HOLY FAMILY NURSING AND MIDWIFERY TRAINING COLLEGE

BEREKUM

A CLIENT/FAMILY CENTERED MATERNITY CARE STUDY ON

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BY

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SUBMITTED TO THE NURSING AND MIDWIFERY COUNCIL OF GHANA IN PARTIAL FULFILMENT TOWARDS THE AWARD OF LICENSE TO PRACTICE AS A PROFESSIONAL REGISTERED MIDWIFE.

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PREFACE

Client/Family centered maternity care study is a systematic way of administering midwifery care to a pregnant woman and her family throughout pregnancy, labour and puerperium. The Client/ Family Centered Maternity care study also helps the student midwife to use new trends in midwifery like the partograph which is recommended and tested by the World Health Organization (WHO) in the management of labour.

The active management of third stage of labour was also introduced to limit the occurrences of postpartum hemorrhage.

The Client/Family centered maternity care study helps the student midwife to put into practice the Safe Motherhood initiative which has been adopted in order to help reduce the maternal mortality among pregnant women to improve the quality of health care through antenatal, labour and postnatal periods.

The Client/Family centered care study is a required study that every final year student of Registered Midwifery programme is supposed to undertake to satisfy the Nursing and Midwifery Council to help contribute to the award of professional certificate in Registered Midwifery. To achieve these aims, the client, family and the community are all involved in the preparation towards the newborn. It is also necessary to establish good rapport, use a holistic care approach so that client's problems and minor disorders are solved through education, counseling and early measures taken to prevent complication.

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INTRODUCTION

The Client/ Family centered maternity care study was carried out on Madam Fuseini Ayisheitu, 26 years old, Gravida 2 Para 1, who was nursed during the community midwifery practical experience at Derma Health Center during pregnancy, labour and puerperium. Madam Fuseini Ayisheitu was first met on the 1st November, 2021 when she came for antenatal follow up. She was in good health.

Introduction was made to client and permission was sought if she could be used for the study which she accepted without reluctance. She was visited at home to assess her environment and community in which she lives. For the purpose of this study, Madam Fuseini Ayisheitu will be used throughout the study.

Madam Fuseini Ayisheitu problems identified during pregnancy, labour and puerperium were managed by the use of the nursing process. She delivered a healthy baby boy safely and managed properly during puerperium without any complication.

There are four (4) chapters outlined in this script that helped in caring for the mother and the baby.Chapter Onetalks about client's particulars and various histories.Chapter Two; outlines the care given to the client during antenatal period and home visits made to her residence. Chapter Three**;** is the care given to the client during labour and its management. Chapter Four**;** entails the care given to client during puerperium.

The various histories taken and care given to client is to establish rapport and mutual relationship between the client and family so that client can voice out her sentiments without restraint and go through her pregnancy, labour and puerperium safely without complication.

A care plan was drawn to identify problems and management given with the use of nursing process at the end of each chapter. Summary and conclusion, bibliography, signatories as well as various appendices like antenatal records, laboratory records, postnatal and pharmacology of drugs are all included.

LITERATURE REVIEW

PREGNANCY

According to Marshall andRaynor(2014), indicated that the pregnancy starts from the time conception is confirmed until the beginning of labour and also the midwife facilitates woman-centered care by providing her with accessible and relevant information to help her make an informed choice throughout pregnancy.

This book went on further to say that the aim of antenatal care is to monitor the progress of pregnancy optimize maternal and fetal health. To achieve this, the midwife critically evaluates the physical, psychological and sociological effects of pregnancy on the woman and her family. The key principles of antenatal care by the midwife:

1. Providing a holistic approach to the woman' care that meets her individual needs.
2. Recognizing complications of pregnancy and appropriately referring women to the obstetric team or relevant health professionals or other organizations.
3. Facilitating the woman and her family in preparing to meet the demands of birth, and making a birth plan.
4. Offering parenthood education within a planned programme or on an individual basis.

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

Myles (2014) 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 certain hormones namely estrogen and progesterone. These hormones are responsible for the major changes that takes 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 solely on the mother for survival when in utero. According to Myles (2014) variety of care that are rendered to the expectant mothers and their entire families include history taking, physical examination (head to examination and abdominal examination i.e. inspection , palpation and auscultation),laboratory investigation(urine, blood and stool),administration of routine drugs(folic acid, ferrous sulphate and multivitamins).According to Myles (2014),the anatomical and physiological change in the uterus plays an essential role in pregnancy by protecting and supporting the fetus, placenta and amniotic fluid. At the time of labour it is able to contract regularly and forcibly to expel the fetus due to its unique properties of contractility and elasticity.

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

Konar(2013) defined pregnancy as the development of growing foetus in uterus. Konar further explains that the duration of pregnancy has traditionally been calculated by the clinician in terms of 10 lunar months or 9 calendar months and 7days or 280 days or 40wks calculated from first day of the last menstrual period. This is called menstrual or gestational age. He further explains that the period of pregnancy is divided into 3 sets of months. The first 3months is known as first trimester (conception to first 12wks). The next 3 months following the first is the second trimester (13- 28wks) while the last 3 months is known as the 3rd trimester (29-40 wks.).

LABOUR

According toMyles (2014) stated that, labour purely is the physical sense, may be described as the process by which the foetus, placenta and membranes are expelled through the birth canal. Labour has four stages. Stage one compromises of latent phase and may be last 6 to 8 hours in prim gravida when the cervix dilates from 1cm to 4cm. The active phase within the first stage is when the cervix usually undergoes more rapid dilatation. This begins when the cervix is 4cm dilated and in the presence of rhythmic contractions, progressively dilates to 10cm or full dilatation, second stage of labour is the expulsion of the foetus. It begins when the cervix is fully dilated and the woman has the urge to expel the baby. There is stretching of the clitoris, gaping of the anus and bulging of the perineum. Labour completes when baby is born. In multigravida women, it last 15-30 minutes whiles in prim gravida women. The fourth stage is a period of careful observation of the mother made to assess excessive bleeding and the firmness of the contracting uterus immediately after the third stage of labour and it last six hours after delivery of the placenta.

According toMarie (2013) defined labour as a series of events that takes place in the genital organs in effort to expel the viable products of conception out of the womb through the vagina into the outer world. Labour is called normal if it fulfills the following criteria;

1. Spontaneous in onset

2. with vertex presentation

3. without undue prolongation

4. Natural termination with minimal aids

5. Without having any complication affecting the health of the mother and/ or the baby

The features of true labour signs are:

1. Painful uterine contraction at regular intervals
2. Appearance of bloody slimy fluid ‘’Show’’
3. Progressive effacement and dilatation of the cervix
4. Formation of the’’ bag of waters’’

The events of labour are divided into four stages; first, second, third and fourth stage. First stage starts from the onset of true labour pain and ends with full dilatation of the cervix. Its average duration is 6 hours in multipara. Second stage starts from full dilatation of the cervix and ends with expulsion of the foetus from the birth canal. Third stage begins after the expulsion of foetus and ends with the expulsion of the placenta and membranes (afterbirth). Average duration is about 15 minutes in both multi and prim gravida. Fourth stage is the stage of observation after

expulsion of the afterbirth. Four factors are significant in the process of labour; that is the pelvis, passenger, powers and psyche. These are known as the four P's.

According to Marshall andRaynor(2014) stated that the onset of labour is a process; not an event; therefore, it is very difficult to identify exactly when the painless (sometimes painful) contraction of pre labour develop into progressive rhythmic contractions of established labour. Diagnosing the onset of labour is extremely important, since it is on basis of this finding that decisions are made that will affect the intrapartum care and support subsequently. Konar (2013) defined labour as series of events that takes place in the genital organs in an effort to expel the viable products of conception out of the womb through the vagina into the outer world. The onset of labour is determined by a complex interaction of maternal and fetal hormones and is not fully understood. It would appear to be multifactorial in origin, being a combination of hormonal and mechanical factors. Levels of maternal estrogen rise sharply during the last weeks of pregnancy, resulting in changes that overcome the inhibiting effects of progesterone. High levels of estrogen cause uterine muscle fibres to display oxytoxic receptors and form gap junctions with each other. Estrogen also stimulates the placenta to release prostaglandins that induce a production of enzymes that will digest collagen in the cervix, helping it to soften.

Varneys (2014) described the onset of labour 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 labour. There are four stages of labour that has being established; the first, second third and fourth stages. The first stage of labour 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 labour 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 labour and partograph recording. The second stage of labour begins with the expulsion of the foetus from the birth canal, it starts when the cervix is fully dilated and the woman has the urge to expel the foetus and ends when the foetus is born. The third stage of labour is the complete expulsion of the placenta and its membranes as well as the arrest of hemorrhage. The fourth stage of labour is 6 hours after the delivery of the placenta and membranes and continues with close monitoring of the client and baby.

Tiran (2008) defined labour as the process by which product of conception are expelled from the uterus through the birth canal. She continued that labour 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 or artificial stimulation until baby, placenta and membranes have completely expelled by the maternal effort through the vagina.

Labour, according to Frazer and Copper(2009) is a process by which the fetus, placenta and membranes are expelled through the birth canal and this labour is divided into four stages; the first stage of labour is the period of onset of regular uterine contraction till full dilatation of the cervical os and it last 12-14 hours in the prim gravida woman and 6-12 hours in the multiparous woman. The second stage of labour is from the full dilatation of the cervical os which is 10cm up to complete expulsion of the fetus. The third stage of labour also starts from the separation and expulsion of the placenta and membranes and subsequent control of hemorrhage. It usually last within 5-15 minutes after the birth of the infant. The fourth stage of labour is the six

hours'vigilant observation of the mother and the baby. It also deals with the establishment of lactation and detection of abnormalities and any complication in both mother and baby.

PUERPERIUM

Marshall andRaynor (2014) stated that puerperium starts immediately after the delivery of the placenta membrane and continues for six (6) weeks. In many cultures around the world 40 days for recuperation is a time-honored practice. The general expectation is that by six weeks after birth all the systems in a woman's body will have recovered sufficiently from the effects of the pregnancy and recovered to their non-pregnancy state.

Ojoand Briggs (2006) stated that puerperium is a period of six weeks of delivery when the uterus and other organs of the reproductive system return to its pre pregnant state. During puerperium, the puerperal woman regains her strength that was lost during labour. During this period, care of the new born baby and lactation are established.According to Marie (2013) puerperium is the period following childbirth during which the body tissues, especially the pelvic organs revert back approximately to the pre-pregnant state both anatomically and physiologically. The period is divided into;

1. Immediate –within 24 hours
2. Early- up to 7 days
3. Remote –up to 6 weeks
4. 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 to

fingers for the few days but by the end of the first week, narrows down to admit the tip of a finger only. The external os never revert back to the nulliparous state. Marie Elizabeth further explains that during puerperium 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:

1. Lochia rubra (red) 1 -4 days.
2. Lochia serosa (yellowish or pink or pale brownish) 5- 9 days.
3. Lochia alba (palewhite) 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.

Varney's **(**2014) defined puerperium as when there is a delivery of the placenta and membranes, and when the woman begins the physiologic transition to the non-pregnant state lasting for 6 weeks. By the 6 weeks most women have completed the last of the physiologic transitions; uterine involution is complete, lochia has ceased and laceration is well established.

Ojo and Briggs (2006), described labour as the painful, rhythmic uterine contractions. Labour is divided into four stages for descriptive purposes. The first stage of labour is the period from onset of regular rhythmic uterine contraction to full dilatation of the cervical os. It last for 12 to 14 hours in prim gravida and 6 to 12 hours in multigravida. The second stage of labour starts from full dilatation of the cervix to the complete expulsion of the foetus. It last about 1 hour in prim gravida and 5 to 40 minutes in a multigravida. The third stage of labour entails complete expulsion of placenta and its membranes usually within 5 to 15 minutes. The fourth stage of labour is 6 hours after the delivery of the placenta and membranes and close monitoring of the client and baby

Myles (2009) stated that puerperium starts immediately after the delivery of the placenta and membranes and continues for six weeks after which all the system in the woman's body will recover from the effects of pregnancy and return to their non- pregnant state. Myles also strikes the difference 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.

WHY CLIENT WAS CHOSEN

As required by the Nursing and Midwifery Council of Ghana every student midwife must undertake the client/family centered maternity care study to help contribute to the award of professional certificate in Registered midwifery, the client should fall under the normal criteria, that is; the woman should have delivered at least one and at most three with no complications during pregnancy, labour and puerperium. She should have regular antenatal attendance record and should be a woman whose labour presumably will be uneventful.

Madam Fuseini Ayisheitu G2P1 reported to the antenatal clinic on the 1st November, 2021 and she complained of waist pains. She explained that her previous pregnancy was not like that. Client was educated that it is due to the descent of fetal head into pelvis that is causing the waist pains. Enquiries were made from her after glancing through her Antenatal record book, and she qualified to be used for the study. Opportunity was taken for introduction as a student midwife from Holy Family Nursing and Midwifery Training College, Berekum on Community midwifery practical experience for a period of six weeks. Permission was sought from her if she could be used for the study. She agreed and was told to share her problems.

The midwife in-charge was informed and permission was granted.

CHAPTER ONE

CLIENT'S PARTICULARS

1.0 INTRODUCTION

This chapter is about assessment of the client and her family, which involves gathering of data from the client and her family. Information was acquired through observation, interview, medical records and antenatal records. This information helps the student midwife to provide holistic care for the client and her family taking into consideration the physical, psychological and spiritual needs.

1.1 PERSONAL AND SOCIAL HISTORY

MadamAyisheitu gravida 2 para 1 is a 26-year-old woman who stays and comes from Derma in Ahafo Region. Her house number is A16. She weighs 52 kilograms and she is about 158 centimeters tall and is dark in complexion. She is a Muslim and had her primary school at Derma Presbyterian school. Madam Ayiseitu does not smoke cigarette nor drink alcohol. Client had her educational level up to Primary School. She is a weaver and at the same time farmer. Client married to Mr. Fuseini who is 32 years of age and a Farmer too. Client lives in her own house with the husband at, a suburb in Derma. Client made it known that her child was staying with the grandparent. Madam Ayisheitu mentioned that, her mother is her next of kin. Madam Ayisheitu and her husband are both fluent in Twi and Dagati.

1.2 FAMILY HISTORY

Madam Ayisheitu is born to Mr. and Mrs. Fuseini. Both are from the Upper East Region but do not stays there. Client is the last born of four (4) siblings. According to client there are no known histories of hypertension, heart disease, sickle cell disease, diabetes mellitus, liver cirrhosis, epilepsy and mental illness in her family. She also added that, there are no known congenital abnormalities such as missing digits, extra digits, cleft palate, cleft lip, imperforate anus and spinal bifida in the family. Client stated that herself and family seek for medical treatment and include prayers whenever they are not feeling well. There are no multiple pregnancies present in the family and She said all her family members who passed away died naturally.

1.3 MEDICAL HISTORY

According to Madam Ayisheitu, she never had any chronic illness, like hypertension, heart disease, sickle cell disease, diabetes mellitus, measles, liver cirrhosis, respiratory disorder, tuberculosis, epilepsy, anaemia and any mental illness. She has not undergone any surgical procedure but only said she sometimes suffers minor headache which she visits the clinic immediately to seek for medical treatment at OPD basis. client has no known allergy to food or any drug.

1.4 SURGICAL HISTORY

Madam AyishetuSaid she has never undergone any surgical procedure. She also mentioned that she has never sustained any injury or road traffic accident that called for any abdominal or spine surgery or affected her pelvis or subsequent effect on pregnancy and labour. On examination, there was no scar indicating previous laparotomy such as caesarean section or appendectomy. She has neither received blood transfusion nor donated before.

1.5 MENSTRUAL HISTORY

Madam Ayisheitu said she had her menarche at the age of 17 and her menses lasts for 6 days during every month. She said the colour of her menstrual blood was dark red and has 28 days' menstrual cycle. She also said that she changes her pad twice daily and when soaked as well, indicating she has normal menstrual flow. Her last menstrual period was 17th March, 2021 and her expected day of delivery was calculated as 24th December, 2021.

1.6 HOBBIES AND LIFESTYLE

Madam Ayisheitu is a woman who sleeps at 10:00pm and wakes up at 5:30am. She said that when she wakes up in the morning, she does her morning prayers with the family. After that, she brushes her teeth, sweeps her room and compound, throw her rubbish away at the dumpsite, which is two minutes' walk away from her house. Client expressed that she normally prepares breakfast for the family. After preparing breakfast, she takes her bath and heads towards farm or start weaving. She mentioned that, she likes singing and dancing very much andsaid she prefers tuozaafiwith ayoyo soup and meat to other foods.

Client said she eats three times daily, but ever since she became pregnant she eats on demand. She also said that she prepares supper at 4:00pm and enjoyed it with her family. Madam Ayisheitu said she normally engages herself in a family chat with her family on phone every night as a means of strengthening their family bond. She also mentioned that she empty's her bowel when she feels the urge to do so and voids frequently when she takes in enough fluid.

1.7 PAST OBSTETRIC HISTORY

Pregnancy

Madam Ayisheitu gravida 2 para 1 went through her pregnancy successfully without any complication. She had her previous pregnancy in the year 2016. According to client giving birth with a five (5) years interval is something being planned by the couple. Madam said during her previous pregnancy, she only experienced some minor disorders such as headache, backache, waist pain, lower abdominal pain and many more. which she reported to the clinic and they were explained to her as a normal physiological changes in pregnancy which would resolve as pregnancy progresses. She also said she has never had any spontaneous or induced abortion and still birth in her life. She delivered her child at term. She has never suffered any pregnancy induced condition like gestational diabetes and pregnancy induce hypertension (pre-eclampsia). She also visited antenatal clinic for at least five (5) times during her previous pregnancy and received all doses of sulphadoxinepyrimethamineand three doses of diphtheria injection.

Labour

Madam Ayisheitu delivered her child spontaneously per vagina at the health center. She further stated that the duration for her delivery did not exceed 18 hours. Clients child was delivered at Derma health center, that was a male and weighed 2.9kg at birth from records. She also said she has never had any perineal tear or been given episiotomy during her previous delivery. She added that she had never experienced post-partum haemorrhage. Her placenta was delivered completely with no retained product of conception. She said her estimated blood loss for

herprevious delivery was moderate. Her child had no birth injuries, asphyxia or jaundice. He was active at birth and healthy.

Puerperium

Client said she started breastfeeding him within the first hour after birth and practiced exclusive breastfeeding for 6months and then added complementary feeds after the 6months for one and half years. She had a safe breastfeeding with no complication. She added that her child did not have any abnormalities like cleft lip, extra digits or webbed digits. Her child was fully immunized against the vaccine preventable diseases according to schedules. Her child never suffered any illness. She herself did not experience any illness such as puerperal psychosis, anaemia and malaria. She also did not experience problems like post-partum haemorrhage, puerperal pyrexia, puerperal sepsis, mastitis among others. In relation to family planning, she uses the natural family planning method. She also stated that her family and husband supported her in taking care of her baby and some of the household chores.

1.8 PRESENT OBSTETRIC HISTORY

Madam Ayishetu first visited the clinic on 7th May, 2021. Her gestational age was 11^{+2} weeksher last normal menstrual period was 17th March, 2021 and her expected date of delivery was calculated as 24thDecember, 2021. On scan, Madam Ayisheitus expected date of delivery as 5thDecember, 2021. Her vital signs, weight and laboratory investigations on that day were as follows:

Temperature…….. 36.0˚C

Pulse…….. 82bpm

Respiration…… 20bpm

Blood pressure …….110/70mmHg

Weight ……. 50kg

Height …….. 158cm

Symphysiofundal height.....None Palpable

Lab investigations

Haemoglobin level	12.3g/dl
Sickling	Negative (-)
Blood group	AB
Rhesus factor	Positive (+)
Urine for pregnancy test	Positive (+)
HIV	Negative (-)
HEP-B	Negative (–)
VDRL	Non-reactive

Protein in urine ……. Negative (–)

Glucose in urine…… Negative (-)

G6PD……. No Defect

Stool for routine examination indicated no abnormality.

On examination (head to toe), no abnormality was detected. Pelvis was adequate and education on danger signs was given. Madam Ayishetu complain of headaches was educated on the need to attend antenatal clinic regularly. She was put on the following drugs and was scheduled for the next visit.

1. Tab multivitamins 200mg daily x 30

2. Tab folic acid 5mg daily x 30

3. Tab ferrous sulfate 200mg bd daily for 30 days

4. Tab paracetamol 1g tid for 3 days

Her antenatal card revealed that she had visited the clinic eight times. She visited the clinic on a four-week basis and her major complaints were lower abdominal pains, headache and waist pains. She was given routine drugs and paracetamol for the complaints she made.

She was given various education anytime she visited the clinic.

CHAPTER TWO

2.0 INTRODUCTION

Antenatal care refers to care given to a pregnant woman from the time conception is confirmed until the beginning of labour. Basically, this chapter deals with the first encounter with the client, during first and second home visit, client's subsequent visits to the antenatal clinic, subsequent antenatal home visits as well as the nursing care plandrawn for the problem identified.

ANTENATAL CARE

2.1 FIRST CONTACT WITH CLIENT

Madam Ayisheitu for the first time on Monday 1st November, 2021 when she was 36^{+1} weeks pregnant and it was her seventh visit to the antenatal clinic at Derma Health Center around 10:30am. Introduction was made as a student midwife from Nursing and Midwifery Training College, Berekum, who has been stationed at Derma Health Center for six weeks clinical and to write a care study on a chosen client. The desire to take her as a client was expressed to her and she agreed. All the procedures to be carried out on her were explained to her understanding and she agreed for them to be done. Client complained of waist pains and further explained that she has never experienced it before in her previous pregnancy. Client was advised that every pregnancy comes with a different experience hence she should try and cope with it. Her vital signs, weight together with some laboratory investigations were checked and recorded as

Mother

Temperature	36.4˚C
Pulse	84bpm
Respiration	22cpm

Blood pressure	115/71 mmHg
Weight	55 kg
Hemoglobin level	13.0 g/dl

Urine testing

Specimen bottle was given to Madam Ayisheitu to collect urine to be checked for the presence of protein and glucose by the use of a urine reagent strip. It was explained to her that midstream urine was needed. The urine collected was checked for colour, sediments and blood products but none were present. It was smelt for bad odour but there was none. The strip was then dipped into the urine and removed immediately. The edge of the strip was tapped against the side of the urine container. It was then compared with the reagent bottle colour chat. The result for both protein and glucose were negative. Hands were washed with soap under running water and dried with a clean towel. Results were recorded in the antenatal book.

Head-to-toe examination

Head and neck

Client hair was neatly braided. Lice and dandruff were absent on the scalp. There was no edema and rashes on the face or the eyelids. The sclera was checked for jaundice and the conjunctiva for pallor but none was detected. The nose and the ears were examined for pain and discharge but none was present. The lips were examined for dryness, pallor, sore and cracks but none was detected. There was absence of halitosis, the gum was inspected for bleeding which was absent

and the tongue was neither pale nor coated. The neck was inspected and palpated for enlarged lymph nodes and distended veins but none was present.

Breast examination

Both breasts were exposed and inspected for the size and shape and the condition of the skin. One breast was covered and she was asked to put the hand of the part to be examined under her head. The breast was palpated thoroughly in a circular manner with the inner aspect of the fingers and there were no masses, lump, cracks or sore nipple. The areola was squeezed gently cleaned with dry cotton wool swab to examine if there is any abnormal discharge like pus and blood. Same procedure was performed on the other breast and no abnormality was detected. Client was educated and taught how to perform self-breast examination.

Extremities

Client upper extremities were examined for equality, edema of the finger and pallor of the palms and no abnormality was detected. The lower extremities were also examined for edema, equality, tenderness in the calf muscle and varicose veins but none was detected.

Back

The back was examined for spinal or vertebrae abnormalities and sacral edema but none was detected.

Abdominal Examination

Inspection; the abdomen was medium in size and ovoid in shape. Linear nigra,scars and straiae-gravidarum were absent.

Measurement of the Symphysiofundal height; the Symphysiofundal height is measured in centimeters and a measuring tape is used in taking the measurement. The zero end of the tape measure was placed on the fundus of the uterus and was extended to the upper boarder of the symphysis pubis and the Symphysiofundal height was obtained 36 centimeters. Gestational age was 36+1

On fundal palpation; the palms were first rubbed together to prevent induced contractions. Standing at the right hand side of the woman and facing the head of the woman, the fundus was palpated with both palms and the buttocks of the fetus were felt occupying the upper pole of the uterus. The fundus was at the xiphisternum.

On lateral palpation; one hand was used to stabilize one side of the maternal uterus and the other hand was moved gently in a circular manner at the right side of the abdomen and the fetal limbs were palpated which were rough. This was repeated at the left side of the abdomen and the foetal back was felt.

On pelvic palpation; the lower limbs of the client were faced, both hands were placed closely together and pointing downwards and inwards below the umbilicus, the presentation was cephalic and the lie was longitudinal with left occipito-anterior as fontal position.

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

On Auscultation; A fetoscope was rubbed in the palms to make it warmed and was placed at the area where the back was located to listen to the fetalheartbeat. Whiles listening to the heart beat, one hand was placed at the maternal radial pulse area to ensure that it's not the maternal pulse being listened to. The fetal heart rate was checked for one minute and recorded as 145 beat per minute.

Vulva examination

Permission was sought to inspect the genital area and she agreed. Hands were washed with soap and water and dried with a clean towel. Gloves were worn. The vulva was inspected for edema, scar, genital warts, rashes, ulcer of the vulva, discharges and varicose veins but none was present. The mons pubis was well shaved. Client was encouraged to continue practicing good vulva hygiene. Client was asked to assume lateral position and sit up before getting out of bed. Hand washing was done and dried with clean dry towel. All findings were recorded in client's antenatal book and communicated to her. Client was advised on good nutrition and exercise. She was asked not to lift heavy objects and avoid prolonged standing. She was advised to have enough rest and sleep Client was asked to continue routine drugs and since she complained of waist pains she was given paracetamol. Tablet paracetamol 1gram tds x 3. She was reminded of her date of appointment which was 8thNovember 2021 if she has not delivered. Client was asked to report to the clinic if any abnormality was observed. Appointment for home visit was scheduled for 2nd November, 2021. Direction to her house was taken and permission was sought

from the Midwife-in-charge to follow client to her house and it was granted. Client was escorted closely to her house and a landmark was shown for further directions to her house.

2.2 FIRST ANTENATAL HOME VISITS

The first visit to Madam Ayisheitu house was on 2nd November 2021 at 11:00 am, which was on Tuesday. The journey was easy because her house was closer to the clinic. The main landmark to her house is right behind the Alive guest house. The aim of the visit was to observe the environment where she lives, her source of water and light, the number of people she shares her room with, where she attends natures call (toilet), how she disposes off her refuse and also how she relates with her family members and her neighbours.

2.3 PHYSICAL ENVIRONMENT

On arrival, it was realized that Madam Ayisheitu lives with her husband. A warmly welcomed was given and a seat was offered in her room and also water to drink which she was thanked for that. Client was asked how, herself and husband were faring which she responded they were all fine. She was asked whether she was doing something but the response was no so conversation started. During our interaction, it was identified that she lives in a single room with her husband.

The room was well kept and the furniture neatly arranged, it had adequate lightening, the windows were well arranged for proper ventilation and she was congratulated and asked to keep it up. Again she was asked whether she sleeps under an insecticide treated bed net and she said yes. She was again educated on the importance of sleeping under an insecticide treated net.

Madam Ayisheitu had a kitchen. The kitchen was neatly kept; she has a kitchen cupboard in which she had neatly arranged her utensils. There were no dirty dishes found in the kitchen. Her toilet and bathroom was well kept because she scrubs every day. A dustbin with a well-fitting lid

was seen outside the house which she said she empties it every morning into the public refuse dump which is some few matters away from their house. Client fetches water from the next house.

Madam Ayisheitu was educated on the importance of maintaining good personal hygiene and encouraged to continue with her medication. She was asked to bring her layette and was inspected, everything was intact as thought and she was congratulated on that. She was asked to nominate a companion to help her when her time is due and was educated on complication readiness that is to get the contact of a taxi driver. She was asked whether she had any complaint that day and she complained of headache, heartburns which was explained to her as a result of not taking enough rest and was educated to minimize the rate of doing house chores and take a time to relax and heart burns due to the relaxation of the cardiac sphincter of the stomach causing reflux of acidic contents of the stomach into the lower esophagus and was educated to minimize the intake of spicy food, stay away from nauseated things and eat in bit. She was made aware that it was a normal physiology which will resolve after delivery. She was thanked and permission as sought to leave. She was informed about the next visit to be 8th November, 2021

2.4 PSYCHOSOCIAL

Madam Ayisheitu and her family have cordial relationship with each other. Madam Ayisheitu has a warm and friendly relationship with the tenants and other family members staying around the house and neighbors. Her friends most at times visit her and she also visit them at her leisure time. Madam Ayishetu introduced me to her neighbors. She is also a leader of women followership at her church and also attends all social gathering such as naming ceremonies, funerals. She has respect for all manner of people and likes to make new friends. Madam

Ayisheitu was encourage to keep it up.

2.5 SECOND ANTENATAL HOME VISIT

The second home visit to Madam Ayisheitu's house was on the 8thNovember, 2021 at 3:30pm. She was met in the house chatting with some of her relatives who had visited her. They were greeted and a warm welcome was given and a seat offered. The wellbeing of the family was inquired and she said they were all doing well by God's grace. The aim of the visit was to inquire about her health whether some changes have been made on how to keep and arrange her bedroom well and neat. Client was asked about her previous complains and she said was better now. She was asked to make her layette ready and have a purse with her insurance card and money in it. The client was educated on birth preparedness and complication readiness that is, client should contact a taxi driver in case of emergency and get a blood donor. She was then congratulated and asked to keep it up. Education on rest and sleep as well as true labour signs were given to her and she was told to report to the clinic anytime she sees any of the signs. She was also encouraged to arrange with a taxi driver who would take her to the hospital when in labour. She was allowed to ask questions and appropriate answers were given. She complained of waist pain. The physiology was explained to her as a result of the increasing weight of the gravid uterus and the effect of hormone relaxationjoint, then she was educated on true sign of labour such as appearance of show, regular rhythmic contractions anytime she experiences that she should not hesitate to come to the heath facility. Permission was sought to leave, she was thanked and reminded of her next visit to the clinic.

2.6 SUBSEQUENT VISIT TO THE CLINIC BY CLIENT

Madam Ayisheitu visited the clinic on 15thNovember, 2021. She was welcomed and given a chair to sit. An enquiry was made about her health and that of the family and she said they are all doing well. Madam Ayisheitu's previous complain was asked and she said she was doing well.

Madam Ayisheitu's health was enquired and she complained of constipation and backache. It was explained to her that the backache is due to the pressure exerted by the growing foetus on the sacral nerves. She was encouraged to take in more fluid and fruits to aid in bowel movement to manage constipation. Client was examined from head to toe and no abnormality was detected. Vital signs and other observation were checked and recorded as follows;

MOTHER

Observation

Temperature	36.4c
Pulse	82bpm
Respiration	20cpm
Blood pressure	102\62mmHg
Weight	56kg
Symphysiofundal height	37cm
Descent	5/5th
Fetal heart rate	148bpm

Urine was tested for protein and glucose which tested negative.

Client was advised to take in food rich in vitamins, minerals and proteins. She was also advised to take in enough fruits that contains roughages and was encouraged to take in more fluid. She was educated on perineal hygiene and encouraged to take in her routine drugs. She was accompanied to the road side and was bid farewell.

2.7 NURSING CARE PLAN

PROBLEMS IDENTIFIED

Client complained of;

1 1 /11/21waist pains

2 8/11/21 headache

3 15/11/21 heart burns

4 22/11/21 constipation

5 29/11/21 backache

SHORT TERM OBJECTIVES

1. Madam Ayisheitu's waist pains will resolve within 24 hours.
2. Client's headache will resolve within 24 hours
3. Client heart burns will subside within 24 hours
4. Client will regain bowel movement once a day within 48 hours.
5. Madam Ayisheitu's backache will reduce within and 24 hours.

LONG TERM OBJECTIVES

Madam Ayisheitu will be healthy throughout pregnancy, labour and puerperium without any complications to both baby mother

NURSING CARE PLAN

Date /Time	Nursing Diagnosis	Nursing Objectives/ Outcome Criteria	Nursing Orders	Nursing Intervention	Date/ Time	Evaluation	Sign
1/11/21 At 9:30am	Waist pains related to the effects of pregnancy hormones on the musculoskeletal system	Madam Ayisheitu's waist pains will resolve within 48 hours as evidenced by: 1. Client verbalized that her waist pains have resolved 2. Midwife observes client perform daily activities without complains of waist pains.	1 Reassure client to allay anxiety. 2. Encourage client to assume proper body mechanic when lifting. 3. Encourage client to rest in between activities 4. Encourage client to wear low heel sandals. 5. Encourage client to take prescribed analgesics.	1. Client was reassured that the pain is temporal and hence will resolve. 2. Client was encouraged to bend from knee instead of waist. 3. Client was encouraged to take at least two hours' rest during the day. 4. Client was encouraging to wear low heel sandals 5. Tablet Paracetamol 1g tid was served as prescribed.	3/11/21 At 9;30 am	Goals fully met as client verbalized that she no longer feels the waist pain.	Y.E

NURSING CARE PLAN CONTINUE

Date/ Time	**Nursing Diagnosis**	**Nursing Objectives/ Outcome Criteria**	**Nursing Orders**	**Nursing Intervention**	**Date/Time**	**Evaluation**	**Sign**
8/11/21 At 10:00am	Headache related to stress from her occupation	Client's headache will reduce within 24 hours as evidence by 1.Client verbalizing that the pain has resolved 3. Client's sistertestify; client is able to do some daily activities such as sweeping	1.Reassure client 2. Advise client to have enough rest in between activities 3. Check vital signs 4. Encourage client to have enough sleep 5.Administer prescribed analgesics (paracetamol	1. Client was reassured that the headache would resolve within 24 hours. 2. She was advised to have enough rest because the headache was as a result of tiredness. 3.Vital signs were checked to rule out hyperthermia 4. Client was encouraged to have enough sleep and to sleep early. 5. Tab paracetamol 1g was given three times a day	9/11/21 At 10:00am	Goal met as client was relieved of headache	**YE**

			1gram)				
Date /Time	**Nursing Diagnosis**	**Nursing Objectives/ Outcome Criteria**	**Nursing Orders**	**Nursing Intervention**	**Date/ Time**	**Evaluation**	**Sign**
1 5 / 1 1 / 2 1 A t 11:00am	Heart burns related to the relaxation of the cardiac sphincter causing reflux of acidic contents of the stomach into the lower esophagus	Client's heartburns will resolve within 24 hours as evidenced by. 1. Client verbalizing that the burning sensation in her chest has resolved. 2. Midwife visualizing that client expressed no sign of burning sensation.	1. Educate client on the physiology of heart burns 2.Encourage client to eat dry foods. 3.Encourage client to relax for 2 hours before going to bed after eating 4. Educate client to eat in bit by bit. 5.Serve prescribed antacids.	1. Client was told it was caused by relaxation of the cardiac sphincter of the GIT due to the effect of progesterone 2. Client was encouraged to eat foods like biscuits and roasted foods 3.Client was encouraged to relax for at least two hours before going to bed. 4.Client was encouraged to eat at least two hours earlier than she used to. 5. Aluminum hydroxide	16/11/21 At 11:00am	Goal met as client reported that the intensity of heartburns is reduced	YE

				served 10mls tid 7 days			

TABLE 1: NURSING CARE PLAN

Date /Time	**Nursing Diagnosis**	**Nursing Objectives/ Outcome Criteria**	**Nursing Orders**	**Nursing Intervention**	**Date/Time**	**Evaluation**	**Sign**
22/11/21 At 9:00am	Constipation related to inadequate fiber intake.	1.Madam Ayisheitu will regain her normal bowel movement once a day within 48 hours as evidenced by 1. Client verbalizing that she has no difficulty in emptying her bowel.	1. Reassure client. 2. Encourage client to take at least 8 cups of water. 3. Encourage client to take in fruit and vegetables. 4. Encourage client to take at least about 500mls of fluids on empty stomach preferably in the	1. Client was reassured on free bowel movement 2. Client was encouraged to take at least 8 cups of water daily 3. Client was educated to take in fresh fruit and vegetables e.g. Kontomire, orange etc. 4. Client was encouraged to drink at least 500mls of warm or cold fluids on empty stomach preferably in	24/11/21 At 9:00am	Goal fully met as client verbalized that she empties her bowel once daily.	YE

		2. Midwife observing client has empty her bowe	morning. 5. Advice client on active exercise.	the morning. 5. Client walked around as a form of exercise.			

TABLE 1: NURSING CARE PLAN

Date /Time	**Nursing Diagnosis**	**Nursing Objectives/ Outcome Criteria**	**Nursing Orders**	**Nursing Intervention**	**Date/Time**	**Evaluation**	**Sign**
29/11/21 At 9:00am	Backache related to pressure on sacral nerves by the presenting part of the fetus.	Client backache will reduce within 24hours as evidenced by 1. Client verbalizing that her backache has reduced. 2. Client scoring aless mark on comparative pain assessment scale.	1. Reassure client. 2. Educate client to maintain a good sitting posture 3. Educate client to avoid prolong standing. 4.Administer prescribed analgesics. 5.Educate client to wear low heels shoes	1. Client was reassured. 2. Client was educated on supporting the back when sited. 3. Client was educated to avoid prolong standing. 4.Paracetamol 1gram was administered. 5. client wore to heels shoes		Goal fully met as client reported that her backache has reduced	YE

CHAPTER THREE

LABOUR

3.0 INTRODUCTION

This chapter describes the management of labour, the immediate care of the newborn, examination of the newborn and the care plan drawn for the management of the problems encountered during labour and delivery. The goal of care during labour and delivery is to ensure the mother and baby are free from any complications.

3.1 ADMISSION AND MANAGEMENT OF FIRST STAGE OF LABOUR

Admission

On Wednesday 1st December,2021, Madam Ayisheitu reported to the labour ward at Derma Health Center at 7:31pm with her sister. Rapport was established and they were offered seats. Client was taken to the nurses' station for necessary information to be taken while reading through her antenatal card. She was asked if she had experienced any danger signs like, bleeding from the vagina, leakage of liquor and persistent vomiting and she responded no.An enquiry about her last meal was made and she said she had her last meal at 4:00pm and it was banku with okro soup and moved her bowel that morning. Client was told that she was in competent hands and that the staff will ensure that she is in a safe hand and will have a safe delivery.

Madam Ayisheitu complained of lower abdominal pains and appearance of mucoid bloody discharge started at 6:30pm

and also the appearance of ‘show’. Madam Ayishetu and her sister were reassured that everything was going to be alright. Madam Ayisheitu was sent to the examination room and assisted to change her clothing. Permission was sought to examine her and all procedures were explained to her.

She was then asked to pass urine and her urine measured 100mls, the sample was tested for albumin, sugar and acetone but the results were negative. She was assisted to lie on the couch in a supine position and a quick examination from head to toe revealed no abnormality.

Her vital signs checked and recorded were as follows:

MOTHER

Temperature	36.2^{o}C
Pulse	80bpm
Respiration	22cpm
Blood pressure	112/70 mmHg

Abdominal examination, the shape was ovoid with normal size and there was Linea nigra present.

The Symphysiofundal height was 39 centimeters while the gestation was 40weeks + 4days, foetal buttock was felt occupying the upper pole of the uterus. Foetal limbs were palpated at the right side and the foetal back was felt at the left side of the mother’s abdomen, lie was longitudinal and the presentation cephalic with a descent of 4/5th above the pelvic brim. The foetal heart beat was 141 beats per minute.

After the palpation, hands were warmed by rubbing them together in order to check for contractions. There was two (2) contractions in ten (10) minutes lasting thirty (30) seconds and thirty-five (35) seconds.

Vaginal examination permission was sought from Madam Ayishetu for vaginal examination. A tray already set had two sterile gallipots with one containing cotton, Savlon lotion, sterile gloves, a receiver for the used swabs and a sanitary pad. Hands were washed with soap under running water and dried with clean dry towel. A pair of sterile gloves was put on and client was asked to assume a dorsal position with the knee flexed for examination. The vulva was inspected for oedema, wart, scars and varicose veins but there was none present. The dominant hand was used to pick the cotton wool and dipped into the lotion; swab was dropped from dominant hand into the non-dominant hand and swab per stroke. Labia majora was wiped from anterior to posterior and the used swab was disposed of into a receiver. Labia minora was wiped from anterior to posterior and the used swab was disposed. The vestibule was pated using the non-dominant hand and the dominant hand was used to swab the vestibule from anterior to posterior. The used swab was disposed into the receiver. Client's permission was sought and the right middle and index finger was inserted into the vagina by firmly pressing downwards. This caused relaxation of the vaginal walls and muscles. The condition of the vagina was warm and moist and cervix was soft, thin and well applied to the presenting part. The cervix was effaced and dilatation was four (4) centimeters. Ischial spines were blunt and pubic arch was wide, sacral promontory was not reached at 11cm. Membranes were intact and there was no moulding (0). A clean perineal pad was applied on the vulva and client was asked to lie on her left side to prevent supine hypotension syndrome. Glove were disposed of. All findings and the progress of labour were

explained to client. The dilatation board was used to explain the cervical dilatation and progress of labour to her. Client was thanked for cooperating and all information gathered was recorded. Client was made comfortable in bed and encouraged to ambulate.

Preparation for birth

A skilled helper was identified, that was the staff midwife on duty who was also supervising the delivery. The non-skilled helper was the client's sister and she was made aware that she would be called to help when needed. The phone number of BechemGovernment hospital as made ready in case of any emergency and also a nearby driver was informed that in case of emergency he would be called.

The delivery room was prepared for delivery; the room was made clean and warm by drawing the curtains closer, lights were switched on, and touch light was also made ready in an event of light out. Client was assisted to wash her hands, chest and abdomen with clean water and soap prior to delivery and dried with clean towel to prepare for skin to skin contact. Delivery set was made available waiting to be set at appropriate time. Oxytocin and other emergency drugs like magnesium sulphate were also made available.

Resuscitation area was made ready by switching on the light to keep the place warm if needed, all equipment such as ventilation bag and mask, stethoscope needed to help baby breath were assembled and tested for their function.

Management of first stage

The fetal heart rate, maternal pulse, duration of contractions in 10 minutes was done every 30minute, temperature, blood pressure, respiration as well as vaginal examination was done 4

hourly and the results was plotted on the partograph. She complained of being anxious. She was reassured she is in the hands of competent midwives.

Madam Ayisheitu was reassured that labour was progressing well and was encouraged to pass urine frequently to prevent full bladder, since this could impede descent of the fetus and contraction of the uterus.

Madam Ayisheitu was asked to lie on her left lateral to prevent supine hypotension syndrome she complained of loss of appetite and was reassured. Sacral massage was performed for her. She was also encouraged to eat light diet bit by bit.

At exactly 12:00am, she was due for second vaginal examination; client was seen mishandling her perineal pad and was advised of risk of infections. The procedure was explained to Madam Ayisheitu and was asked to empty her bladder before doing the next vaginal examination. At this time, the fetal heart rate recorded was 146 beats per minute with good volume and rhythm. Descent of the fetal head was $1\backslash5^{th}$ and uterine contractions were 4 in 10minute lasting 42and 39seconds respectively. On vaginal examination cervical dilatation was 7cm with membranes intact and moulding of 1+

Her vital signs were checked and recorded as follows.

MOTHER

Temperature	36.5^{o}C
Pulse	105bpm
Respiration	21cpm
Blood pressure	120/70 mmHg

Fetal	146
Descent	1/5
Dilatation	7cm

All the findings were communicated to her and recorded on the partograph. Madam Ayishetu was educated on perineal hygiene. She was advised not to touch her pad when in place. She was then given water to wash her hands and cleaned with a wet towel. She was also given sips of water since she was sweating profusely. The delivery room was made ready with a sterile trolley set, oxygen cylinder and suctioning machine were checked and they were all in good condition. The trolley contained the following;

Top shelf containing sterile items are as follows:

- Scissors
- Four towels
- Two artery forceps
- Drape
- Cord scissors
- 2 gallipots with cotton swabs and gauze
- Receiver for placenta
- Episiotomy scissors

Bottom shelf

- Drum containing gauze and cotton wool
- chittle forceps

- Jug for measuring the amount of blood loss
- Urethral catheter and drainage bag
- Examination gloves
- Identification band
- Episiotomy set
- Perineal pad
- Mackintosh
- Cord clamp in his pack
- Oxytocin drug, vitamin k.
- Examination gloves
- Antiseptic lotion
- Fetoscope
- Sterile gloves in his pack

Other instruments include sutures, lidocaine, face mask, goggle, boots, plastic apron; baby's cot with cot sheets and baby's dress, bed pan, light source was directed to the bed immediately.

At 1;30am Madam Ayishetu complained of severe bearing down sensations with the uterine contractions becoming more expulsive. Another vaginal examination was done and cervical dilatation was 10cm, descent of $0/5^{th}$ with spontaneous rupture of membranes with clear liquor and moulding of two ++. The anus was gapping with the perineum bulging.

MANAGEMENT OF THE SECOND STAGE OF LABOUR

Madam Ayisheitu was transferred to the second stage room and was positioned on the delivery bed at 1:48am. She was told to be cooperative during delivery. Madam Ayisheitu was asked to empty her bladder and then was assisted to lie in the dorsal position with knees flexed apart. She was reassured and every procedure to be done was explained to her. Protective clothing such as mackintosh apron, rubber boots and goggles were worn. Hands were washed with soap under running water, dried with sterile towel and sterile gloves were worn on both hands.

She was reminded that her baby would be delivered unto her abdomen to provide warmth and initiate bonding. The delivery trolley and instrument were checked. A clean perineal pad was applied to the anus to keep the delivery area clean. Madam Ayisheitu was encouraged to push with each contraction and rest in between contractions.

As labour progressed, the head advanced gradually and flexion was aided by gently pressing the occiput downwards in other to allow the smallest diameter of the skull to distend the vulva and the perineum. Descent of the fetal head continued till crowning of the head occurred, Madam Ayisheitu was asked to stop pushing and pant at this stage to prevent rapid expulsion of the head which could lead to perineal tears and intracranial injury. The sinciput, face and chin swept the perineum and the head was slowly delivered by extension by holding the two parietal bones. The eyes were cleaned with separate sterile swabs from the inner cantus of the eye outwards. The mouth and nose were cleaned with gauze swabs. Baby's neck was checked for cord around it but there was none felt Restitution took place and few seconds later there was external rotation of the

head which indicated that there has been internal rotation of the shoulders. This brought the shoulders into anterior-posterior diameter of the pelvic outlet. She was asked to push with the next contractions. Both palms were placed on either side of the baby's ear and gently pressed the head downwards to deliver the anterior shoulder which escaped under the symphysis pubis. The posterior shoulder swept the perineum and was delivered. The rest of the body was delivered by lateral flexion unto the mother's abdomen at 2:00am.

An alive healthy female baby was delivered and cried soon after delivery. The baby was quickly cleaned from head to toe with a clean cot sheet and covered with another clean cot sheet while on her mother's abdomen. The cord clamp was placed two finger breadths away from baby's umbilicus and the second clamp three finger breadths away from the first clamp the cord was then cut in between the two clamps and baby separated from mother.

Client's abdomen was gently palpated to rule out any undiagnosed twin. The midwife in-charge gave 10 units of injection oxytocin intramuscularly on the outer mid-thigh of the client within one minute after palpating the uterus.

APGAR score for the first minute 8/10. The baby was showed to her mother to identify the sex. Client was congratulated for her efforts. The baby was placed in between the mother's breast to continue skin-to-skin contact and covered them with a new sheet. Mother was informed that the baby was going to be in between her breast for an hour to improve bonding and initiate breastfeeding.

The Apgar score assessment was as follows:

INDICATOR	**FIRST MINUTE**	**FIFTH MINUTE**

Appearance	**2**	**2**
Pulse	**2**	**2**
Grimace	**1**	**1**
Activity	**1**	**2**
Respiration	**2**	**2**
Total	**8\10**	**9\10**

3.2 ACTIVE MANAGEMENT OF THE THIRD STAGE OF LABOUR

Madam Ayisheitu was informed and procedure was explained to her. The uterus was palpated for any undiagnosed twin, after which injection oxytocin 10 units was administered intramuscularly after palpating the uterus. The cut end of the cord was reclamped closer to the client's vulva with forceps, a sterile receiver was placed close to the perineum to collect the placenta, membranes as well as blood loss.

The non-dominant hand (left) was placed on the uterus to feel for contractions. When contractions were felt, the dominant hand (right) held the cord with the clamp. With contractions, the left hand was removed and placed just above the symphysis pubis with the palm facing the mother's umbilicus. The placenta was delivered by firmly grasping the cord and applying the controlled cord traction in downward direction while counter traction was applied with the left hand to prevent inversion of the uterus. Steady traction was maintained until the placenta became visible at the vulva.

Both hands were removed simultaneously to cup the placenta. In teasing movement to ease pressure on the membranes to prevent tearing, the placenta and membranes were completely

delivered at 2:06am. A quick assessment of the placenta was made with lobes intact and complete membranes. The placenta was put in the receiver for thorough examination later. The uterus was massaged and blood clots were expelled.

The client's vagina, cervix and perineum were examined after consent was sought from client under a good light source. The index and middle finger were wrapped with sterile gauze to view the cervix, the anterior and posterior vaginal walls in clockwise direction, for tears at the vaginal walls but there was none.

Client was cleaned, and a new pad placed at her perineum, she was transferred to detention room and made comfortable in bed. She was taught and encouraged to massage her uterus. She was encouraged to change her pad to prevent infection and urinate whenever she has the urge to prevent post-partum hemorrhage. She was congratulated for her cooperation. Baby was still maintained in skin-to skin with mother with breastfeeding initiated. She was asked to report in case she sees any changes.

3. 3 IMMEDIATE CARE OF THE BABY

The immediate care of the baby started as soon as the head of the baby was born. Different sterile gauze was used to clean the baby's eyes from inner canthus to the outer canthus to prevent infection. The neck was felt for cord around it which was absent. Baby was delivered unto mother's abdomen. The baby was dried thoroughly to keep the baby warm and stimulate breathing. The cord was clamped 2 finger breadths away from the baby's abdomen and the second 3 finger breadths from the first clamp. The cord was then cut between the two clamps. The baby was shown to mother to confirm the sex of the baby. Identification band was prepared with the mother's name, baby's sex and date of birth and was tied around the baby's wrist. Baby

was then placed on the mother's abdomen to initiate skin to skin. The wet sheet was removed and mother and baby were covered with a warm sheet and the head covered with a cap to prevent hypothermia.

The baby was put to breast to ensure the natural release of oxytocin to help with the contraction of the uterus, initiate lactation and promote bonding between mother and baby. The baby was then nursed on the mother's chest to continue skin to skin for an hour with head turned to one side, in order to facilitate drainage of secretions to prevent aspirations.

3.4 EXAMINATION OF PLACENTA AND MEMBRANES

After client was made comfortable in bed, the placenta was placed on a flat surface and examined thoroughly in the sluice room. The maternal surface was examined in a cupped hand with no missing lobe, and membranes were intact. The cord was situated at the center of the placenta and there was one vein, two arteries in the cord and no abnormality was detected. The placenta was held by the cord allowing membranes to hang down. The membranes were spread out to aid in inspection. On examination; the chorion and amnion were intact. The fetal surface was smooth with shiny and bluish-grey in colour. The maternal surface of the placenta was red with complete lobes separated by grooves (sulci).

The placenta was discarded after decontamination. The instruments and equipment used were soaked in 0.5% chlorine solution and were removed after 10 minutes, washed, rinsed and air dried and made ready for sterilization and storage. Hands were dipped in 0.5% chlorine solution before discarding the gloves. Amount of blood loss was 150mls. Client was congratulated for the effort made.

3.5MANAGEMENT OF FOURTH STAGE OF LABOUR

This is the period of six hours after delivery of the placenta during which both the mother and baby are monitored continuously in order to detect early complications, Madam Ayisheitu and her baby were monitored for six hours before transferring them to the lying-in-ward.

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

MOTHER

Observation

Temperature	36.5ºC
Pulse	73bpm
Respiration	20cpm
Blood pressure	120/75mmHg

Madam Ayisheitu was asked to empty her bladder frequently in order to help contractions of the uterus. Client was served with warm beverage and also encouraged to establish bonding and to initiate and maintain lactation. She was educated on how breastfeeding enhances the release of oxytocin which would improve uterine contractions, drainage of lochia, control of haemorrhage and also as a form of family planning.

Madam Ayisheitu was examined from head to toe, her conjunctiva was pink and no abnormality detected. Uterus was well contracted and symphysio-fundal height was 17cm, there was no active bleeding from the vagina. She was encouraged to report if she sees any profuse bleeding. She was asked to change her pad when soiled in order to prevent infection. Madam Ashyietu's vital signs and uterus were checked every 15 minutes for 2 hours and 30 minutes for 1 hour and

then hourly for three hours and findings recorded on the partograph. The findings were within the normal range. The baby was also monitored at the same interval to ensure that breathing was normal and the colour of its skin was pink.

Prevention of diseases

The following procedures were performed to prevent infection to the eye and cord and also prevent hemorrhagic disease of the newborn. Prevention of disease is done within the first 90 minutes.

Two (2) drops of Chloramphenicol eye drop was instilled on each eye, the cord was dressed with sterile cotton soaked with methylated spirit and vitamin K 0.5mg was given intramuscularly to the baby after head to toe examination was done. Baby skin was smeared with baby oil to provide warmth. Hands were washed with soap under running water and cleaned with dry towel.

Examination of the newborn

The baby was put on a covered flat surface. Baby was then exposed systematically as it was examined from head to toe in the presence of the mother. Baby's colour was pink on observation.

Head and neck

The head was examined for shape and size, widened sutures, bulging and depressed fontanelles, any edematous swelling, caput succedaneum. The ears were examined for size, shape, patency and softness of the cartilage. The eyes were examined for the presence of eye balls, colour, pallor, jaundice, deformities and alignment of the ears. The nose was examined for shape, size,

patency, deviated septum and discharges. The buccal cavity was inspected for false teeth, tongue tie, colour of tongue and gum, cleft lip and palate by using the little finger to feel for palate and sub mucous cleft. The neck was also palpated for enlarged lymph node, rigidity and congenital goiter.

Chest and abdomen

Respiratory movement was normal, nipples were in alignment, and breast had no mass. The abdomen was examined for shape and size, with no bleeding from the umbilical site and abnormalities such as omphalocele and gastrochisis were absent.

Extremities

The upper extremities were inspected for equality, number of palmer creases, clubbed fingers, extra or loss digits. No abnormality was detected. Baby's ability to perform Moro and grasp reflex was also checked. The lower extremities were inspected for equality, clubbed feet, extra or loss digits but none was present. Congenital hip dislocation was also checked using the Ortolani's test and there was no dislocation since a 'clunk' was not heard.

Back

The back was also examined with baby lying laterally. The back was palpated for swelling, spinal bifida and meningocele, but none was detected.

Genitalia

The genitalia were examined and the labia majora covering the labia minora. The clitoris was present The urethra and anus were patent since the baby passed urine and meconium.

Measurement

Measurements on the baby were taken; Head circumference 34 centimeters, Length of the baby was 49 centimeters. Baby's weight was 2.9 kilograms. Gloves were removed and disposed aseptically before washing and drying hands. Findings were documented and communicated to her. Baby's vital signs and weight were checked and recorded as follows

BABY

Temperature	36.8˚C
Apex heart beat	130bpm
Respiration	40cpm
Weight	2.9 kg
Length	49
Head Circumference	34cm

MOTHER

Client was reassured and encouraged to have enough rest and sleep. The mother's initial vital signs were checked and recorded as follows;

MOTHER

Temperature	36.5˚C

Pulse	73bpm
Respiration	20cpm
Blood pressure	120/70mmHg

The fundus was rubbed to facilitate contraction. Blood clots were expelled and blood lost was 100mls, and the Symphysiofundal height was 17 centimeters. Client was transferred to the lying-in-ward and baby put to breast.At the end of the fourth stage, the amount of urine passed was 100 milliliters. Lochia was red in colour (rubra), small in quantity and had no foul smell. Client was educated on frequent micturition and changing of perineal pads when soaked, how to fix baby to breast, the importance of exclusive breastfeeding for the first six months and feeding on demand was stressed on as well. Client's sister and mother were allowed to see her and she was served with warm porridge and bread to restore energy. General condition of client was good and all labour notes were recorded on the partograph sheet.

3.6 SUMMARY OF LABOUR

Date of delivery	2nd December, 2021
Time of delivery	2:00am
Time of placenta expulsion and membranes	2:06am
Type of delivery	Spontaneous vagina delivery
Estimate blood loss	150mls

Duration of labour

First stage of labour	5hours 35minutes
Second stage of labour	25 minutes
Third stage of labour	6 minutes
Total duration of labour	6 hours 6 minutes

Condition of baby

Sex	Female
Birth weight	2.9kg
Apgar score at 1st minute	8/10
Apgar score at 5th minutes	9/10
Full lengths	49cm
Head circumference	33cm
Chest circumference	32cm
Meconium	Passed
Urine	Passed
Abnormality	None detected
General condition	Satisfactory

Condition of mother

Blood pressure	120/70mmHg
Pulse	73bpm
Respiration	20cpm
Temperature	36.5^{o}C
Uterus	Contracted
SFH	17cm
Lochia	Rubra
Condition	Satisfactory

Condition of placenta

Maternal surface	Normal (Dark red)
Fetal surface	Normal (Bluish grey)
Lobes and membranes	Complete and healthy
Blood vessels	2 Arteries, 1 vein
Cord situation	Central

3.7 NURSING CARE PLAN ON LABOUR

PROBLEMS IDENTIFIED

On 09/12/2021, client complained of

1. Lower abdominal pains.
2. Nausea and vomiting.
3. Anxiety.
4. Loss of appetite

5. Fatigue

SHORT TERM OBJECTIVES

1. Client will cope with lower abdominal pains within 2hours and throughout of labour.
2. Client nausea and vomiting will subside within 2 hours
3. Client's anxiety will be allayed within 30 minutes.
4. Client will eat half a meal served within 1 hours.
5. Client willrelive from fatigue within 24 hours.

LONG TERM OBJECTIVES

Labour will progress normally and end successfully without any complication to both mother and baby.

Table 1: NURSING CARE PLAN

Date/ Time	Nursing diagnosis	Nursing objectives/ Outcome criteria	Nursing orders	Nursing interventions	Date/ Time	Evaluation	Sign
2/12 /21 At 6:45am	Lower abdominal pains related to uterine contractions.	Client will be able to cope with lower abdominal pains within 2hours and throughoutlabour as evidenced by client verbalizing that 1.She is coping well with the pain. 2.The midwife observing that client has a little facial expression	1. Reassure client to cope with the lower abdominal pains. 2. Explain the physiology of labour pains to her. 3. Encourage client to perform deep breathing and relaxation exercises 4. Engage client in conversation as a form of divisional therapy. 5. Massage the sacral region of client.	1. Client was reassured that labour would soon end. 2. It was explained to her that the pain was due to the contractions and that is necessary for delivery of the baby. 3. Client was encouraged to take deep breathing, in and out. 4.Clent was encourage to have conversation as a form of divisional therapy 5. Client's sacral region was massaged by the midwife.	2/12/20 At 8:45am	Goal fully met as client is coping well with the pains.	YE

TABLE 2: NURSING CARE PLAN

Date/ Time	**Nursing diagnosis**	**Nursing objective/ Outcome criteria**	**Nursing orders**	**Nursing intervention**	**Date/ Time**	**Evaluation**	**Sign**
9/12/20 At 7:05am	Nausea and vomiting related to process involve in labour	Madam Ayisheitu nausea and vomiting will subside within 2 hours as evidenced by; 1. Client verbalizing that she is no longer feels nauseated and vomiting. 2. Midwife witnessing that client has stopped vomiting and nauseating.	1. Reassure client that the condition can be managed. 2.Encourage client to eat in bits. 3. Hydrate client to prevent dehydration. 4. Move away all nauseating objects from client. 5. assist client to perform oral care	1. Client was reassured of being in competent hands. 2. Client was encouraging to eat in bits. 3.Client was given oral fluids to replace fluid loss. 4. Nauseating objects were moved away from client. 5. client performed oral care	9/12/20 At 9:05am	Goal fully met as Madam Ayisheitu verbalized that she no longer feels vomiting and nauseating	**YE**

TABLE 2: NURSING CARE PLAN

Date/ Time	**Nursing diagnosis**	**Nursing objective/ Outcome criteria**	**Nursing orders**	**Nursing intervention**	**Date/ Time**	**Evaluation**	**Sign**
2/12/21 At 9:45 am	Anxiety related to unknown outcome of labour	client anxiety will be allayed within 1 hour as evidenced by 1. Midwife observing that client is calm in bed. 2. Client verbalizing she is no more anxious	1. Reassure client. 2. Explain every procedure to client understanding. 3. Allow client's relatives to be with her during labour. 4. Allow client to ask questions. 5. Stay by client to make her comfortable and feel cared for.	1. Client was reassured that labour will progress normally. 2. All procedures such as vaginal examination was explained to client's understanding. 3. Client's sister was allowed to be with her during labour 4. Client was allowed to ask questions and she was answered tactfully in language she understands. 5. Client was made comfortable and she to engage her in conversation placed a chair.	2/12/21 At 10:45am	Goal fully met as midwife reported that client was relaxed in bed. Client said she was no more anxious.	YE

TABLE 2: NURSING CARE PLAN

Date /Time	Nursing Diagnosis	Nursing Objectives/ Outcome criteria	Nursing Orders	Nursing Intervention	Date/Time	Evaluation	Sign
2/12/2021 At 10:00am	Loss of appetite related to stresses of labour	Client will regain her normal eating patterns within 2 hours as evidenced by; 1. the birth companion visualizing that client is able to eat. 2. Client verbalizing that she has taken half of meal served.	1.Reassure client that, she will regain her normal eating pattern. 2. Educate client to practice oral hygiene to help increase her appetite. 3. Serve client's favorite food in a well-ventilated environment 4. Serve client's food attractively. 5. Administer vitamin supplements	1. Client was reassured that her normal eating pattern would return to normal. 2. Client was encouraged to practice oral hygiene by brushing her teeth at least twice daily to increase her appetite. 3. Client was served with two balls of banku with okro in odorless environment. 4. Client's food was served attractively by garnishing the food. 5. Vitamins supplements such as folic acid, multivitamin was administered to client.	2/12/2021 At 12:00pm	Goals fully met as Madam Ayisheitu was able to eat half a meal served.	YE

TABLE 2: NURSING CARE PLAN

DATE\TIME	NURSING DIAGNOSIS	Nursing Objectives/ Outcome Criteria	Nursing Orders	Nursing Intervention	Date/Time	Evaluation	Sign
2\12\2021 At 11.ooam	Fatigue related to stress of labour.	1.Client will be relieved of fatigue within 24 hours as evidenced by 2. client verbalizing that she is feeling less fatigue **3**.Midwife observing client looks active	1.Reassure client on the progress of labour to allay anxiety 2.Educaate client on rest and deep breathing exercise in between contraction. 3.Serve client with energy drinks. 4.Encourage her to adopt comfortable but harmless position. 5.Provide client with comfort measures such as opening windows and switching on fans	1.Client was reassured on the progress of labour 2.She was educated on rest and breathing exercise in between contraction. 3.Client was served milo drink 4.She was encouraged to adopt a left lateral position. 5.Windowswere opened for client and fans switched on for comfort.	3\12\2021 At 11,00am	Goal achieved as client reported physical wellbeing	YE

CHAPTER FOUR

PUERPERIUM

4.0 INTRODUCTION

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

4.1 DAY OF DELIVERY[DAY OF DISCHARGE]

Madam Ayisheitu was sent to the lying- in, and was made comfortable in bed with her baby. She was encouraged to empty her bladder frequently in order to prevent the occurrence of postpartum hemorrhage, early ambulation was encouraged to promote effective circulation and involution of the uterus. Madam Ayisheitu was also educated to change her perineal pad frequently when soaked to help prevent infections and was taught to wash hands with soap under running water after removing her perineal pad, visiting the toilet and before handling and breastfeeding the baby. Madam Ayisheitu was served with porridge. The vital signs were monitored every 15 minutes for 2 hours, 30minutes for 1 hour and then hourly for another 3 hours. She later complained of lower abdominal pains which was explained to her that it was after pains and was physiological. She was reassured and 1g of Paracetamol was administered to help relieve her of the pains. Madam Ayishetu was sent to the lying–in after delivery. She was made comfortable in bed with her baby and was encouraged to have some rest of which she complied.

She was encouraged to breastfeed on demand, how to position and attach baby to breast properly and practice exclusive breastfeeding. Madam Ayisheitu was also encouraged to eat

balanced diet and report any abnormal bleeding. Head to toe examination was done on the mother and there was no deviation from normal.

Mother's Vital Signs were checked and recorded as follows;

MOTHER

Temperature	36.0˚C
Pulse	73bpm
Respiration	20cpm
Blood pressure	120/70mmHg

Vital Signs for baby and weight was checked and recorded as follows

BABY

Temperature	36.5˚C
Respiration	40cpm
Apex beat	140bpm
Weight	2.9kg

4.2 Subsequent care of the baby

Baby was monitored continuously and the condition of baby was good. Baby was bathed six (6) hours after delivery. Immediately after the baby bath, cord was dressed and was also checked for bleeding. Baby was dressed and wrapped in a warm cot sheet to keep it warm to prevent hypothermia. Baby's temperature was maintained by wrapping baby well and also the temperature was assessed. Client was advised not to put anything such as cow dung on

the cord when she goes home. The breathing rate was also checked and was within the normal range.

Madam Ayishetu was educated on exclusive and frequent breastfeeding at least 8 to 12 times a day and on demand, proper hand washing before and after handling the baby was encouraged. Client was educated on the newborn care such as cord care and also observe for any danger sign such as irregular breathing, jaundice, fever and report immediately to the nearest health facility.

Baby bathing and cord dressing

REQUIREMENTS

Top shelf

Soap

Towels: 1 big towel and 3 small ones

Cot sheets 2

Sponge

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

Gallipot containing cotton wool swab

Thermometer

Pack for cord dressing

Down shelf

Cream / powder

Basin

Gloves

Mackintosh

2 Jugs containing hot and cold water each

Two receptacles for used water and dirty linen

A receiver receptacle for used swab

Methylated spirit

Procedure

Bathing of the baby was done six hours following delivery. Madam Ayisheitu's consent was sort to bath the baby which she accepted. She was asked to watch closely in order to enable her learn how to bath baby at home. Requirements needed for the procedure were gathered.

Procedure was explained to the mother on how to bath the baby and all items to be used were assembled. Plastic apron was worn. Cold and hot water were mixed and temperature tested with elbow with confirmation by mother. Hands were washed with soap under running water, dried and gloves worn. Baby was placed on a protected flat surface and undress after which she was wrapped with a clean cot sheet. Baby was not over exposed to prevent hypothermia. Eyes were clean with cotton wool swabs from inner cantus out followed by baby's face and dried. The nape of baby's neck was supported with one hand protecting the ears with the middle finger and the thumb. Baby's head was washed with soapy sponge still supporting the nape and the body resting on the elbow with head lifted to the edge of the basin. Soap was rinsed off the head and dried. Baby was placed back on protected flat surface and exposed. Arms and front of the trunk were washed paying attention to skin folds. Baby's back was

turned with one arm supporting the chest with the hand holding the distal arm of the baby. The back was washed down to the feet paying attention to the skin folds. Baby was firmly supported and rinsed thoroughly from the trunk to the limbs. Baby was placed on flat surface and covered with a clean big towel. He was dried with a small towel, paying attention to skin folds. Baby was smeared with pomade and dressed with socks and cap put on. He was then wrapped loosely in a cot sheet and the cord exposed.

Hands were thoroughly washed again with soap under running water and air dried as well. Sterile gloves were worn after setting the tray for cord dressing. The cord was first inspected for bleeding but there was none detected. The tip of the cord was held with one swab. The whole cord was cleaned usingcotton and spirit from the base up. The cord was left exposed for some few minutes to allow it to dry and 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 of. Hands were washed with soap under running water. Mother was also advised not to apply anything on it or touch it. Findings were reported and documented.

First day post delivery

The mother was educated to avoid applying hot compresses on the fontanelles with the intentions of healing a wound. It was explained to her family that the fontanelles will naturally close. She was educated on exclusive breastfeeding of the baby on demand and to wash her hands before touching the baby to prevent sending infections to him and also after breastfeeding she should put the baby on her lumps and tap the back till he blows air. She was educated to clean the cord with cotton and spirit as she was taught and avoid wetting or applying herbs to the cord and to report to the clinic if the clamp went off or see the cord bleeding and any other abnormal sign on the cord and on the baby in general. She was also

educated and assisted on how to position herself and fix the baby well to the breast. Client was educated to complete all the immunization before the child attains 18months and was also educated on the Birth and Death registry

Before they went home, the child was immunized with polio O vaccine 2 drops per mouth and BCG vaccine 0.05ml was administered intra-dermal to the right upper arm. Madam Ayisheitu was educated not to apply anything on the injection site, she was also told that the baby may have slight fever and swelling at the site of injection which would subside**.** Client informed of the first postnatal visit to the clinic to be on the 9nd December, 2021.

She was given the following drugs;

Tab Folic Acid	5mg 1 daily for 30days
Tab Ferrous Sulphate	200mg 1 daily for 30days
Tab multivitamin	200mg 1 daily for 30days
Tab metronidazole	400mg tds for 7days
Caps Amoxicillin	500mg tds for 7days
Tab paracetamol	1g tds for 7days

She was helped to pack her things and was informed on intended post-natal visits for a period of one week which was explained to her that she will be visited at home for seven days,

morning and evening for the first three days then once daily from the fourth day which she agreed.

4.3 SECOND DAY POST DELIVERY (FIRST POST NATAL HOME VISIT)

On 3rdDecember 2021, at 8:00am and 4:00pm Madam Ayisheitu was visited in her house. Both mother and baby looked healthy on arrival. The family was much pleased to be visited. Explanation was given to Madam Ayisheitu that she and the baby would be examined from head to toe to detect any abnormality for early treatment, she was asked to empty her bladder. The conjunctiva was examined and it was not pale, the breasts were examined and it was engorged, baby was not breastfeeding well, the uterus was well contracted and the symphysio fundal height measured 16cm.The perineum was clean when inspected, lochia was red with moderate flow and there was no bad odour. Madam Ayishetu was taught to express breast milk to reduce congestion of breast milk and breastfeed baby on demand. Madam Ayisheitu complained of backache and after pain. She was asked to demonstrate how she breastfeeds her baby and she breastfed baby using poor posture and wrong attachment of baby to the breast. She was taught how to position herself correctly when breastfeeding her baby and good attachment of baby to breast. Her vital signs were taken and recorded as

MOTHER

ObservationMorning Evening

Temperature	36.1c	36.2c
Respiration	20cpm	23cpm
Pulse	82bpm	84bpm
Blood pressure	110\70	120\70
Lochia	Red	Red

SFH	16cm	16cm
Breast	Normal	Normal

Baby

Temperature	36.1^{o}C	36.2^{o}C
Pulse	82bpm	84bpm
Respiration	20cpm	23cpm
Blood pressure	110/70mmHg	120/70mmHg
Lochia	Red	Red

Permission was sought to top and tail the baby in front of mother to observe and it was granted. Baby was examined from head to toe thoroughly to examine for mouth abnormality and determine the cause of poor feeding but no abnormality was found. Madam Ayisheitu was encouraged to breastfeed baby on demand. She was encouraged to completely empty one breast before she breastfeeds baby with the other breast. The baby had passed meconium and urine when the diaper was removed and it was inspected before top and tail. As the baby was being topped and tailed, it was also demonstrated to Madam Ayisheitu. The cord was also dressed with cotton wool soaked in methylated spirit; it was cleaned and kept dry, and there was no bad odour.

The baby's vital signs and weight were checked and recorded as;

BABY

Observation Morning Evening

Temperature	36.3^{o}C	36.4^{o}C
Pulse	128bpm	132bpm
Respiration	41cpm	43cpm
Weight	2.8kg	2.8 kg

Permission was sought to leave and she was reminded that she will be visited the next day.

4.4 THIRD DAY POST PARTUM (SECOND POST NATAL HOME VISIT)

On 4thDecember, 2021, the second visit was made to Madam Ayisheitu house around 8: 00amand 4:00pm. Madam Ayisheitu now said her condition has improved. She was reminded today was her first postnatal visit to the clinic and she said she was going to come. Permission was sought to examine both mother and baby. The head to toe examination was also done on her and no abnormalities were detected. Her perineum was clean, the lochia was found to flow moderately the colour was red (rubra) and without bad odour. The symphysio fundal height was 15centimeters. Her vital signs were checked and recorded as follows;

MOTHER

Observation Morning Evening

Temperature	36.2^{o}C	36.2^{0}c
Pulse	76bpm	78bpm
Respiration	21cpm	20cpm

Blood pressure	100/60mmHg	110/70mmHg
Lochia	Rubra	Rubra
SFH	15cm	15cm

The baby was topped and tailed, general examination was carried out and no abnormality was present. The cord was neatly dressed with no abnormality detected. It was clean and dry. The baby had passed stools and urine, the colour of the stool was brownish yellow and according to Madam Ayishetu.

Baby's vital signs and weight were taken and recorded as follows;

BABY

Observation Morning Evening

Temperature	36.7^{o}C	36.7^{o}C
Apex heart beat	136bpm	140bpm
Respiration	42cpm	41cpm
Weight	2.7kg	2.7kg

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

4.5 FOURTH DAY POSTPARTUM (THIRD POSTNATAL HOME VISIT)

On 5th December, 2021, the third home visit was made to Madam Ayisheitu's house at 8:00am and 4:00pm, she was greeted. Mother and baby were doing well. Permission was sought to inspect client's perineal pad and lochia was serosa, moderate in flow without any

offensive smell. Her breasts were lactating well. Symphysio Fundal height was 14 centimeters. Her vital signs were checked and recorded as follows;

MOTHER

Observation Morning Evening

Temperature	36.5^{o}C	37.0^{o}C
Pulse	80bpm	82bpm
Respiration	20cpm	22cpm
Blood pressure	110/70 mmHg	110/60 mmHg

The baby was topped and tailed. General examination was carried out and no abnormality was present. The baby also passed stool and urine. The cord was neatly dressed and was detaching. Baby's vital signs and weight were taken and recorded as follows;

Observation	Morning	Evening
Temperature	36.8^{o}C	36.8^{o}C
Apex heart beat	134bpm	140bpm
Respiration	44cpm	42cpm
Weight	2.7kg	2.7kg

4.6 FIFTH DAY POST PARTUM (FOURTH POSTNATAL HOME VISIT)

The fourth home visit was made to Madam Ayisheitu's house at 8:00am to 4pm on 6th December, 2021. The health status of mother was inquired and she complained of engorgement of breasts and was educated on the need to breastfeed the baby on demand and it will resolve. Madam Ayisheitu also complained of insomnia and was educated to sleep

during the day when the baby is asleep also share the house chores with the grandmother. Lochia was pink (serosa) with moderate flow without odour on inspection. Head to toe examination was done and everything was normal. Symphysiofundal height was 13centimeters. Her vital signs were checked and recorded as follows;

MOTHER

Temperature	36.1^{o}C
Pulse	78bpm
Respiration	20cpm
Blood pressure	110/60mmHg
Lochia	Serosa
SFH	13cm

Baby was bathed since the cord had fallen off the previous night, no abnormality was found.The stump was then dressed and the area was clean and dry. The baby passed stools, yellow in colour and urine.

Baby's vital signs and weight were taken and recorded as follows;

BABY

Temperature	36.7^{o}C
Apex heart beat	136bpm
Respiration	42cpm
Weight	2.8kg

4.7 SIXTH DAY POST PARTUM (FIFTH POSTNATAL HOME VISIT)

The fifth postnatal home visit was on 7th December, 2021 at 8:00am to 4pm. Greetings were exchanged with client and her family after which a seat was offered in client's room. Mother and baby were both in a healthy condition when it was inquired. Madam Ayishetu said the baby cries a lot, she was reassured that the crying of the baby will reduced when she feeds the baby on demand and changes his diaper frequently because babies have lusty cry to evoke attention. After the head to toe examination, no abnormality was detected. Inspection of the lochia was done and the colour was pink (serosa) without any bad odour and flow was moderate. Client complained of loss of appetite. Symphysio fundal height of Madam Ayisheitu was 12centimeters. Client's vital signs were checked and recorded as follows: Observation

MOTHER

Temperature	36.7°C
Pulse	80bpm
Respiration	21cpm
Blood pressure	120/70mmHg
Lochia	Serosa
SFH	12cm

Baby was bathed, head to toe examination was done and no abnormalities were found on the baby. Stump was then dressed and the area was clean and dry. Vital signs and weight were taken and recorded as follows:

Observation

BABY

Temperature	36.3ºC
Apex heart beat	142bpm
Respiration	44cpm
Weight	2.9kg

Madam Ayishetu was reminded of the next visit to her house. She said she was very grateful. Permission was sought to leave.

4.8 SEVENTH DAY POSTPARTUM (SIXTHPOSTNATAL HOME VISIT)

The sixth day postnatal home visit was done on 8th December, 2021 at 8:00am to 4pm. Greetings were exchanged with client and her family and a seat was offered in client's room. Mother and baby were both in a healthy condition and mother said the baby's crying had minimized and now sleeps a lot. On head to toe examination, no abnormalities were detected. Her breast was lactating well. Inspection of the lochia was done and the colour was pink (serosa) normal flow without any bad odour. Madam Ayisheitu said the baby had pass stool that morning before arrival. Symphysio fundal height was 11centimeters.

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

MOTHER

Temperature	36.1ºC
Pulse	79bpm
Respiration	20cpm

Blood pressure	110/60mmHg

Baby was already bathed, head to toe examination was done and no abnormality was found on the baby. The stump was then dressed and the area was clean and dry. Baby's vital signs and weight were taken and recorded as follows:

BABY

Temperature	36.8^{o}C
Apex heart beat	140bpm
Respiration	42cpm
Weight	2.8kg

Education was given to her on the importance of ensuring good personal hygiene and the need to feed the baby frequently on demand. She said she appreciated that a lot, and she was thanked for her cooperation. Permission was sought to leave.

4.9 EIGHT DAY POSTNATAL (SEVENTH POSTNATAL HOME VISIT)

The seventh day postnatal home visit was done on 9th December, 2021 at 8:00am to 4pm. Greetings were exchanged with client and her family and a seat was offered in client's room. Mother and baby were both in a healthy condition. On head to toe examination, no abnormalities were detected. Her breast was lactating well. Symphysio- fundal height was 10centimeters. Inspection of the lochia was done and the colour was pink (serosa) normal flow without any bad odour. Madam Ayisheitu said the baby had pass stool that morning before arrival.

Client's vital signs were checked and recorded as follow

MOTHER

Temperature	36.0ºC
Pulse	80bpm
Respiration	21cpm
Blood pressure	120/70 mmHg

Baby was already bathed, head to toe examination was done and no abnormality was found on the baby. The stump was then dressed and the area was clean and dry.

Baby's vital signs and weight were taken and recorded as follows:

BABY

Temperature	36.3ºC
Apex heart beat	135bpm
Respiration	40cpm
Weight	2.9kg

She was educated on the danger signs inbaby like and the need to seek early care. She said she appreciated that a lot, and she was thanked for her cooperation, she was reminded that today was her one-week postnatal visit to the clinic. Permission was sought to leave.

4.10 ONE WEEK POST NATAL VISIT TO THE CLINIC

On 9th December, 2021 at 10:00am, Madam Ayisheitu and her baby came to the facility. A seat was offered to client, she looked healthy. Procedure to be carried out was explained to her and she consented. Madam Ayisheitu was asked to empty her bladder before the head to toe examination. Midstream urine was taken and checked for protein and sugar and all tested

negative. Head to toe examination was done and everything was within the normal range. Lochia was checked and it was flowing, the colour was pink (serosa). Haemoglobin level was 13.0g/dL. Her vital; signs were checked and recorded

MOTHER

Temperature	36.5^{o}C
Pulse	76bpm
Respiration	20cpm
Blood pressure	125/72mmHg

Procedure to be carried out on Madam Ayisheitu was explained to her. Privacy was provided and she was assisted to lie on the couch for the head to toe examination. Hands were washed with soap under running water and dried with a clean towel.

Head to toe examination was done on her. On the head, hair was neat and tied with a ribbon, the conjunctiva was not pale, 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, no engorgement, sore or cracked nipples were detected. The abdomen was palpated and there was no tenderness, no scars, enlarged liver or spleen on examination and the uterus was 10cm. There was no edema, varicosities nor tenderness in calf. The perineum was intact and there was no offensive vaginal discharge and the lochia is present. She was thanked for the cooperation and helped to dress up.

Head to toe examination was done on baby but no abnormalities were found. Umbilical stump was healed. Baby's weight was 3.0kg. She was also educated on the importance of the child welfare clinic. Both mother and baby were handed over to the midwife in-charge for

continuity of care and were educated to consult them in case of any problem. Baby's vital signs was checked and recorded

BABY

Temperature	36.3ºC
Apex heart beat	125bpm
Respiration	40cpm

4.11 SECOND POSTNATAL VISIT TO THE CLINIC

According to the midwife in charge madam Ayishetu visited the clinic with the baby on 10th January, 2021; she was welcome to the clinic by the midwife in charge. Both mother and baby were in healthy condition and had no complain. Her hemoglobin level was 14.1 gram per deciliter as checked and urine test for protein and sugar were negative. Her recordings were as follows

MOTHER

Temperature	36.7ºC
Pulse	80bpm
Respiration	20cpm
Blood pressure	120/70mmHg
Weight	70kg

BABY

Temperature	36.4^{o}C
Respiration	42cpm
Apex beat	134bpm
Weight	4.2 kg

Physical examination was done and no abnormality was detected, breast was lactating well uterus was well involuted and menstruation has not commenced.

Baby's general condition was good head to toe examination was done and baby's posterior fontanelles were closed. Client was handed over to the midwife in charge at the health center for baby immunization against polio, diphtheria, pertussis, tetanus, haemophilus influenza type B, hepatitis B given to children at six weeks.

The extra vaccines namely pneumococcal and rotavirus for protection against pneumonia and diarrhea respectively was also reminded to be given, they were handed over to the child welfare clinic and family planning unit to ensure continuity of care and were educated toconsult them in case of any problem. Client was congratulated.

Explanation was given to Madam Ayeishetu on the need to be handed over to the midwife in-charge for continuity of care.

PROBLEM IDENTIFIED

Client complained of;

10/12/21 After pains

10/12/21 Backache

13/12/21 Breast engorgement.

13/12/21 Insomnia

14/12/21 Loss of appetite.

SHORT TERM OBJECTIVES

After pains will resolve within 48hours

Backache will resolve within 48 hours

Breast engorgement will reduce within 24 hours

Madam Ayisheitu will have adequate sleep at least 2hours at day time and 6 hours at night within 24 hours.

Madam Ayisheitu will regain her normal appetite within 48 hours.

LONG TERM OBJECTIVE.

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

Table 2: MADAM AYESHEITU'S CARE PLAN DURING PUERPERIUM

DATE/ TIME	NURSING DIAGNOSIS	OBJECTIVE/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
10/12/21 At 9:00am	After pains Related to involution of the uterus.	Client's after pain will resolve within 48 hours as evidenced by 1. client verbalizing that the pains have resolve. 2. Midwife observing that client's face looks cheerful.	1. Reassure client that her pain will resolve. 2. Encourage client to void frequently. 3. Encourage client to breastfeed frequently and on demand. 4. Encourage client to lie with her face down and with pillow under her abdomen 5. Give prescribed analgesics.	1. Client was reassured by explaining the Physiology of after pains. 2.Client was encouraged to void at least two hours. 3.Client was encouraged to breastfeed frequently and on demand. 4.Client was encouraged to lie with her face down with pillow under her abdomen 5.Client was given paracetamol 1g daily before breastfeeding.	12/12/21 At 9:00am	Goal fully met as client said that she was relieved of pain.	YE

DATE/ TIME	NURSING DIAGNOSIS	OBJECTIVE/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
10/12/21 At 10:00am	Backache related to poor posture during breast feeding	Madam Ayisheitu's back pain will resolve within 48hours as evidence by 1. Midwife visualizing that she no longer complain. 2. midwife observing that client is breastfeeding baby comfortably and in good posture.	1. Reassure client that backache will resolve. 2. Educate client on the correct positions used in breastfeeding during breastfeeding. 3. Apply gentle massage over the area. 4. Encourage client to have enough rest 5. Served prescribed pain relived	1. Client was reassured that her backache will resolve. 2. Client was educated on to sit straight and support her back when breastfeeding 3. Client was encouraged to gently massage the area. 4. Client had 2 hours' rest in-between activities 5. Client was served with Tab paracetamol 1g as prescribed	12/12/21 At 10:00am	Goal fully met as client verbalizes that she has been relieved of backache	YE

DATE/ TIME	NURSING DIAGNOSIS	OBJECTIVE/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
13/12/21 At 7:00am	Breast engorgement related to poor attachment of baby to breast	Madam Ayisheitus breast engorgement will reduce within24 hours as evidenced by 1. client verbalizing that the pain has reduced 2.midwife observing that the fullness has resolved.	1. Reassure client to allay anxiety 2. Teach client to position and fix baby well to breast. 3. Ask client to apply cold compress on the breast. 4. Encourage client to continue breastfeeding. 5. Tell her to completely empty her breast.	1. Client was reassured by explaining the cause of engorgement to her that, failure to allow the baby to empty one breast before giving the other caused the engorgement. 2. The various breastfeeding positions thus sitting and side lying were demonstrated to client. 3. Client applied a cold damp towel on her breast. 4. Client was encouraged to continue breastfeeding baby on demand. 5. Client was told to ensure that baby empties one breast completely before giving her the other breast.	14/12/21 At 7:00am	Goal fully met as client verbalized that her pain was no more and breast engorgement subsided and midwife observing that there is no engorgement.	**YE**

DATE/ TIME	NURSING DIAGNOSIS	OBJECTIVES/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
13/12/21 At 7:00pm	Inadequate sleep related to night breast feeding.	Client will be able to sleep for at least 2 hours within 24 hours as evidenced by client verbalizing that she was able to sleep. 2.midwife observing that client looks active	1. Encourage client to have periodic rest during the day when baby is asleep. 2. Educate client to breast feed baby to his satisfaction. 3. Encourage her relative to help her with the household chores. 4. . Encourage Madam Ayisheitu to have a warm bath in the evening before bed. 5. Encourage client to limit the number of visitors	1. Client was encouraged to have a periodic rest when baby sleeps. 2. Client was educated to breast feed baby to his satisfaction. 3. Client's relatives were encouraged to help her with the household chores. 4. She was encouraged to have a warm bath before bed. 5. Client was encouraged to limit the number of visitors	14/12/21 At 7:00pm	Goal fully met as client verbalizes that she has adequate sleep	YE

DATE/TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/TIME	EVALUATION	SIGN
14/12/21 At 8:00am	Loss of appetite related to stresses of labour	Madam Ayisheitu will regain her normal pattern within 48hours as evidence by 1. client verbalizing that she is able to eat 2. support person observing client eating half of a meal served	1. Reassure client that she will gain her normal eating pattern. 2. Encourage client to practice oral hygiene to help increase her appetite. 3. Serve client's favourite food in a well ventilated environment. 4. Serve client's food attractively. 5. Administer vitamin supplements.	1. Client was reassured that she will gain her normal eating pattern. 2. Client was encouraged to practice oral hygiene by brushing her teeth at least twice daily to increase her appetite. 3. Client was served with two balls of banku with okro in an odourlessenvironment. 4. Client's food was served attractivelyby garnishing the food. 5. Vitamin supplement such as folic acid, multivitamin were administered.	16/12/21 At 8:00am	Goal fully met as client verbalizes that she is able to eat half male served.	**YE**

SUMMARY AND CONCLUSION

The Client/Family Centred Maternity Care Study was conducted on Madam Ayisheitu Fuseini a 26-year-old gravida 2 para 1 and her entire family through pregnancy, labour and puerperium and she went through these processes safely without any complications.

Madam Ayisheitubecame a regular attendant to the clinic since 7th May, 2021. She was managed through pregnancy, labour and puerperium safely through which all minor disorders were taken care of using the nursing care plan and goals were met when evaluated. She had a spontaneous vaginal delivery to a life female baby on 2ndDecember, 2021. Client and family were visited for the first seven days after delivery.

She visited the clinic on her first week and six weeks postnatal. Madam Ayisheitu was given a focused and comprehensive care throughout her pregnancy, labour and puerperium. Madam Ayisheitu and her baby were in a healthy condition and they were handed over to the Midwife-In-Charge for continuity of care.

Client and her family were much grateful at the end of the study.

The care rendered to Madam Ayisheitu has helped in equipping me with skills necessary to meet the needs of pregnant, labouring and puerperal women. It has also established between us a good interpersonal relationship.

The care study is an important and managerial tool which gives opportunity to student midwives to put into practice theoretical knowledge and to be able to deal with obstetric problems as midwifery professional.

TERMINATION OF CARE.

Explanation was given to Madam Ayisheitu on the need to be handed over to the midwife in charge for the continuity of care on 17th December, 2021 at 11:00am. Explanation was made to her that the program was ending that day but client was reassured of midwife in charge's competency. Client was accompanied to her house and a seat was offered. Client and husband were thanked for their corporation, information was provided and permission was sought to leave.

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APPENDIX 1

TABLE 3: COMPLETE DIAGNOSTIC INVESTIGATION ON MADAM AYISHIETU FUSEINE

DATE	SPECIMEN	INVESTIGATION	NORMAL RANGE	FINDINGS	REMARKS
20/08/2021	Urine	Protein	Negative	Negative	Normal
		Glucose	Negative	Negative	
	Blood	Haemoglobin level	11-16gms/dl	13.0 gms/dl	Normal
		PMTCT	Negative	Negative	
		Syphilis	Negative	Negative	
		Rhesus factor	Negative/Positive	Positive	
		Grouping	A, B, AB, O	AB	
		Sickling Test	Negative	Negative	
20/08/2021	Urine	Glucose	Negative	Negative	Normal
		Protein	Negative	Negative	

COMPLETE DIAGNOSTIC INVESTIGATION CONTINUED

DATE	SPECIMEN	INVESTIGATION	NORMAL RANGE	FINDINGS	REMARKS
24/10/21	Urine	Protein Glucose	Negative Negative	Negative Negative	Normal
24/10/2021	Urine	Protein Glucose	Negative Negative	Negative Negative	Normal
24/10/2021	Urine Blood	Protein Glucose Haemoglobin level	Negative Negative 11-16gms/dl	Negative Negative 12.5gms/dl	Normal Normal

APPENDIX II

Table 4: PHARMACOLOGY OF DRUGS FOR THE MOTHER

NAME OF DRUG	CLASSIFI-CATION	DOSAGE	ROUTE	ACTION AND USES	ACTUAL EFFECT	SIDE EFFECT	SIDE EFFECT EXPERI-ENCED
Folic acid	Vitamin preparation	5 milligram once daily	Orally	Proper formation and function of red blood cell	Haemoglobin level increased	Nausea and vomiting	None observed
Tetanus injection	Vaccine	0.5 milligram stat (3^{rd} dose)	Subcutaneously	Protection against tetanus	Tetanus was prevented	Fever and urticaria rash	None observed
Tablet sulphadoxinepyrimethamine	Anti-malaria and prophylaxis	3 tablets given at 16 weeks/quickening repeated at 4-week interval till delivery.	Orally	Prevention of malaria	Prevention of malaria in pregnancy	Nausea, itching, headache, Dizziness	None observed

NAME OF DRUG	CLASSIFI-CATION	DOSAGE	ROUTE	ACTION AND USES	ACTUAL EFFECT	SIDE EFFECT	SIDE EFFECT EXPERI-ENCED
Tablet paracetamol	Analgesics	1 gram three times daily for three	Orally	Helps to relieve pain	Pain was relieved	Prolong use causes damage to the liver	None observed
Capsule vitamin A	Group A vitamin supplement	200,000 units	Orally	Growth development and proper sight	Normal vision and healthy skin	Vomiting	None observed
Injection oxytocin	Oxytocic drug	10 units	Intramuscularly	Stimulate uterine contractions	Good uterine contraction and control of bleeding	Nausea and vomiting	None observed
Tablet multivitamin	Vitamin preparation	200 milligrams daily	Orally	Increases appetite. Help in the formation of red blood cell	Increases appetite	Gastrointestinal disturbance	Constipation

Table 5: PHAMARCOLOGY OF DRUGS FOR THE BABY

NAME OF DRUG	CLASSIFI-CATION	DOSAGE	ROUTE	ACTION/ USES	ACTUAL EFFECT	SIDE EFFECT	SIDE EFFECT EXPERIENCED
Vitamin K	Coagulant	1milligram	Intramuscular	Production of prothrombin	No bleeding	None	None observed
Chloramphenicol eye drop	Prophylaxis antibiotic	2-3 drops	Instillation	Prevents eye infection	Infection was prevented	Nephroxicity	None observed
Polio vaccine	Antigen	2 drops	Orally	Production of antibodies against poliomyelitis	Diarrhoea and fever may occur.	None	None observed
Injection Bacillus ChalmetteGuerin (BGC)	Antigen	0.05 Milligram	Intradermal	Vaccinates neonates against tuberculosis	Tuberculosis prevention	Blister formation	None observed
Pnuemo Coccal	Antigen	0.5 milligram	Intramuscularly	Vaccinates neonates against pneumonia	Pneumonia prevention	Redness at the side of injection and fever	None observed
5 in 1 vaccine (Pentavalent)	Antigen	0.5 milligram	Intramuscularly	Vaccinates neonates against diphtheria, pertussis (whooping` cough), tetanus, hepatitis B,	Prevention of childhood preventable diseases	Low grade fever	None observed

				haemophilus influenza type B			
Retro virus	Antigen	1.5 milligrams (2 drops)	Orally	Prevention of gastroenteritis	Gastroenteritis prevention	None	None observed

APPENDIX III

Table 6: ANTENATAL RECORDS

Date	**Wt**	**Vital signs (bp/tpr)**	**Urine/ Pro-tein/ Sug-ar**	**Hb (gdl)**	**Gest-ation in weeks**	**Fund al hei-ght**	**Pres-Enta-Tion**	**Des-Ce-nt**	**Fetal Heart Rate**	**Com-Plains**	**Treat-Ment**	**Rem-arks**
7/5/21	50kg	110/70 36.0^{o}c 82bpm 20cpm	Negativ e/ Negativ e	12.0g/ dL	11^{+}2wee ks	_	_	_	-	Headache	Routine drugs Paracetamol	Well
4/6/21	51kg	109/66 36.1^{o}c 80bpm 20cpm	Negativ e/ Negativ e	12.1g/ dL	15+2 Weeks	14cm	_	_	M+	No complains	Routine drugs and First SP	Well
2/7/21	48kg	102/60	Negativ e/	-	19^{+}2	19 cm	_	_	158bpm	No complains	Routine drugs	Well

		36.0^{o}c 84bpm 24cpm	Negative		Weeks						and Second SP	
30/7/21	49kg	112/70 36.4^{o}c 78bpm 20cpm	Negative/ Negative	-	$22^{+}2$ Weeks	24 cm	Cephalic	-	161bpm	Lower Abdominal Pain	Routine drugs, Paracetamol and Third SP	Well
27/8/21	50kg	106/74 36.5^{0}c 74bpm	Negative/ Negative	12.3g/ dL	$26^{+}2$ Weeks	24 cm	Cephalic	-	132bpm	Waist Pains	Routine drugs, Paracetamol and Fourth SP	Well

Date	**Wt**	**Vital signs (bp/tpr)**	**Urine/ pro-tein/ Sug-ar**	**Hb (gdl)**	**Gest-ation in weeks**	**Fund al hei-ght**	**Pres-Enta-Tion**	**Des-Ce-nt**	**Fetal Heart Rate**	**Com-Plains**	**Treat-Ment**	**Rem-arks**
24/10/21	52kg	115/62 $36.5^{O}c$ 20cpm 79bpm	Negative/ Negative	12.5g/ dL	32+2 Weeks	30cm	Cephalic	-	144bpm	No complains	Routine drugs	Well
1/11/21	55kg	115/71 $36.4^{0}c$ 88bpm 24cpm	Negative/ Negative		36+1 Weeks	36cm	Cephalic		145bpm	Waist pains	Continue routine drugs and fifth SP	Well
8/11/20	55kg	100/64 $36.5^{0}c$ 82bpm	Negative/ Negative	12.8g/ dL	37+1 Weeks	36cm	Cephalic		146bpm	Headache	Routine drugs and sixth dose of SP	Well

Date	**Wt**	**Vital signs (bp/tpr)**	**Urine/ pro-tein/ Sug-ar**	**Hb (gdl)**	**Gest-ation in weeks**	**Fund al hei-ght**	**Pres-Enta-Tion**	**Des-Ce-nt**	**Fetal Heart Rate**	**Com-Plains**	**Treat-Ment**	**Rem-arks**
15/11/21	56kg	102/62 36.4^0c 82bpm 20cpm	Negative/ Negative	13.0g/ dL	38^+2 Weeks	37cm	Cephalic	$5/5^{th}$	148bpm	Heart burns and waist pains	Continue Routine drugs Paracetamol	Well
22/11/21	56kg	101/64 36.2^0c 86bpm 24cpm	Negative/ Negative	_	39^+2 Weeks	36cm	Cephalic	$5/5^{th}$	146bpm	constipation	Continue Routine drugs Paracetamol	Well
29/11/21	57kg	107/69 36.3 26bpm	Negative/Negative	-	40+4	35cm	Cephalic	5/5	148bpm	Backache	Continue Routine drugs paracetamol	Well

SIGNATORIES

1. STUDENTS NAME;YEBOAH EDNA

SIGNATURE……

DATE……

2. NAME OF MIDWIFE IN-CHARGE ; NYARKO DORIS

SIGNATURE……

DATE……

3. NAME OF SUPERVISOR ; MRS. CELESTINE AHIAWONU

SIGNATURE……

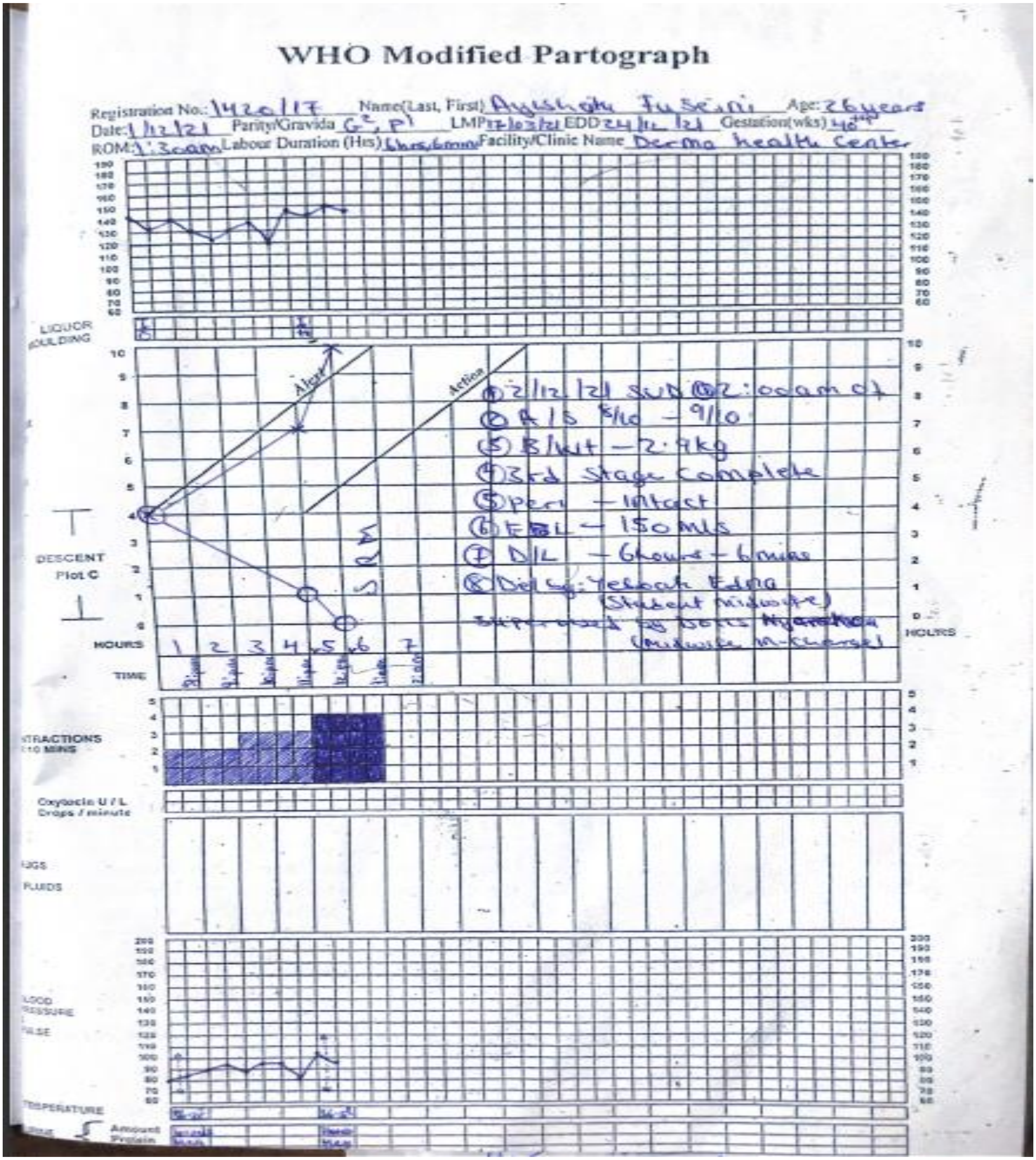
DATE……

4. NAME OF PRINCIPAL; MS MONICA NKRUMAH

SIGNATURE…….

DATE……

[COLLEGE STAMP]


WHO Modified Partograph
Registration No.: 1420/17
Name(Last, First)
Age: 26 years
Date: 1/12/21
Parity/Gravida G2, P1
LMP
EDD
Gestation(wks) 40
ROM
Labour Duration (Hrs)
Facility/Clinic Name Dermo health Center
LIQUOR
MOULDING
Alert
Action
DESCENT
Plot O
HOURS
TIME
CONTRACTIONS
Oxytocin U/L
Drops / minute
DRUGS
IV FLUIDS
BLOOD PRESSURE
PULSE
TEMPERATURE
URINE
Amount
Protein

LABOR NOTES

Client admitted at the facility at 7:31pm with complain
of labour pains. Labour progressed well. Client had a
spontaneous vaginal delivery to alive female child with a
birth weight of 2.9kg, head circumference -34cm, length of
baby - 49cm. third stage actively managed and completed wi
by CCT. Estimated blood lost - 150mls. Baby APGAR Score
for 1 minute and 5 minutes are 8/10, 9/10 respectively
Mother and baby looks active and healthy.

Please circle or write responses.

DELIVERY

DATE: 2/12/21 TIME: 2:00am METHOD: (Spontaneous) / Vacuum Extraction / C/S / Oth

PERINEUM: (Intact) / Episiotomy / Laceration

ANESTHESIA: (None) / Local / General

THIRD STAGE

Active Management: (Yes) / No Medication: Time 2:1am Type/Dose Oxytocin(1mu/IM)

PLACENTA: TIME: 2:6am (Complete) / Incomplete

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

BABY

Weight: 2.9kg

Sex: Male / (Female)

Baby Position: (Vertex) / Breech / Other

APGAR

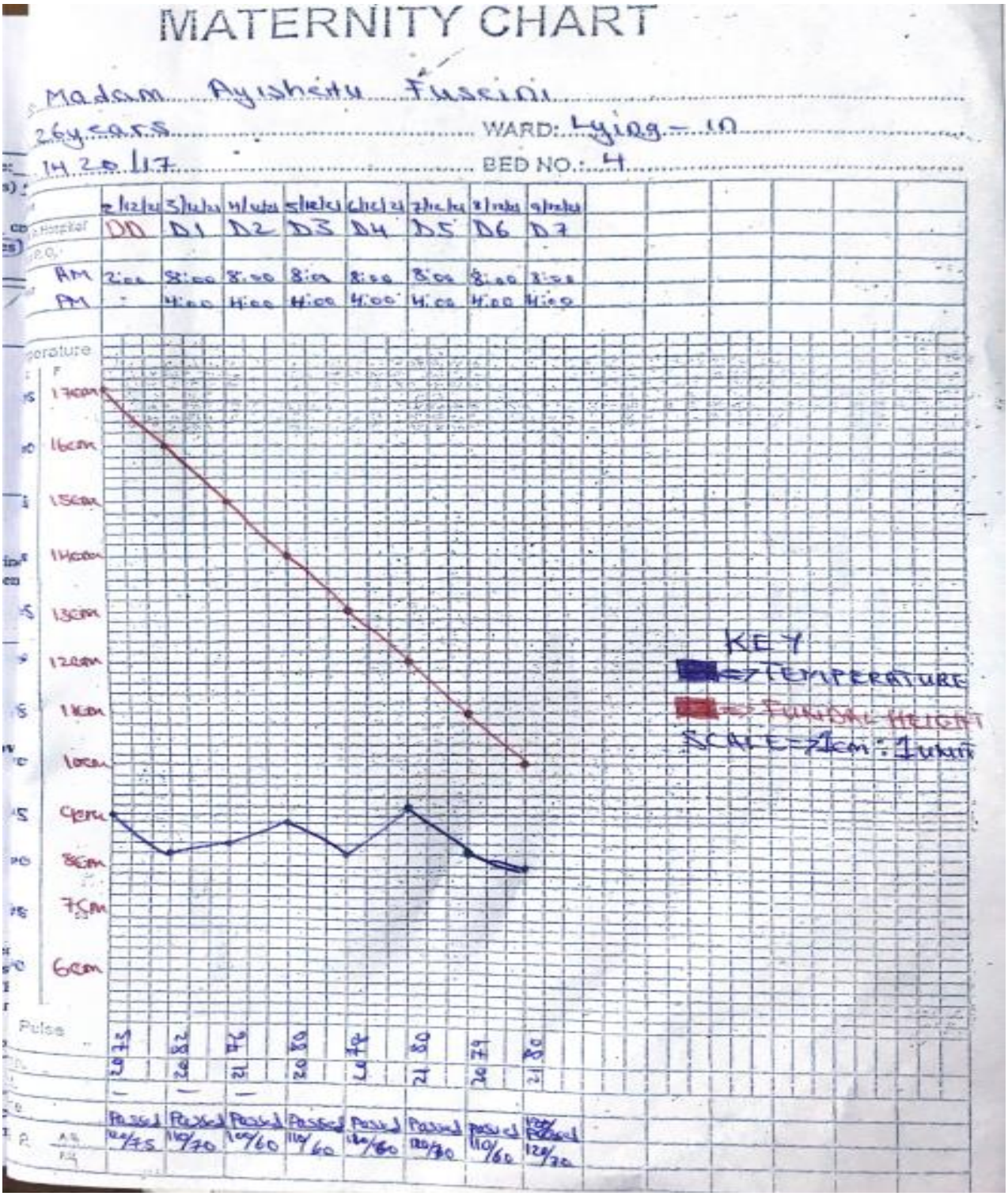
Time	Color	Breath	Heart	Tone	Reflex	TC
1min	2	2	2	1	1	8/
5min	2	2	2	2	1	9/

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

FOURTH STAGE MONITORING

Frequency	Time	B/P.	Pulse	Fundus	Bleeding	Bladd
Every 15 minutes first 2 hours	2:30am	132/	75bpm	17cm	150mls	
	2:45am	140/	80bpm	Contracted	Small	150 M
	3:00am	115/	78bpm	Contracted	No bleeding	-
	3:15am	117/	80bpm	Contracted	No bleeding	
	3:30am	120/	85bpm	Contracted	No bleeding	
	3:45am	120/	82bpm	Contracted	No bleeding	100ML
	4:00am	116/	81bpm	Contracted	No bleeding	-
	4:15am	117/	80bpm	Contracted	No bleeding	
Every 30 minutes For 1 hour	4:45am	120/	81bpm	Contracted	No bleeding	
	5:15am	120/	76bpm	Contracted	No bleeding	100ML

Birth Attendant Yeboah Edna (Student Midwife) Date 2/12/21


MATERNITY CHART
Madam Ayisheth Fuseini
26 years
WARD: Lying-in
14.2.17
BED NO.: 4
D0
D1
D2
D3
D4
D5
D6
D7
AM
PM
KEY
TEMPERATURE
FUNDAL HEIGHT
SCALE=1cm: 1unit
Pulse

NEW BORN EXAMINATION FORM

Name: Baby Ayushatu | Date of Assessment: 2/12/21 | Time:
Date of Birth: 2/12/21 | Time of Birth: 2:00AM | Sex: ☐ M ☑ F | Age at time of Assessment (days/hrs) 2
Astational Age ☐ 40 th ☐ | Mode of Delivery: ☑ Vaginal ☐ Assisted Vaginal ☐ C-Section
APGAR: 1min 8 5min 9 | Birth Weight: ☐ 2.9 kg ☐ | Length: 49 cm | Head Circumference: 33 cm
Temperature at time of Assessment: 36.8 °C | Urine passed: (Yes) No | Meconium passed: (Yes)
Name of Assessor (Midwife/Doctor): Edna Yeshoal

1. Respiration
Rate 40 BPM
- ☐ 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: 140 BPM
- ☑ Normal (100-160)
- ☐ <100 *
- ☐ >160*

19. Femoral pulse
- ☑ Present
- ☐ Not palpable*

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

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

22. Limbs
- ☑ Normal
- ☐ Abnormal _____

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

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

24. Anus
- ☑ Patent
- ☐ Imperforate*

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

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

*May indicate severe disease that requires urgent referral

Diagnoses (if known) _____

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

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

NEW BORN EXAMINATION FORM

Baby Ayishatu — Date of Assessment: 2/12/21 — Time:

…: 2/12/21 — Time of Birth: 3:00am — Sex: [ ] M [✓] F — Age at time of Assessment (days/hrs): 1 hour

…: [ ] 4th [ ] Mode of Delivery: [✓] Vaginal — Assisted Vaginal — C-Section

…in 8 [ ] 5min [ ] 9 — Birth Weight: [ ] 2.9 kg [ ] — Length: 49 cm — Head Circumference: 33 cm

… at time of Assessment: 36.8 °C — Urine passed: (Yes) No — Meconium passed: (Yes) No

…essor (Midwife/Doctor): Edna Yeboah

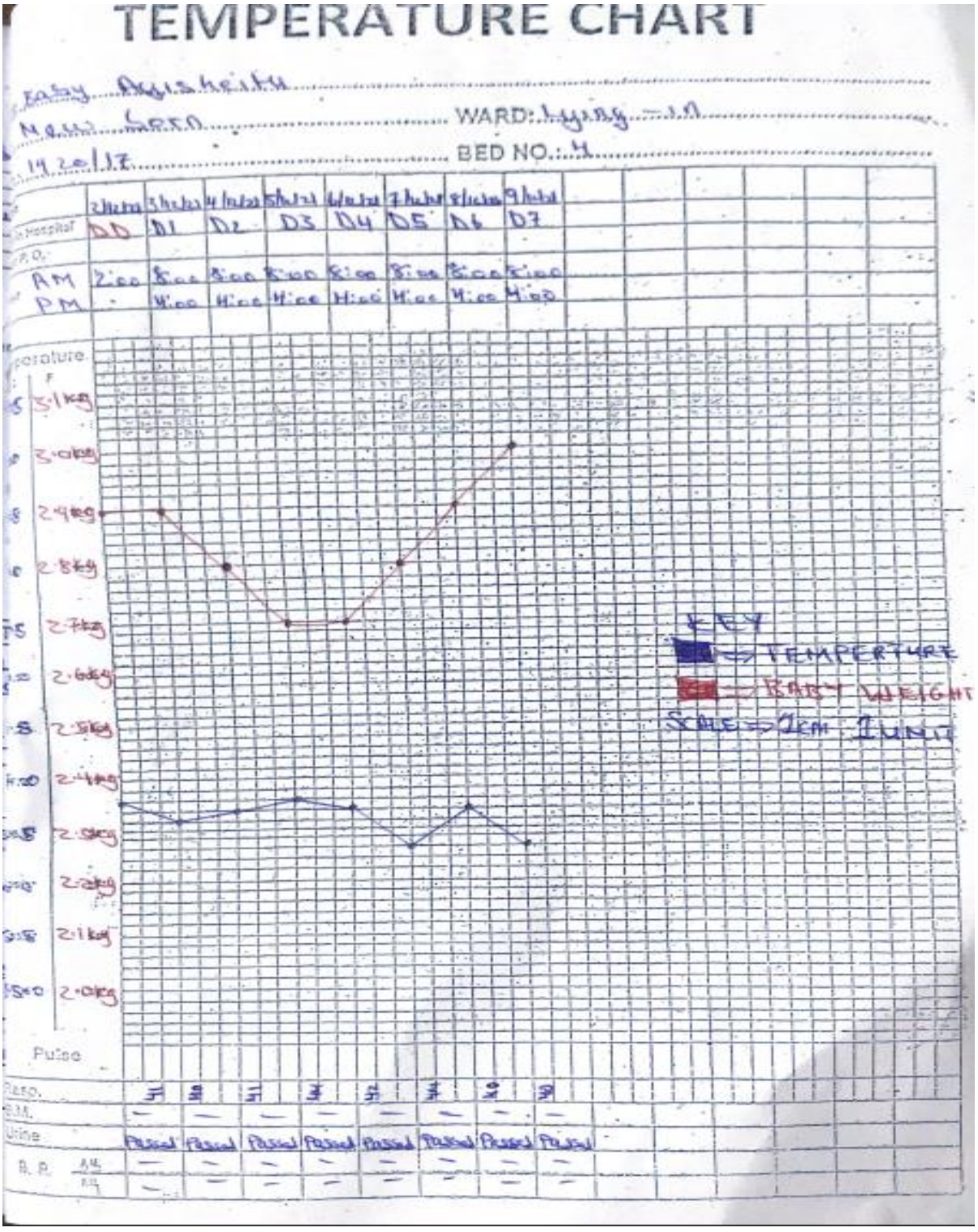
…ition …Pm … b/m * … b/m * … …ns * …* … …Movemnet …eous symmetric …ents …/Absent Movement in …* …ement … …d * …over …dy but blue hands/feet …lover * …ed * …ining pus …ng …* …*	**7. Suck** [✓] Good [ ] Weak [ ] Absent **8. Head swelling** [ ] Caput succedaneum [ ] Cephalhaematoma [ ] Subgaleal hemorrhage [✓] 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: 130bpm [✓] Normal (100-160) [ ] <100 * [ ] >160* **19. Femoral pulse** [✓] Present [ ] Not palpable* **20. Abdomen** [✓] Normal [ ] Distended* [ ] Scarphoid* [ ] Abdominal defect* [ ] Masses: [ ] Other **21. Back (spine)** [✓] Normal [ ] Abnormal Swelling * [ ] Hairly patch over spine [ ] Abnormal dimple [ ] Abnormal curvature	**22. Limbs** [✓] Normal [ ] Abnormal **23. Genitalia** **Male Genitalia** [ ] Normal [ ] Undescended testes [ ] Abnormal meatus [ ] Hernia [ ] Other: **Female Genitalia** [✓] Normal [ ] Fistula(meconium/urine through abnormal opening in vagina) * [ ] Large clitoris * [ ] Other: **24. Anus** [✓] Patent [ ] Imperforate* **25. Resuscitation provided** [✓] One [ ] Suction/stimulation [ ] Bag and mask [ ] Endotracheal Tube [ ] Ventilator/CPAP **26. Services provided** [✓] Vitamin K1 given [✓] Eye care provided [✓] Cord care provided [✓] Breastfeeding initiated [✓] Breastfeeding established [✓] Immunization (BCG/Polio) [✓] BCG [✓] Polio Immunization [✓] Antibiotics in mother [ ] Antenatal corticosteroids

…dicate severe disease that requires urgent referral

…es (if known) Spontaneous vaginal delivery

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

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


TEMPERATURE CHART
WARD:
BED NO.:
KEY
TEMPERTURE
BABY WEIGHT
SCALE => 1KG. UNIT

NEW BORN CHART

Name: Baby Ayisheity ..... No: ..... Birth Weight: 2.9kg .....

Sex: Female ..... Mother's No: IH.Ro.17 ..... Length: 49cm .....

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

Date of Birth: 2/12/21 ..... Time: 2:00am ..... Date of Discharge: 3rd/12/21 .....

Date	2/12/21		3/12/21		4/12/21		5/12/21		6/12/21		7/12/21		8/12/21		9/12/21							
No. of Days	D0		D1		D2		D3		D4		D5		D6		D7							
Weight	2.9kg		2.9kg		2.8kg		2.7kg		2.7kg		2.8kg		2.9kg		3.0kg							
	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM
Temperature	36.8°C		36.6°C	36.4°C	36.7°C	36.7°C	36.8°C	36.8°C	36.7°C		36.3°C		36.8°C		36.3°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							
Remarks	Head Neck Trunck No abnormality detected																					

SIGNATORIES

1. STUDENTS NAME:YEBOAH EDNA

SIGNATURE.....

DATE.....5/10/2022.....

2. NAME OF MIDWIFE IN-CHARGE ; NYARKO DORIS

SIGNATURE.....(f2N).....

DATE.....5/10/2022.....

3. NAME OF SUPERVISOR ; MRS. CELESTINE AHIAWONU

SIGNATURE.....(F2N).....

DATE.....04/09/2022.....

4. NAME OF PRINCIPAL; MS MONICA NKRUMAH

SIGNATURE.....(A).....

DATE.....30th September, 2022.....

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

[COLLEGE STAMP]