pyrimethamine	Antimalarial	3 tablets taken at 4 weeks interval	Oral	Destroy malaria parasites	Nausea vomiting and drowsiness	None observed
Injection Tetanol Toxoid	Antigen	0.5mls	Intramuscular	Stimulate the formation of antibodies against tetanus organism	Slight rise in temperature Inflammation of injection site pain and tenderness	None observed
Injection oxytocin	Oxytocin agent	10 unit	Intramuscular	Stimulate uterine muscle contraction and controls bleeding 2. Used for augmentation of labour	Uterine rupture if overdose is given	None observed

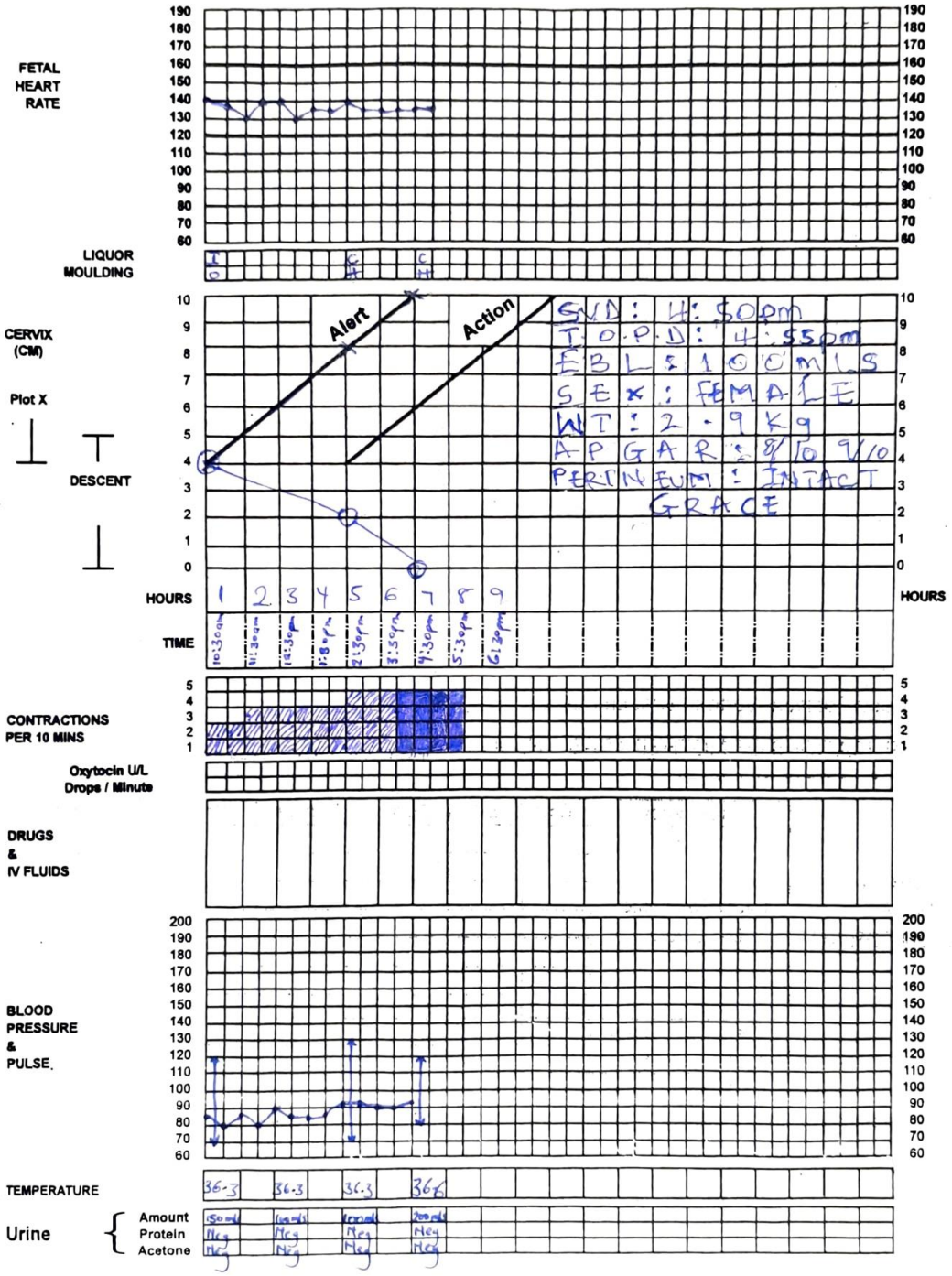
APPENDIX IV

PHARMACOLOGICAL DRUGS FOR BABY

DRUG NAME	CLASSIFICATION OF DRUG	DOSAGE OF DRUG	ROUTE OF ADMINISTRATION	ACTION AND USES	SIDE EFFECT OF DRUG	REMARKS
Injection vitamin k	Antihemorrhagic vitamin	0.5 ml to 1 ml	Intramuscular	1.helps in clotting of blood 2.helps to prevent hemorrhagic disease of the newborn	Flashes in the face	None observed
Bacillus Calmette Guerin (BCG)	Antigen against tuberculosis	0.05ml	Intramuscular	Stimulate production of antibodies against tuberculosis.	Small pustule which persists for some weeks	Blister observed
Polio vaccination	Vaccine against poliomyelitis	2 drops	Oral	Stimulate production of antibodies against poliomyelitis	Nausea	None observed
Methylated spirit	Antiseptic	Quantity needed.	External use only.	It has quick drying effects and inhibits growth of microorganisms	May cause irritation	None observed
Topical tetracycline	Antibiotics	2 times daily for 7 days	Instillation	It is used to treat infection of the eye	May cause irritation	None observed

WHO Modified Partograph

Registration No. 250/22 Name (Last, First) Elizabeth Ayin Age 30yrs
Date 29/05/2023 Parity/Gravida 2 / 3 LMP 12/11/22 EDD 22/8/23 Gestation (wks) 39
ROM (Time, Date) 21:30 / 29/5/23 Labour Durable (Hrs) ____ Facility/Clinic Name EMILE MEMORIAL



LABOUR NOTES

At 4:50pm Client delivered a live female baby, active management of third stage done where 10 units of oxytocin was administered to the mother to deliver the placenta. The uterus was well massage to expell blood clots. Placenta was correctly delivered. Essential care was given - Vital signs, eye care and cord care was done. Both mother and baby were made comfortable in bed and still under monitoring.

Please circle or write responses.

DELIVERY

DATE: 29/08/23 TIME: 4:59pm METHOD: (Spontaneous) / Vaccuum Extraction / C/S / Other

PERINEUM: (Intact) / Episiotomy / Laceration

ANESTHESIA: (None) / Local / General

THIRD STAGE

Active Management: (Yes) / No Medication: Time 4:51 Type / Dose Oxytocin 10units

PLACENTA: Time: 4:55pm Complete / Incomplete

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

BABY

Weight: 2.9kg

Sex: Male / (Female)

Baby Position: (Vertex) / Breech / Other

APGAR

Time	Color	Breath	Heart	Tone	Reflex	TOTAL
1 min	1	2	2	1	2	8/10
5 min	2	2	2	1	2	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	5:05pm	120/70	84bpm	1 6cm	Moderate	200mls
	5:20pm	121/70	84bpm	16cm	Not active bleeding	—
	5:35pm	120/72	84bpm	16cm	Not actively bleeding	—
	5:50pm	121/70	83bpm	16cm	Moderate	100mls
	6:05pm	120/74	83bpm	16cm	Normal	—
	6:20pm	121/71	83bpm	16cm	Normal	—
	6:35pm	120/70	84bpm	16cm	Normal	250mls
Every 30 minutes for 1 hours	7:05pm	121/78	81bpm	16cm	Normal	—
	7:35pm	120/70	84bpm	16cm	Normal	300mls

Birth Attendant Framoh Grace Date 29/08/2023
assisted by

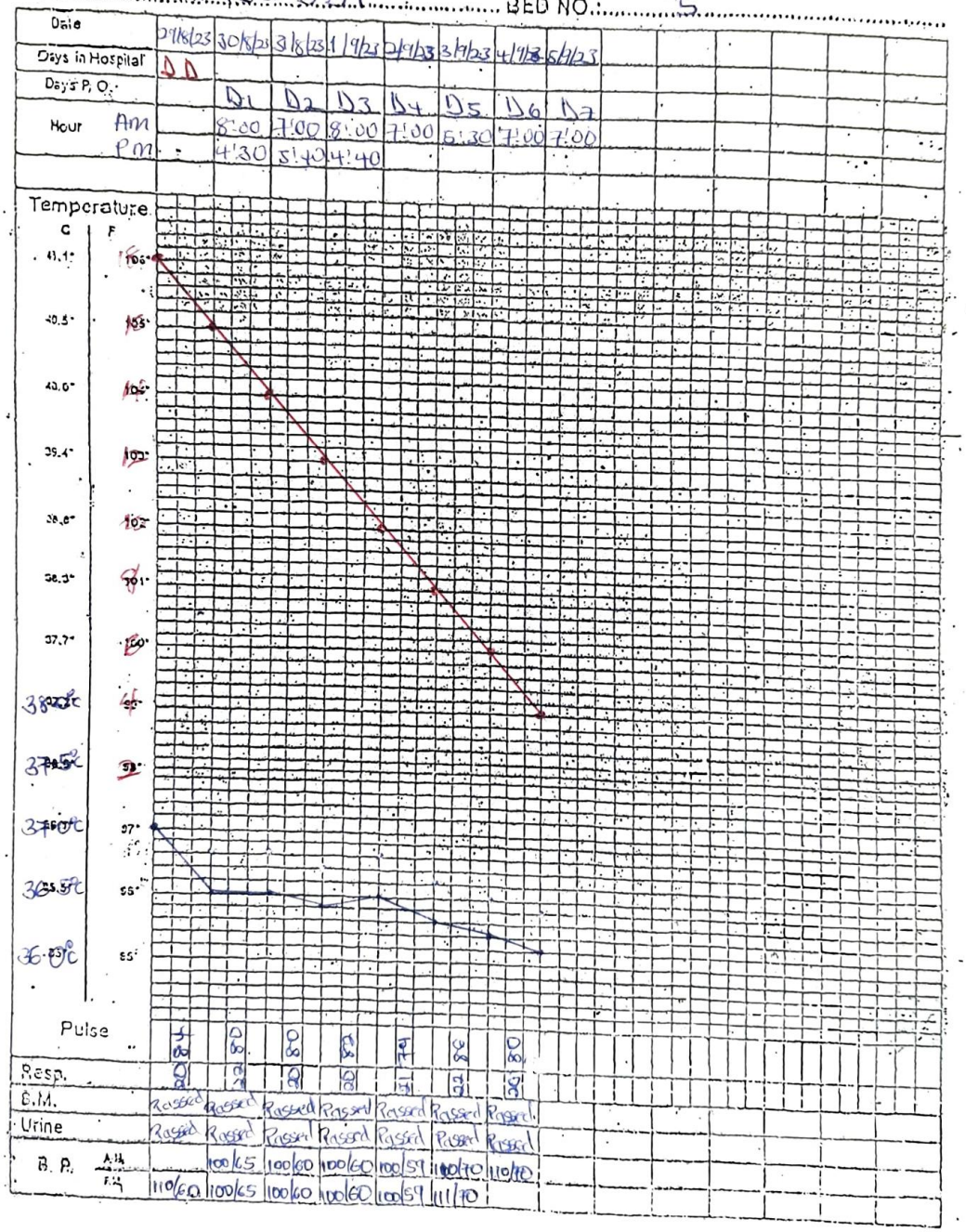
LSS 4th Edition external review draft-ACNM (to be published 2008)

MATERNITY CHART

NAME: Madam Elizabeth Adu

AGE: 30 years WARD: Lying - In

IP NO.: AAA30551 BED NO.: 5



Date	29/8/23	30/8/23	31/8/23	1/9/23	2/9/23	3/9/23	4/9/23	5/9/23
Days in Hospital	DD							
Days P. O.		D1	D2	D3	D4	D5	D6	D7
Hour Am		8:00	7:00	8:00	7:00	5:30	7:00	7:00
Pm		4'30	5:40	4:40				
Temperature C / F								
Pulse	100	80	80	80	72	80	80	
Resp.	20	20	20	20	18	20	20	
B.M.	Passed	Passed	Passed	Passed	Passed	Passed	Passed	
Urine	Passed	Passed	Passed	Passed	Passed	Passed	Passed	
B. P. Am		100/65	100/60	100/60	100/59	100/70	110/70	
Pm	110/60	100/65	100/60	100/60	100/59	111/70		

NEW BORN EXAMINATION FORM

Name: Baby Abena Elizabeth Date of Assessment: 29/08/23 Time: 4:55pm
Date of Birth: 30/08/23 Time of Birth: 4:50pm Sex: ☐ M ☑ F Age at time of Assessment (days/hrs) 24h
Astational Age ☐ 39+2 ☐ Mode of Delivery: ☑ Vaginal Assisted Vaginal C-Section
APGAR: 1min 7 5min 7 Birth Weight: ☐ 2·9 kg ☐ Length 52 cm Head Circumference: 34 cm
Temperature at time of Assessment: 36-8 °C Urine passed: (Yes) No Meconium passed: (Yes) No
Name of Assessor (Midwife/Doctor): Framoh Grace

1. Respiration
Rate_____
☐ Rate < 30 b/m *
☐ Rate < 60 b/m *
☑ 30-60 b/m
☐ Retractions *
☐ Grunting *
☐ Stridor *

2. Activity/Movemnet
☑ Spontaneous symmetric movements
☐ Reduced/Absent Movement in ≥1 limb *
☐ No Movement

3. Tone
☑ Normal
☐ Floppy *
☐ Increased *

4. Colour
☑ Pink all over
☐ Pink body but blue hands/feet
☐ Blue all over *
☐ Pale *
☐ Jaundiced *

5. Cord
☑ Normal
☐ Red. draining pus
☐ Bleeding

6. Cry
☑ Normal
☐ Shrill *
☐ Absent *

7. Suck
☑ Good
☐ Weak
☐ Absent

8. Head swelling
☐ Caput succedaneum
☐ Cephalhaematoma
☐ Subgaleal hemorrhage
☑ No swelling

9. Sutures
☑ Normal
☐ Overlapping
☐ Fused
☐ Widely Separated *

10. Fontanel
☑ Normal
☐ Sunken *
☐ Raised *
☐ Wide (>5cm)*

11. Eyes
☑ Normal
☐ Subconjunctival bleed
☐ White pupil or cornea
☐ Eye discharge
☐ Other

12. Ears
☑ Normal (size / shape/position).
☐ Abnormal:_____

13. Mouth
☑ Normal
☐ Cleft palate
☐ Cleft Lip
☐ Other:_____

15. Neck
☑ Normal
☐ Swelling
☐ Webbed
☐ Other:_____

16. Clavicle
☑ Normal
☐ Swelling/Fracture

17. Chest
☑ Normal (Shape/movement)
☐ Abnormal_____

18. Heart rate
Rate: 136
☑ Normal (100-160)
☐ <100 *
☐ >160*

19. Femoral pulse
☑ Present
☐ Not palpable*

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

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

22. Limbs
☑ Normal
☐ Abnormal_____

23. Genitalia
Male Genitalia
☐ Normal
☐ Undescended testes
☐ Abnormal meatus
☐ Hernia
☐ Other: _____

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

24. Anus
☑ Patent
☐ Imperforate*

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

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

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

NEW BORN EXAMINATION FORM

Name: Baby Abena Elizabeth Date of Assessment: 29/08/2023 Time: 4:55
Date of Birth: 29/08/23 Time of Birth: 4:56pm Sex: ☐ M ☑ F Age at time of Assessment (days/hrs) 5min
Astational Age ☐39 ☐ Mode of Delivery: ☑ Vaginal Assisted Vaginal C-Section Head Circumference: 34 cm
APGAR: 1min 10 5min 10 Birth Weight: ☐2.9 kg ☐ Lenght: 52 cm Meconium passed: (Yes) No
Temperature at time of Assessment: 36.8 °C Urine passed: (Yes)
Name of Assessor (Midwife/Doctor): Framoh Grace

1. Respiration
Rate_____
☐ Rate < 30 b/m *
☐ Rate < 60 b/m *
☑ 30-60 b/m
☐ Retractions *
☐ Grunting *
☐ Stridor *

2. Activity/Movemnet
☑ Spontaneous symmetric movements
☐ Reduced/Absent Movement in ≥1 limb *
☐ No Movement

3. Tone
☑ Normal
☐ Floppy *
☐ Increased *

4. Colour
☑ Pink all over
☐ Pink body but blue hands/feet
☐ Blue all over *
☐ Pale *
☐ Jaundiced *

5. Cord
☑ Normal
☐ Red. draining pus
☐ Bleeding

6. Cry
☑ Normal
☐ Shrill *
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7. Suck
☑ Good
☐ Weak
☐ Absent

8. Head swelling
☐ Caput succedaneum
☐ Cephalhaematoma
☐ Subgaleal hemorrhage
☑ No swelling

9. Sutures
☑ Normal
☐ Overlapping
☐ Fused
☐ Widely Separated *

10. Fontanel
☑ Normal
☐ Sunken *
☐ Raised *
☐ Wide (>5cm)*

11. Eyes
☑ Normal
☐ Subconjunctival bleed
☐ White pupil or cornea
☐ Eye discharge
☐ Other

12. Ears
☑ Normal (size / shape/position)
☐ Abnormal:_____

13. Mouth
☑ Normal
☐ Cleft palate
☐ Cleft Lip
☐ Other:_____

15. Neck
☑ Normal
☐ Swelling
☐ Webbed
☐ Other:_____

16. Clavicle
☑ Normal
☐ Swelling/Fracture

17. Chest
☑ Normal (Shape/movement)
☐ Abnormal_____

18. Heart rate
Rate: 136
☐ Normal (100-160)
☐ <100 *
☐ >160*

19. Femoral pulse
☑ Present
☐ Not palpable*

20. Abdomen
☑ Normal
☐ Distended*
☐ Scarphoid*
☐ Abdominal defect*
☐ Maases:_____
☐ Other_____

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

22. Limbs
☑ Normal
☐ Abnormal_____

23. Genitalia
Male Genitalia
☐ Normal
☐ Undescended testes
☐ Abnormal meatus
☐ Hernia
☐ Other:_____

Female Genitalia
☑ Normal
☐ Fistula(meconium/urine through abnormal opening vagina)-*
☐ Large clitoris *
☐ Other:_____

24. Anus
☑ Patent
☐ Imperforate*

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

26. Services provided
☑ Vitamin K1 given
☑ Eye care provided
☑ Cord care provided
☑ Breastfeeding initiated
☑ Breastfeeding establishe
☑ Immunization (BCG/Pol
☑ BCG ☐ Polio Immuniz
☑ Antibiotics in mother
☑ Antenatal corticosteroid

*May indicate severe disease that requires urgent referral

Diagnoses (if known)_____

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

NEW BORN CHART

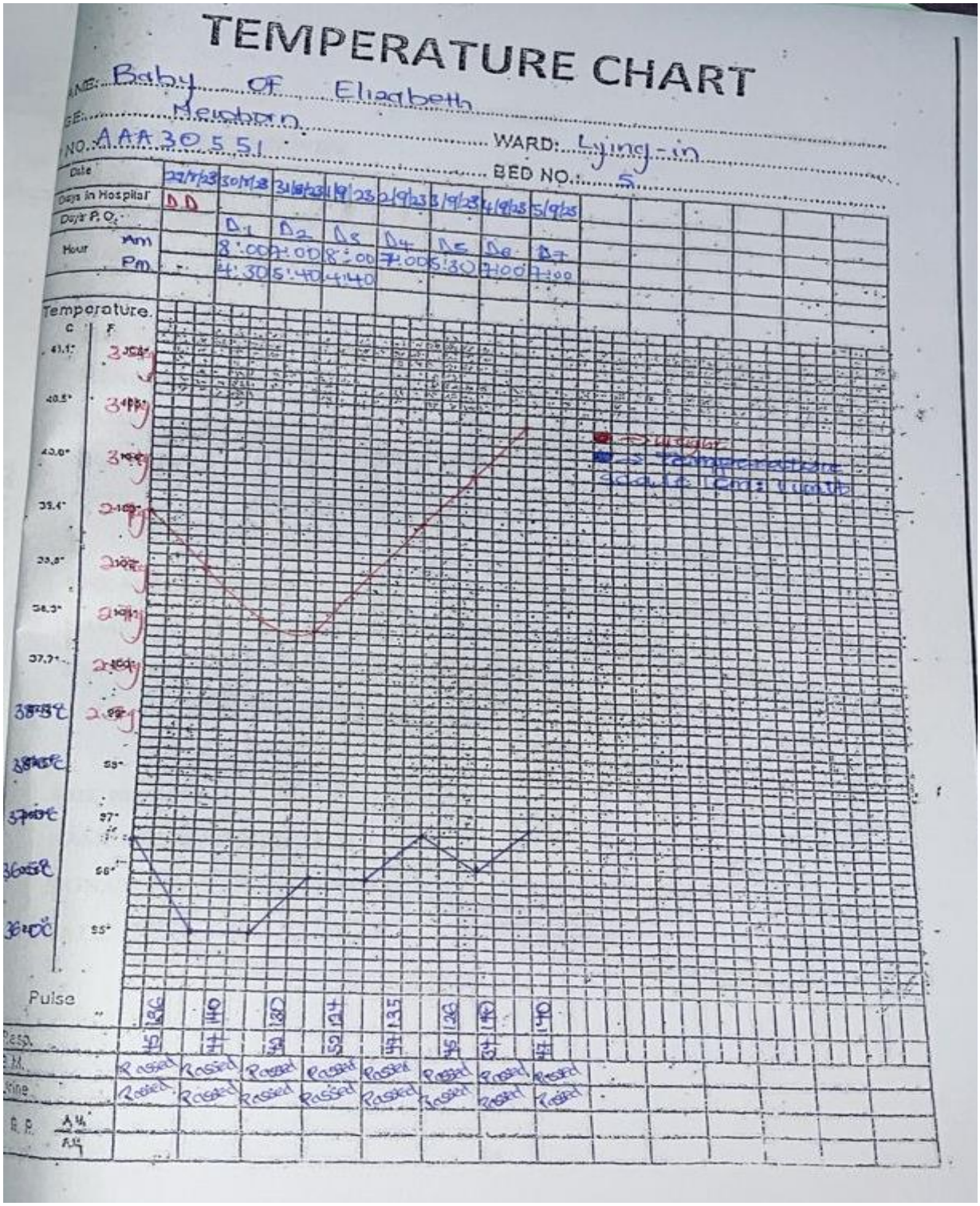
Name: Baby Abena Elizabeth ..... No: 66130 ..... Birth Weight: 2.9kg

Sex: Female ..... Mother's No: 66130 ..... Length: 52cm

Nature of Delivery: Spontaneous Vaginal Delivery ..... Diagnosis: Term baby

Date of Birth: 29/08/2023 ..... Time: 4:50pm ..... Date of Discharge: 30/08/2023

Date	29/08/23		30/8/23		31/08/23		1/09/23		2/09/23		3/09/23		4/09/23		5/09/23							
No. of Days	D0		D1		D2		D3		D4		D5		D6		D7							
Weight	2.9kg		2.8kg		2.7kg		2.7kg		2.8kg		2.9kg		3.0kg		3.1kg							
	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM
Temperature		36.8°C	36.0°C	36.2°C	36.0°C	36.2°C	36.5°C	36.2°C	36.5°C	36.2°C	36.9°C		36.6°C		37.0°C							
Stools	Passed	Passed	Passed	Passed	Passed	Passed	Passed	Passed	Passed	Passed	Passed	Passed	Passed		Passed							
Urine	Passed	Passed	Passed	Passed	Passed	Passed	Passed	Passed	Passed	Passed	Passed	Passed	Passed		Passed							
Remarks	Head Neck Trunk Genitalia — No Abnormalities Detected																					


TEMPERATURE CHART
NAME: Baby of Elizabeth
AGE: Newborn
NO. AAA30551
WARD: Lying-in
BED NO.: 5
Date
Days in Hospital
Days P. O.
Hour
Temperature
Pulse
Resp.
B.M.
Urine
B. P.

SIGNATORIES

THE STUDENT MIDWIFE

NAME: FRAMOH GRACE

SIGNATURE: .....

DATE: 07-06-2024

THE SUPERVISOR THE MIDWIFE-INCHARGE (EMIL MEMORIAL HOSPITAL WENCHI)

NAME: ALEXANDRAI GBREL

SIGNATURE: .....

DATE: 07/06/2024

THE SUPERVISOR

NAME: CELESTINE AHIAWORNU

SIGNATURE: 07/06/2

DATE: 07/06/2024

THE PRINCIPAL

NAME: MONICA NKRUMAH

SIGNATURE: .....

DATE: 07/06/2024

PRINCIPAL
HOLY FAMILY NURSING AND
MIDWIFERY TRAINING COLLEGE
BEREKUM