HOLY FAMILY NURSING AND MIDWIFRY TRAINING COLLEGE

BEREKUM

A CLIENT/ FAMILY CENTERED MATERNITY CARE STUDY

ON

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BY

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

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PRFEFACE

The family centered maternity care is a systematic approach used in nursing an expectant mother and her family through pregnancy, labour and puerperium. This is based on a thoughtful understanding and uniqueness of the client as an individual with specific problems and needs that should be addressed. The aim of this care study is to ensure that, the pregnancy results in a healthy mother, baby and a family. During this period of care, the physical, psychological, spiritual and social well-being of the client and family are taken into consideration. The family centered maternal care study is an academic work which gives the student midwife an opportunity to nurse her client using the nursing process and the partograph to implement and evaluate her pregnancy, labour and puerperium using the knowledge and skills acquired during the training. The report on the care study is compiled into a document which is part of the Nursing and Midwifery Council of Ghana's fulfilment in awarding professional certificate to the student midwife as a registered midwife after three years training.

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INTRODUCTION

The family centered maternity care study is a study that was conducted on Madam Mary, A 28 years old Ghanaian woman and was born in the year September, 8, 1993. She is from Kasapin but stay's with her husband at Hwiediem in Ahafo Region, She is gravida 3 para 2 all alive. Comprehensive midwifery care was given from antenatal throughout her labour and puerperium.

This study was conducted on Madam Mary, a 28years old Gravida 3 Para 2 all alive. She hails from Kasapin in the Ahafo region of Ghana. She was met on the 18th November, 2021at Pentecost clinic, Kasapin with 36weeks gestation and had come for her eighth antenatal care.

The study is in four (4) chapters beginning from pregnancy to puerperium. Chapter one talks about the client general background including her social, medical, surgical, menstrual, past obstetric histories. It continues with chapter two which gives a detailed narative about how the care rendered during the period of her pregnancy. Chapter three is on labour till the end of six hours after delivery. Chapter four is the care during puerperium up to the first ten-day postnatal clinic visit. Chapter2,3 and 4 ends with a care plan drawn for her with the problems which were identified throughout the period, it also has the appendices for the study.

LITERATURE REVIEW

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.

Myles (2009) states that as soon as pregnancy is confirmed, many physiological changes take place in the body and return to its pre-pregnant state during puerperium due to the effect of hormones namely estrogen 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, they are one way or the other an advantage for the mother and the growing fetus since the fetus depends meanly on the mother for survival in utero. variety of care that are rendered to the expectant mothers and their entire families which includes history taking, physical examination (head to toe examination and abdominal examination. inspection, palpation and auscultation), laboratory investigation (urine, blood and stool), administration of routine drugs (folic acid, fersolate and multivitamin), and tetanus toxoid, education on minor disorders, danger signs of pregnancy, diet, travelling, rest and sleep, exercise, personal and environment hygiene, birth preparedness and complication readiness.

Fraser & Cooper (2009), states that, all changes in the mother's body during pregnancy are due to the effects of specific hormones. These changes enable her to nurture the foetus, prepare her body for labor and develop her breast and lay down stores of fats to provide calories for production of breast milk during puerperium. Psychological state is also affected by hormonal changes. The gestational period is divided into three Trimesters. The first trimester is from the time of conception to the 12^{th} week. The second trimester is from the 13^{th} week to the 24^{th} week whilst the third

trimester is from the 25th week to the 38thweek of pregnancy antenatal care is given to the woman throughout the period and should commence from the time pregnancy is diagnosed and continue until the safe delivery of the baby.

Marie Elizabeth (2013) defines pregnancy as when the woman's egg and a man's sperm cell unit to form zygote. The duration of pregnancy has been calculated by the clinicians in terms of 10 lunar months or 9 months and 7 days or 280 days or 40 weeks, calculated from the first day of the last menstrual period. This is called menstrual or gestational age. It is divided into 3 trimesters, a period of three months in each trimester. The first trimester begins from the fertilization of the ovum to 12 weeks of gestation. The second trimester begins from the 13th week to the 24th week of pregnancy. The third trimester starts from the 25th week to the 40th week. General check-up is done at interval of 4 weeks up to 28 weeks; at interval of two weeks up to 36 weeks and thereafter weekly till the expected date of delivery. Ideally this should be more flexible depending on the need, and the convenience of the patient.

Tiran (2008) pregnancy is the condition of having a developing embryo or fetus within the body from conception to the delivery of the fetus. The normal duration is about two hundred and eighty (280) days, forty (40) week or nine (9) months seven (7) days counted from the first day of the last normal menstrual period to delivery. Physiological and psychological changes occur due to the effect of estrogen and progesterone which provide nutritive and protective environment for the developing embryo and also prepares the breast for lactation.

(King 2014) pregnancy is a time of profound anatomic and physiologic changes in a woman's body. Maternal physiologic systems make adaptations needed to support the developing foetus and at the same time, maintain maternal homeostasis. Pregnancy last approximately two hundred and

sixty-six days (266) or thirty-eight weeks (38) from ovulation. The antenatal period is into trimesters, first trimester is considered to be weeks 1 to 12 (12weeks) because organogenesis is completed at the end of twelve weeks and the risk of spontaneous abortion is significantly reduced at time. Historically, the second trimester was considered to be weeks 13 to 28 weeks was limit of viability. The third trimester extend from 29 to 40 weeks. The term 'post-date' or post term is typically used to describe a pregnancy beyond forty weeks (40).

(Weller B.F, 2009) states that, pregnancy is a state of being with a foetus from the time of conception to the expulsion of the foetus. The normal period is 280 days or 40 weeks counted from the last day of the normal menstrual period. Pregnancy is divided into three trimesters, a period of three months in each trimester. The first trimester begins from the fertilization of the ovum to 12 weeks of gestation. The second trimester begins from the 13th week to the 24th week of pregnancy. The third trimester starts from the 25th week to the 40th week. Physiological changes occur in the body under the influence of hormones which affect all the systems and organs with the greatest change taking place in the uterus as it has to accommodate and nourish the developing fetus, prepare the woman body for labor, develop her breast and lay down stores of fats to provide calories for production of breast milk during puerperium. Any disorder due to the physiological changes is managed to prevent complications such as anemia which can endanger the life of both the mother and growing fetus.

Ojo and Briggs (2011) states that when pregnancy occurs, menstruation ceases for some weeks or months after delivery. Most women experience some minor disorders such as morning sickness, nausea, frequency of micturition, heart burns among others. Such conditions may not be life threating but can be harmful: the women therefore need to be educated on these conditions so that

they can understand and cope with their occurrence. Antenatal care is the advice, supervision and attention a pregnant woman receives to ensure good health as well as early detection and treatment of complications which may affect the woman or her baby.

LABOUR

Konar (2011) states that, labor is a series of event that takes place in the genital organ in an effort to expel the viable products of conception out of the womb through the vagina into the outer world. Onset of labor is very much unpredictable to foretell precisely the exact date of onset of labor. It not only varies from case but even in different pregnancies of the same individual. Conventionally events of labor are divided into four stages: First stage starts from the onset of true labor pains and ends with full dilatation of the cervix. average duration is twelve hours (12) in primigravida and six hours (6) in multipara. Second stage starts from the full dilatation of the cervix (not from the rupture of the membranes) and ends with expulsion of the fetus from the birth canal. It has got two (2) phases thus the propulsive phase starts from full dilatation up to the descent of the presenting part to the pelvic floor and the expulsion phase is distinguished by maternal bearing down efforts and ends with delivery of the baby. Its average duration is two hours (2) in primigravida and thirty minutes (30) in multipara. Third stage begins after expulsion of the fetus and ends with expulsion of the placenta and membranes (after-births) and control of hemorrhage. Its average duration is about fifteen minute (15) in both prim gravida and multipara. The duration is, however, reduced to five minutes (5) in active management. Fourth stage is the stage of observation for at least one hour (1) after expulsion of the after-births. General condition of the patient and the behavior of the uterus are to be carefully monitored. Under bladder care, patient is encouraged to pass urine by herself as full bladder often inhibits uterine contraction and may lead to infection. If the woman cannot go to the toilet, she is given a bed pan. Privacy must be maintained and comfort must be

ensured. If the patent fails to pass urine especially in late first stage, catheterization is to be done with strict aseptic precautions. Rest and ambulation; if the membranes are intact, the patient is allowed to walk about. This attitude prevents venacava compression and encourages descent of the head. Ambulation can reduce the duration of labor, need of analgesia and improves maternal comfort. Labor is monitored electronically or analgesic drug (epidural analgesia) is given, she should be in be. The transition from the first stage to the second stage is evidenced by the following feature Increasing intensity of uterine contractions, urge to defecate with descent of the presenting part, Complete dilatation of the cervix on vaginal examination.

Varneys (2014) describes the onset of labor as the occurrence of regular painful contractions that promote dilatation of the cervix. Contractions that occur at regular intervals with increasing frequency, duration, and intensity are hallmark of labor. There are four stages of labor that has being established; the first, second, third and fourth stages. The first stage of labor starts with cervical dilatation which begins with regular rhythmic uterine contractions until the cervix is fully dilated. During this stage enquiry is to be made about the onset of labor pains or leakage of liquor if any through general and obstetrical examinations including vaginal examination are to be carried out and recorded. Records of antenatal visits, investigation reports and any specific treatment given if available are to be reviewed. There is an assessment of progress of labor and partograph recording. The second stage of labor begins with the expulsion of the fetus from the birth canal, it starts when the cervix is fully dilated and the woman has the urge to expel the fetus and ends when the fetus is born. The third stage of labor is the complete expulsion of the placenta and its membranes as well as the arrest of hemorrhage. The fourth stage of labor is 6 hours after the delivery of the placenta and membranes and continues with close monitoring of the client and baby.

Myles (2014) states that, labor purely in physical sense, may be described as the process by which the fetus, placenta and membranes are expelled through the birth canal. Labor has four stages. Stage one comprises of latent phase and may last 6 to 8 hours in primigravidae. 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 labor is the expulsion of the fetus. 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. Labor completes when baby is born. In multigravida women, it last 15-30 minutes. Third stage begins after the expulsion of fetus 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 labor and it last six hours after delivery of the placenta.

The National Safe Motherhood Service Protocol (2008) states that normal labor begins with a regular painful uterine contractions lasting at least twenty (20) seconds (timed by a trained observer) occurring at a frequency of at least two contractions in every ten minutes and with cervical dilatation of at least 3 centimeters. Signs that women may experience prior to labor includes show (pink mucous discharge from the vagina), engagement of the baby's head. The hormone oxytocin is responsible for the strong regular contractions of labor which when released cause the uterus to contract. Labor contractions feel very different from Braxton Hicks contractions that women experience during pregnancy but the most important difference is that labor contractions come regularly. Each one starts gradually, builds up to a peak and then fades away. Typically, when labor begins, contractions are short in length around 20 – 30 seconds long. As labor progresses contractions become gradually longer and stronger which dilates the cervix.

Tiran (2008) defined labor as the process by which product of conception are expelled from the uterus through the birth canal. Labor normally occurs spontaneously at term, that is between 38 and 42 weeks of pregnancy. The fetus should present with vertex and once started, the contractions should increase in strength and frequency without interruption and artificial stimulation until fetus, placenta and membranes are expelled by the maternal effort through the vagina. partograph is the graphical recording of labor progress obtained by assessment of visual patterns of cervical dilatation and descent of the presenting part in conjunction with records of maternal and fetal wellbeing.

PUERPUERIUM

National Safe Motherhood Service Protocol (2008) postnatal period is the period that starts from the end of delivery of the placenta and membranes and control of hemorrhage to six weeks after delivery. The purpose of postnatal care is to maintain the physical and psychological wellbeing of the mother and child. Postnatal care includes education of the mother on the care of her baby, detection and treatment or referral of any abnormalities for further management. The essential components of postnatal care are therefore: Comprehensive screening to detect complications in both mother and baby, Treatment of complications in mother and baby, Assessment and support for infant feeding, Malaria and anemia prevention. Some common discomforts of postpartum period in mothers listed are after pains, perineal pain, bowel and urinary changes, stretch marks, fatigue, sleeplessness, backache, headache, hemorrhoids and mood changes in the two weeks. Those associated with the newborn are caput succedaneum, tongue tie, rashes and vomiting after feeds. The major causes of death in this period are infections, hypertensive complications, hemorrhage and thromboembolism of which predisposing factors include: Conditions or

complications during the antenatal period, Complications of labor, related to duration of labor and mode of delivery

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

Konar (2013) puerperium is the period following childbirth during which the body tissues, specifically the pelvic organs reverse back approximately to the pre-pregnant state both anatomically and physiologically. This begins as soon as the placenta is expelled and last for approximately six weeks when the uterus becomes regressed to the non-pregnant size called involution, the period is arbitrarily divided into(a) immediate-within 24 hours;(b) early-up to 7 days and remote up to 7days. In its anatomical consideration, the uterus immediately following delivery becomes firm and retract with alternate hardening and softening. The uterus measures about 20×12×7.5 centimeters (length, breadth and thickness) and weighs about 1000grams. At the end of six weeks, its measurement is almost similar to that of the non-pregnant state and weighs about sixty (60) grams. The physiological consideration of involution is most marked in the body of the uterus where the changes occur in the muscles, blood vessels and endometrium.

Marie Elizabeth (2013) puerperium is the period following childbirth during which the body tissues, especially the pelvic organs reversed back approximately to the pre-pregnant state both

anatomically and physiologically. The period is divided into; Immediate –within 24 hours, Early- up to 7 days, Remote –up to 6 weeks, immediately following delivery, the uterus becomes firmer and retracted with alternating hardening and softening. At the end of 6 weeks, its measurement is almost similar to that of the non-pregnant state and it weighs 60 grams. The lower uterine segment becomes thin, flabby and collapsed structure. The cervix contracts slowly; the external os admits a fingers for the few days but by the end of the first week, narrows down to admit the tip of a finger only. The external os never revert back to the nulliparous state. Puerperium is the number of muscle fibers is not decreased but there is substantial reduction in the myometrium cell size. The arteries are constricted by contraction of its wall and thickening of the intima followed by thrombosis. New blood cells grow in the thrombi. Soon after birth it takes a long time (4 to 8) for the vagina to involute. The vaginal discharge for the first fortnight during puerperium is the lochia. The lochia originates from the uterine body, cervix and vagina. Depending upon the variation of the color of the discharge it is named as Lochia rubra (red) 14 days. Lochia serosa (yellowish or pink or pale brownish) 5- 9 days. Lochia alba (pale white) 10 -15 days. The average amount of discharge, for the first 5-6 days is estimated to be 250 ml. With all definitions and changes. it can be deduced that puerperium is the period from birth to 6 weeks of delivery.

Ojo & Briggs (2011) defined puerperium as a period that starts after the delivery of the placenta and ends when the uterus return to its pre pregnant state. The first ten day of puerperium is term as the lying –in period where close observation of both mother and baby are considered. During this period, bonding is fostered through the establishment of breastfeeding. The puerperal woman regains her strength that was lost during labor. Care of the baby and lactation are established during this period. The management which the mother and baby required during puerperium is based on three principles; Promoting physical and psychological well-being of mother and baby, encourage

good infant feeding and maternal to child relationship, supporting and strengthening the mother's confidence to enable her to fulfil her mothering role within her family and culture status. At the end of labour the uterus is still very large and mobile, the genital tract is greatly bruised, distended and perhaps lacerated. The abdominal muscle is flaccid. Within the period of six weeks' puerperium, the bruises heal and genital organs and any other which underwent changes during pregnancy return to their pre-gravid states. This process of readjustment is called involution and laceration is established during this period. Involution is brought about by shriveling up of muscle fibers and the absorption of their substance, partly into the bloodstream and partly into the lochia. The lochia is made up of blood from the site where the placenta was attached and crumbling of the uterus which had developed so greatly in pregnancy, in the first two days after child birth, the lochia mainly consists of blood consistently red in colour and is called lochia rubra. The amount of blood decreases rapidly and the lochia become pinkish in colour called lochia serosa. After the 9^{th} it becomes paler known as alba. This book also talks about some minor disorders that may occur after delivery as begins to change to it non- pregnant state. After pains; after delivery, the uterus does not stop contracting. The contraction continues painlessly for the most part, but in some women, particularly multigravida, painful contractions persist in the few days of the puerperium and may require analgesics Backache, it mostly affect one out of five women in few weeks after delivery but occasionally occurs a month after childbirth. Backache appears to be more common if the woman has had epidural anesthesia or a long second stage of labour. There is no specific treatment and backache gets better by itself. Painful urination, in the first 24hours after delivery, the mother sometimes finds it difficult to pass urine because of the stretching of the vaginal and bladder tissues during delivery. It is managed with early ambulation. The uterus immediately after delivery begins its process of involution or reduction in size. It generally takes

6weeks for complete physiologic involution and for the reproductive system to be restored to its non- pregnant state occurs when the process of involution is prolonged as a result of hemorrhage, infection or retained placenta parts. Uterine involution involves the return of the uterus to its non –pregnant state, diminishing in size and weight and anatomic location back into the pelvis. The placental site usually is completely healed without scarring by 6weeks. Immediately after delivery, the uterus weighs about 100g. Breastfeeding or breast stimulation assist in hastening of uterine involution.

WHY I CHOSE MY CLIENT

Madam Mary G3P2AA was chosen as a client on 18th November, 2021 at Pentecost Clinic, Kasapin in the Ahafo Region. During interaction, client was worried of having severe lower abdominal pains. Upon her complains decision was made to educate the client on the cause of lower abdominal pain in late pregnancy and other minor disorders of pregnancy, knowing that is one of the physiological changes in late pregnancy, decision was made to take her as client in order to support her. Introduction was made as a student midwife from Holy Family Nursing and Midwifery Training college Berekum and was at the clinic for practical experience. Permission was sought from her to be taken as a client for the care study which she accepted. Client was shown

to the incharge and approval was given to use her for the case study. All necessary particulars were collected. Appointment for home visit was also booked. Direction to her house was given and phone numbers were exchanged. Client was thanked and she left after the routine procedures.

CHAPTER ONE

CLIENT'S PARTICULARS

1.0 INTRODUCTION

This chapter provides an overview of Madam Mary, her family, and the community in which she lives, including social, surgical, family, past and present obstetrical, menstrual history, and lifestyle.

1.1 PERSONAL/SOCIAL HISTORY

Madam Mary is the name of the chosen client. She is 28 years old. She is from Kasapin in the Asunafu Nouth District and now resides in Hwiadiem in Ghana's Ahafo Region. Madam Mary is a dark-skinned woman of average build and strength, weighing 71 kilograms at booking with a gestational age of 12 weeks and a height of 160 cm according to her antenatal care record card. She communicates in Asante Twi and Her highest form of education is to the Junior high level. She is a trader and devoted Christian who attends Pentecost church. The man she gave birth with Mr. Stephen Asamoah. His highest form of education is at the junior high level. He is trader by occupation and stays at Hwiadiem in the Asutifi South District. According to Madam Mary, her next of kin is her mother whom she stays with.

1.2 FAMILY HISTORY

Madam Mary is the second born of Madam Nyerkowaa. Her father is no more. They are family of four including her mother as well as her siblings. According to the Medical history of her family as given by the client, there are no known inherited, Medical condition such as diabetes, cardiovascular disease like hypertension, sickle cell and mental illness has never been cleansed to

her family members. There are also no multiple gestation, no known congenital abnormalities like cleft lip and cleft palate, missing digits or extra digits.

1.3 MEDICAL HISTORY

Client confirmed she has never suffered any known medical condition such as hypertension and diabetes mellitus. according to her, she has never been admitted to a hospital except when she is in labour. She has no history of drug and food allergy too.

1.4 SURGICAL HISTORY

Client has never undergone any surgical procedure before. She had never been involved in any injury through either obstetrical procedure or any accident which could have called for surgery or affected her pelvis. On examination there was no scar, indicating previous Laparotomy such as caesarean section or appendectomy.

1.5 MENSTRUAL HISTORY

According to Madam Mary, she had her Menarche at the age of fifteen (15 years). Client Menstrual flow is Moderate and last for 6 days.

She has no Dysmenorrhea and uses sanitary pad (proper pad) during Menstruation.

Client had never experienced any menstrual disorders or miss her regular menstrual period until she got pregnant. Client could not remember her last menstrual period as Evidence by her Antenatal care records but her early scan gave her an expected date of delivery to be 14th December, 2021.

1.6 CLIENT LIFESTYLE AND HOBBIES

Madam Mary, usually wakes up around 5:30am and goes to bed 9:30pm. When client wakes up in the morning, she prays before moving out of her room. She washes her face, empties her bowel, she brushes her teeth with brush and toothpaste, start her household chores like sweeping and

dumping of refuse. She then prepared breakfast for herself and her family. Prepares her children for school, takes her bath and finally goes to sell her things. At 3:30pm client prepared super for the family every evening after meals, Client washes the cooking utensils and assist her children to bath, client takes her bath, assist her children in doing their homework, watch television and return to bed 9:30pm. Client said during weekends she washes their used clothes and sometimes goes to farm with her mother because she is with her mother and she has nothing to do. Madam Mary goes to church on Sundays with her family client said she doesn't have a fixed number of times she eats but on demand and make sure she eats three times daily. Client normally eats rice and stew with egg and usually takes fruit after meals. She attends natures call once a day in the morning and often urinates about four –to-five times daily depending on the amount of fluid intake. She neither smokes nor drinks any alcoholic beverage.

1.7 PAST OBSTETRICAL HISTORY

Madam Mary is Gravida 3 Para 2 all alive according to her and the Antenatal records. She had no Abortion, Ectopic, pregnancy induced hypertension and gestational diabetes. Client had no danger signs of pregnancy such as severe abdominal pains, Anemia, Bleeding, headache and vomiting during her previous pregnancy. The interval between her pregnancies is 2 years and experienced minor disorders such as Backache, Waist pains, abdominal pain, headache and frequency in micturition during her previous pregnancies. Client indicated that she attended five antenatal sessions before giving birth and had three tetanus toxoid in her pregnancy, all the five sulphadoxine pyrimethamine (S.P) was administered during her previous pregnancies. According to her, her children was delivered spontaneously per vagina at Goaso Hospital. Client said immediately after birth, her general condition has always been satisfactory. Client also said her duration for her children did not exceeds 10hours. She said placenta was delivered few minutes

after the babies was delivered blood loss was moderate she had a healthy babies with no abnormalities such as cleft lip and cleft palate, spinal bifida. Her first baby birth weight was 3.2kg and the other was 2.8kg, there wasn't any complication such as postpartum hemorrhage. She started breastfeeding them immediately after delivery and before she was sent to lying in. client also said all her babies was immunization against the childhood preventable disease. She said each baby was breastfed exclusively for 6month and added complementary food such as porridge with soya bean, egg yolk, infant cereals, vegetables and water which she was taught at child welfare. She was using the Oral Contraceptive as a family planning method as the way of preventing any unwanted pregnancy.

1.8 PRESENT OBSTETRIC HISTORY

Madam Mary reported to the clinic on the 1st June 2021 at St. Elizabeth catholic hospital, Hwiadiem. The midwife who attended to her took her history at the time her pregnancy was 12weeks with no complains. Madam Mary's last menstrual period was obtained from her scan as on 7th march, 2021. Her vital signs, weight and other investigation were taken recorded as follows; Temperature 36.6degree Celsius, Pulse 88beat per minute, Respiration 22cycles per minute, Blood pressure110/60milllimeters, Weight 71kilogram, Height168centimeters.

Hemoglobin	11.1grams per deciliter
Sickling	negative
Blood group	O
Rhesus factor	positive
Stool	no abnormality detected
Urine (protein and glucose)	negative
Syphilis	negative

VDRL	negative
Hepatitis B test (HBsAg test)	negative
Blood film for malaria	No malaria parasite was seen
G6PD	No defect

These findings were to serve as baseline data to be compared to future findings to detect any deviation from normal. Head to toe examination was performed to detect abnormalities. Client had no complains and it was documented that she was given health education on nutritious diet, rest and sleep, personal hygiene and ultrasound

scan during pregnancy.

She was given the following routine drugs;

Tablet folic acid	5mg daily times 30days
Tablet ferrous sulphate	200mg daily for 30day
Tablet multivitamin	200mg daily for 30days

She visited the clinic subsequently as scheduled until she was met and chosen for the study.

CHAPTER TWO

ANTENATAL

2.0 INTRODUCTION

This chapter talks about the first contact with the client, her subsequent visit to the clinic, home visits during antenatal period and care plan drawn after problems have been identified and interventions done to make client comfortable.

2.1 FIRST CONTACT WITH THE CLIENT

The first contact with Madam Mary at the Antenatal clinic was on the 18th November, 2021 at Pentecost Clinic, Kasapin. it was her eighth Antenatal visit. The client was at 36weeks pregnant. At the time of visit she was offered a seat after which a rapport was established client was selected during interaction, Client was worried of having severe lower abdominal pain. Upon her complains decision was made to educate her on the cause of lower abdominal pain in late pregnancy, knowing that is one of the physiological changes in late pregnancy and that it is a knowledge deficit on the part of the client, decision was made to take her as client in order to support her. Introduction was made to her as a student Midwife from the Holy Family Nursing and Midwifery Training College Berekum Sent for clinical practice. She was informed she would be taken as a client for care study and managing her during her pregnancy, Labour and puerperium. client accepted it whole heartedly and gave the permission. All questions asked by client, regarding the process were answered and all doubts cleared. She was thanked for her co-operation.

The Midwife in charge was informed about the selected client. Urine sample was then taken and tested for sugar and protein, which were negative. It was followed by checking her vital signs, weight and Hb, findings were as follows: Temperature36.8degree Celsius, pulse 80beat per minute, Respiration 19cycles per minute, Blood pressure 110/60millimetres of mercury. Client

weighed 75 kilograms and her hemoglobin level 11.7gram per deciliter. The procedure for head to toe examination was explained to her. After wards client was sent to the examination room for physical examination. Privacy was provided and client was assisted to undress put on a gown and helped unto the couch for head –to-toe examination. Hands were washed with soap under running water and dried with clean towel. On the head, hair was neatly braided dandruff, lice and scalp. There was no edema of the face or eyelids. The conjunctival were checked for pallor and sclera was checked for Jaundice but none was detected. The eyes and ears were examined for pain and discharges as well as the nose but none was detected. Gum was also in good condition and there was no halitosis and the tongue was neither coated nor pale. The neck was inspected and palpated for enlarged lymph nodes and distended veins but nothing of that sort was detected. Client was asked to put one hand under her head and breast examination was done to see if there is a lump inflamed at the axillary lymph nodes and there was no abnormality seen. The nipples were prominent and centrally situated. She was taught self-breast examination, a week after menstruation and report any abnormality to the clinic.

The upper extremities: were inspected for equality, over grown nail, extra digits, capillary refill and pallor of palms and no abnormality was detected she also asked to make a first to detected any tingling sensation or edema of the hands which were absent. The lower extremities: were inspected and they were free from oedema, tenderness in the calf muscle, varicose veins and they were of equal size. At the back, no oedema of the sacral region or deformity of the spine was detected.

Abdominal examination, before this procedure, the palms were rubbed together in order to provides warmth and not induce contraction.

Inspection; the abdomen was ovoid in shape and medium in size. There was no scar, but striae gravidarium, linear nigra and total movement were seen.

Measuring of symphysio fundal height; locating the upper border of the symphysis pubis, the zero end of the measuring tape was placed there and extended to the fundus of the uterus.

The symphysiso –fundal height was noted to be 31centimeters and gestational age was 36 weeks.

Fundal palpation; facing client, fundal palpation was done with both palms curved inwards at the fundus of the uterus. It was detected that the buttock of the foetus was occupying the fundus.

Lateral palpation; on lateral examination, with one hand stabilizing the right side of the maternal uterus, the other hand was moved gently on the left side of the maternal uterus and rough part were felt indicating limbs. This was repeated at the right side and a smooth part was felt, indicating the foetal back. This was repeated at the right side and a smooth part was felt, indicating the foetal back. This helps to locate where to place the foetoscope to listen to foetal heart rate

Pelvic palpation; this was done facing the lower limbs of the woman with her knees slightly fixed. The palms were curved inward below the umbilicus. A hard mass was felt indicating the presence of the head, the presentation was cephalic and lie was longitudinal.

Descent of the head; the anterior shoulder of the foetus and symphysis pubis was located. Five fingers were admitted between the anterior shoulders and the symphysis pubis, indicating that the descent was $5/5^{th}$ above the pelvic brim.

A**uscultation**; with this, foetoscope was warmed by rubbing in palm and placed at the smooth surface which is an indication of the back and to listen to the foetal heart sounds at the same time the maternal pulse was palpated to know the differences between them. Foetal heart was counted for full one minute and recorded 134beat per minute with good rhythm.

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

Vulva examination; client was informed about the procedure and permission was granted. Hand washing was carried out. She was politely asked to bend her knees and part her legs. The vulva

was inspected for oedema, warts, ulcers, scars, varicose veins and discharges of which none was observed. The mons pubis was well shaved. All findings were well communicated to client. Client was afterwards congratulated for maintaining good personal hygiene. she was encouraged to keep it up. Finally, she was assisted to dress up and lie at a lateral position and also to sit up before getting off the bed. Hand washing was done and all findings recorded in her antenatal card. Client was again made aware of why there is the need for her to keep a small container, of which she could spit in. she was told, it would help to prevent indiscriminate spitting which may lead to the spread of infection if there is any, also she was told to use chewing gum to reduce the rate of salivation. Client also complained of constipation and she was educated it was due to hormonal action of progesterone on the intestinal wall thereby diminishing peristalsis, and also not taking in enough fluid and vegetables; also increase the intake of fluids to keep the soft stools soft and easy to pass and do well to attend to natures call whenever the urge is felt, Education on true labor signs was done and client was made to ask question bothering her and was answered accordingly. The following routine drugs were administered to her;

- Tab folic acid 5mg daily for 7days
- Tab IIIpolymath maltose complex 60mg daily for 7days
- Tab multivitamin 20mg daily for 7days

Client was scheduled for antenatal visit and review date communicated to her as 25th November, 2021. Client was asked to report to clinic if any abnormality is observed prior to the scheduled date. Appointment for home visit was schedule on 20th November, 2021. Direction to her house was taken and phone numbers were exchanged.

2.2 FIRST ANTENATAL HOME VISIT

On Saturday 20thNovember at 5:15pm, Madam Mary was visited as promised. The purpose of the visits was to have interaction with client and also to assess the physical environment and the sanitary conditions with regards to maintaining good hygiene. The mission of the visit was made known to her as already discussed during the antenatal session that she will be visited at home to know how she fairing. Client expressed her appreciation towards the visit also the family was really happy for seeing me especially her mother, when I went there the mother was done cooking and I was invited, I was full so thank her and rather took in water. I waited for them to finish eaten, after they has done with the eaten she was asked about her husband and she said he was in different town working there and her son and daughter too were also fine. There was small and a brief inspection about house and a brief introduction was made to her and her mother. According to client the house is for her mother.

PHYSICAL ENVIRONMENT

The house is two bedrooms built with cement blocks, roofed with aluminum sheets but it is not painted outside but inside the rooms are painted light blue with white coloured ceilings. There is a porch attached to the front of each room. her house number was AK/107. The place was well cleaned and utensils nicely arranged. The occupants of the room are client and her three-year-old son and her two years old daughter. Her mother was living in the other room. it was observed that, the mattress was covered with a treated mosquito net, this means client is cautious of the effect of malaria on her as a pregnant woman hence the use of the net to help prevent the attack of mosquito at night. She was however encouraged to continue to sleep in the treated net. It was observed that the room was spacious with her items neatly packed and kept in its place and well ventilated with two windows facing each other. She was congratulated to keep it up. The lavatory is a kind of pit

latrine, located behind the house with the bathroom. The environment was neat without weeds and their source of water was from pipe which she stores in a barrel covered with a lid that is kept in her porch, which is use for their household chores as well as drinking. They have a pit at the back of the house where they empty their refuse and burn. Clients items for delivery were found to complete. She was congratulated and also advise to include antenatal record book, national health insurance booklet together with some money. Client complained of backache for which she was advised to perform passive exercise, to limit sitting at one place for prolonged period and also sit with her back straight. She also complained of frequency of micturition and physiology was explained to her that is as a result of foetal head pressing on the bladder. At 6:15pm, Madam Mary and her mother were thanked for their nice reception and permission was sought to leave. Client was then reminded of her next visit on 25/11/2021.

PSYCHOSOCIAL ENVIRONMENT

Madam Mary, her husband, children and family genial relationship with each other. She has a warm and friendly relationship with her neighbours. Client said she has a few friends but she visits them at her leisure time and they also visits her too. Madam Mary also said that she has respect for all human being, especially her elders. Madam Mary said she attend her neighbour and also friends wedding as well as funerals that comes along. She also said she attend community meeting and durbars held.

2.3 SECOND ANTENATAL HOME VISIT

The second home visit was on Saturday 27th November, 2021, around 4:00pm in the evening. The aim of this visit was to check on madam Mary and her family and improvement in previous complains and advice given to her during the first visit and to educate her on birth preparedness and complication readiness. Upon, arrival, Madam Mary and her Mother were around

including her son and daughter. There was exchange of greetings. She then offered a seat after which conversation started. She was asked the outcome of the backache. She then explained that she now sits with her back straight on advise offered previously and so it is getting better and she also keep her bedpan closer to her bed so her sleep is not interrupted that much then she was advised to arrange with a taxi driver who would be readily available to take her to the clinic should labour commences at an odd hour. Client was counciled on the need to save money towards delivery and any emergency. Madam Mary was encouraged to identify an appropriate blood donor who will be available to donate during emergency and support person. Client complained of waist pain, which was explained to her that it is as a result of the foetal head descending into the pelvis during the latter part of pregnancy. And she was reassured. She was then reminded of the actual signs of labour which includes, show, painful rhythmic contractions and severe abdominal pains. She was then congratulated for her cooperation and then reminded of the date for her next visit, permission was sought to leave as client led the way to the entrance of the house and bid farewell.

2.4 SUBSEQUENT VISIT TO THE CLINIC

On 25th November, 2021 client came to the clinic for Antenatal care. She was offered a seat to rest for a while. Madam Mary was asked if she has any complaints and she said Heart burns, she was encouraged to sit for some time after meals before going to bed and take less spicy foods. She also complained of lower abdominal pain and the physiology was explained as decent of the fetal head into the pelvic bone. Client was asked to empty her bladder and specimen was taken for sugar and protein test, but the result was negative for both. Client was examined from head- to- toe and no abnormality was detected. Vital signs and other examinations done were recorded below: Temperature 36.6degree Celsius pulse 82beat per minute, Respiration 22cyles per minute, blood

pressure100/60millimetre of mercury, weight 75kilograms, symphysio fundal height 35centimetres, presentation was cephalic and descent 4/5th fetal heart rate 128beat per minute and gestational age of 37 weeks. After checking all these, Routine drugs were given to client as follows; Tab folic acid 5mg daily for 3 days, Tab fersolate 200mg daily x 30 days**,** Tab multivitamin 200mg daily x 30 days. The four stages of labour were explained to her, She was thank and after that she took her leave.

A day after a phone call was made to find out if there is improvement in client's previous complain of which, she verbalized that lower abdominal pain and heart burns has subsided.

2.5 ANTENATAL CARE PAN

Problems identified during Antenatal care

On 20th November, 2021 client complains of

1. Sleeplessness

On 25th November, 2021

2. Heart burns

3. Lower Abdominal pain

On 27th November, 2021

4. Backache
5. Waist pain

Short term objectives

1. Madam Mary will be able to sleep for at least 1 hour 30 minute during the daytime and 5 hours at night within 24hours.
2. Client will be relieved of backache by the end of pregnancy.
3. Client will be relieved of waist pain within 24hours and till the end of pregnancy.
4. Client will be relieved of heart burns within 48 hours
5. Client will cope with lower abnormal pain within 24 hours and throughout pregnancy.

Long term objectives

Madam Mary will go through pregnancy, labour, and puerperium successfully with no complication to her and the foetus.

CARE PLAN FOR PREGNANCY

DATE/ TIME	NURSING DIGNOSIS	NURSING OBJECTIVES/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
20/11/21 5:5/15pm	Sleeplessness related to frequency of micturition	Client will be able to sleep for 1 and half hours during the daytime and hours at night as evidence by client verbalizing that she was able to sleep.	1.Reassure client to ally fear and anxiety 2.Encourage client to reduce intake of fluids containing diuretics. 3.Encourage client to keep a bedpan closer to her bed at night 4. Encourage client to take warm shower before beb 5.Explain physiology of frequency of micturition to her	1. Client was a reassured that it will be managed. 2.Client took no fluids containing natural diuretics such as tea in the evening 3. Client kept bedpan closer to her bed at night. 4. Client to warm bath prior to bedtime 5. Client was taught that, the capacity of the bladder is reduced by the foetal head.	5/12/2021 10 :35am	Goal fully met as client said she has been able to sleep	

CARE PLAN FOR PREGNANCY

DATE/ TIME	NURSING DIGNOSIS	NURSING OBJECTIVES/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALU ATION	SIGN
25/11/2021 8:30am	Heartburns related to progesterone relaxing the cardiac sphincter	Client will be relieved of heart burns within 48hours as evidenced by client facial expression	1. Support client emotionally 2. Explain the physiology of heartburns to the client. 3. Educate client to reduced fatty and spicy foods. 4. Educate client to eat in bits but at a frequent interval. 5. Educate client not to go to bed early after eating .	1. Client was supported emotionally that she will be relieved of heartburns. 2. Physiology of heartburns was explained to client that it is the reflux of acidic gastric content into the oesophagus 3. Client reduced fatty and spicy foods. 4. Client ate in bit but at shorter intervals. 5. Client was educated to sit for sometimes before going to bed after eating.	5/12/2021 10:42am	Goal fully met as client verbalize, she has been relieved of heart burns.	

CARE PLAN FOR PREGNANCY

DATE/ TIME	NURSING DIGNOSIS	NURSING OBJECTIVES/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
25/12/2021 8:30am	Lower abdominal pain related to descent of the fetal head.	Client will cope with and be relieved of lower abdominal pain by the end of pregnancy as evidence by client posture**.**	1 Reassure client to allay fair and anxiety 2 Explain the cause of lower abdominal pains to the client 3. Encourage client to wear low heel shoes 4. Encourage client husband to help client with household chores	1.Madam Mary was reassured on the available measures which will decease her pain 2. Madam Mary was educated on the cause of lower abdominal pains 3. Madam Mary was encouraged to wear low heel shoes. 4.Client husband helped her with household chores	5/12/2021 10:36am	Goal fully met as client verbalize that she has been relieved of lower abdominal pain	

CARE PLAN FOR PREGNANCY

DATE/ TIME	NURSING DIGNOSIS	NURSING OBJECTIVES/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
27/11/2021 4:00pm	Backache related to relaxation of joint in late pregnancy.	Client will cope with and be relieved of backache by the end of pregnancy as evidence by client posture	1. Reassure client to ally fair and anxiety 2. Explain the physiology of backache to client. 3.Teach client on good body mechanics 4. Administer prescribe medication 5. Encourage client's family to help her with household chores. 6. Encourage client to sleep on a firm mattress.	1.Client was reassured she will be relieved of back ache after delivery 2 Explanation of the physiology of backache in late pregnancy was given to client. 3. Client was taught on good body mechanics 4. prescribe medication was served. 5. Client's family helped with her household chores. 6.Client slept on a firm mattress	5/12/2021 10:35am	Goal fully met as evidenced by client verbalized that she has been relieved of backache	

CARE PLAN FOR PREGNANCY

DATE/ TIME	NURSING DIGNOSIS	NURSING OBJECTIVES/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
27/11/2021 4:00pm	Waist pain related to descent of fetal head putting pressure on sacral nerves	Client will cope with waist pain within 24hours and till the end of pregnancy as evidence by client body language	1. Reassure client to ally fair and anxiety 2. Encourage Madam Mary to have 2hours rest during the day. 3. Educate Madam Mary to seat in between activities. 4. Educate Madam Mary to engage in exercises 5.Give prescribe analgesics	1.Madam Mary was reassured on the available measures which will decease her pain 2. Madam Mary had 2 hours of rest during the day. 3. Madam Mary understood and sat down in between activities 4. Madam Mary was educated to engage herself in exercises 5. Prescribe analgesics were served (tab paracetamol 1g(prn)	5/12/2021 10:40am	Goal fully met as evidenced by client verbalized that she has been relieved of waist pain.	

CHAPTER THREE

LABOUR

3.0 INTRODUCTION

This chapter talks about the care given to the client during labor, delivery, immediate care of the newborn, examination of the newborn and care plans drawn for the management of the problems encountered during this period.

3 .1 MANAGEMENT OF FIRST STAGE OF LABOUR

Admission

Client arrived at the facility on 4th December, 2021 at 5:00am, Madam Mary reported to Pentecost Clinic, Kasapin. with the history of labour pains. She was accompanied by her mother and complained of severe lower abdominal pains. She was reassured and encouraged to cope since it is a sign of true labour. She was told again that this would reduce when she delivers. They were warmly welcomed and a seat was offered. Client and relative were reassured of the competency of the team and their readiness to render a holistic care. Her antenatal records book was first taken from her and glanced through. According to client she started experiencing contractions during the dawn at 12:30am. She was asked what food she had taken and she responded she has not eaten anything and when asked of her last bowel activity, she said she had emptied her bowel before taking her bath. She also stated that she had not taken any medication or applied anything on the abdomen. Madam Mary was reassured and procedures were explained to her and consent was gained. Her vital signs was taken and recorded as below; Temperature 36.7degree Celsius, pulse 69beats per minute, Respiration 22cycles per minute Blood pressure 100/60millimetres per mercury. A specimen bottle was given to her for the midstream urine collection for urine

examination. The amount of urine produced was 100mls. A urine reagent strip was used to test for glucose, acetone and protein and the color of urine was amber, clear and not offensive. The results were negative. Hands were washed with soap under cleaning running water and dried with a clean dry towel. Having explained the procedure and her consent sought, head to toe general examination was conducted but no abnormality was detected. Inspection, foetal movement were obvious, with no scar on the abdomen it is also large in size with a globular shape and prominent linear nigra and straie gravidarium. On palpation, presentation was cephalic, lie longitudinal, descent of $3/5^{th}$ above the pelvic brim. Symphysio fundal height measured was 36cm. On auscultation, foetal heart rate was 132beats per minute, it was audible and regular in rhythm. Contractions were and recorded as 2 in 10-minute lasting 25second. Hand washing was done after the procedure. Client was informed vagina examination is the next procedure to be performed and it was explained to her that it was to assess the dilitation of the cervix and adequacy of the pelvis for delivery, then tray was prepared containing two sterile gallipots, one with cotton wool swabs and the other containing savlon antiseptic solution, a sterile glove and a receiver for used swabs was brought to the bedside. Client was helped to bend her knees and spread legs gently. Hand washing was done and dried and the sterile glove was put on. Standing at the right side of client, the vulva was inspected for scars varicosities, clitoridectart, oedema vulva warts, sores and scars from previous delivery or any abnormal growth of which none was detected. No offensive discharge was also noted. Mons pubis was also shaved. The midwife in charge helped pour the savlon solution onto the sterile swabs of cotton wool. Using the dominant hand, a swab was taken and dropped into the non-dominant hand. The back of the palm was used to tap the inner aspect of client's thigh to avoid startling her and the majors was cleaned from anterior to the posterior once and swab was discarded into receiver. same repeated for minora and the vestibule. With the use of non-dominant hand, the vestibule was

parted and the right index finger was inserted into the vagina gently but firmly pressing downwards and the index finger was added, the vagina was moist and warm and had distensible walls. The cervix was soft and thin, dilatation was 4cm at 5:30am. The presenting part was well applied to the cervix, membranes were intact. Degree of moulding could not be assessed due to intact membranes. Sacrum was well curved and ischia spines were blunt. Bringing the fingers out a fix was made and the knuckles place in between the ischial tuberosities and the intertuberous diameter to determine was adeguate as all four knuckles were accummodated. Client was cleaned with a clean perineal pad and a fresh one applied. She was helped to stretch her legs and made to lie on her left side. Gloves were immersed in 0.5%chlorine solution and removed by inverting and then disposed. Hand washing was performed and hands dried. Findings were communicated to her using the dilatation board. Client was covered with cloth and made comfortable in bed in the left lateral position, Client was encouraged to frequently empty her bladder to aid in the descent of the foetal head. At 9:30am; client was due for next assessment. On examination, uterine was 100mls, contractions were 4 : in 10 lasing for 50seconds,Blood Pressure110/70mmHg, Temperature37.1 degree ceicius vaginal examination was done with cervical dilatation of 8cm, moulding was (+) and membranes were still intact and foetal heart rate was 140beats per minutes and descent was $1/5^{th.}$

3.2 PREPARATION FOR BIRTH

As part of the preparations for birth, helpers were identified, that is skilled and unskilled helpers. The skilled helper was the Midwife in-charge who will give a helping hand when the need arises and the unskilled helper was client mother. The emergency plan was reviewed by making numbers of fellow midwives and obstetrician in the receiving hospital in referral cases were made readily available. The taxi driver was also available as his service may be needed as a means of

transportation to help with advanced care if it becomes necessary. The area for delivery was prepared by ensuring that it was clean, warm and well-lighted. Madam Mary was helped to wash her hands and abdomen in order to prepare for skin-to-skin contact. Nearby windows and doors were closed to stop draught and to keep the room warm. Light was switched on and fan turned off. Hand washing was performed thoroughly with soap and clean water in order to prevent the spread of infection. A dry, flat and safe space was prepared for the baby to receive ventilation if needed. She was also assisted to do deep breathing exercise. Client was engaged in conversation to serve as a form of diversional therapy in order to divert her attention from the pain and anxiety.

Setting of Trolley; The trolley was set with the following instruments and items on top and button shelf;

The top shelf which contain the sterile instrument contain the delivery pack and is made up of

- Two artery forceps
- One cord scissors
- Sterile Gallipot containing sterile cotton wool
- Sterile Gallipot for solution
- Sterile Drapes
- Sterile Receiver for placenta
- Episiotomy scissors

Button shelf also contains;

- Drum containing gauze and cotton wool
- Chisle forceps in its container
- Bulb syringe

- Sterile gloves
- Perinea pads
- Cord clamps
- Savlon
- Injection tray containing 10 units of oxytocin
- Measuring jug
- Identification band
- Examination gloves
- Cot sheets
- Bedpan

At 11:30am, client complained of lower abdominal pains and fatigue so she was asked to take in her malt in order to regain some strength. Client had spontaneous rupture of membranes. Vaginal examination was repeated to rule out cord prolapse and confirm dilatation and it was fully dilated (10cm). The colour of the liquor was clear, moulding was (++), descent of the foetal head was $0/5^{th}$, Contractions were 4:10 lasting for 50seconds and foetal heart rate was 138 beats per minute. She was encouraged to continue the deep breathing exercise and was also informed of the progress of labour. The midwife in charge was called to confirm full dilatation

3.3 MANAGEMENT OF THE SECOND STAGE OF LABOUR

After explaining every procedure to the client, she was then assisted onto the delivery bed. Protective clothing such as plastic apron, safety boot, face mask and goggles were worn. Hands were washed and dried, sterile gloves were worn and delivery pack was then opened. Client was assisted into a comfortable position of her choice. The vulva and upper thighs were cleaned with cotton wool swabs soaked in savlon solution. She was draped with sterile sheets on both thighs,

on the abdomen and under the buttocks to maintain a sterile field for the foetus. Client was then reminded that the baby would be delivered unto her abdomen of which she agreed. With the second stage confirmed by the last vagina examination, she was encouraged to push with each uterine contraction and to rest in between the contractions when it wears off. As she pushed and the head was advancing, a clean perineal pad was placed on the anus to prevent feces from getting into contact with the baby's face. The middle and the index fingers of the dominant hand were placed on the foetal head to aid flexion and to prevent sudden expulsion of the foetal head which could cause perineal tears and intracranial hemorrhage. Flexion was aided to allow the smallest diameter of the foetal head to pass through the birth canal. After crowning has taken place she was asked to breathe through her mouth and push gently with each uterine contraction. The extension of the head was done and the sinciput, face and chin swept the perineum and the head was born. Sterile gauze was used to clean the face, the eyes from inside to the outside. The neck was felt for cord around it and there was none. Restitution took place followed by external rotation of the head which indicated internal rotation of the shoulders. With each palm on the parietal bones and with downward traction, the anterior shoulder was delivered. The head was flexed upward to deliver the posterior shoulder and with lateral flexion, the trunk and the rest of the body delivered onto the mother's abdomen. Immediately the time of delivery was noted to be 11:45am. The sex of the baby was noticed to be a female and the mother also confirmed.

3.4 IMMEDIATE CARE OF THE NEWBORN

Immediately the baby's head was delivered, sterile gauze was used to clean its face and eyes from the inner canthus outwards. The neck was felt for cord around it which was absent. Immediately the baby was delivered onto the mother's abdomen, the first Apgar score was noted to be 8/10. Liquor was cleaned off the baby with clean cloth to keep baby warm and wet cloth was removed.

The cord was then clamped 2 centimeters away from the baby's abdomen and second clamp 3 centimeters from the first clamp then cut in between the 1st and 2nd clamps. Client's baby was shown to her and she identified it as live female infant and was placed on mother's chest for bonding. They were then covered with a clean, dry cloth to stimulate the baby to breathe and also prevent it from getting cold. An identification band bearing the mother's name, date, baby's sex, time of delivery was placed on the baby's wrist. The fifth minute Apgar score was noted to be 10/10.

Time	Color	Breath	Heart	Tone	Reflex	Total
1min	2	2	2	1	1	8/10
5mins	2	2	2	2	2	10/10

3.5 MANAGEMENT OF THE THIRD STAGE OF LABOUR

The procedure was explained to the client. After palpating the abdomen to check for the presence of an undiagnosed twin, but there was none and ten units of Oxytocin was given intramuscularly to aid uterine contraction and the separation of the placenta at 11:46am. The cord was reclamped with an artery forceps closer to the perineum. A receiver was placed in between client's thighs to receive the placenta and its membranes. The non-dominant hand (left hand) was placed on the fundus and as soon as there was contraction, the left palm was placed just above the symphysis pubis to support the uterus and to prevent uterine inversion. Using the dominant hand (right hand), the clamped cord was held and as the uterus contracted, a gentle pull was applied to the cord in a downward steady motion with counter traction. The process was maintained continuously until the placenta was visible in the vulva. The two hands cupped the placenta while teasing and gently seen her in a steady outward and downward traction. The placenta and its membranes were completely

expelled at 11:51am. A quick inspection was made to ensure that the membranes and lobes were intact and it was placed in the receiver. The cord had one big vein and two arteries. The uterus was rubbed gently in a circular motion to stimulate contraction and to expel clots. Madam Mary was taught how to perform uterine massage and how the uterus should feel after massaging. The perineum was swabbed and examined together with the vulva for tears and lacerations under a good source of light. No tears or lacerations were observed. Client's vagina was then pressed downwards with the middle and index fingers wrapped with gauze to inspect the walls of the vagina and cervix but there was no tear or oedema. There was no active bleeding. The vulva was then cleaned and a clean pad applied. Client was congratulated and made comfortable in bed.

Examination of The Placenta: The placenta was immersed in 0.5 chlorine solution as protocol enhance infection prevention a thorough inspection was carried out to make sure that there is no retained. The placenta was put on flat surface in a well- lighted sluice room. The tip of the cord was cleaned with cotton wool and the blood vessels were checked and were noted to be two arteries and a vein. The cord was of normal size and length with no knots detected the cord was centrally located in the foetal part of the placenta. The foetal part was of normal shiny grayish appearance with blood loss vessels running through. The placenta was turned and maternal side revealed the dark coloured appearance with intact lobes and no infarts. the membranes were checked and no abnormality likes vessels running through and torn membranes were detected. The placenta was discarded into a container with lid to be disposed off. Examination table and items were then cleaned ensuring infection prevention protocols after which hand washing was done and findings documented in records book.

3.6 MANAGEMENT OF THE FOURTH STAGE OF LABOUR

The fourth stage of labour is the first six hours of critical observation of both mother and baby after delivery of the placenta and membranes to detect any deviation from normal. Madam Mary and her baby were observed for one hour after delivery in the lying in- ward. This was to detect any abnormalities for bleeding and contraction of the uterus whiles baby was observed for cord bleeding, any colour change, respiratory pattern and breastfeeding. It also includes vital signs monitoring. After one hour, they were transferred to lying in ward where further observation and monitoring continued for six hours. The uterus was firmed and well contracted and the sympio-fundal height was 18centimeters. perineal pad was observed and blood loss was moderate. She was served with bedpan and she was encouraged to urinate frequently to aid in contraction and involution. Client was made to change her perineal pad. Madam Mary was educated to wash hand with soap and water after urinating, visiting toilet before breastfeeding the baby to prevent infection. She was taught the proper position and attachment. She was also advised to feed baby on demand to help in involution of the uterus. She was subsequently advised to have adequate rest and sleep. She was encouraged to continuously massage her own uterus to enhance contraction. Baby was also observed to be suckling well. She was told to report any profuse bleeding either from the baby's cord or herself.

Mother vital signs was checked and recorded as temperature 36.2degree celsuis, pulse 70beat per minute, Respiration 19cycles per minute, Blood pressure 100/60millimetre of mercury. Baby vital signs was checked and recorded as Temperature 36.8 degree celsuis, pulse 134beat per minute, Respiration 44cycles per minute, Apgar first one minute 8/10, and fifth minute minute10/10, sex Female, Abnormalities Nil. Client was served with malt to help restore lost energy and later served with fufu and light soup.

Prevention of Infection; Hands were washed and dried before handling the baby. Tetracycline eye was instilled on the eye as prophylaxis against eyes infection and was injected with 1mg of vitamin K intramuscularly on the thigh to aid in clothing. Attention was paid to the cord by cleaning it with sterile cotton soaked with methylated spirit and kept dry to prevent infection. Mother was educated to wash hands before and after breastfeeding baby. She was further encouraged to breastfeed on demand.

Examination of The New Born

Client was informed the head to toe examination was to be performed on the baby. Hand washing was done and dried with clean towel and glove was worn. The baby was wrapped and put on a warm, flat and safe surface at the mother beside. Baby was exposed systematically as it was examined head to toe. Baby was examined in the presence of mother. The baby coloured was pink on observation. The head and scalp were normal with no caput succedaneum, bulging or sucking fontanelles. The eyes opened spontaneously when the baby was held in an upright position and conjunctiva was clear and nose was patent. The mouth was examined by pressing the angle of the jaw which opened the mouth and tongue gum, and palate where inspected; the upper notch of the pinna was at the same level with the canthus of the eye. External auditory meatus was patent and the cartilages in the pinner was checked for it softness. The shape and size was also noted and no abnormality was detected. The neck was inspected and palpated with no swelling such as congenital goiter, enlarged lymph node; rotation and flexion were good. The chest was examined; the respiratory movement was regular and the respiratory rate was 44cpm. The space between the nipples was noted and the nipples were in alignment. The abdomen was round with no bleeding or discharge from the umbilical cord. The cord was examined and there was one vein and two arteries. The genitalia area was examined and the anus was patent as baby passed meconium before

examination. The length and movement of the limbs where also noted. The digits were counted to be normal and separate to exclude clubbing and webbing. The axillae, elbow groin and popliteal spaces were examined for inflamed lymph nodes but were without any abnormality. The spine was also examined with baby put in prone position. The back was palpated for swelling, dimpling, hairy patches to exclude spinal bifida. The baby was weighed and the weight was 3.1kg, head circumference was 34cm, foetal height 44cm, vitamin k, 1mg was given to baby intramuscularly to prevent bleeding. The baby was classified as normal. Gloves were removed and disposed aseptically before washing hands with soap under running water and dried with clean dry towel. Baby was wrapped and given to mother to breastfeed. All findings were recorded as; Temperature 36.9degree Celsius, Apex heart rate 132beat per minute, Respiration 44cycles per minute, Apgar score first minute 8/10, Apgar fifth minute 10/10, Sex was female and no abnormality was detected. Baby Condition was good.

Condition of the Mother

Client was made comfortable in bed and was helped to fix baby to breast. Vital signs were checked and the following examination were done and recorded as follows: Temperature 36.9degree Celsius, Blood Pressure 100/60, pulse 77beats per minute, Respiration 19cycles per minute.

3.7 SUMMARY OF LABOUR

Duration of Labour

Client was admitted to the ward with complaints of labor pains. Labor progressed normally and client had spontaneous vaginal delivery of a live female child at 11:45am. Active Management of Third Stage of labor was done. Perineum was intact and blood loss was small (150 milliliters). Condition of baby was very good as well as mother. The placenta and its membranes were intact. Duration of labour lasted for six (6) hours twenty(20) minutes

3.8 CARE PLAN DURING LABOUR

Problems identified during labour

On 4/12/2021, client complains of

1. Client complained of lower abdominal pains

2. Client was noted to be Anxious

3. Client complains of frequency of micturition

4. Client complained of fatigue

.3.8 SHORT TERM OBJECTIVES

1. Client will cope with lower abdominal pain within 1hour and throughout her labour

2. Client anxiety will be resolved within 1 hour and to the end of labour

3. Client will cope with frequency of micturition within 30 minutes and to the end of labour.

4. Client's will be relieved from fatigue within 2 hours and to the end after labor.

3.9 LONG TERM OBJECTIVE

Madam Mary will go through labour and puerperium successfully without any complication to the mother and baby.

CARE PLAN FOR LABOUR

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
4/12/2021 05:30am	Lower abdominal pains related to descent of the foetal head.	Client will cope with lower abdominal pain throughout labour as evidenced by 1. client verbalizing.	1.Reassure client to ally fair and anxiety 2. Educate client on the causes of lower abdominal pain. 3. Give sacral massage 4. Provide diversional therapy. 5. Teach client on deep breathing exercises	1. Client was reassured. 2. Client was taught that lower abdominal pain is due to contraction and decent of the presenting part. 3. She was given sacral massage 4. Client was engaged in a conversation. 5.Client was taught on deep breathing exercises and she was doing it.	4/12/21 11: 45pm	Goal fully met as client verbalized that she was able to cope with the pain.	

CARE PLAN FOR LABOUR CONTINUED

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
4/12/2021 09:15am	Anxiety related to unknown outcome of labour	Client will be relieved of anxiety within as evidence by client verbalizing	1. Reasure client to allay fear and anxiety. 2. Educate her on the effect of anxiety on labour. 3. Explain the stages of labour to the client. 4. Explain every procedure to the client. 5. Update client with progress of labour.	1.Client was reassured that she will be seen through labour and delivery successfully 2. Client was taught that anxiety can prolong labour. 3. The 3 stages of labour and what it entails were explain to the client. 4. Every procedure to be carried out on client were explained to the client 5. Client was update with the progress of labour using the dilatation board	4/12/2021 12:00pm	Goal was met as client said she was no longer anxious.	

CARE PLAN FOR LABOUR CONTINUED

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
4/12/21 07:50am	Frequency of micturition related to pressure on the bladder by the presenting part.	Client will be relieved of frequency of micturition within 6 hours as evidence by client verbalizing.	1.Reassure client to ally fear and anxiety 2. Encourage client to keep pail within her reach 3.Explain the physiology of frequency of micturition in labour 4.Give emotional support	1.Client was reassured that the condition was temporal and she will be relieved after delivery 2. Client was keeping a clean covered pail by her bedside. 3. Client is now aware Physiology of frequency of micturition is due to reduction in the bladder capacity by the descending foetal head. 4 Midwife was with the client throughout labour.	4/12/21 1:35pm	Goal met as client said she has been relieved of frequency of micturition.	

CARE PLAN FOR LABOUR CONTINUED

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
4/12/2021 At 9:15am	Fatigue related to stress of labour	Client will be relieved of fatigue within 6 hours as evidence by client verbalizing it	1.Reassure client to ally fear and anxiety 2.Encourage client to rest 3.Teach and encourage client to do deep breathing exercise 4.Serve client with energy food. 5.Encourage client to be calm	1. client was reassured 2. client was encouraged to rest in between labour 3.client was encourage to do deep breathing exercise 4. client was served with fruit juice 5.client was made to be calm	4/12/21 1:35pm	Goal fully met as midwife observe client relaxed and comfortable	

CHAPTER FOUR

PUERPERIUM

4.0 INTRODUCTION

This chapter consists of the care given to the client and the baby from the day of delivery till six weeks' postnatal period.

4.1 DAY OF DELIVERY

Madam Mary and her baby were still being monitored every 15minutes for 2hours, 30miutes for 1hour and hourly for 3hours. Client and her baby were transferred to the lying-ward for observation and they were made comfortable in bed. Both mother and baby were kept warm. She was encouraged to breastfeed her baby to promote bonding between them and also stimulate uterine contractions to aid involution of the uterus. She was also encouraged to empty her bladder frequently to help in fast involution of the uterus and also to prevent the occurrence of postpartum hemorrhage. She complained of after pains physiology of after pain was explained to her. Madam Mary was encouraged to apply warm compress to her lower abdomen and was educated to urinate frequently since full bladder could alter uterine contractions and brings about postpartum hemorrhage. She was given tablet paracetamol 1gram start to reduce the pain and was told that pain was as a result of contractions of the uterus. She was given vitamin A capsules 200,000international unit as well. Madam Mary was served with Malt initially and later ate Fufu and light soup with beef which was brought to her by her mother. She was encouraged to breastfeed her baby, take her bath and rest for some time. Her vital signs were checked and recorded as follows: Temperature 36.7degree Celsius, pulse 88beat per minute, Respiration 21cycles per minute, Blood pressure 110/60millimetres of mercury. The symphysio fundal height was measured to be 18centimeters, uterus was firm and well contracted. Lochia was also inspected and it was

red(rubra) in colour and small in amount with no bad odour. The baby was examined from head to toe and no abnormality was detected. The client's relatives were asked to excuse mother and baby so that they could have some rest and sleep. Madam Mary was encouraged to eat good nourishing and balanced diet, adequate intake of fluids, more fruit and roughages to enhance bowel movement and to repair all worn out tissues. She was gain encouraged to exercise especially the abdominal and pelvic floor exercise. Madam Mary's mother was advised to help her daughter in the care of the baby and also the household chores. She was then informed of possible discharge on the next day.

4.2 SUBSEQUENT CARE OF THE BABY

The baby's cord was observed for bleeding but there was none. Baby's colour was normal(pink), and the breathing and general activity was good. Urine and meconium were passed; all reflexes were normal. The baby was given immunization, which were bacillus Chalmette Guerine (BCG) vaccine 0.05millimetre intradermal at the right upper arm to prevent tuberculosis and oral polio vaccine 0(OPVO)2drops at the back of the tongue to prevent poliomyelitis. The baby was wrapped in a warm dry sheet to maintain body temperature and she was placed beside her to suckle. The mother was advised not to apply anything at the injection site. The vital signs and other measurement was taken, length was 45Centimetres, head circumference was 31Centimeters, weight was 3.1kg, skin colour was pink, suckling was present and there was no cord bleeding. Temperature 36.7degee Celsius, pulse 132beats per minute, Respiration 46cycles per minute. All findings were communicated to the mother and recorded. The next day, Madam Mary was informed about the need for the baby to be bathed and she respond positively. The baby was bath 6hours observation with warm water. Client was asked to watch closely how to bath baby and practice

Baby bath; requirement

1.Soap

2.Sponge

3.Cream/ powder

4.Sterile cotton in a gallipot or wrapped

5.Methylated spirit

6.Basin

7.Towels: 1 big towel and 3 small ones

8.Cot sheets 2

9.Apron

10.Gloves

11.A clean baby dress, cap and socks (if available)

12.Mackintosh

13.2Jugs containing hot and cold water each

14.Two receptacles for used water and dirty linen

15.A receiver for used swab.

The procedure was explained to mother and a tray was set. A plastic apron was worn and hands were washed with soap, water and dried with a clean towel. The water was mixed and the temperature was tested using the elbow. Gloves were worn and baby was placed on a flat surface. She was undressed and wrapped in a big towel. The eyes were cleaned with cotton wool swabs soaked in clean water from inner canthus outwards. Her face was cleaned with damp face towel and dried. The nape of baby's neck was supported with one hand. Her ears were then plugged using two fingers of the hand and the head was washed with soapy sponge. With the body resting on the elbow and still supporting the nape, the baby was place at the edge of the bowl to rinse the soap off the head and dried. Her arms and front of trunk were washed paying attention to skin folds. The baby's back was turned with one hand supporting the chest and washed back down to feet paying attention to the skin folds. She was immersed in a bath of warm water with the head above the water and rinsed thoroughly. The baby was place on a flat surface covered with clean sheet. The baby was dried by using a clean small towel paying attention to the skin folds. The baby was oiled and dressed leaving the cord exposed. The cord was dressed by using six sterile cotton wool swabs soaked in methylated spirit. The tip of the cord clamp was held with one sterile cotton wool swab and another was used to clean the base of the cord, both anteriorly and posteriorly each with a separate swab from the base upwards. The tip of the cord was cleaned with another swab and the cord was left exposed and the last swab was used to clean the cord clamp. The baby was dressed, wrapped and, given to mother to breastfeed. The waste materials were discarded according to infection prevention protocol. Gloves were removed and disposed off, Hands were washed with soap and water before handling the baby.

4.3 FIRST DAY POST DELIVERY (DAY OF DISCHARGE)

Madam Mary and her baby looked healthy with no abnormality detected after head to toe examination. Her vital signs and other assessment were recorded as follows; Temperature 36.2degree Celsius, pulse 87beats per minute, Respiration 21cycles per minute, Blood pressure 110/60millimetre of mercury. Hemoglobin level was 11.6gram per deciliter, The conjunctiva was inspected for any sign of anemia but it was absent, Quick puerperal assessment was then made. Breast was lactating, the fundal height measured 16cm. The perineum was inspected and was found to be cleaned, lochia was rubra(red), with moderate amount of flow.

Permission was sought to inspect the perineal pad. The lochia was small and not offensive. She was encouraged to change her perineal pad frequently to prevent ascending infections to the uterus. Permission was sought to examine the baby. Hands were washed with soap and water and dried with clean dry towel. On general examination no abnormalities ware detected. For the baby, the cord was checked for bleeding and discharge and there was none. The baby was topped and tailed paying attention to skin folds. The cord was dressed with sterile cotton wool swabs soaked in methylated spirit. The baby passed meconium and urine which was normal, the baby was dressed, wrapped and put to breast. Madam Mary was educated on the effect of hot compress application on baby's head in other to close the fontanels and was discouraged from doing so. Baby weight was 3.0kilograms. Vital signs were checked and recorded as follows Temperature: 37.1degree Celsius, pulse 134beat per minute, Respiration 43cycles per minute. The midwife in charge re-assessed mother and baby but no abnormality was detected. Client was educated on maintaining baby's temperature by wrapping baby as taught. She was encouraged to practice exclusive breastfeeding on demand especially at night and educated on the importance of breastfeeding to the mother such as it serves as a family planning method, it is not expensive and aids in the

contraction of the uterus with the release of oxytocin and to the baby, it provides all the right nutrients in the right proportions, reduces the risk of contamination and aids development. Client was further advised to keep the cord clean and to prevent using local herbs on the cord. She was educated on how to recognize danger signs like fever, difficulty in feeding in the child and offensive vaginal discharge in the mother and report immediately to the clinic. She was also encouraged to have enough rest. She was informed of her discharge. Routine drugs were prescribed as the protocol of the facility, the dosage and time of drugs were explained to her. She was assisted to pack her things and encouraged to register the baby at birth and death registry. Client was informed of continuity of care for seven days where she would be visited at home. She was also told about her first postnatal visit to the clinic on 14th December, 2021. She was then discharged home at 10:45am and prescribed drugs were given as below;

Tablet folic acid	5milligram once daily for 7days
Tablet ferrous sulphate	200milligram once daily for 7days
Vitamin A capsule	200,000 international units
Tablet paracetamol	1000 milligram three times daily for 5days.

4.4. FIRST POST NATAL HOME VISIT

Madam Mary and her baby were visited on 5th December, 2021 at 5:15am in the evening. On arrival Madam Mary was having a conversation with her mother. They were happy to see me and welcomed me nicely. Greetings were exchanged and a seat was offered. General condition of both mother and baby was good. Client was informed of the procedures to be carried out. Hands were washed and dried with a clean towel. The conjunctiva was examined and there was no pallor. The breasts were soft and lactating well. The uterus was well contracted with symphysio fundal height

of 16cm. The perineum was clean dry and intact, lochia was small red (rubra) and not offensive. Client was asked about her after pain and she said it has subsided but complained of loss of appetite. She was reassured that she would resume her normal eating habit. She was educated on mouth care before and after eating. Vital signs were checked and recorded as Temperature 36.7degree celsuis, pulse 70beat per minute, Respiration 19cycles per minute, Blood pressure 110/60millimetre of mercury. General examination was carried out on the baby from head to toe and there were no abnormalities detected, the cord was neatly dressed and it was dry with no infection. the baby weight was 3.0kilogram. vitals signs were also checked and recorded as Temperature 37.1degree celsuis pulse 138 beat per minute Respiration 40cycles per minute. Client and family were congratulated and permission was sought to leave and she was informed of the next visit.

4.5. SECOND POSTNATAL HOME VISIT

On 6th December 2021 at 9:15am client was visited to assess both baby and mother. On observation, the general condition of the family was good. The procedure to be carried out was explained to her. The symphysio-fundal height was 14cm. The perineum was inspected and it was clean, dry and intact with small bright red lochia (rubra) and not offensive. Her vital signs were checked and recorded in the morning as follows; Temperature 36.5 degree Celsius, pulse 75beat per minute, Respiration 21cycle per minute, Blood pressure 100/70millimetre of mercury. The baby passed stool and urine, examined from head to toe and no abnormality was detected baby weight was 2.9kg, Baby vital signs were checked and recorded as Temperature 37.1degree celsuis, pulse 132beat per minute, Respiration 40cycle per minute. In the evening at 5:00pm, baby temperature was 36.9degree celsuis but other findings were the same as in the morning. Findings were communicated to the client and also she was thanked and permission was sought to leave.

4.6 THIRD POSTNATAL HOME VISIT

The third postnatal home visit was on the 7th December, 2021 at 9:15am. Client, baby and family were doing well. Permission was sought out so head to toe examination was conducted and everything was normal. Client complains of sleeplessness and was encouraged to feed baby well and ensure that she is full and winded before sleeping. The symphysio fundal height measured 12centimeters. Breast was lactating well but was engorged, sore or cracked nipples were absent. Her perineal pad was inspected. The flow oflochia was small, pink in colour (serosa) and not offensive. Her vital signs were recorded in the morning as; Temperature 36.3gdegree Celsius, pulse 70beat per minute, Respiration 22cycle per minute, Blood pressure 110/60millimetre of mercury. Baby passed stool and urine. Examination was done on baby from head to toe and no abnormalities were detected, baby weight was 2.8kilogram. Baby vital sign were also checked and recorded as 36.5degree celsuis, pulse130 Respiration 40cycle per minute. In the evening at 5:15pm, the outcome of the findings was not different from the morning visit, madam Mary was educated on personal hygiene, and permission was sought to leave.

4.7 FOURTH POSTNATAL HOME VISIT

Madam Mary and her family were visited again on 8th December, 2021 at 8:00 am. Client, baby and family looked healthy on arrival. Top and tail had already been performed for the baby. Head to toe examination was carried out and no abnormality was detected. Baby's cord was dressed with six cotton wool swabs and methylated spirit, it was dry, not offensive and almost off. Head to toe examination was carried out on mother and no abnormality was detected. Breast was lactating well. The Symphysio fundal height was 10centimetres, perineum was clean and intact. Lochia was small, serosa and not offensive. She also complained of backache and she was reassured and educated on other positions used in breastfeeding such as lying on her side to breastfeed and was

also educated to support her back with pillow when sitting. Client was asked if the baby has passed stool and she replied that she passed brownish yellow stools. morning vital signs were checked and recorded as follows: Temperature 36.8degree Celsius pulse 87beat per minute, Respiration 19cycles per minute, blood pressure 110/60millimetreof mercury. The Baby vital signs were checked and recorded as follows: Temperature 37.1degree Celsius pulse 138beat per minute, Respiration 42cycles. Baby weight was 2.8kilogram. Mother was encouraged to ask questions. All findings were communicated to her and the necessary documentation was done. She was thanked and permission was sought to leave. Client was thanked and permission was asked to leave.

4.8 FIFTH POSTNATAL HOME VISIT

On 9th December, 2021 client was visited at 8:00am. On arrival, Client and her mother was alone in the house. Greetings were exchanged and a seat was offered. Mother and baby's general condition was good. The cord was off. Baby passed brownish yellow stool and urine during bath. Head to toe examination was done but no abnormality was detected. The stump of the cord was dressed with cotton wool swab soaked in methylated spirit and it was dry and not offensive. Madam Mary was also examined from head to toe. The Symphysio Fundal height was 8cm, perineum was clean and lochia was small serosa in colour and not offensive on examination. She complained of breast engorgement and client was educated to apply warm compress and cold compress alternatively. Madam Mary's vital signs and other assessment were checked and recorded as; Temperature 36.9 degree Celsius, Pulse 77 beat per minute, Respiraton 19cycles per minute, Blood pressure 100/60millimetre of mercury. Baby's vital signs recorded as follows, Temperature 36.7degree Celsius, pulse 138beats per minute, Respiration 44cycles per minute, Baby weight was 2.9kilogram. Client was encouraged to continue with the exclusive breast

feeding. Client and her family were thanked for their time and cooperation. Client was informed of termination of care on the seventh day and there was interaction for a while and permission was sought to leave. Client and family members were however informed of the last home visit and the termination of care on the first postnatal visit. They had a sad facial expression but were reassured that they will be left in competent hands.

4.9 SIXTH POSTNATAL HOME VISIT

On 10th December 2021 at 8:15am Client and family were visited. The whole family was in good health. Procedures to be done were explained to her. Head to toe examination was done on the baby and there was no abnormality detected. For the mother, Symphysio fundal height was 6cm. The perineal pad was inspected and the flow was scanty and pink in colour and not offensive. Her vital signs were checked and recorded as follows; Temperature 36.3 degree Celsius, pulse 67beat per minute, Respiration 20cycles per minute, Blood pressure 110/60millimetre of mercury. It was noticed that the baby had passed yellowish stool when his diapers was removed before the bath. Clients mother was asked to bath the baby and clean the umbilical stump with cotton wool swab and methylated spirit under supervision and she did it well. The baby looked healthy, was able to suck well. Head to toe examination was done and no abnormality was detected. Baby weight was 3.0kilograms. Client was educated on the baby's weight. the cord stump was clean, dry and not offensive. Baby morning vital signs were checked and recorded as follows; Temperature 36.7 degree Celsius, pulse 136beats per minute, Respiration 48cycles per minute. Client was encouraged to continue with the exclusive breast feeding and was also educated on proper attachment and positioning of the baby during breastfeeding. She was also encouraged on postpartum exercise and the intake of nutritious diet for strong immunity and promotion of lactation. She was reminded of the first post-natal visit to the clinic. Client and her family were

thanked for their time and cooperation and they were made aware that the next day was going to be the last home visit.

4.10 SEVENTH POST NATAL HOME VISIT

Madam Mary and her family were visited again on the seventh day postnatal thus 11th December 2021 at 8:40am. Client was doing well as well as the baby and the entire family. All procedures to be carried out were explained as before. Hands were washed and examination from head to toe was done and no abnormality was detected. Vital Signs were checked and recorded as, Temperature 36.8 degree Celsius, pulse 78beat per minute, Respiration 19cycles per minute, Blood pressure110/60millimeter of mercury. Lochia was inspected and it was pink (serosa) with no odour, fundal height was 4centimetre, uterus was firm and well contracted, breast was lactating. The baby was examined after bathing and dressing of the stump was done. The wound was healing. The baby's vital signs and other assessment were recorded as Temperature 36.9degree Celsius, pulse 143beat per minute, Respiration 44cycles per minute. The baby weight was 3.1kilogram. The baby was dressed and handed over to the mother for breastfeeding. Emphasis was made on her perineal care and the intake of nutritious diets as well as avoidance of hot application on the fontanelles. Client was encouraged to continue exclusive breastfeeding for 6 months. Madam Mary was reminded of the 1st day postnatal visit to the clinic and its importance and also the need to immunize the baby at the Child Welfare Clinic against the childhood preventable disease. Client was told to report to the hospital when there was any problem as soon as possible and client was informed of the last visit as it was told to her early in the seventh postnatal visit. Then Madam Mary was thanked for her cooperation and permission was asked to leave.

4.11 FIRST POST NATAL VISIT TO THE CLINIC

On 14 December 2021, client and her baby came to the clinic at 8:30am. They were welcomed and a seat was offered to her. Client and baby were looking healthy and neatly dressed. The purpose of this visit was to maintain the physical and psychological well-being of the mother and child. Client was asked of how she and family were coping with the new born, workload, rest and sleep of which she responded that everything was fine. General observation was made on her gait, mood and behavior towards baby and all were good. Her consent was sought for the procedure to be carried out on her and the baby. She was asked to empty her bladder and a sample of urine was taken to test for glucose and protein and all tested negative. Hemoglobin level was 12.6grams per deciliter. Her vital signs were checked and recorded as below; Temperature 36.3degree Celsius, pulse 88beat per minute, Respiration 22cycle per minute, Blood pressure 110/60millimetre of mercury. Client's urine was checked for protein and sugar and they both tested negative. Privacy was provided and Madam Mary was helped to undress and lie on the examination bed. Hands were washed with soap under running water and dried with a clean dry towel. Head to toe examination was done on her. On the head, her hair was neat. The conjunctiva was pink, no discharges from the eyes, nose and ears. There was no abnormality detected in the mouth, and there was absence of enlarged nodes on the neck. Breast was lactating well, sore or cracked nipples were absent. Madam Mary was encouraged on the good practices. The abdomen was firm, there was no tenderness, no scars, enlarged liver or spleen on examination. The uterus was involuting well with a symphysio fundal height of 2cm. There was no oedema, varicosities and tenderness in calf muscle. The perineum was intact and there was no offensive vaginal discharge and the lochia was small and the colour was alba. She was thanked for the cooperation and helped to dress up. Mother was asked to do postnatal exercise under supervision. Her baby was also examined from head to

toe and no abnormality was detected. The umbilical stump was inspected and it was healed. The baby was healthy and active The baby weight was 3.2kg. The baby morning vital signs are as follows: Temperature 36.6degree Celsius, pulse 126beat per minute, Respiration 40cycle per minute. Mother was encouraged to ask questions but she said there was none. Client was educated on exclusive breastfeeding and importance of attending child welfare clinic. All findings were recorded and communicated to mother. She was informed of the six weeks post-natal visit on 22nd January, 2022.

4.12 SECOND POSTNATAL VISIT TO THE CLINIC

According to the midwife in charge, Madam Mary reported on 22nd January, 2022 for six weeks' postnatal care. There was no abnormality detected on examination. The uterus was not palpable. The client and the baby were fine. Mother's vital signs recorded as follows: Temperature 36.7degree Celsius, pulse 88beats per minute, Respiration 19cycles per minute, Blood pressure 100/60millimetre. Client's urine was checked for protein and sugar and they both tested negative. Hemoglobin level was 12.8grams per deciliter. Head to toe examination was performed on baby with no abnormalities found. The baby was given the due vaccinations that was oral polio 1, Penta 1(diphtheria, hepatitis B, tetanus, pertussis and haemophilus influenza B), 0.5millilitres intra muscularly at left lateral thigh, pneumococcal vaccine 0.5mls at right lateral thigh (protection against pneumonia) and rotavirus 1.5mls orally was given (protection against diarrhoea) was given. Madam Mary was informed of the side effect and encouraged to report to the facility any time she encountered any health related problems. The baby's weight was 3.9kilograms. vital signs were checked and recorded as follows: Temperature 36.7degree Celsius, pulse 137beat per minute, Respiration 41cycles per minute.

4.13 TERMINATION OF CARE

Madam Mary and her family were made aware on the first time of interaction that the care would be terminated during the postnatal review visit where she and her baby would be handed over to the public health nurse in –charge for continuity of care. Madam Mary and her family were able to go through pregnancy, labour and puerperium successfully by adhering to all education given to them on 14th December, 2021 which was the first postnatal visit to the clinic. Both client and baby were handed over to the public health nurse for continuity of care. Profound gratitude was expressed to the client and family for their total cooperation. They were also grateful for the care and support

4.15 CARE PLAN DURING PUERPERIUM

Problems Identified During Puerperium

On 5/12\2021, Madam Mary Complains of

1. After pains
   On 6/12/2021, Client Complains of
2. Loss of appetite
   On 7/12/2021, Client Complains of
3. Sleeplessness
   On 8/12/2021, Client Complains of
4. Backache
   On9/12/2021, Client Complains of
5. Breast engorgement

SHORT TERM OBJECTIVES

1. Client after pains will be relieved within 72 hours.
2. Client will eat one -third of food served within 24hours.
3. Client will be able to sleep 1 hour during daytime and 3hours during the night within 24hours.
4. Client will be relieved of backache within 72hours.
5. Client will be relieved from breast engorgement within 72 hours.

LONG TERM OBJECTIVES

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

CARE PLAN DURING PUERPERIUM

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
5/12/2021 7:00am	After pain related to involution of the uterus	Madam Mary will be relieved of after pain within 72hours as evidenced by client verbalizing	1.Reassure client to allay fear and anxiety 2. Explain the physiology of pain. 3.Educate client on postnatal exercises 4.Encourage client to empty bladder whenever she has the urge. 5.serve prescribed analgesics.	1. Client was reassured. 2. It was explained to client that the pain is due to contraction of the uterus. 3. Client was educated on postnatal exercises like kegel exercises. 4. Client was encouraged to empty her bladder frequently. 5. client was served with analgesics(paracetamol 1g)	8/12/21 At 10:00am	Goal fully met as Madam Mary verbalized that she has been relieved of after pain	

CARE PLAN FOR PUERPERIUM CONTINUED

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
6/12/21 8:30am	Loss of appetite related to hormonal changes during labour	Client will eat one -third of food served within 24hours as evidenced by client verbalizing that she could eat one-third of food served.	1. Reassure client. 2. Serve client's favorite food. 3. Serve foods attractively. 4. Administer vitamin supplements. 5. Encourage client to take meals in smaller quantities but at frequent intervals.	1. Client was reassured that her eating pattern would return to normal 2. Client favorite food was served. 3. Foods were served attractively examples garnishing the food. 4. Vitamin supplement were administered. 5. Client took her meals in smaller quantities but at frequent intervals.	7/12/21 3:00 pm	Goal achieved as Client said she has been able to eat.	

CARE PLAN CONTINUED

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES / OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
7/12/21 08:30 am	Sleeplessness related to breastfeeding at night.	Client will be able to sleep 1 hour during the day and 3 hours during the night within 24hours as evidence by client verbalizing that she can sleep for 3 hours at night and 1 hour during the day.	1. Reassure client. 2. Encourage client to take a nap when baby sleeps and whenever possible. 3. Educate partner and relative to support client in household chore and care of the baby. 4.Encourage client to feed baby well and ensure that he is full and winded before sleeping 5.Advise client to change baby's diaper when soaked before sleeping	1. Client was reassured that she would be able to sleep well. 2. Client was encouraged to take a nap when baby slept and whenever possible. 3. Partner and relatives were educated to support client in household chore and care of the baby. 4. Client fed baby fully and winded her before sleeping 5.Client was advised to change baby's diaper when soiled before sleep	10/12/21 08:30 am	Goal met as Madam Mary said that she has been able to sleep.	

CARE PLAN CONTINUED

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
8/12/21 8:30am	Backache related to exaggerated position during pregnancy.	Client will be relieved of backache within 72hours as evidenced by client verbalizing	1. Reassure client. 2. Explain the physiology of backache to client 3Apply a gentle massage on her back. 4. Educate client against the lifting of heavy loads. 5. Encourage family members to help in the care of the baby	1. Client was reassured that she will be relieved of pains 2. physiology of backache was explained to client 3. Gentle massage was applying over her back. 4. Client was educated against lifting heavy loads. 5. The family members were encouraged to help in the care of the baby.	11/12/21 8:30 am	Goal met as client said she has been relieved of backache.	

CARE PLAN CONTINUED

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
9/12/21 8:30 am	Breast engorgement related to hormonal activities in breast.	Client will be relieved from breast engorgement within 72 hours as evidenced by client verbalizing.	1. Reassure client. 2. Apply warm compress and cold compress alternatively. 3. Educate client how to express breast milk. 4. Educate client to continue breast feeding the baby. 5. Encourage the client to feed the baby on demand.	1. Client was reassured. 2.Client was assisted to apply warm and cold compress alternatively 3.Client was taught how to express breast milk manually and she demonstrated it. 4. She was educated on the importance to completely expel breast milk which helps reduces pains 5.Client fed the baby on demand	11/12/21 8:30 am	Goal met as evidenced by client verbalized that she has been relieved from breast engorgement.	

SUMMARY

This script is a Family Centered Maternity Care, given to Madam Mary Nyarko, a 28 years old woman gravida 3 Para 2. She hails from Kasapin within the Asuafo North district in the Ahafo Region. She was met at Kasapin Pentecost Clinic, on 18th November, 2021 when she was 36weeks+2days gestation. During interaction client was worried of having severe lower abdominal pain Client went through pregnancy with some minor disorders which were managed successfully. Madam Mary labour and delivery were managed carefully without any complications. She delivered spontaneously of alive female infant with birth weight of 3.1 kg on the 4th December, 2021 at 11:45am who cried immediately after birth. Madam Mary puerperium was successful. Breast problem, sub-involution, puerperal psychosis and cord infection were not noticed. Education on good nutrition, personal hygiene, exclusive breastfeeding and family planning were given to ensure a comprehensive care to client and her baby as well as her family as a whole. Mother and baby were visited at home for seven days, and also came for first and second postnatal visits then, finally handed over to the Health Nurse for further management on 22nd January, 2022. The Family Centered Maternity Care has afforded the opportunity to identify the various needs of the expectant woman during pregnancy, labour and puerperium. The knowledge and experience acquired will be translated to other expectant mothers, their families and the community members during the practice as a midwife

CONCLUSION

In conclusion, the client/family centered maternity care study has exposed the writer to situation where the knowledge received in the classroom has practically been demonstrated on the client and family from pregnancy to puerperium. This has also enhanced the ability to perform them and render them to any pregnant woman in the course of practice wherever to help reduce maternal and infant morbidity.

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APPENDIX I: ANTENATAL RECORDS OF MOTHER

DATE	WEIGHT (KG)	BLOOD PRESSURE	URINE FOR PROTEIN AND SUGAR	GAST-ATION IN WKS	FUNDAL HEIGHT	PRESENTATION	DESC-ENT	FETAL HEART RATE	COMPLAINS	TREAT-MENT	REMARK
01/6/21	70	100/60	Neg/Neg	12weeks	-	-	-	-	No complains	Routine drugs	Well
29/6/21	70	100/70	Neg/Neg	16weeks	14cm	-	-	125bpm	No complains	Routine drugs	good
27/7/21	71	100/60	Neg/Neg	20weeks	18cm	Cephalic	-	130bpm	No complains	Routine drugs	Well
24/8/21	72	110/70	Neg/Neg	24weeks	20cm	Breech	-	132bpm	No complains	Routine drugs	good
21/9/21	74	110/70	Neg/Neg	28weeks	25cm	Cephalic	-	132bpm	Lower abdominal pain	Routine drugs	Well
19/10/21	72	100/60	Neg/Neg	32weeks	28cm	Cephalic	-	136bpm	Backache	Routine drugs	good
04/11/21	72	96/55	Neg/Neg	34wks+2 days	30cm	Cephalic	5/5th	134bpm	Lower abdominal pain	-	Well
18/11/21	74	100/60	Neg/Neg	36wks+2 days	33cm	Cephalic	5/5th	129bpm	Headache	Routine drugs	good
25/11/21	74	100/60	Neg/Neg	37weeks +2days	35cm	Cephalic	4/5th	131bpm	Lower abdominal pain	-	good
2/12/21	75	110/60	Neg/Neg	38weeks +2days	36cm	Cephalic	4/5th	137bpm	Lower abdominal pain and headache	-	Well

APPENDIX II: COMPLETE DIAGNOSTIC INVESTIGATION

DATE	SPECIMEN	INVESTIGATION	NORMAL VALUES	FINDINGS	REMARKS
01/6/21	Blood Urine	Hemoglobin Blood group Rhesus factor Sickling G6PD Protein Glucose	11.4-16g/dl A, B, AB, O Positive/Negative Negative Reactive/Non-reactive Negative Negative	11.1g/dl O Positive Negative Non-reactive Negative Negative	Normal Normal Normal Normal Normal Normal Normal
29/6/21	Urine	Protein Glucose	Negative Negative	Negative Negative	Normal Normal
27/7/21	Urine	Protein Glucose	Negative Negative	Negative Negative	Normal Normal
24/8/21	Urine	Protein Glucose	Negative Negative	Negative Negative	Normal Normal
21/9/21	Urine	Protein Glucose	Negative Negative	Negative Negative	Normal Normal

COMPLETE DIAGNOSTIC INVESTIGATION CONTINUED

DATE	SPECIMEN	INVESTIGATION	NORMAL VALUES	FINDINGS	REMARKS
19/10/21	Urine	Protein Glucose	Negative Negative	Negative Negative	Normal Normal
4/11/21	Urine Blood	Protein Glucose Hemoglobin	Negative Negative 11.4-16g/dl	Negative Negative 12.1g/dl	Normal Normal Normal
18/11/21	Urine	Protein Glucose	Negative Negative	Negative	Normal Normal
25/11/21	Urine Blood	Protein Glucose Hemoglobin	Negative Negative 11.4-16g/dl	Negative Negative 12.1g/dl	Normal Normal Normal
2/12/21	Urine	Protein Glucose	Negative Negative	Negative Negative	Normal Normal

APPENDIX III: PHARMACOLOGY OF DRUGS USED (MOTHER)

NAME OF DRUGS	CLASSIFIC-ATION	DOSAGE	ROUTE OF ADMINIST-RATION	ACTION & USE	ACTUAL EFFECTS	SIDE EFFECT OF DRUGS	SIDE EFFECT EXPERIENCED
Tablet ferrous sulphate	Iron supplement	200 milligram once daily	Orally	Proper formation and functioning of red blood cell.	Hemoglobin level increase	Diarrhoea and black stool.	None
Tablet folic acid	Vitamin preparation	5 milligram daily once daily	Orally	It helps in iron absorption of iron.	Increase formation of red blood cells	Nausea and vomiting	None
Tablet multivitamin	Vitamin preparation	200 milligram once daily	Orally	Increased appetite. Helps in the formation of red blood cell	Increase appetite.	Gastro intestinal disturbances	Constipation
Tablet sulphadoxine prime thamine	Malaria prophylaxis	3 tablets start at 16weeks/ after quickening and repeated at 4 weeks interval till delivery.	Orally	Treatment and prevention of malaria	Prevention of malaria	Nausea, itching, dizziness, vomiting.	None

PHARMACOLOGY OF DRUGS CONTINUED

NAME OF DRUGS	CLASSIFIC-ATION	DOSAGE	ROUTE OF ADMINIST-RATION	ACTION & USE	ACTUAL EFFECTS	SIDE EFFECT OF DRUGS	SIDE EFFECT EXPERIENCED
Injection tetanol	anti-tetanus	0.5 milligram	Subcutaneously	Helps in the prevention of tetanus	Client protected against tetanus	slight fever and chills	None
Injection oxytocin	Oxytocic drug	10 units in 1milligram	Intramuscularly	Increase uterine contraction and controlling of bleeding.	Increase uterine contraction and controlling of bleeding.	Hypotension and hyper stimulation of the uterus	None
Tablet paracetamol	Analgesic and antipyretic	100 milligram 3 times daily	Orally	Helps to reduce increased body temperature and pain	Pain was reduced	Liver damage	None
Capsule vitamin A	Group A vitamin supplement	200,000 units for 2 days	Orally	Growth development and proper sight	Normal vision and healthy skin	Vomiting	None

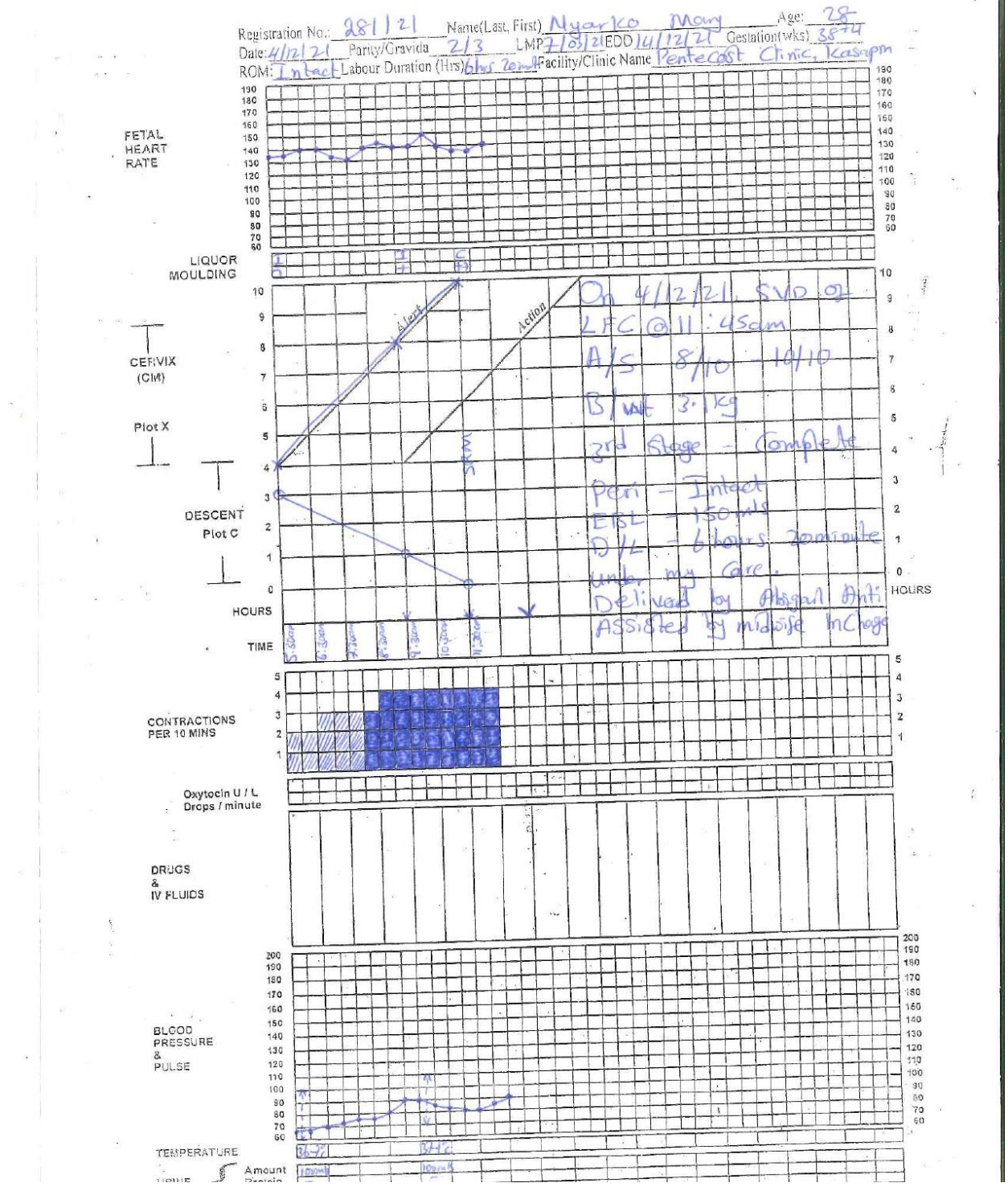
APPENDIX IV: PHARMACOLOGICAL DRUGS USED (BABY)

DRUGS	CLASSIFI-CATION	DOSAGE	ROUTE	ACTION AND USE	ACTUAL EFFECTS	SIDE EFFECTS	SIDE EFFECT EXPERIENCED
Vitamin k	Group K vitamins	1 milligram	Intramuscularly	Production of prothrombin. Aids in clotting	No bleeding	None	None
Tetracycline	Antibiotics		Instillation	To prevent infection	Infection of the eye was prevented	None	None
Oral polio vaccine 0	Antigen vaccine	2 drops	Orally	Production of antibodies	Baby is under observation	There may be diarrhea	None
Injection Bacillus Chalmette Guerin	Antigen vaccine	0.05 milliliter	Intradermal	Production of antibodies and prevention of tuberculosis	Baby is under observation	Blister formation	None

PHARMACOLOGICAL DRUGS USED CONTINUED

DRUGS	CLASSIFI-CATION	DOSAGE	ROUTE	ACTION AND USE	ACTUAL EFFECTS	SIDE EFFECTS	SIDE EFFECT EXPERIENCED
Pentavalent(5 in 1) vaccine	Antigen	0.5milliliter	Intramuscularly	Stimulate the production of antibodies against Diphtheria, Tetanus, haemophilus, influenza, hepatitis B, pertussis	Low grade fever	None	None
Pneumococcal vaccine 1	Antigen	0.5milliliter	Orally	Stimulate the production of antibodies against streptococcal infection	Redness at the site of injection and fever	None	None
Polio vaccine 1	Antigen vaccine	2 drops	Orally	Production of antibodies against poliomyelitis	Baby is under observation	There may be diarrhea	None
Rotavirus vaccine 1	Antigen Vaccine	1.5milliliter	Orally	Immunity against rotavirus	Baby is under observation	Vomiting	None

WHO Modified Partograph



LABOR NOTES

Client reported to the ward at 5:00am with the complains of lower abdominal pain. On examination, Gestational age of 38 weeks, 4 days, SFH - 38cm, FHR - 132 bpm, Descent 3/5, Cervical dilation 4cm, BP - 100/60mmHg Respiration 22cm, Temperature 36.7°C, Pulse 60 bpm. At 11:45am, Client has Spontaneous Vaginal delivery to a live female Child with APGAR Score of 8/10 and 10/10. Birth weight of 3.1kg, Head Circumference of 34cm, Fetal Height of 44cm, placenta and membranes was delivered at 11:51am Mother and baby were Clean and Put in Comfortable bed.

Please circle or write responses.

DELIVERY

DATE: 4/12/2021 TIME: 11:45am METHOD: (Spontaneous) / Vacuum Extraction / C/S / Other

PERINEUM: (Intact) / Episiotomy / Laceration

ANESTHESIA: (None) / Local / General

THIRD STAGE

Active Management: (Yes) / No Medication: Time 11:46am Type/Dose 10 unit of oxytocin

PLACENTA: TIME: 11:51am (Complete) / Incomplete

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

BABY

Weight: 3.1 kg

Sex: Male / (Female)

Baby Position: (Vertex) / Breech / Other

APGAR

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

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

FOURTH STAGE MONITORING

Frequency	Time	B/P	Pulse	Fundus	Bleeding	Bladder
Every 15 minutes first 2 hours	12:6pm	100/60	69	18cm	(Moderate)	
	12:21pm	102/60	69			200 mls
	12:36pm	110/70	70			
	12:51pm	100/60	72			Empty
	1:6pm	110/60	75			
	1:21pm	100/60	88			Empty
	1:36pm	110/70	88			
	1:51pm	110/70	70			Empty
Every 30 minutes For 1 hour	2:21pm	110/70	70			
	2:51pm	100/60	80			100 mls

Birth Attendant Morgan Ant... Date 4/12/2021

MATERNITY CHART

NAME: Madam Mary Nyarko

AGE: 28 years WARD: Lying - In

IP NO.: 281 / 21 BED NO.: 3

Date	4/12/21	5/12/21	6/12/21	7/12/21	8/12/21	9/12/21	10/12/21	11/12/21
Days in Hospital	DOD	D1	D2	D3	D4	D5	D6	D7
Days P. O.								
Hour Am		10:45	9:5	9:15	5:00	8:00	8:15	8:40
Hour Pm	12:45	5:15	5:00	5:15				
Temperature C								
SFH cm								
Pulse	70	82	75	70	67	72	64	78
Resp.	19	21	21	22	19	19	20	19
B.M.	—	—	—	—	—	—	—	—
Urine	Passed	Passed	Passed	Passed	Passed	Passed	Passed	Passed
B. P. AM		100/60	100/60	110/60	110/60	100/60	110/60	110/60
B. P. PM								

43.1° 40.5° 40.0° 39.5° 39.0° 38.5° 38.0° 37.5° 37.2° 36.5° 36.0° 35.0°

106° 104° 102° 101° 100° 99° 98° 97° 96° 95° 94° 93°

KEY

TEMPERATURE

SYMPHYSIO-FUNDAL HEIGHT

SCALE 1cm - 1unit

NEW BORN EXAMINATION FORM

Name: Baby Ama Nyarko Date of Assessment: 4/12/2021 Time: 12:45pm
Date of Birth: 4/12/2021 Time of Birth: 11:45am Sex: ☐ M ☑ F Age at time of Assessment (days/hrs) 1 hr
Astational Age 38 weeks, 4 days Mode of Delivery: ☑ Vaginal Assisted Vaginal C-Section
APGAR: 1min 8/10 5min 10/10 Birth Weight: ☐ 3.1 kg ☐ Length: 44 cm Head Circumference: 34 cm
Temperature at time of Assessment: 36.9 °C Urine passed: Yes ✓ No Meconium passed: ✓ Yes No
Name of Assessor (Midwife/Doctor): Abigail Ants.

1. Respiration
Rate 44
☐ 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: 132bpm
☐ 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) Normal Baby.

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

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NEW BORN EXAMINATION FORM

Name: Baby Ama Nyarko Date of Assessment: 4/12/2024 Time: 7h

Date of Birth: 4/12/2024 Time of Birth: 11:45am Sex: ☐ M ☑ F Age at time of Assessment (days/hrs) 7h

Astational Age 38 ☐ wk 4 ☑ d Mode of Delivery: ☐ Vaginal Assisted Vaginal C-Section

APGAR: 1min 9/10 5min 10/10 Birth Weight: ☐ 3.1 kg ☐ Length: 44 cm Head Circumference: 34 cm

Temperature at time of Assessment: 36.9 °C Urine passed: Yes ✓ No Meconium passed: ✓ Yes No

Name of Assessor (Midwife/Doctor): Abigail Ants

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

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

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- ☐ Floppy *
- ☐ Increased *

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- ☑ Pink all over
- ☐ Pink body but blue hands/feet
- ☐ Blue all over *
- ☐ Pale *
- ☐ Jaundiced *

5. Cord
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7. Suck
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- ☐ Widely Separated *

10. Fontanel
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- ☐ 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: 134
- ☐ 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

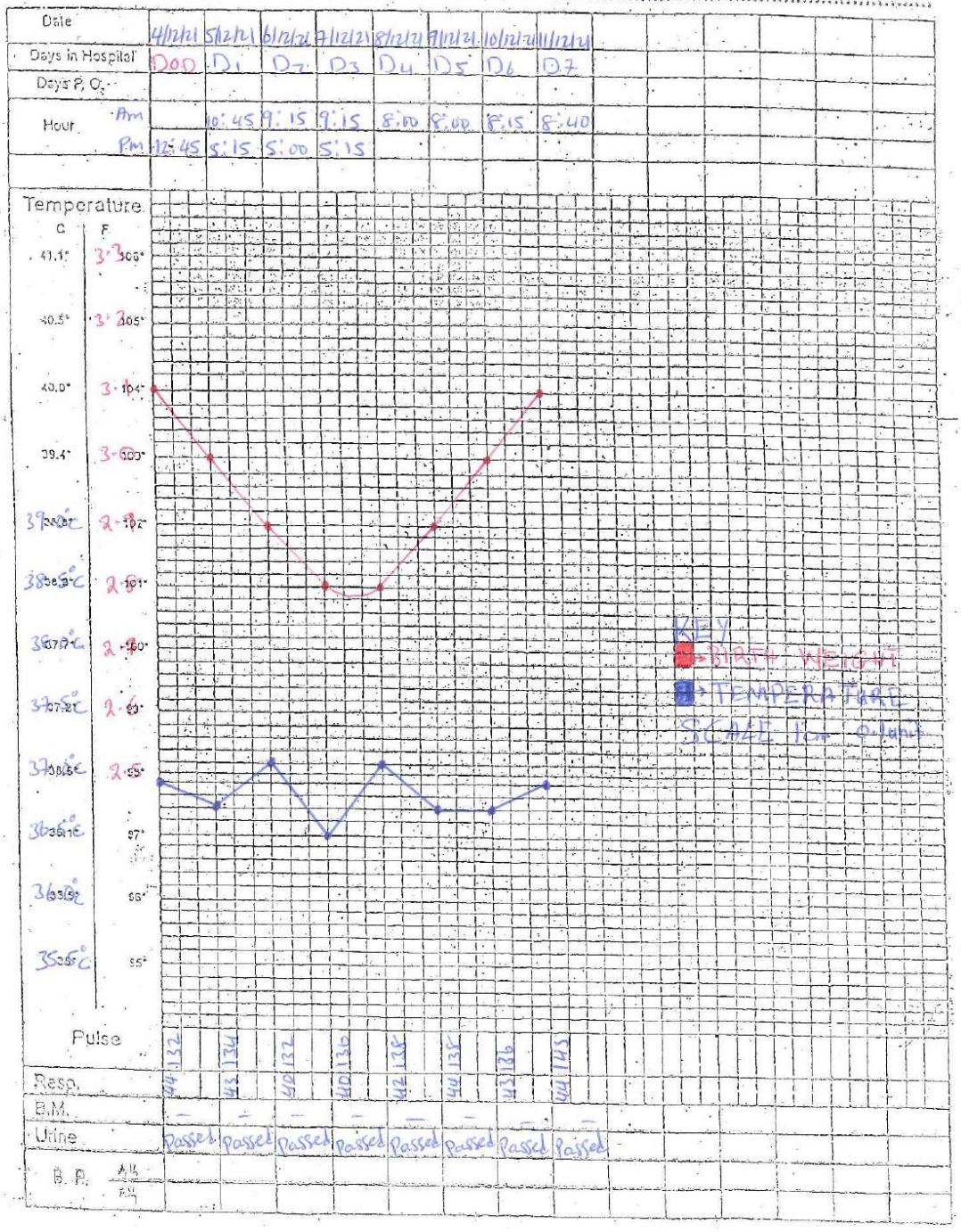
Plan: [ ] Routine Care[ ]Problem. Continue supportive in-patient care [ ] Urgent Referral / Advanced Care[✓] Discharge

TEMPERATURE CHART

NAME: Baby Ama Nyarko

AGE: New born WARD: Lying - in

IP NO.: 281/21 BED NO.: 3



NEW BORN CHART

ıme: Baby Ama Nyarko No: Birth Weight: 3.1kg

x: Female Mother's No: 281/21 Length:

ıture of Delivery: Spontaneous vaginal Delivery Diagnosis: Term baby

ıte of Birth: 4/12/2021 Time: 11:45am Date of Discharge: 5/12/2021

Date	4/12/2021		5/12/2021		6/12/2021		7/12/2021		8/12/2021		9/12/2021		10/12/2021		11/12/2021							
o. of Days	DOD		D1		D2		D3		D4		D5		D6		D7							
Weight	3.1kg		3.0kg		2.9kg		2.8kg		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
emperature	36.9°C	36.7°C	37.1°C	36.7°C	37.1°C	36.9°C	36.5°C	36.5°C	37.1°C		36.7°C		36.7°C		36.9°C							
Stools	Passed	Passed	Passed	Passed	Passed	Passed	Passed	Passed	Passed		Passed		Passed		Passed							
Urine	Passed	Passed	Passed	Passed	Passed	Passed	Passed	Passed	Passed		Passed		Passed		Passed							

emarks: Head, Trunk, Extremities, Genitalia — No Abnormality detected.

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SIGNATORIES

THE STUDENT MIDWIFE

NAME: MISS ANTI ABIGAIL

SIGNATURE: .....

DATE: 28/09/2022

THE MIDWIFE- INCHARGE (PENTECOST CLINIC, KASAPIN)

NAME: MRS. ACHIAA BERIKISU

SIGNATURE: ..... (fm)

DATE: 30/09/2022

THE SUPERVISOR

NAME: Ms Ernestina Mensah

SIGNATURE: .....

DATE: 04/10/2022

THE PRINCIPAL

NAME: MONICA NKRUMAH

SIGNATURE: ..... (fm)

DATE: 06/10/2022

ACADEMIC CO-ORDINATOR - NURSING
HOLY FAMILY NURSING & MIDWIFERY
TRAINING COLLEGE, ESAMANSIM

STAMP