

**A PATIENT / FAMILY CARE STUDY ON  
MADAM TWEWA MARGARET**

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**INDEX NUMBER: 4122180036**

**A PATIENT / FAMILY CARE STUDY SUBMITTED TO NURSING AND MIDWIFERY  
COUNCIL OF GHANA IN PARTIAL FULFILMENT FOR THE AWARD OF LICENSE  
TO PRACTICE AS A PROFESSIONAL REGISTERED MIDWIFERY**

**AUGUST - 2022**

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## **PREFACE**

Good health is an essential aspect of life which everyone dreams of having, including expectant mothers who want to have healthy babies. The family centered maternity care study is a comprehensive nursing and midwifery care rendered to a pregnant woman, her family and the community members at large to enable her to go through pregnancy, labour and puerperium safely using complete midwifery measures.

In rendering this type of care, the individual is cared for in all aspects of life including spiritual, social, and psychological as well as her physical wellbeing which are considered within the framework of the family and the community at large.

The family centered care study is also an academic work which gives the student midwife the opportunity to choose a pregnant woman and nurse her through late pregnancy, labour and puerperium, putting into practice the knowledge and skills she has acquired during her training to care for the client.

The family centered maternity care study is also a requirement of the Nursing and Midwifery council (NMC) as a partial fulfilment of the assessment to become a qualified midwife.

## **ACKNOWLEDGEMENT**

My first debt of gratitude goes to the Almighty God for His grace, strength, wisdom and guidance throughout my training and writing of this care study.

Sincerest appreciation is to the entire tutorial and non-tutorial staff of Holy Family Nursing and Midwifery Training College, Berekum and more especially to the Principal, Ms. Monica Nkrumah, my supervisor, Ms. Martha Kyeremaa for her keen supervision and corrections to make this script a success.

Special thanks to my client, Madam Twewaa Margaret and her family for allowing themselves to be used for the care study and providing me with the necessary information required in the writing of the script.

Sincere gratitude goes to the midwife in-charge, Mrs. Christiana Atiemo of Asare Health Centre and her hardworking staff for their support and tolerance given to me during my stay with them. To them I say a big thank you and God bless you all. My warmest gratitude and honor goes to my family more especially my father, Nana Boadu Ayebofo, my mother Mrs. Agnes Osei Bonsu and my siblings (Evans, Ampomah and Prince) for supporting me financially, emotionally and psychologically throughout my three-year course of study, it's my prayer that the almighty God bless them abundantly.

To the authors and publishers whose books were used as references during the writing of the script, God should continue to grant them abundant knowledge and intelligence to help continue with their good work.

## **INTRODUCTION**

The family centered maternity care study consists of the nursing care given to an expectant mother, her family and Community during late pregnancy, labour and early puerperium. This family centered maternity was carried out on Madam Twewaa Margaret, aged 37 years, gravida 3 para 2 all alive. She was nursed from 37 weeks of gestation throughout pregnancy, labour and puerperium at Asare Health Centre. The study began on the 5<sup>th</sup> November, 2021 and lasted for 4 weeks in which delivery and postnatal care was given to her without any complications to her and the baby.

The care study consists of four chapters. Chapter one deals with personal history, medical history, surgical history, past obstetrical history, present obstetrical history, family history and home environment (physical and psychosocial). The chapter two entails antenatal care and problems identified during the care and their interventions. The chapter three also consist of management of labour and identified problems with their interventions. The chapter four also involves management of the puerperium, problems identified and interventions.

## **LITERATURE REVIEW**

### **PREGNANCY**

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

(Weller B.F, 2009) pregnancy is a state of being with a foetus from the time of conception to the expulsion of the foetus. The normal period is 280 days or 40 weeks counted from the last day of the normal menstrual period. Pregnancy is divided into three trimesters, a period of three months in each trimester. The first trimester begins from the fertilization of the ovum to 12 weeks of gestation. The second trimester begins from the 13th week to the 24th week of pregnancy. The third trimester starts from the 25th week to the 40th week. During this period, a lot of physiological changes occur in the body under the influence of hormones which affect all the systems and organs with the greatest change taking place in the uterus as it has to accommodate and nourish the

developing foetus, prepare the woman body for labour, develop her breast and lay down stores of fats to provide calories for production of breast milk during puerperium. Any disorder such as heartburns, constipation, backache due to the physiological changes is managed to prevent further complications which can endanger the life of both the mother and growing foetus.

(King,2014) Pregnancy is a time of profound anatomic and physiologic changes in a woman's body. In addition to the reproductive organs, all maternal physiologic systems make adaptations needed to support the developing foetus and at the same time, maintain maternal homeostasis. Pregnancy last approximately two hundred and sixty-six days (266) or thirty-eight weeks (38) from ovulation. The antenatal period is into trimesters, first trimester is considered to be weeks 1 to 12 (12weeks) because organogenesis is completed at the end of twelve weeks and the risk of spontaneous abortion is significantly reduced at time. Historically, the second trimester was considered to be weeks 13 to 28 weeks was limit of viability. The third trimester extend from 28 to 40 weeks. The term 'post-date' or post term is typically used to describe a pregnancy beyond forty weeks (40).

Fraser & Cooper (2009) all changes in the mother's body during pregnancy are due to the effects of specific hormones. These changes enable her to nurture the foetus, prepare her body for labour and develop her breast and lay down stores of fats to provide calories for production of breast milk during puerperium. Its further states that, the woman's psychological state is also affected by hormonal changes. Its further states that, the gestational period is divided into three Trimesters. During pregnancy, antenatal care is given to the woman throughout the period and should commence from the time pregnancy is diagnosed and continue until the safe delivery of the baby. The assessment components of Antenatal care are history taking, social, menstrual, obstetric, medical and surgical history, family history and lifestyle, risk assessment. Physical examination,

weight, blood pressure, urinalysis, blood test, head to toe examination, and record keeping. Also, every pregnancy is a unique experience for the woman and each pregnancy that the woman experiences differs from the other. This is why it is important that the midwife has a fair knowledge and understanding of the common disorders of pregnancy which include constipation, fatigue, headache, lower abdominal pain, waist pains, leg cramps, backache, increase vaginal discharge, heartburns, frequent micturition and so on in order to educate the woman on how to cope with the condition and minimize its effects on the pregnancy.

Bailliere's Midwives Dictionary (12<sup>th</sup> edition) Pregnancy is the period when the fertilized ovum embeds in the maternal uterus until is born. Is the state from conception to the delivery of the baby; normal duration is 280 days (40 weeks or 9 months and 7 days), counted from the first day of last According normal menstrual period to delivery, or 265 days from conception to delivery.

The anatomical and physiological adaptations occurring throughout pregnancy affect virtually every body system. The timing and intensity of the changes vary between systems but all are designed to support fetal growth and development and prepare the mother for birth and motherhood.

Perry (2006) Pregnancy is the period of physical and physiological preparation for childbirth and parenthood. According to him expectant mother ideally should begin prenatal visit soon after the first missed menstrual period for early detection of complication and to ensure good health of the expectant mother and foetus. He also stated that normal pregnancy last for about forty (40) weeks or two hundred and eighty (280) days and healthcare providers refer to early, middle and late pregnancy as trimesters.

Ojo & Briggs (2006) when pregnancy occurs, menstruation ceases and returns some weeks or months after delivery. The hormones progesterone and oestrogen are produced in large quantities

which exert some action on the various systems of the pregnant woman. The most outstanding of these changes is the growth which occurs in the uterus. The patient is usually the first person to suspect pregnancy. Her suspicion is often based on the fact that she has missed her period, the amenorrhea occurs because, following the implantation of the fertilized ovum.

Marshall & Raynor (2014) 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 informed choices 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:

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

Marie Elizabeth (2013) defines pregnancy as when the woman's egg and a man's sperm cell unit to form zygote. The duration of pregnancy has traditionally been calculated by the clinicians in terms of 10 lunar months or 9 months and 7 days or 280 days or 40 weeks, calculated from the first day of the last menstrual period. This is called menstrual or gestational age. It is divided into 3 trimesters (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.

Tiran (2008) 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 of oestrogen and progesterone which provide nutritive and protective environment for the developing embryo and also prepare the breast for lactation.

Konar (2013) defines 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 7 days or 280 days or 40 weeks 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 3 months is the second trimester (13- 28 weeks) while the last 3 months is known as the 3rd trimester (29-40 weeks).

## LABOUR

Myles (2014) labour may be described as the process by which the fetus, placenta and membranes are expelled through the birth canal. Labour has four stages. Stage one comprises of latent phase and may last 6 to 8 hours in prim gravidae. 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 fetus. It begins when the cervix is fully dilated and the woman has the urge to expel the baby. There is stretching of the clitoris, gaping of the anus and bulging of the

perineum. Labour completes when baby is born. In multigravida women, it last 15-30 minutes. Third stage begins after the expulsion of foetus and ends with the expulsion of the placenta and membranes (afterbirth). The fourth stage is a period of careful observation of the mother made to assess excessive bleeding and the firmness of the contracting uterus immediately after the third stage of labour and it last six hours after delivery of the placenta.

Marie Elizabeth (2013) defines 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. ‘‘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 multiparae. 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 primigravidae. 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.

Marshall & Raynor (2014) the onset of labor is a process; not an event; therefore, it is very difficult to identify exactly when the painless (sometimes painful) contraction of pre labor develop into progressive rhythmic contractions of established labor. Diagnosing the onset of labor 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 labor 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 labor 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 oestrogen cause uterine muscle fibres to display oxytocic receptors and form gap junctions with each other. Oestrogen 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) describes 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 fetus from the birth canal, it starts when the cervix is fully dilated and the woman has the urge to expel the fetus and ends when the fetus is born. The third stage of 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) defines 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.

Frazer and Copper (2009) states that labour is a process by which the fetus, placenta and membranes are expelled through the birth canal and thus 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.

Korah and Philip, (2002) labour is the process by which the foetus, placenta and membranes are expelled through the birth canal. Labour is divided into four stages; first, second, third and fourth stages. The first stage of labour is the period from the onset of regular uterine contractions to full dilatation of the cervical os. The second stage of labour starts with full dilatation of the cervical os to complete expulsion of the baby. The third stage of labour entails complete expulsion of the placenta and membranes and also involves the control of bleeding. During the first three stages, the progresses of labour, the fetal and maternal conditions are monitored closely with the partograph to detect any deviation from normal. The monitoring begins when the woman in labour is in the active phase that is when the cervical os is 4cm dilated. The fourth stage is a period of six hours following the delivery of the placenta. During this period, the mother and baby are closely observed to detect any complications that may arise.

Ojo and Briggs, (1982) labour is the process by which the uterus empties its contents after 38 weeks of pregnancy. They further explained that normal labour starts spontaneously at term with the foetus presenting by vertex and the process is accomplished within 24 hours by an unaided maternal effort without any serious injury to the mother or the baby. Ojo and Briggs also added that labour is divided into four stages. The first stage of labour is the period from the onset of regular uterine contractions to full dilatation of the cervical os. The second stage of labour starts with full dilatation of the cervical os to complete expulsion of the baby. The third stage of labour entails complete expulsion of the placenta and membranes and also involves the control of

bleeding. During the first three stages, the progresses of labour, the fetal and maternal conditions are monitored closely with the partograph to detect any deviation from normal. The monitoring begins when the woman in labour is in the active phase that is when the cervical os is 4cm dilated. The fourth stage is a period of six hours following the delivery of the placenta. During this period, the mother and baby are closely observed to detect any complications that may arise.

## PUEPERIUM

Myles (2008) following the birth of the baby and expulsion of the placenta, the mother enters a period of physical and psychological recuperation. Puerperium starts immediately after the delivery of the placenta and membranes and continues for six weeks. The overall expectation is that by six weeks after the birth of the baby, all the body systems will have recovered from the effects of pregnancy and return to their non-pregnant state. Myles also 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.

McFerrin and Martin, (2004) puerperium is the period of six weeks following the birth of the baby during which the organs that were affected by the pregnancy return to their pre-pregnant state. The woman progressing through the puerperium is called a puerperal woman. During this period, the bruises heal and the genital organs and any other organ which underwent changes during pregnancy return to their pre pregnant state. The process by which the uterus goes back to its pre

pregnant state is called involution. Lactation is also established and the mother recovers from the strains and stress of pregnancy and labour.

Ojo & Briggs (2006) 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. Ojo and Briggs, (1982) also explained that lochia is the term used to describe the discharge from the uterus during the puerperium. During the puerperal period, the woman is educated on what goes on throughout the puerperal period and how to cope with these changes. Also, the puerperal woman needs a lot of rest and sleep, regular exercise, intake of adequate fluids and nutritious diet rich in protein, carbohydrate and vitamins. The mother is educated on how to care for the baby to prevent infections. Among this education include cord dressing, changing of napkins frequently and exclusive breastfeeding. Emphases are also laid on family planning within six weeks after childbirth.

Marie Elizabeth (2013) describes puerperium as the period following childbirth during which the body tissues, especially the pelvic organs revert back approximately to the pre-pregnant state both anatomically and physiologically. The period is divided into;

- Immediate –within 24 hours
- Early- up to 7 days
- Remote –up to 6 weeks
- Immediately following delivery, the uterus becomes firmer and retracted with 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 reverts back to the nulliparous state. Marie Elizabeth further explains that during puerperium the number of muscle fibres is not decreased but there is substantial reduction in the myometrial cell size. The arteries are constricted by contraction of its wall and thickening of the 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 colour of the discharge it is named as:

- Lochia rubra (red) 1 -4 days.
- Lochia serosa (yellowish or pink or pale brownish) 5- 9 days.
- Lochia alba (pale white) 10 -15 days.

The average amount of discharge, for the first 5-6 days is estimated to be 250 ml.

With all definitions and changes it can be deduced that puerperium is the period from birth to 6 weeks of delivery.

Konar (2011) puerperium is the period following childbirth during which the body tissues, specifically the pelvic organs revert back approximately to the pre-pregnant state both anatomically and physiologically. This begins as soon as the placenta is expelled and lasts for approximately six weeks when the uterus becomes regressed to the non-pregnant size called involution, the period is arbitrarily divided into (a) immediate-within 24 hours; (b) early-up to 7 days and remote-up to 6 weeks. In its anatomical consideration, the uterus immediately following

delivery becomes firm and retract with alternate hardening and softening. The uterus measures about 20×12×7.5 centimeters (length, breadth and thickness) and weighs about 1000grams. At the end of six weeks, its measurement is almost similar to that of the non-pregnant state and weighs about sixty (60) grams. The physiological consideration of involution is most marked in the body of the uterus where the changes occur in the muscles, blood vessels and endometrium.

## **WHY CLIENT WAS CHOSEN**

Madam Margaret G3 P2 reported to the antenatal clinic on the 5<sup>th</sup> November 2021 at the Asare Health Centre at 9:00am where she came for her usual antenatal visit. During one on one interaction with the client, it came out clearly that client was not willing to do exclusive breast feeding. Decisions was made to take her as my client to support her practice exclusive breast feeding. The midwife in-charge was informed about the intention to use Madam Margaret for the care study which permission was granted. Care study and what it entailed was explained to Madam Margaret and she readily agreed to be used and promised to give all she could to help throughout the study. She was assured of confidentiality and quality healthcare.

## **CHAPTER ONE**

### **ASSESEMENT OF CLIENT AND FAMILY**

#### **1.1 MEDICAL HISTORY**

According to Madam Margaret, she has never suffered from conditions like heart diseases, hypertension, diabetes mellitus, kidney disease, sickle cell disease, and prolong cough for more than one month. She has no known allergies such as food, drugs, and other substances. She is not on any medication except her routine drugs.

#### **1.0 PERSONAL AND SOCIAL HISTORY**

Madam Margaret Twewaa was born on 25th September, 1984 and is 37 years of age. She is a native of the Bono tribe but resides at Taiano number II. in the Jaman South district of the Bono region. Madam Margaret is fluent in the Bono and Twi dialect. According to her, she had her formal education up to Junior High School. She is a farmer and happily married to Mr. Gyan Johnson. They have been married for eight years and are blessed with two children; a boy and a girl. The first born is eight years old and the second born is three years old.

The couple, together with their children are Christians by religion and always visit the church on Sundays to worship God. Madam Margaret does not have any social habits like smoking or alcoholism as well as her husband. According to her, her husband as well as her mother are very supportive during and after her period of pregnancies. Madam Margaret said her next of kin is her husband who is a farmer and a driver by profession. “fufu” and “light” soup is her favorite

meal but sometimes she also enjoys ampesi and kontomire stew. Her hobbies are cooking and singing. She intends to deliver at Asare Health Centre.

## **1.2 FAMILY HISTORY**

Client, according to her is the second daughter of Mr. Munufie Simon and Madam Grace Adinkra. Madam Margaret has three older siblings; Mr. Samuel Munufie, Madam Sara Munufie and Mr. James Twene. They work as a Teacher and a Trader respectfully. According to my client, there is no known history of hypertension, HIV/AIDS, asthma, heart disease, sickle cell disease, mental illness, birth defects and diabetes mellitus but has a history of multiple pregnancy.

## **1.3 SURGICAL HISTORY**

Madam Margaret said she had never undergone any surgical procedure neither had she ever been involved in any road traffic accident that had affected her pelvis or any of her reproductive organs, which may affect the diameters of the pelvis, making labour difficult. Also, she had no history of ectopic pregnancy and had never received any blood transfusion.

## **1.4 PAST OBSTETRIC HISTORY**

Madam Margaret gravida 3 para 2 all alive carried all her pregnancies to term without any history of complications such as still birth, abortion or ectopic pregnancy. She gave birth to her first child on 6th September, 2013 and her second child on 6th April, 2018. Intervals between her previous pregnancies are five (5) years. According to Madam Margaret, she carried both her pregnancies to term without any ill health like antepartum hemorrhage, pregnancy induced hypertension, anemia and pre-eclampsia. Madam Margaret said she had all her three doses of Sulphadoxine Pyrimethamine (SP) as an intermittent preventive treatment (IPT) against Malaria for each pregnancy. She said she received her first and second doses of tetanol diphtheria immunization during her first pregnancy and her third dose during her second pregnancy. Madam Margaret had spontaneous vaginal delivery for both of her babies with no assistance like caesarean section,

vacuum extraction, forceps delivery or episiotomy. According to her, during her last pregnancy, her labour did not exceed 18 hours and she did not experience any complication like prolonged labour, obstructed labour or cord prolapse. Placenta was delivered completely without any retained products with moderate blood losses in both deliveries. She had an intact perineum following the delivery of her babies. She did not experience any ill health such as post-partum hemorrhage, maternal shock, uterine rupture, amniotic fluid embolism or disseminated intravascular coagulopathy following each delivery. Both babies as well as mother were in good health after delivery and did not encounter any ill health condition after delivery. Her first baby who was a boy weighed 3.2kg and the second girl who is also a boy weighed 3.1kg. She also did not have any problems during puerperium as such puerperal psychosis, puerperal sepsis or infection. Madam Margaret, according to her, practiced exclusive breastfeeding for both her children and continued for two years for both children. She gave her children normal diet immediately after weaning them. She resumed menstruation in six months after the delivery of both her children. She did not practice any artificial family planning method but rather the natural family planning method which is the calendar method. According to Madam Margaret, her babies were fully immunized against the various vaccine preventable childhood diseases like tetanus, measles, diphtheria and others. Her mother was around to support her in the household chores and her husband I.M also supported her financially.

### **1.5 PRESENT OBSTETRIC HISTORY**

As recorded in Madam Margaret's antenatal card, she first reported to Asare Health Centre on 21st May, 2021 when her gestation was 13 weeks old. According to Madam Margaret, her last menstrual period was on 15<sup>th</sup> February, 2021 and her expected date was calculated as 21st November, 2021. Her first fetal movement according to Madam Margaret was felt at the 17th

weeks. According to Madam Margaret, in all her pregnancies she craves for unnatural food substances like dust and clay. During Madam Margaret antenatal visit, past and present obstetrical history were taken. Vital signs, physical examination and monitoring revealed the following; Blood pressure 110/70mmHg, Temperature 36.2°C, Pulse 82bpm, Respiration 22cpm, Weight 65kg, Laboratory investigations results; Haemoglobin 12.4g/dl, Rhesus factor; Positive, Sickling; Negative, VRDL; Negative, Blood group B, Urine for glucose/protein; Negative, HIV screening; Negative, Blood film for Malaria parasite; No malaria parasite seen, HBsAg; Non-reactive, Glucose 6 phosphate dehydrogenase; No defect. Physical assessments were carried out and no abnormalities such as oedema of the extremities, pallor and varicosities were detected. Abdominal examination was done. On inspection striae gravidarum and linear nigra were present. From her records, she complained of lower abdominal pains and waist pains, she was encouraged to have adequate rest, sleep and also avoid strenuous work. She was served the following routine drugs.

Tablet Folic Acid - 5mg daily x 30days

Tablet multivitamin - 200mg once daily x 30days

Tablet fersolate - 200mg tds x 30days

She has received her third doses of tetanol diphtheria and also received her monthly Sulphadoxine Pyrimethamine on direct observational therapies as required.

## **1.6 HOME ENVIRONMENT (PHYSICAL AND PSYCHOSOCIAL)**

According to Madam Margaret, she stays at Taiano number II in her husband's house together with her husband and the two children. She said her house is very neat with toilet and bathroom facility. She also said her house is a compound type built with cement blocks and roofed with

aluminum sheets. Madam Margaret said her family occupies two rooms with her kitchen inside. She said she and her family sleep under a well hanged treated mosquito net.

According to Madam Margaret, she fetches water from a bore hole pipe just in the house next to theirs and stores in a clean container covered with a well-fitting lid. She said their source of light is from electricity and they have a good drainage system. She also said they have a well-covered dustbin in which they dispose their rubbish in and empty it into the public refuse dump every morning. Psychosocially, Madam Margaret said she has a good relationship with her husband as she is very friendly and easily makes friends. She also said she had a good relationship with her children, as well as her neighbor.

## **1.7 LIFESTYLE**

Madam Margaret is a woman who sleeps around 9:00pm and wakes up around 5:00am. when she wakes up in the morning, she does her routine prayer 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, washes her dishes and also prepare her children for school. Client expressed that she normally prepares breakfast for the family before the children goes to school. After preparing breakfast, she takes her bath and takes her children school. 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 becomes ready for the family to enjoy around 5:40pm. She said they all sit together and take their supper around 5:42pm. She normally baths her children and takes her bath right after supper. Thereafter she supervises the kids to do their homework. At 8:30pm, she sees to it that her children go to bed. Madam Margaret said she normally engages

herself in a family chat with her family every night on phone as a means of strengthening their family bond.

## **ANTENATAL CARE**

### **2.0 INTRODUCTION**

Antenatal care is the specialized care that is given to a pregnant woman from the time that conception is confirmed until the beginning of labour in order to maintain a state of good health of the woman and to improve her chances of delivering a healthy baby at term. This chapter talks about the first contact with client, first and second home visits, her subsequent visits to the clinic, problems identified care plan drawn for the resolution of problems. Antenatal services are important to prevent and promote health care.

### **2.1 FIRST INTERACTION WITH CLIENT**

On Friday 5th November, 2021, at 9:00am, client was met at the Asare Health Centre, where client was a regular attendant of. Her antenatal booklet was collected and read to note the previous recording. It was realized she was 37 weeks pregnant and gravida 3 para 2 all alive. The midwife in charge was already informed about a quest to find a client who met the criteria to be used for the client and family centered maternity care study and the midwife in-charge explained and sought consent from the client to be used for the study, the client was found to have met the criteria. Madam Margaret was assisted through the routine laboratory investigations after vital signs were checked and recorded. Her hemoglobin level was 11.8g/dl and her HIV screening result was negative. Client's weight was 85 kilograms. Her vital signs

and weight were checked and recorded as: Temperature 36.1°C, Pulse 84 bpm, Respiration 24 cpm, Blood pressure 110/70mmHg, Body weight 85kg, Haemoglobin 11.8g/dl.

After all these procedures, she was asked to empty her bladder and specimen bottle was given to her to collect mid-stream specimen of urine to test for urine protein and glucose. Protective clothing like apron and gloves were worn. The quantity, colour, odour, smell and sediments were noted. A chemically prepared strip was picked and dipped into the urine sample. The strip was immediately removed and the edge of the strip taped against side of the urine container to prevent spilling of urine onto the clothes. After one (1) minute, the stick was compared with the corresponding colour on the container. There was no change in color of the strip indicating a negative result when compared closely with the corresponding color chart on the container. Findings were recorded and discussed with both midwife in-charge and client. Client's permission was sought to perform physical examination from head to toe and the procedure was explained to her. Bladder was emptied, privacy was ensured and she was helped to undress, assisted to lie on the examination couch and covered with a clean cloth. Hands were washed with soap and water and dried with clean dry towel. Client was examined from head to toe, under supervision of the midwife in charge.

#### Physical examination

Head; the head was examined first during the physical examination. Client hair was examined for cleanliness, lice, dandruff, ringworms, alopecia, skin infection and any other abnormalities but none was detected. Madam Margaret was congratulated and praised for keeping her hair clean and advised to keep it up. Client's face was then inspected for edema, rashes and chloasma and nothing abnormal was detected. Her eyes were also inspected for pallor of the conjunctiva; yellowish (jaundice) of the sclera but no abnormality was detected. The ears were also inspected for discharge

and alignment with the eyes and nothing abnormal was detected. The mouth was inspected for dryness, cracks, and infection of the lips. The gum and tongue for pallor, sores or lesions and the teeth for decay but no abnormality was detected. She was encouraged to brush her teeth two times daily and rinse her mouth after each meal. The neck was palpated for enlarged thyroid gland, distended neck vein and enlarged lymph nodes and no abnormality was detected.

Breast examination; the procedure was explained to client and consent was sought before her breast was exposed. The breast was exposed to check for size, shape, signs of pregnancy, dimpling and nipple retraction and condition of the skin. One breast was covered and she was asked to put her hand of the part to be examined under her head. The breast was palpated systematically in a circular manner using the inner aspect of the fingers and client was taught self-examination. Nipples were squeezed gently for colostrum and were examine for odour, blood which were cleaned with a clean cotton wool swab. The same procedure was done for the other breast and no abnormality was noted. Client breastfeeding history was inquired and client verified desire to breastfeed exclusively 6 months as it done for her son. Client was reminded to examine breast at home as it was done at the facility frequently and if she sees any abnormality she should report to the health Centre.

Extremities: Madam Margaret was asked of tingling and tightness of the finger on making a fist, the hands and fingers were inspected for edema, pallor in the palm and nail bed and no abnormality was noted. The finger nails were well trimmed. The legs were inspected for size and equality and palpated for edema, tenderness in the calf muscles, size, and equally but no abnormality detected. She was encouraged to avoid prolonged standing and to perform regular exercise like walking to enhance proper circulation to prevent varicosity. Back; the back was examined for deformity of the spine (scoliosis), edema of the sacral region and no abnormality was detected.

## Abdominal examination

The procedure and the reason for this examination were explained to the client's understanding. The purpose for this examination is to observe the signs of pregnancy, assess fetal size and growth, auscultate for fetal heart, locate fetal parts, and detect any deviation from normal. She was assisted to lie in a dorsal position with arms by her side to relax the abdominal muscles. Hands were washed with soap and water and dried with clean towel. Standing on her right hand side the abdomen was exposed. On general palpation of the abdomen there was no tenderness, masses, enlargement of the spleen and liver as well as supra pubic tenderness.

Inspection; during inspection of the abdomen it was observed to be ovoid in shape and medium in size. There was the presence of linea nigra and striae gravidarum. No scars were found on the abdomen which indicates signs of previous surgical procedure performed on the abdomen such as caesarean section and myomectomy. On questioning client about the presences of quickening, Madam Margaret said she felt fetal movement.

Measurement of symphysio fundal height; to measure the symphysio fundal height the hands were warmed by rubbing palms together before the upper border of the symphysis pubic and the uterine fundus were located. The zero part of the tape measure was placed on the fundus and extended along on the contour of the abdomen along the midline to the upper border of the symphysis pubis. The tape measure was recorded in centimeters. The symphysio fundal height was 35cm.

Fundal palpation; the procedure was explained to the client and permission was granted. The palm was warmed. The palm was faced and the palm was placed on either side of the fundus after

warming them. The fingers were curved around top of the fundus to determine what lies in the fundus or upper pole of the uterus. A soft part was felt in the fundus which indicated the buttocks. The fundal height compared with gestational age. The symphysio fundal height measured 35cm and gestational age was 37 weeks which corresponded with the expected date of delivery.

Pelvic palpation; the woman's feet were faced and she was asked to bend knees slightly in order to relax the abdominal muscle. She was helped to relax by guiding her to breathe out slowly. The palms of the hands were placed on either sides of the uterus, with the palms just below the level of the umbilicus and the fingers directed towards the symphysis pubic and thumbs almost meeting. A hard mass was felt at the lower pole of the uterus which indicated the head.

Descent palpation; by abdominal palpation, descent was assessed in term of fifths of fetal head palpable above the symphysis pubic. The anterior shoulder was located below the umbilicus and two fingers were placed over the anterior shoulder. Symphysis pubic was located and the right ulna border was placed just above the symphysis pubis and the anterior shoulder. Five finger breath were accommodated which is 5/5.

Auscultation; the fetal stethoscope was warmed by rubbing in palm and placed on the right side of the mother's abdomen. Maternal pulse was located. The ear was placed against the stethoscope to listen to fetal heart beat for one minute comparing with maternal pulse. The rhythm and volume was recorded. The fetal heart rate was 140 beats per minute strong and regular. Madam Margaret said she felt fetal movement when she was asked.

**Vulva examination:** Client permission was sought for vulva inspection and she agreed. A pillow was placed under her head and covered by blanket to provide warmth. The vulva was well shaved and clean. Hands were washed with soap and water and was dried with a clean towel, clean gloves

worn on both hands and the vulva and the perineum was examined for abnormal discharges, rashes, warty growth and ulcers, episiotomy scars and varicose veins. The labia majora was examined for size and shape, redness, swelling and tenderness and nothing abnormal was detected.

Madam Margaret was thanked for her cooperation and all findings were communicated to her. All equipment's used were decontaminated appropriately. The gloves were removed and also discarded. Hands were washed thoroughly with soap under running water and dried with a dried towel. Client was encouraged to have enough rest and also taught how to perform exercise in pregnancy such as pelvic rock which will help relieve backache, head and shoulder lift which strengthens abdominal muscles, kegel exercise which strengthens pelvic floor muscles that makes delivery easier and rib cage lift which strengthen leg muscles and also it improves breathing. Client was also encouraged to her drugs as prescribed. Health was given on birth preparedness and complication readiness plan, eating of nutritious diet that is food that contains energy given food, body building food and protective food to prevent anemia. The following drugs were given to Madam Margaret;

- Tab Ferrous Sulphate 60mg daily for 7 days
- Tab Multivitamin 200mg daily for 7 days
- Tab Folic acid 5mg daily for 7 days
- She gave directions to her house and phone numbers were exchanged. Having agreed to be used for the study, arrangement was made to visit her house on 7th November, 2021. She was thanked and saw her off to the exit of the clinic.

## **2.2 FIRST HOME VISIT TO CLIENT**

The first visit to Madam Margaret's house was on 7<sup>th</sup> November, 2021 at 2:30pm. The main aim of the visit was to know where she lived and meet other members of her family and also talk about birth preparedness and complication readiness plan. On the way to her house, it was observed that the road leading to her house was tarred, in good shape and easily accessible by vehicles. It was not too difficult locating the client's house by using the directions given, just behind the bore hole water. On arrival at Madam Margaret's house, it was observed that all members of the family were home because it was Sunday, they did not go to farm. There was establishment of rapport which interaction with her started. Madam Margaret lived with her husband and two children in a well roofed, cream painted block house. The house had enough windows for adequate ventilation. She was educated to open the windows everyday so as to ensure that there was enough fresh air circulating in the room to help prevent the spread of diseases. Their source of water was a bore hole pipe. Madam Margaret had a big barrel with a well-fitting lid in which she stores her water and use when there is a water shortage. She was educated to have her barrel cleaned regularly with soap and water to prevent the barrel from harboring germs that may contaminate the water stored in it and in turn cause diseases. Her compound was clean and there was a well-covered dustbin at the corner of her house where she disposed her rubbish. Client stated it was emptied daily at a nearby refuse dump. They had a very good drainage system. Madam Margaret and her family were sleeping in a well hanged treated mosquito net. She was commended on the cleanliness of her environment and was encouraged to always keep her surroundings clean to prevent diseases and breeding mosquitoes. Her husband was encouraged to ensure Madam Margaret keeps physically active during pregnancy so as to help her stay healthy and prevent

excessive weight gain and also the exercise should not be strenuous and she should take breaks between activities so as to avoid unnecessary stress. Her family was encouraged to help her in household chores so she could have enough rest. Items for delivery were brought for inspection and it was complete. She was congratulated for purchasing all the items and was encouraged to add her National Health Insurance card and some money along not forgetting her antenatal booklet. Enquiries about her previous complains of constipation and heartburns were made and she said she had regained her normal bowel movement and is coping with the heartburns as well. She again complained of mild backache. It was explained to her that it was a physiological disorder during pregnancy and that, it was due to the effects of estrogen and relaxin hormones which relax the sacroiliac ligaments and the exaggeration of the lumbar curve by the weight of the gravid uterus. She was then encouraged to have enough rest, practice good posture and wear low heeled shoes to help relieve the backache and to take her drugs as prescribed. She and her family were thanked for their cooperation and left with the promise of visiting her again. She was also reminded of her next visit to the hospital which was on 12th November, 2021.

### **2.3 SECOND HOME VISIT**

The second home visit to Madam Margaret was on Saturday 13<sup>th</sup> November, 2021 around 4:00pm. Greetings were exchanged. Her husband was around and her mum and her children were present. The compound was observed and it was clean. She was congratulated on that and told her to keep it up. Enquiries about the rest of the things for confinement was made and it was realized that they were completed and neatly packed. Reinforcement on the education given previously on eating a healthy diet, exercise, enough rest and sleep was done. She was also educated on deep breathing exercises which she will be using during labour. She was reminded on the signs of true labour, birth preparedness and complication readiness. She was asked if she had any complains and she

mentioned she had been having frequent urination and fatigue as well. The physiology was explained to her that it was as a result of pressure of the enlarging uterus on the urinary bladder reducing the capacity of the bladder and thus making her urinate frequently and it was as a result of the stress of pregnancy that made her feel tired(fatigue). She was educated to have enough rest and sleep. Permission was sought to leave. She was thanked for her co-operation.

#### **2.4 SUBSEQUENT VISIT TO THE CLINIC**

Madam Margaret reported to the clinic 12th on November, 2021. She was warmly welcomed and asked of her health and that of the family members which she responded they were in good health. She was taken through the routine examination and made the following observations which was recorded as; Temperature 36.3°C, Pulse 84bpm, Respiration 24cpm, Blood pressure 100/60mmHg, Body weight 86kg, Urine for sugar and protein; negative.

Madam Margaret was asked to empty her bladder. She was instructed to collect the midstream urine which she did. The urine sample was tested for protein and glucose which both came out as negative. Privacy was provided for her and she was assisted to undress and lie dorsal on the couch. Hand hygiene was performed and under the supervision of the midwife in-charge, she was examined and no abnormalities were detected.

During the inspection of the mouth, she was asked if she had consumed any non-nutritious substance and she said no. She was congratulated for complying with the education that was given to her. An examination was done on her abdomen. On fundal palpation, the symphysio fundal height was 36cm with gestational age of 38 weeks. Position was right occipito anterior, the lie was longitudinal on lateral palpation and presentation was cephalic. The descent was 5/5th above the pelvic brim on pelvic palpation. On auscultation, fetal heart rate was 138bpm with regular and a good volume. She was helped to get off the couch to dress up. All findings were communicated

to her and was recorded in the antenatal record book. About her previous complains on back pains, she said she is coping with the pains. She was able to summarize the education given on backache during the last visit. She was encouraged to take her routine drugs and was also educated to report to the clinic if there is any problem. She was thanked and reminded of my next visit and was accompanied to the road side and bid farewell.

### **SUBSEQUENT ANTENATAL VISIT TO THE CLINIC**

On 19th November 2021, Madam Margaret reported to the clinic. She was received warmly and offered a seat. She was asked of her health and that of her family and she said they were all doing well. Client was taken through the routine examination and the following observations were made and recorded as: Temperature 36.2°C, Pulse 84bpm, Respiration 24cpm, Blood pressure 100/70mmHg, Weight 86kg.

Madam Margaret was asked to empty her bladder and take a sample of her urine for protein and glucose testing. Both tests came out negative. The general physical examination that was performed on her revealed no abnormalities. On abdominal examination, fundal height was 36cm. The lie was longitudinal, presentation was cephalic and descent was 5/5th palpable abdominally and gestational age was 38 weeks. On auscultation, fetal heart rate was 137bpm and regular with good volume. Madam Margaret was helped off the couch and all findings were communicated to her and recorded in her antenatal card. She had no complains and made known that she was coping with the frequent urination and fatigue. She was then told to continue with her routine drugs. She was thanked for her cooperation and advised to report to the hospital anytime labour sets in and then saw her off to the gate.

## **2.5 NURSING CARE PLAN DURING ANTENATAL**

Nursing care plan is a guide to nursing care rendered to a client as an individual with specific needs that ought to be addressed. It involves identifying problems, analyzing them, setting objectives and implementing interventions that will meet the objectives. Evaluation is part of the process and it is carried out to ascertain whether the goals or objectives set have been achieved.

### **PROBLEMS IDENTIFIED DURING ANTENATAL CLINIC**

1. Heartburns
2. Constipation
3. Backache
4. Fatigue
5. Frequency of micturition

### **SHORT TERM OBJECTIVES**

1. Client's heartburns will be reduced within 72 hours and cope with throughout pregnancy.
2. Client will pass stools once within 48 hours.
3. Client backache will be subside within 72 hours and cope with it throughout pregnancy.
4. Client fatigue will be reduced within 32 hours and cope throughout pregnancy.
5. Client will cope with frequency of micturition till 72 hours after delivery.

### **LONG TERM OBJECTIVES**

Client will go through pregnancy, labour and puerperium successfully without any complication to the mother

**TABLE 1: NUSING CARE PLAN DURING ANTENATAL**

<b>DATE / TIME</b>	<b>NURSING DIAGNOSIS</b>	<b>NURSING OBJECTIVE/ OUTCOME CRITERIA</b>	<b>NURSING ORDERS</b>	<b>NURSING INTERVENTION</b>	<b>DATE / TIME</b>	<b>EVALUATION</b>	<b>SIGN</b>
07/11/21 2:30pm	Heartburns related to regurgitation of stomach's content.	Client's heartburns will be reduced within 72 hours and cope with pregnancy as evidenced by; Client's action.	<ol style="list-style-type: none"> <li>1.Reassure client.</li> <li>2. Explain the physiology of heartburns to client.</li> <li>3.Encourage client to elevate the head end of the bed.</li> <li>4.Encourage Client to minimize the intake of fatty and spicy meals.</li> <li>5.Encourage client to minimize the intake of caffeinated drinks and acidic foods.</li> <li>6.Serve prescribed drugs.</li> </ol>	<ol style="list-style-type: none"> <li>1.Client was reassured that her heartburns will resolve by the end of the pregnancy.</li> <li>2. The physiology of heartburns was explained to client.</li> <li>3. The head end of her bed was elevated with pillows.</li> <li>4. Client was encouraged to minimize the intake of fatty and spicy meals.</li> <li>5.Client was encouraged to minimize the intake of caffeinated drinks and acidic foods.</li> <li>6. Prescribed drugs was served.</li> </ol>	10/11/21 2:30pm	Heart burns reduced as indicated.	A C

**TABLE 2: NURSING CARE PLAN DURING ANTENATAL**

<b>DATE / TIME</b>	<b>NURSING DIAGNOSIS</b>	<b>NURSING OBJECTIVES</b>	<b>NURSING ORDERS</b>	<b>NURSING INTERVENTIONS</b>	<b>DATE / TIME</b>	<b>EVALUATION</b>	<b>SIGN</b>
7/11/21 2:30pm	Constipation related to slow intestinal peristaltic movement.	Client will pass stools once within 48hours. as evidenced by client verbalizing it.	1.Explain the physiology of constipation to client. 2.Encourage client to take in 8 sachet of water every day. 3.Encourage client to take in foods rich in fiber and roughages three times a day. 4.Encourage client to engage in exercise.	1. The physiology of constipation in late pregnancy was explained to client. 2.Client was encouraged to take in 8 sachet of water every day. 3.Client was encouraged to take in fruits and vegetables three times a day. 4.Client was encouraged to engage exercises such as walking.	9/11/21 2:30pm	Constipation reduced as indicated.	A C

**TABLE 3: NURSING CARE PLAN DURING ANTENATAL**

<b>DATE / TIME</b>	<b>NURSING DIAGNOSIS</b>	<b>NURSING OBJECTIVE</b>	<b>NURSING ORDERS</b>	<b>NURSING INTERVENTIONS</b>	<b>DATE / TIME</b>	<b>EVALUATION</b>	<b>SIGN</b>
7/11/21 2:30pm	Backache related to relaxation of the pelvic ligaments by the hormone relaxin.	Client backache will be subside within 72 hours and cope with it throughout pregnancy. as evidenced by client's behavior.	1.Reassure client. 2.Teach client good body mechanisms. 3.Explain the physiology of the backache to client. 4.Give client sacral massage. 5.Serve prescribed analgesics.	1.Client was reassured that she will be relieved after delivery. 2.Client was taught good body mechanisms. 3.Physiology of backache was explained to client. 4.Sacral massage was given to client. 5.Prescribed analgesics was served.	10/11/21 2:30pm	Backache reduced as indicated.	A C

**TABLE 4: NURSING CARE PLAN DURING ANTENATAL**

<b>DATE / TIME</b>	<b>NURSING DIAGNOSIS</b>	<b>NURSING OBJECTIVES</b>	<b>NURSING ORDERS</b>	<b>NURSING INTERVENTION</b>	<b>DATE / TIME</b>	<b>EVALUATION</b>	<b>SIGN</b>
13/11/21 4:00pm	Frequent urination related to descending fetal head pressing on the bladder .	Client will cope with frequent urination till 72 hours after delivery as evidenced by client's behavior.	1.Reassure client.  2.Encourage client to reduce the intake of fluids when she is about to go to bed.  3. Explain the physiology of frequency of micturition to client.  4.Encourage client to place a pail close to her for easy access.	1. Client was reassured of normal micturition after child birth.  2.Client was encouraged to reduce fluid intake when she is about to go to bed.  3.Physiology of frequent in micturition was explained to client.  4.A pail was put at client's reach.	17/11/21 4:30pm	Frequent urination reduced as indicated.	A C

**TABLE 5: NURSING CARE PLAN DURING ANTENATAL**

<b>TIME/DATE</b>	<b>NURSING DIAGNOSIS</b>	<b>NURSING OBJECTIVES</b>	<b>NURSING ORDERS</b>	<b>NURSING INTERVENTIONS</b>	<b>DATE / TIME</b>	<b>EVALUATION</b>	<b>SIGN</b>
13/11/21 4:30pm	Fatigue related to stress from pregnancy.	4 Client fatigue will be reduced within 32 hours and cope throughout pregnancy as evidenced by client's behavior.	<ol style="list-style-type: none"> <li>1. Reassure client.</li> <li>2. Encourage relatives to assist in household chores.</li> <li>3. Educate client to rest in between activities.</li> <li>4. Encourage client to reduce household activities.</li> <li>5. Teach client good body mechanisms.</li> </ol>	<ol style="list-style-type: none"> <li>1. Client was reassured.</li> <li>2. Client's husband was encouraged to assist his wife in household chores.</li> <li>3. Client had rest and sleep for 2hours in between activities</li> <li>4. Client was encouraged to reduce household activities</li> <li>5. Client was taught good body mechanisms.</li> </ol>	14/11/21 4:30pm	Goal fully met as evidenced by client's behavior.	A C

## **CHAPTER TWO**

## **CHAPTER THREE**

### **MANAGEMENT OF LABOUR**

#### **3.0 INTRODUCTION**

This chapter talks about labour and involves management of the first stage of labour, management of second stage of labour, immediate care of the baby at birth, management of third stage of labour, examination of the placenta and membranes and management of fourth stage of labour.

#### **3.1 ADMISSION AND MANAGEMENT OF FIRST STAGE OF LABOUR**

Madam Margaret reported to the hospital on 21st November, 2021 at 5:10pm. Madam Margaret was accompanied by her sister - in law and complained of severe waist pains, lower abdominal pain and painful rhythmic uterine contraction. They were warmly welcomed, offered a seat. Her antenatal card was collected and quickly glanced through. Her labour history was taken and according to Madam Margaret she started seeing signs of labour such as show and painful uterine contractions around 12:30pm. She was inquired about any intake of drugs at home before coming to the hospital and she said no. She also said she didn't take any food before coming and she had been vomiting since 4pm, client was reassured and the physiology was explained to her to be hormonal changes. She was asked if she felt the fetal movement and she said yes. She was also asked if her membranes had ruptured and she said no. She was then admitted into the admission and discharge book and recorded all history and findings as well as documentation of her details in the ward state. Madam Margaret's delivery items were checked and labeled. She appeared anxious and looked tired. She was reassured that she was in safe hands and that she will be taken care of by competent and hardworking staff. She was asked to empty her bladder and the amount

of urine passed was 150mls. Her urine was then collected and tested for protein and glucose which both came out as negative. She was provided privacy at her bed side and was assisted to change into an examination gown and assisted to lie in a left lateral position and her vital signs was checked and recorded as follows; Temperature 36.3°C, Pulse 90bpm, Respiration 24cpm, Blood pressure 100/70mmHg

A tray for head to toe examination and another for vaginal examination were set. The procedure was then explained to her which she had knowledge about because she had been previously educated on. Hand hygiene was performed. The hands were warmed and placed on her fundus to time her contractions for 10minutes. Her contractions were 3 in 10 lasting for 30 seconds respectively. On auscultation with the fetoscope, the fetal heart rate was 130bpm with good volume and regular rhythm. She was examined from head to toe and there were no abnormalities. She was informed that she had to be examined on her abdomen using inspection and palpation. She was assisted to lie in a dorsal position for the abdominal examination. On inspection, the abdomen was globular in shape with no scars and the size corresponded to the gestational age which was 38+3weeks. Striae gravidarum and linear nigra were present. Fetal movement was also present. Symphysis-fundal height was 36cm. Fundal palpation was done with the fetal buttock occupying it. On lateral palpation, fetal back was at the right side indicating left occipito anterior position. With her legs bent slightly, she was asked to breathe through the mouth. Pelvic palpation was done on her which revealed the presentation to be cephalic and descent was 5/5th palpable abdominally. Permission from Madam Margaret to perform vaginal examination was sought and she agreed. Still in the dorsal position, she was instructed to flex her knees. Hand hygiene was done and sterile gloves were put on. On inspection, the vulva was clean and the mons veneris was shaved. There was no scar from previous birth, edema, vulva warts or varicose veins. The

perineum was intact. The vulva with sterile cotton wool swabs soaked in savlon solution. The middle and index finger were into her vagina. The vagina was warm, moist and its walls were easily distensible. The cervix was soft, elastic and effaced. The cervix was situated at the posterior fornix of the vagina. The presenting part was well applied to the cervix. The cervical dilatation was 4cm with the membranes intact, no molding felt. Ischial spines were blunt and pubic arch was wide, sacral promontory was not reached at 11cm. There was a blood stained mucoid (Show) on the examining fingers. The midwife in-charge confirmed the findings that Madam Margaret was in true labor. The vulva was then cleaned and she was asked to apply a new clean pad. She was then made comfortable in bed and assisted to lie at the left lateral position to prevent supine hypotension syndrome. The findings were communicated to her and recorded on the partograph and in the nurse's notes. She was thanked her for cooperation and informed that monitoring of her contractions would be done, fetal heart rate and maternal pulse would be checked every 30minutes. It was added that, her cervical dilatation, descent, blood pressure and temperature will also be checked every 4 hours. It was also made known to her that her urine will be checked anytime it was passed out. She was encouraged to empty her bladder frequently to facilitate the descent of the fetal head and improve uterine contractions. She was also encouraged to change her perineal pad whenever it was soiled to prevent infection, to walk around to aid in descent and also told to lie on her left side to allow increased blood supply to the placenta site. She was encouraged to walk around to help alleviate the pain and help labor progress. Client was thanked for her cooperation and was reassured of competent care. Findings were documented as at 9:00pm; uterine contraction 2:10 lasting for 20 and 25 seconds respectively, fetal heart rate 136bpm, maternal pulse 90bpm, maternal blood pressure 110/70mmHg, membranes intact, descent 3/5<sup>th</sup>, molding (0), temperature 36.6.

## **PREPARATION FOR BIRTH**

In preparing for birth, helpers were identified including the skilled and unskilled personnel. The midwife in-charge was identified as the skilled personnel and the client's mother was identified as the unskilled personnel. The doctor on call was notified about the client's admission. Client's brother had donated blood at the blood bank when an enquiry was made. Emergency boxes (like PPH and Eclampsia) with their appropriate items were available. The delivery room had been already cleaned. Client was encouraged to wash hands and she was informed that the windows will be shut and fans will also be put off to provide a warm environment for the baby when it is time for delivered of which she agreed. Room was well lighted and ventilated. Madam Margaret was also educated that the baby would be delivered onto her abdomen on a sterile towel and she will have to support the baby. She was also informed that her abdomen will be cleaned for skin-to-skin care with the baby. The resuscitation box had all the items needed such as a stethoscope, scissors, cord clamp, sucker, self -inflating bag and mask of different sizes. The self-inflating bag was tested to see whether it was functioning, also the radiant bulb was switched on to provide warmth to the cot. Other items like cot sheets were also made available. Referral centers and their numbers as well as ambulance and its driver were all checked to be available. Delivery items were also made available. Client was encouraged to assume any position favorable but not harmful to her. She was encouraged to possibly assume a left lateral position to increase placental perfusion and prevent supine hypotension. She was encouraged to ambulate to aid in the descent of the fetal head. A bed pan was provided for her and was encouraged to urinate when she feels the urge to

further aid in descent of the fetal head. Client was encouraged to take in water or any sweetened fluid to prevent dehydration. Madam Margaret was reminded of the deep breathing exercises so as to conserve energy for the second stage. Sacral region was massaged during contractions to relieve her from pain and was continuously and closely monitored on the partograph throughout the first stage of labour, maternal and fetal conditions were recorded and labour progressed well. Client was monitored on the partograph as follows; fetal heart rate, uterine contractions and maternal pulse were checked every thirty (30) minutes. The cervical dilation, descent, membranes, molding, blood pressure and temperature were checked every four (4) hours. Urine test for protein and acetone was done every four (4) hours. Client was reassured again of competent care to be rendered and all procedures were explained before their performance. All findings were communicated to her. At 10:50pm, uterine contraction was recorded as 2:10 lasting 30 and 35 seconds respectively, fetal heart rate 132bpm, maternal pulse 88bpm. At 10:50pm, uterine contraction was 3:10 lasting 30, 35 and 38 seconds respectively. Fetal heart rate 134, maternal pulse 88bpm. Madam Margaret complained of lower abdominal pains, she was reassured and the physiology of the abdominal pains was explained to her. She was asked to take deep breathing exercise with each contraction and rest in between. At 10:50pm, uterine contraction was 3:10 lasting 35, 38 and 40 seconds respectively, fetal heart rate 138bpm, maternal pulse 88bpm. At 10:50pm, uterine contraction was 3:10 lasting 36, 38 and 40 seconds respectively, fetal heart rate 142bpm, maternal pulse 89bpm. At 10:50pm, uterine contraction was 3:10 lasting 30, 35 and 40 seconds respectively, fetal heart rate 146bpm, maternal pulse 86bpm. Client complained of hunger and she was given milo beverage which she took about 200mls. At 10:55pm uterine contraction was 3:10 lasting 30, 36 and 40 seconds, fetal heart rate 144bpm, maternal pulse 86bpm. At 11:00pm uterine contraction was 3:10 lasting 35, 38 and 42 seconds, fetal heart rate 145bpm, maternal pulse 86bpm. At

11:00pm, vaginal examination was due. The procedure was explained to client and permission was sought from her which was granted. Vaginal examination was done on her under aseptic technique and the cervical dilation was 8cm with descent of 1/5<sup>th</sup> with membranes intact. There was no molding. Client passed 200mls of urine which was tested for protein and glucose. Both were negative. Vital signs were checked and recorded as blood pressure 110/70mmHg, temperature 36.4°C, maternal pulse 88bpm, fetal heart rate 146bpm, uterine contraction 3:10 lasting 42, 48 and 50 seconds. At 11:00pm uterine contraction was 3:10 lasting 45, 50 and 55 seconds, fetal heart rate 150bpm, maternal pulse 88bpm. Client was sweating profusely during the peak of contractions. Her face was wiped with a damp towel and she was also given about 200mls of water to drink which she vomited about 100mls. At 11:05pm, uterine contraction was 3:10 lasting 50, 55 and 58 seconds, fetal heart rate 150bpm, maternal pulse 88bpm. Madam Margaret complained of feeling the urge to bear down as well as passing faeces. She was informed that it was almost time for the baby to be born. She was encouraged to continue with the breathing exercises and not to push until she was told to do so. Descent was 0/5<sup>th</sup> palpable abdominally. Vaginal examination was repeated and cervical dilatation was 10cm which indicated full dilatation. Membranes ruptured spontaneously with clear liquor and ++ molding. The client was encouraged to breathe through her mouth. The perineum was quickly examined, the vulva and anus were gaping, perineum was bulging and a trickle of blood was evident. Progress of labour was communicated to the midwife in-charge which she confirmed client was ready to be delivered. All findings were plotted on the partograph and explained to client. Madam Margaret was transferred to the second stage room and helped onto the couch. She was reassured of competent working staff.

### **3.2 MANAGEMENT OF SECOND STAGE OF LABOUR**

Madam Margaret was sent to the second stage room at 11:05pm and was helped to get onto the delivery bed and positioned in a dorsal position. A sterile delivery trolley was sent to her bedside. Her knees were flexed with thighs wide apart and feet on the stirrups as she lay on the delivery bed. All procedures were explained to Madam Margaret and she was reassured. Her abdomen was covered with a sterile cot sheet. Protective clothing was worn (mackintosh apron, safety boots, goggles, and nose mask). Handwashing was done and two pairs of sterile gloves were put on. Madam Margaret's vulva was swabbed with sterile swabs soaked in savlon solution. A clean pad was applied to her anal region to prevent fecal contamination of the delivery area. She was then told that her baby will be delivered onto her abdomen and reassured her again to help allay her anxiety. Madam Margaret was encouraged to push with each contraction and rest between contractions to prevent exhaustion. The fetal heart rate and maternal pulse were checked in-between contractions. This was to detect any deviation from normal and give early treatment but all were normal. The fetal head advanced gradually with each contraction. The fingers of the right hand were placed on the advancing head to maintain flexion in order to allow the diameter of the fetal skull to distend the perineum and vulva while supporting the perineum with a pad in the left hand. Descent of the head continued till the head crowned. After crowning, Madam Margaret was told not to push but pant to prevent rapid expulsion of the head which can result in the perineum to tear. The head was delivered by extension as the sinciput, face and chin swept the perineum. Cord around the neck was checked but there was none. The eyes were cleaned with sterile swabs from the inner canthus to outer canthus. There was restitution of the head, internal rotation of the shoulders and external rotation of the head. Hands was placed on both lateral aspects of the head and Madam Margaret was asked to push gently with the next contraction while a gentle downward

traction was applied and the anterior shoulder was delivered. The posterior shoulder was also delivered right after the anterior shoulder. The rest of the body was delivered by lateral flexion onto Madam Margaret's abdomen at 11:10pm. The baby delivered was a live male infant and she cried soon after birth with an APGAR score in the first minutes of 9/10, 10/10. Client was congratulated on the safe birth of her new born and thanked her for her cooperation and effort throughout the delivery.

### **IMMEDIATE CARE OF THE BABY**

Immediately the baby was born, he was with warm cord sheet. There was no suctioning of the mouth and nose since the baby had a good breath and cried as soon as he was delivered. This indicated patency of airway. A cap was placed on her head and socks on her feet to prevent hypothermia. The baby was placed skin to skin on his mother's abdomen to promote bonding and provide warmth. The baby was then covered with a warm clean sheet. After three minutes of birth, the first gloves which was by then soiled was removed in order to use the second gloves. The cord was clamped with cord clamp about 3cm away from the abdomen of the baby and the artery forceps was clamped 2cm away from the first clamp. The cord was covered with gauze to prevent splashing of blood and was cut to separate the baby from the mother. The baby was showed to the mother to identify the sex which she confirmed to be a male. Client was assisted to initiate breastfeeding. This was to also aid in the delivery of the placenta. An identification band bearing mother's name, sex of baby, date and time of delivery was placed on the wrist of the newborn. The APGAR score assessed in the first and fifth minute read as follows;

<b>Time</b>	<b>Colour</b>	<b>Breath</b>	<b>Heart</b>	<b>Tone</b>	<b>Reflex</b>	<b>TOTAL</b>
<b>1 minute</b>	1	2	2	2	2	9
<b>5 minute</b>	2	2	2	2	2	10

### **3.3 MANAGEMENT OF THIRD STAGE OF LABOUR**

The third stage of labour starts after delivery of the baby and ends with complete expulsion of the placenta and its membranes and control of bleeding was actively managed. The cut end of the cord was placed in a sterile receiver near the perineum to collect placenta, membranes and blood loss. Her abdomen was palpated for an undiagnosed twin but there was none. Client was then given injection oxytocin 10 units intra-muscularly on her thigh within one minute to help in the active management of 3rd stage. Uterine contraction was felt for and was well contracted. The left hand was placed above the level of symphysis pubis with the palm facing the umbilicus, pressure was exerted on the upward direction whilst the clamped end of the cord was held with the right hand. Using controlled cord traction, the cord was pulled on gently until the placenta was visible at the vulva. It was cupped with both hands to ease pressure on the friable membranes. The placenta and membranes were pulled gently until they were completely expelled at 11:15pm into a kidney dish for further examination. The uterus was massaged immediately after the delivery of the placenta to aid uterine contraction, arresting hemorrhage as well as expelling clots. Consent was sought from client that her cervix, vagina, perineum and vulva would be examined. A good light source was directed to the perineum. Two sterile gauze were wrapped on the index finger for inspection using clockwise method. The vagina and cervix were inspected thoroughly to determine laceration but there was none. Afterwards, the lateral sides were also examined and they were

intact. The vulva, perineum and upper thigh were cleaned and a clean perineal pad was applied. Client was wiped off blood and a clean perineal pad was applied to make her comfortable. She was congratulated and her baby was shown to her and she confirmed the sex of the baby. Blood loss estimated was approximately 100 millilitres. Instruments used were decontaminated in 0.5% chlorine solution for ten minutes after which the instruments were washed and sterilized. She was encouraged to urinate frequently whenever she had the urge to, so that the uterus can be well contracted and involute to prevent post-partum hemorrhage.

#### **EXAMINATION OF THE PLACENTA AND MEMBRANES**

A thorough inspection of the placenta and membranes is done in order to ensure that no part of it is being retained during delivery. The placenta was immersed in 0.5% chlorine solution and it was examined. The placenta was held by the cord with the membranes hanging and the membranes were examined for completeness and it was intact. The placenta was then laid on a flat surface for further examination. The amnion was peeled from the chorion up to the umbilical cord and was fully viewed, the lobes fitted together without any gap and edges also forming a uniform circle at the maternal surface and this indicated there was no missing lobe, there were no white patches on the maternal surface, there was also no blood vessels radiating into the membranes which indicated absence of succenturiate lobe. The cord was situated at the center of the placenta with one vein and two arteries which were seen in the cord. There was no abnormality detected. The placenta was discarded after decontaminating it according to the protocol of the facility. The instruments and equipment used were soaked in 0.5% chlorine solution for ten minutes and washed, rinsed, dried and repacked for sterilization. Hands were dipped in chlorine solution before discarding the gloves. Hand hygiene was performed and documentation was done as well.

### **3.4 MANAGEMENT OF FOURTH STAGE OF LABOUR**

The fourth stage of labour is a period of close monitoring and observations of mother and baby for the next six hours following the delivery of the placenta, membranes and subsequent arrest of hemorrhage. Client and her baby were transferred to the lying in ward after putting the baby skin to skin for an hour. Monitoring of Madam Margaret and the baby continued strictly for the first 6 hours after expulsion of the placenta and membranes and arresting of hemorrhage. Vital signs were checked every 15minutes for 2hours, 30 minutes for 1hour and one hourly for the remaining three hours and recorded. Post- delivery vital signs were checked and recorded as follows; Mother; Temperature 36.5 degree Celsius, Blood pressure 100/60mmhg, Respiratory rate 20cpm, Pulse 86bpm and Baby; Temperature 36.3degree Celsius, Respiratory rate 40cpm, Heart rate 132bpm. Madam Margaret was asked to empty her bladder frequently in order to help contractions of the uterus. She was educated on how breastfeeding enhances the release of oxytocin which would improve uterine contractions, drainage of lochia, control of hemorrhage and also as a form of family planning. The uterus was well contracted with the symphysio fundal height 20cm. Her perineal pad was inspected for amount and color of lochia. On inspection, the lochia was bright red, moderate blood loss and not offensive. Client was encouraged to change her pad frequently when it's soaked and to wash her hands before handling the baby. She was given porridge with bread after which she continued breast feeding. Baby was put to breast and the mother was reminded again on the importance of exclusive breastfeeding and to also breastfeed on demand.

### **EXAMINATION OF THE NEW BORN**

The procedure was explained vividly to the client, examination gloves were worn and the baby was examined head to toe to detect any deviation from normal. Baby was put on a flat surface,

Baby was exposed and the general condition, respiration and skin colour was noted and covered again to be examined from head to toe.

On examination of the head, the sutures and fontanelles were examined with no abnormality detected. There was no laceration on the scalp and no caput succedaneum as well. The head circumference was measured and it was 36 cm. The pinna of the ears was well formed and there were no discharges from the ear. The eyes were in alignment with the ears. There was no pallor of the conjunctiva or jaundice on the sclera. The nose was well formed with septum dividing it. Nose was patent with no discharges. The mouth was examined for the presence of false teeth, cleft palate and tongue tie but there was none. Rooting, suckling and swallowing reflexes were present. There was no enlargement of lymph nodes, rigidity, congenital goiter and swelling of the neck.

On breast examination, there was no engorgement of the breast. The nipple was at the center of the areolar. There was no distention of the abdomen, enlarged spleen or liver as well as bleeding of the cord. There were three blood vessels that run through the cord which indicated two arterial cord vessels and a cord vein. The spine was examined with the baby lying in prone position. The back was palpated for swellings, spinal bifida or a missing vertebra, meningomyelocele but there was none. The skin was examined for skin color, vernix caseosa, and lanugo, peeling of the skin, rashes and birth mark. There were no abnormalities with some amount of vernix caseosa. The upper extremities were equal with no extra digits. There were palmer creases and no webbed fingers. Grasping and Moro reflexes were present.

The lower extremities were also equal without an extra digit. Both legs were examined with no talips and congenital dislocation of the hip. Knee flexes were normal. On inspection of the genitalia, the scrotum and the testicles were palpated for descended testes and there were no

abnormalities noticed. Baby passed meconium and urinated soon after birth indicating the patency of the anus and urethra.

### **PREVENTION OF DISEASES**

Baby Margaret was given vitamin K1 to prevent bleeding. Gentamycin eye drop was applied on the eyes to prevent infections. The cord was also dressed with chlohexidine gel. Again, two drops of polio 'O' was given by mouth and injection BCG 0.05ml was administered intradermal to prevent polio and tuberculosis. Client was also educated not to apply anything on the injection site. In all no abnormality was detected. Gloves were removed and disposed of according infection prevention protocol proper hand washing was performed and dried with a clean towel. Baby was given to his mother. All findings were communicated to the mother and recorded. Madam Margaret was thanked. The baby's vital signs and weight were checked were recorded as follows; Temperature 36 .3 °C, Apex beat 132 bpm, Respiration 40 cpm, Weight 3.3 kg. She was also told that the baby may have swelling at the site of injection which would subside. Baby was wrapped in clean dry sheet and put to breast.

### **SUMMARY OF LABOUR**

Date of delivery	21st November, 2021
Time of delivery	11:10pm
Mode of delivery	Spontaneous vaginal delivery
Time placenta and membranes delivered	11:15pm

### **DURATION OF OBSERVABLE LABOUR**

1st stage	5:10pm – 11:10pm – 7 hours 0 minute
2nd stage	11:05pm – 11:10pm – 5 minutes

3rd stage	11:10pm – 11:15pm – 5 minutes
<b>Total</b>	<b>7 hours 10minutes</b>

### **GENERAL CONDITION OF THE MOTHER**

Blood pressure	-	100/60mmHg
Temperature	-	36.5°C
Pulse	-	86bpm
Respiration	-	20cpm
Fundal height	-	20cm
Condition of perineum	-	Intact
Blood loss	-	Approximately 100mls
Condition of mother		Good

### **GENERAL CONDITION OF THE BABY**

Sex	male
Weight	3.3kg
Head circumference	36cm
Length	50cm
Condition of the baby	Good
Apgar score 1 <sup>st</sup> and 5 <sup>th</sup> minutes	9/10,10/10
Abnormalities	No abnormality detected

### **CONDITION OF THE PLACENTA**

Lobes and membranes	Complete and healthy
Cord vessels	Two arteries one vein

Fetal surface	Greyish blue
Maternal surface	Dark red
Placenta and membrane	Healthy
Date of delivery	21/11/21
Time of delivery	11:10pm

### **3.5 NURSING CARE PLAN DURING LABOUR**

#### **PROBLEMS IDENTIFIED**

1. Waist pain.
2. Lower abdominal pain.
3. Vomiting
4. Anxiety

#### **SHORT TERM OBJECTIVES**

1. Client will cope with waist pains throughout labour.
2. Client will cope with lower abdominal throughout labour.
3. Client will be relieved of vomiting within 3 hours.
4. Client will be allayed of anxiety an hour after delivery.

#### **LONG TERM OBJECTIVES**

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



**TABLE 1: NURSING CARE PLAN DURING LABOUR**

<b>DATE / TIME</b>	<b>NURSING DIAGNOSIS</b>	<b>NURSING OBJECTIVES</b>	<b>NURSING ORDERS</b>	<b>NURSING INTERVENTIONS</b>	<b>DATE / TIME</b>	<b>EVALUATION</b>	<b>SIGN</b>
21/11/21 <u>5:10pm</u>	Waist pain related to descent of fetal head.	Client will cope with the waist pain throughout labour as evidenced by client's action.	1.Reassure client. 2.Explain the physiology of waist pain to client. 3.Encourage client to adopt a comfortable but harmless position. 4.Perform sacral massage. 5.Encourage deep breathing exercise.	1.Client was reassured. 2.Physiology of the waist pain was explained to client. 3.Client was helped to adopt a comfortable but harmless position. 4.Sacral massage was performed to reduce pain. 5.Client was encouraged to do deep breathing exercise with each contraction and rest in between.	21/11/21 <u>11:30pm</u>	Goal fully met as evidenced by client behavior.	A C

**TABLE 2: NURSING CARE PLAN DURING LABOUR**

<b>DATE / TIME</b>	<b>NURSING DIAGNOSIS</b>	<b>NURSING OBJECTIVES/ OUTCOME CRITERIA</b>	<b>NURSING ORDERS</b>	<b>NURSING INTERVENTIONS</b>	<b>DATE / TIME</b>	<b>EVALUATION</b>	<b>SIGN</b>
21/11/21 5:10pm	Lower abdominal pain related to regular, painful rhythmic uterine contractions.	Client will cope with lower abdominal pains throughout labour as evidenced by client's action.	<ol style="list-style-type: none"> <li>1. Explain the physiology of lower abdominal pain.</li> <li>2. Reassure client.</li> <li>3. Perform sacral massage.</li> <li>4. Encourage client to adopt a comfortable but harmless position.</li> <li>5. Encourage client to do deep breathing exercise.</li> </ol>	<ol style="list-style-type: none"> <li>1. Physiology of lower abdominal pain was explained to client.</li> <li>2. Client was reassured.</li> <li>3. Sacral massage was performed for client to relieve pain.</li> <li>4. Client was encouraged to adopt a comfortable but harmless position.</li> <li>5. Client was encouraged to do deep breathing exercise with each contraction and rest in between.</li> </ol>	21/11/21 5:10pm	Lower abdominal pain reduced as indicated, evidenced by client's action.	A C

**TABLE 3: NURSING CARE PLAN DURING LABOUR**

<b>DATE/ TIME</b>	<b>NURSING DIAGNOSIS</b>	<b>NURSING OBJECTIVES/OUTCOME CRITERIA</b>	<b>NURSING ORDERS</b>	<b>NURSING INTERVENTIONS</b>	<b>DATE / TIME</b>	<b>EVALUATION</b>	<b>SIGN</b>
21/11/21 <u>5:10pm</u>	Vomiting related to hormonal changes during labour.	Client will be relieved of vomiting as soon as labour ends.  1.client verbalizing that she no longer vomit.  2. as evidenced by midwife.	1. Reassure client.  2. Explain the physiology associated with vomiting.  3. Remove any nauseating items from client.  4.Provide mouth care after each vomiting.  5.Encourage client to reduce the intake of oily and spicy food.	1.Client was reassured.  2. The physiology of vomiting was explained to her.  3. All nauseating items were moved away from client.  4.Mouth care was given after each vomiting.  5.Client was encouraged on the need to reduce the intake of oily and spicy food.	21/11/21 11:30pm	Goal fully met as client verbalized that vomiting has stopped.	A C

**TABLE 5: NURSING CARE PLAN DURING LABOUR**

<b>DATE / TIME</b>	<b>NURSING DIAGNOSIS</b>	<b>NURSING OBJECTIVE</b>	<b>NURSING ORDERS</b>	<b>NURSING INTERVENTIONS</b>	<b>DATE / TIME</b>	<b>EVALUATION</b>	<b>SIGN</b>
21/11/21 5:30pm	Anxiety related to unknown outcome of labour.	Client will be allayed of anxiety 10 minutes after delivery as evidenced by client's behavior.	1.Reassure client. 2.Explain the physiology of labour to the client. 3.Explain every procedure to be carried out to client. 4.Encourage client to ask questions. 5.Communicate findings to client.	1. Client was reassured. 2. Physiology of labour was explained to client 3. Every procedure to be carried out was explained to client 4.Client was encouraged to ask questions. 5.Findings were communicated to client.	21/11/21 5:30pm	Anxiety reduced as indicated, evidenced by client's behavior.	A C

## **CHAPTER FOUR**

### **PUERPERIUM**

#### **4.0 INTRODUCTION**

This chapter describes care of the mother during puerperium thus from the period of delivery to discharge, the management of both mother and baby from day one to sixth week postnatal. Care plans drawn for the management of problems encountered during puerperium. During this period, the reproductive organs return to their non-pregnant stage and lactation initiated. Also health education, counseling, assessment, support for infant feeding and immunization service for baby was done.

#### **4.1 DAY OF DELIVERY**

##### **EXAMINATION AND SUBSEQUENT CARE OF THE MOTHER**

Madam Margaret was informed of the procedure to be carried on her. Privacy was provided for her and she was asked to empty her bladder. Handwashing was performed. On observation, she looked healthy and there was no sign of postpartum blues. She was helped to lie in a dorsal position afterwards. Her hair was well kept. Upon inspection, her eyes and her conjunctiva were pink with white sclera, with no abnormalities detected in her mouth. Her hands were normally situated and equal upon inspection of her upper extremities. Her palm was pink with shortened finger nails. Both breasts were inspected and were of almost equal in size with normal shapes. The left breast and palpated it first as she supported her occiput with her right palm. Same was done for the right breast and did not detect any abnormalities. Her nipple was prominent and there was no discharge. She was taught self-breast examinations for early detection of any abnormality. Her breast was soft and there was no redness or cracks on the nipple. No lumps were felt and colostrum was

expressed. During inspection of the abdomen, it looked firm and straight gravid arum and linear nigra were present. The uterus was palpated and it felt firm and well contracted. Her symphysio-fundal height was 16cm. Her back was inspected for any rash, edema and tenderness but there was none found. Her lower extremities were examined and they were equal, normal, and free from edema and pain. Permission was sought from Madam Margaret to carry out a vulva examination on her which she readily agreed to. Hands were washed, dried and surgical gloves were worn. Her pad was removed and inspected for the color which was bright red. The amount of blood flow was moderate. The odour of the lochia had no foul smell. A new pad was placed on her vulva and the old one was discarded. The used gloves were removed and discarded, hands were washed. Vital signs were checked and recorded as: Respiration 20cpm, Temperature 36.5, Blood pressure 100/60mmHg, Pulse 86bpm, Fundal Height 16cm. All findings were communicated to her and recorded in the nurse's note. Client was encouraged to urinate frequently to aid in uterine involution. Client was told to change her perineal pad as frequently as it gets soiled to prevent infections. Again, she was encouraged breastfeed her baby on demand and to eat well balanced diets and drink lots of fluids to replenish the fluids lost through labour. It was added that she should have enough rest and sleep in order for her to recover from the stress of labor.

#### **4.2 SUBSEQUENT CARE OF THE BABY**

The baby was examined to exclude any abnormalities or birth injuries in the mother's presence. Before the procedure began, what to be done and the importance of doing the were vividly and clearly explained to the mother. Nearby windows and doors were closed to prevent hypothermia and provide privacy. Hand hygiene was performed and sterile gloves were put on. The baby was placed on a clean flat surface, undressed and wrapped with a cot sheet to prevent hypothermia. The skin was inspected and noted her skin color was pink covered by small vernix caseosa without

any birth mark or lacerations. On examination of the head, there was no caput succedaneum or cephalohematoma formed, sutures and fontanelles were present and normal. Her eyes were normally situated with no yellowish discoloration on the sclera or swelling of the conjunctiva. The nose was evenly placed in relation to the eyes and the ears were in their normal position. The pinnae of the ears were well formed and level with the cantus of the eye. The mouth had no cleft lip or cleft palate and there was no tongue tie or forced teeth. Rooting, suckling and reflexes were present. The neck was normal, easily rotated and no swelling or lymph node felt. The breast tissue was palpated and there were no masses or engorgement. The nipples were centrally situated. On examination of her abdomen, it was round, soft and prominent. Her cord was centrally situated with two arteries and one vein and it was not bleeding. On examining her upper extremities, they were both of equal size and length and she did not have any webbed or extra digits. Palmer creases as well as grasping reflexes was also present. Her legs were well flexed and there was no congenital hip dislocation. Her toes were not webbed and no extra digits detected. The vertebrae were also normal and no spinal bifida detected. Her vagina was normal after it had been examined and so was her urethral orifice. Baby passed urine and meconium which indicated that the urethral and anal orifices were patent. All findings were communicated to the client and recorded them in the nurse's notes. The baby was wrapped and put to her mother's breast to initiate lactation and bonding.

### **BABY'S FIRST BATH AND CORD DRESSING**

The baby was given her first bath after 10 hours after post-delivery at 9:00am in the morning. The procedure was explained to Madam Margaret. Preparation for the baby's bath was made and it included setting up a trolley with baby's sponge, face towel, baby's soap, baby's drape, baby oil, powder, bath thermometer, two clean cot sheet, baby's dress, gallipot containing sterile water,

cotton wool swabs, jug of cold water, jug of warm water, chlorhexidine gel on the top shelf and plastic apron, bucket for dirty water, bathing towel, disposable gloves, container for used linen on the bottom shelf. Nearby windows and doors were closed and ensured that mother was present before the procedure was started. The jugs of water were mixed and tested with the bath thermometer. Plastic apron was worn, handwashing was performed, and gloves were put on. The baby was put on a clean flat surface and undressed. The baby was wrapped with a cot sheet. The baby's eyes were cleaned with cotton wool swabs soaked in sterile water from the inner cantus to the outer cantus and then cleaned her face with a damp face towel and dried it after. The nape of the baby's neck was supported with the left hand and plucked her ears with two fingers of the left hand supporting baby's head. Her head was washed with a soapy sponge. The baby was lifted off the flat surface, supporting the nape of the neck and body resting on the elbow to the edge of the bowl. Her head was rinsed off the soap and dried it with a clean towel. The baby was put back on the flat surface afterwards and exposed her body. Her arms and front of her trunk were washed, paying attention to the skin folds. The baby was turned with one arm supporting the chest and hand holding the distal arm of the baby. Her back was washed down to her feet, paying attention to the skin folds. The baby was supported firmly and was immersed in a bath of warm water, with her head above the water and rinsed her thoroughly. The baby was placed afterwards on the flat surface and was covered with a clean cot sheet. A small towel was used to dry the baby. The used gloves were removed afterwards and was discarded. Handwashing was done and new gloves were put on. The tip of the cord clamp was held with a cotton swab and applied Chlorhexidine gel thoroughly on the base, stem and cut end of the umbilicus. The cord was exposed to dry and heal. The baby was smeared with her oil, powder and was dressed up. The baby was given to Madam Margaret to fix her to breast. The working area was tidied and disposed of waste materials. After the procedure,

handwashing was done and all findings were communicated to Madam Margaret and documented as well.

#### **4.3 FIRST DAY POST DELIVERY (DAY OF DISCHARGE)**

##### **PREPARATION AND EDUCATION ON DISCHARGE**

On 22nd November, 2021, at 10:00 am Madam Margaret woke up healthy with cheerfully looking facial expression. All procedure to be carried out on both mother and baby were explained. Mother then took a warm bath and was served with oats and bread. Permission was sought from client and head to toe examination was done with no abnormalities detected. The breast was soft and lactating. Client complained of interrupted sleep since baby cries a lot. She was encouraged to take naps whenever the baby sleeps. She was also encouraged to breastfeed baby frequently to aid involution. Client vital signs and other observation made and recorded as, Temperature 36.6 degree Celsius, Respiration 22 cpm, Pulse 84bpm, Blood pressure 110/70 mmHg, Lochia Rubra, Fundal height 15cm, Condition of uterus; contracted. The baby was top and tailed and examined from head to toe with no abnormalities detected. The cord was dressed with chlorhexidine gel in the presence of mother. The cord was quite fresh with no odour. Madam Margaret was taught how to dress the cord. The baby was assessed and recorded as; Temperature 36.1°C, Apex heart rate 132bpm, Respiration 40cpm, Skin Color Pink, Cord bleeding -Nil, Condition of cord -Dry, Suckling – Good, Weight 3.3kg, Stool Color -Greenish.

An opportunity was taken to demonstrate to the mother how to bath the baby. The baby was top and tailed, dressed and wrapped nicely in the presence of the mother and family. The baby passed urine and meconium which was normal. The mother was educated not to apply hot compress on the fontanelles with the intension of closing it as they go home. The baby was then handed over to the mother for breastfeeding. Proper positioning and attachment to the breast was encouraged.

Client was reminded on the intake of nutritious diet, fruit and frequent breastfeeding of the baby. Education was given on the change of perineal pad when soiled and the need to wash her hands after removal and before breastfeeding the baby to prevent infections. Client was also educated on postnatal exercises such as kegel, ambulation and family planning as well as exclusive breastfeeding, change of napkins or diapers frequently, wash and dry them in sun and keeping the baby warm always. She was asked to register the baby at the birth and death registry. Madam Margaret was informed about the continuity of care and that she would be visited at home for seven days to check on her condition and that of the baby. Her husband was encouraged to take good care of her and also provide her with physical, emotional, psychological and financial support. She was again educated on the prescribed drugs, its route of administration, dosage and effects.

The baby was reassessed by the Midwife -In- Charge and no abnormality noticed and she confirmed they were ready for discharge was given the following:

Tablet Folic Acid	5mg daily for 14 days
Tablet Ferrous Sulphate	200mg daily for 14days
Tablet Multivitamin	200mg daily for 14 days
Tablet Paracetamol	1g tid for 3days

Client was discharged at 11:00am on the 22nd of November, 2021 and was helped to pack belongings after serving her medications. Her hospital bills were settled by the National Health Insurance Scheme. Client was reminded that she will be visited in the evening and it will continue for seven days. Client was congratulated and bade farewell.

## **HOME VISITS**

### **FIRST POSTNATAL HOME VISIT.**

In the evening of 22nd November, 2021 at 5:30pm, Madam Margaret and her baby were visited for the first time after delivery. They were both in good condition as well as her family. Permission was sought from my client and also explained procedure to her to examine the baby and herself of which she agreed. She was asked to empty her bladder. Madam Margaret and her baby were examined from head to toe and there were no abnormalities. Her fundus was well contracted. The baby was bathed and the cord was dressed afterwards. Madam Margaret put the baby to her breast and it was noticed that the baby suckled well. Client complained of headache and fatigue. She was reassured and was told that it was due to the stress of labour. Client was encouraged to have enough rest and sleep and also educated her on the need to sleep under treated mosquito net to prevent mosquito bites and malaria. The following are the observations made on both mother and baby: Mother; temperature 36.7 °C, Pulse 78bpm, Respiration 21cpm, Blood pressure 100/70mmHg, stool/urine passed, Fundal height 14cm, uterus contracted, breast lactating. Baby: Temperature 36.5°C, heartrate 134bpm, respiration 40cpm, stool/urine passed, weight 3.2kg.

### **SECOND POSTNATAL HOME VISIT**

On 23rd November, 2021 at 7:00am in the morning, Madam Margaret was visited. She, the baby and family were all doing well. A head to toe examination on both the mother and the baby was done and there were no abnormalities. Enquires about her previous complain (headache and after pains) was made, she said she had been relieved but had difficulty in sleeping. She was encouraged to feed the baby on demand even at night and to take a rest during the day when baby is asleep.

Her husband was encouraged to help in the care of the baby and also in the household chores together with her mother so that Madam Margaret could have some rest and sleep to promote her wellbeing. And also encouraged her to comply with the drugs given to her. The baby was bathed and her cord was dressed aseptically. Vital signs of the baby and mother together with observations made were recorded as follows; Baby: Temperature 36.7°C, pulse 134bpm, respiration 42cpm, weight 3.1kg, stools passed. Mother: temperature 36.6°C, pulse 78bpm, respiration 21cpm, Blood pressure 100/70mmHg, fundal height 12cm.

In the evening, findings were not different from the morning visitation.

### **THIRD DAY POSTNATAL HOME VISIT**

On the 24th November, 2021 7:30am in the morning, Madam Margaret was visited in her house. Greetings were exchanged and a warm welcome and seat was offered. She was asked about her health and that of her family and responded that they are all well. Permission was sought from Madam Mary to examine her which she agreed. After hand washing was done with soap under running water and dried. The symphysio fundal height was 12cm. The perineal pad was checked and the colour of the lochia was bright red with no foul smell and scanty in amount. The breast was lactating well. There were no observed abnormalities. Her vital signs were checked and recorded as follows: Mother: temperature 36.6°C, pulse 80bpm, respiration 20cpm, Blood pressure 110/70mmHg, fundal height 13cm. Baby: temperature 36.6°C, pulse 140bpm, respiration 42cpm, weight 3.0kg.

In the evening, findings were not different from the morning visitation.

#### **FOURTH DAY POSTNATAL HOME VISIT**

From the 4th day onwards, Madam Margaret was visited to continue the care. The visits were only in the morning. Both Madam Margaret and the baby were doing well. On the 4th day which was 25th November, 2021 at 8:00am, Madam Margaret was taken through the routine examinations including a head to toe examination. The uterus remained firm and well contracted. The fundal height was 12cm. Lochia was serosa with moderate flow. All findings after the examinations were within normal ranges. and communicated my findings to her. Baby was bathed and dressed the cord with chlorhexidine gel. The cord was almost off. The cord was dry and loose. Madam Margaret was educated not to pull it off or apply herbs but wait for it to fall off itself. The baby was examined from head to toe in the presence of Madam Margaret. and did not detect any abnormalities. The baby was normal and healthy. Madam Margaret was told to put the baby to breast and the baby suckled well on the breast. Enquiries about previous complain of loss of appetite was made and she said she is now able to eat half of her meals. Vital signs and observations made for mother and baby are as follows; Baby: Temperature 36.6°C, Apex beat 133bpm, Respiration 40cpm, Stool Passed Urine Passed, Weight 3.0kg. Mother: Temperature 36.7°C, Pulse 80bpm, Respiration 20cpm, Blood Pressure 110/70mmHg, Fundal Height 12cm, Urine and stool passed, Breasts lactating.

#### **FIFTH DAY POSTNATAL HOME VISIT**

On 26th November, 2021, Madam Margaret and her family were visited. Both Madam Margaret and the baby were doing well. Madam Margaret and the baby was taken through the routines and all findings were in the normal ranges. They were both healthy. Findings were communicated to her and enquiries about her previous complaints were made which she said she had had enough rest and sleep that day. Baby was examined from head to toe in the presence of Madam Margaret

and detected no abnormalities. Baby was normal and healthy. The baby suckled well on the breast. Madam Margaret said that she passes urine at least three times a day and empties her bowel daily. Madam Margaret were examined from head to toe and there were no abnormalities seen. The uterus remained firm and well contracted. Fundal height was 11cm. Lochia was serosa with moderate flow. They were thanked and left after informing them that, my next visit would be my last visit to their homes. Mother and baby's vital signs and recorded observations made as follows; Baby: Temperature 36.7°C, Apex beat 130bpm, Respiration 41cpm, Stool passed, Urine passed, Weight 2.9kg. Mother: Temperature 36.5°C, Respiration 22cpm, Blood pressure 110/80mmHg, Pulse 87bpm and Fundal height 10cm.

#### **SIXTH DAY POSTNATAL HOME VISIT**

On 27th November, 2021, which was the sixth day, Madam Margaret and her family were visited. Madam Margaret and the baby were doing well they warmly welcomed me. the health of the mother and the baby and the response was positive. Madam Margaret and baby were examined and there were no abnormalities detected. They were both healthy. Madam Margaret's fundal height was 8cm. her perineal pad and lochia was serous, moderate with no offensive odor. Baby was toiled and tailed and in the process the cord fell off. baby was dress neatly and gave the baby to the mother to breastfeed. Baby suckled well on the breast. Madam Margaret and baby's vital signs were checked and recorded the observations were as follows; Baby: Temperature 36.5°C, Pulse 145bpm, Respiration 41cpm, Stool passed, Urine passed, Weight 2.9kg. Mother: Temperature 36.8°C, Pulse 90bpm, Respiration 21cpm, Blood Pressure 110/70mmHg, Fundal Height 8cm.

## **SEVENTH DAY POSTNATAL HOME VISIT**

On the 28th November,2021 around 9:00am, Madam Margaret was visited, the baby was doing well as well as the family. Routine examination was carried out on both the mother and baby from head to toe and there was no abnormality detected on any of them. The perineal pad was inspected the lochia was serosa with no odour. The baby was bathed with warm water and kept in a cot sheet. The umbilical cord was dressed well with chlorhexidine gel, urine and stool were also passed. Client made no complains. Client was reminded of the first postnatal visit to the clinic which was on the 29th November,2021 but since it falls on Sunday, she is supposed to come to the clinic on 21<sup>st</sup> November,2021. Client was thanked and permission was sought to leave. Observations as well as vital signs for both mother and baby were also recorded as follows: Mother: Temperature 36.7°C, Pulse 78bpm, Respiration 20cpm, Blood Pressure 110/70mmHg, Fundal Height 6cm. Baby: Temperature 36.8°C, Pulse 130bpm, Respiration 42cpm, Stool passed, Urine passed, Weight 3.0kg

## **4.5 FIRST POSTNATAL VISIT TO THE CLINIC**

Madam Margaret and her baby arrived at the clinic for postnatal care on the 29th November, 2021 accompanied by her mother. Client was neatly dressed and looked cheerful. They were welcomed and given a comfortable seat. Health educations on nutrition, immunization against preventable childhood diseases and family planning as well as care of the baby were given. Client was asked about her condition and that of the baby and she said they were doing well. Client said her baby was able to feed well and always sleeps well. Madam Margaret also confirmed that the baby passed urine and stools regularly. Permission was sought from Madam Margaret to examine the baby generally. She granted the permission and the procedure was explained to her. The baby was taken, undressed and then wrapped with a clean cot sheet and placed on a flat surface for the examination

in the presence of the mother. There were no skin rashes detected on the baby as well as no discharges from the eyes, nose and ears. No discoloration of the mucus membranes, palms, eyes, conjunctiva and feet were observed during inspection. Baby's abdomen was not distended and the umbilical stump was almost healed. The baby was neatly wrapped and was given back to the client's mother for Madam Margaret to be examined too. The baby's vital signs were checked and recorded as follow; Baby temperature 36.7<sup>0</sup> C, Apex beat 134 bpm, Respiration 42 cpm, Weight 3.1kg. Permission was sought from Madam Margaret to examine her from head to toe. The procedure was explained and she was asked to empty her bladder and a sample of urine was taken and tested for glucose and protein and all tested negative. Privacy was then provided. Hands were washed and dried and examination was commenced. On inspection, it was observed that the conjunctiva of the eyes was not pale, the nose was not discharging. Client's breasts were soft with no cracks or sore on the nipples. There was also no abdominal tenderness and the Fundus was not palpable. Hands were washed and dried. There was no drainage of Lochia on inspection. After that findings were communicated to her. Her vital signs checked and recorded as; Temperature 36.8 degree Celsius, pulse 88, respiration 19 and Blood pressure 110/80mmHg.

### **CIRCUMCISION OF THE BABY**

After the examination of the baby, Madam Margaret was informed that the circumcision was about to be done and asked if she wanted to observe but the answer was no. The baby was prepared and circumcised by the midwife in charge. Gel was applied to the circumcised area wrapped with Vaseline gauze after which baby was clothed and given to mother to breastfeed. Education was then given to wash hands with soap under running water before handling baby and to always keep the wound dry to prevent infection and report any signs of bleeding, swelling or discharge.

## **TERMINATION OF CARE**

Madam Margaret was advised to complete all immunization scheduled. Client was reminded of her second postnatal visit to the clinic. It was explained to Madam Margaret that the care being given to her by me has come to an end since the period of study was over. She was handed over to the midwife in charge for the continuity of care. It was made known to her that update on her will be received from the midwife in charge and she will be called if the need arises for any information, and she gladly said she will be available any time needed. She and her family members were thanked for availing themselves and helping me to achieve this study. Madam Margaret expressed her gratitude for the care given to her. She and the family were bid farewell. Baby was registered at the Births and Deaths Registry and client was handed over to the public health nurse for continuity of care.

### **4.6 SECOND POST-NATAL VISIT TO THE CLINIC**

According to the midwife in charge, on the 13th December, 2021. Madam Margaret came to the clinic for six weeks visit. They were warmly welcome and they all looked very healthy. General examination was conducted on the client from head to toe as well as vital signs after her permission was sought. Her vital signs and weight were checked and recorded as follows: Temperature 36.5°C, Pulse 80bpm, Respiration 20cpm, Blood Pressure 110/70mmHg, Weight 67kg. Madam Margaret was given a urine sample container to provide some urine to be sent to the laboratory for urine analysis to be performed. She was educated on the need and procedure to provide midstream urine for the examination. A sample of blood was also taken from Madam Bertha with her consent to be sent to the laboratory for her hemoglobin level to be tested. The results were explained to her as follows; Hemoglobin 14.6g/Dl, Urine protein Negative, Glucose Negative. Madam Margaret was sent to the palpation room where privacy was provided by drawing the curtains and closing doors

and windows. She was helped to lie on the examination bed. Hands were washed with soap under running water and dried with a clean dry towel. Head to toe examination was done on her. On the head, hair was neat and well styled. The conjunctiva was pink and there were no discharges from the eyes, nose and ear. No abnormality was found on the mouth and neck. On the breast, no abnormalities such as sore nipple, engorgement, cracked nipple and mastitis were detected and the breasts were lactating well. On examining the abdomen, no abnormality such as sub involution, tenderness, enlargement of liver and spleen was detected. No scars were found and uterus was not palpable. With the lower extremities, certain condition such as oedema was looked out for. It was detected that she showed no abnormality. Speculum examination revealed no bruises on the cervix but showed slit-like appearance. She had not resumed her menses when asked. She was educated on the need to start a family planning method to prevent unwanted pregnancy. Her baby was also examined from head to toe to look out for abnormalities. On the head, the anterior fontanelle was palpated for pulsation and it was normal. The posterior fontanelle had closed. There were no discharges from the eyes and nose. The skin was nice with no rashes. The chest, upper and lower extremities were normal. The umbilical stump was inspected and it had healed. The lower extremities were normal. The findings on the baby were as follows: Temperature 36.2°C, Respiration 40cpm, Apex heart beat 142bpm, Weight 4.6kg. Madam Margaret and her baby were handed over to the child welfare clinic and family planning unit for the six weeks' immunization against diphtheria, pertussis, tetanus, hemophilic influenza and hepatitis B. She was encouraged to ask questions but she had none and made no complaints either. She was reminded on exclusive breastfeeding, rest and sleep, exercise and nutritious diet, which would help in lactation. She was finally referred to the public health nurse for continuity of care but report to the facility anytime she encounters any health related problem. She was thanked for her co-operation and understandin

## **4.7 NURSING CARE PLAN DURING PUERPERIUM**

### **PROBLEMS IDENTIFIED**

1. Headache
2. After pain
3. Insomnia
4. Loss of appetite

### **SHORT TERM OBJECTIVES**

1. Client will be relieved of headache within 24 hours.
2. Client after pain will resolved within 48 hours.
3. Client will have at least 6 hours sleep within 48 hours during the night.
4. Client will be able to eat half of her meals served within 24 hours.

### **LONG TERM OBJECTIVE GOALS**

Client will go through the puerperal period without any complications to herself and her baby.

**TABLE 1: NURSING CARE PLAN DURING PUERPERIUM**

<b>DATE / TIME</b>	<b>NURSING DIAGNOSIS</b>	<b>NURSING OBJECTIVES/OUTCOME CRITERIA</b>	<b>NURSING ORDERS</b>	<b>NURSING INTERVENTIONS</b>	<b>DATE / TIME</b>	<b>EVALUATION</b>	<b>SIGN</b>
23/11/21 7:00am	Headache related to labour stress.	Client will be relieved of headache within 7 hours as evidenced by: Client verbalizing the absence of headache.	1.Reassure client. 2.Educate client to rest. 3. Encourage support person to assist client in activities. 4.Educate client to limit number of visitors. 5.Serve prescribed analgesic and monitor vital signs.	1.Client was reassured. 2.Client was educated to sleep during daytime while baby is asleep. 3.Support person was encouraged to take care of the baby to allow client have some rest. 4.Client was educated to limit visitors so that she can rest. 5.Prescribed analgesic was served.	24/11/21 7:00am	Headache reduced as indicate client verbalized the absence of the headache.	A C

**TABLE 2: NURSING CARE PLAN DURING PUERPERIUM**

<b>DATE / TIME</b>	<b>NURSING DIAGNOSIS</b>	<b>NURSING OBJECTIVES</b>	<b>NURSING ORDERS</b>	<b>NURSING INTERVENTIONS</b>	<b>DATE / TIME</b>	<b>EVALUATION</b>	<b>SIGN</b>
23/11/21 7:00am	After pain related to involution of the uterus.	Client after pain will resolve within 48 hours as evidenced by client verbalizing that her pain has resolve. 2. Midwife observing that client is comfortable and has no pain.	1. Reassure client 2. Explain reasons of after pain to the client. 3.Encourage client to empty her bladder whenever she has the urge. 4. Encourage client to adopt a comfortable position when breast feeding.	1.Client was reassured that her pain will resolve. 2. It was explained to the client that her pain was due to the involution of the uterus. 3. Client was advised to empty her bladder whenever she has the urge. 4. She was advised to adopt upright position when breast feeding.	27/11/21 7:00am	After pain reduced as indicated, client verbalized that she has been relieved from after pain.	A C

			5. Serve analgesics as prescribed. Eg. Paracetamol.	5. Client was served with tab paracetamol 1g tds x 3			
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**TABLE 3: NURSING CARE PLAN DURING PUERPERIUM**

<b>DA-TE / TI-ME</b>	<b>NUR-SING DIA-GNOSIS</b>	<b>NURSING OBJECTIVES/OUT- COME CRITERIA</b>	<b>NURSING ORDERS</b>	<b>NURSING INTERVENTIONS</b>	<b>DATE / TIME</b>	<b>EVALUA-TION</b>	<b>SIGN</b>
23/11/21 7:00am	Insomnia related to stress of labor.	Client will have at least 6 hours sleep within 48 hours during the night as evidenced by client verbalizing it.	1.Reassure client 2.Encourage support person to help with taking care of the baby. 3.Ensure a noise free and calm environment. 4. Restrict visitors.	1.Client was reassured. 2.Support person was encouraged to assist client to take care of the baby. 3.Mother's room was kept calm and conducive for sleep 4. Visitors was restricted to help her sleep.	23/11/21 7:00am	Insomnia reduced as indicated, client verbalized it.	A C

			5.Encourage client to sleep whenever baby sleeps.	5.Client was encouraged to sleep immediately baby sleeps.			
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**TABLE 4: NURSING CARE PLAN DURING PUERPERIUM**

<b>DATE /TIME</b>	<b>NURSING DIAGNOSIS</b>	<b>NURSING OBJECTIVES</b>	<b>NURSING ORDERS</b>	<b>NURSING INTERVENTION</b>	<b>DATE / TIME</b>	<b>EVALUATION</b>	<b>SIGN</b>
25/11/21 8:00am	Loss of appetite related to labour stress.	Client will be able to eat half of her meals served within 24 hours as evidenced by support person observing client eating half of her meals served.	1. Reassure client. 2.Encourage client to practice oral hygiene. 3. Serve client’s favorite food. 4. Serve client’s food attractively.	1.Client was reassured. 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 her favorite food.	26/11/21 8:00am	Loss of appetite was reduced as indicated, client eating half of her meals served.	A C

			5.Serve prescribed medications.	4.Clients food was served attractively by garnishing the food. 5.Prescribed medication was served.			
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## **SUMMARY AND CONCLUSION**

The Client/Family Centred Maternity Care Study was conducted on Madam Margaret Twewaa a 37-year-old gravida 3 para 2 and her entire family throughout pregnancy, labour and puerperium and she went through these processes safely without any complications. Madam Margaret became a regular attendant to the clinic since 21st 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 male baby on 21st November, 2021 and discharged the next day. 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 Margaret was given a focused and comprehensive care throughout her pregnancy, labour and puerperium. Madam Margaret 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 Margaret has helped in the equipment of 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.

## BIBLIOGRAPHY

Antenatal Record Book registration number 10144/19

*Bailliere's Nurses' Dictionary: for nurses and health care workers*

Fraser, D.M. (2014) *Textbook for midwives (16<sup>th</sup> edition)*, London: Churchill Livingstone, Elsevier Limited

King, L.T, Bruker, MC., Kriebs, J.M., Fahey, J. O., & Gegor, V.H. (2014), *Varney's Midwifery (5<sup>th</sup> edition)*, New Delhi: Jones and Bartlett India Pvt. Ltd.

Konar, H (2011). *Textbook of Obstetrics. (7<sup>th</sup> Ed)*. New Central Book Agency. India.

Marshall, J. & Raynor, M (2014) *Textbook for Midwives (16<sup>th</sup> edition)*. London: Churchill Livingstone Elsevier Ltd.

Tiran, D. (2008). *Bailliere's Midwives Dictionary (11<sup>th</sup> Edition)*, Elsevier: Elsevier Limited

*Varney's Midwifery (6<sup>th</sup> edition)*, Jones & Bartlett India Pvt. Ltd.

Weller F.B (2009) *Bailliere's Nurses dictionary, (25<sup>th</sup> Ed)*, Edinburg; Churchill Livingstone

**APPENDIX I**

**MOTHER'S ANTENATAL RECORDS**

<b>DATE</b>	<b>WEI GHT (KG)</b>	<b>BP (mmHg)</b>	<b>URINE FOR GLUCOSE AND PROTEIN</b>	<b>PRESENTA TION AND POSITION</b>	<b>FETAL HEART RATE (bpm)</b>	<b>GESTAT IONAL AGE IN WEEKS</b>	<b>FUNDAL HEIGHT (cm)</b>	<b>DESCENT</b>	<b>COM- PLAINS</b>	<b>TREAT- MENT</b>	<b>SIGN A C</b>
<b>21/05/21</b>	<b>76</b>	<b>100/60</b>	<b>Negative/Negati ve</b>	<b>_</b>	<b>+</b>	<b>13</b>	<b>-</b>	<b>_</b>	<b>Nausea and vomiting</b>	<b>Routine drugs</b>	
<b>18/06/21</b>	<b>77</b>	<b>110/60</b>	<b>Negative/Negati ve</b>	<b>_</b>	<b>132</b>	<b>17</b>	<b>16</b>	<b>_</b>	<b>No complains</b>	<b>Routine drugs</b>	

<b>16/07/21</b>	<b>78</b>	<b>100/60</b>	<b>Negative/Negative</b>	<b>Cephalic</b>	<b>144</b>	<b>21</b>	<b>18</b>	<b>_</b>	<b>No complains</b>	<b>Routine drugs</b>	
<b>13/08/21</b>	<b>80</b>	<b>110/70</b>	<b>Negative/Negative</b>	<b>Cephalic</b>	<b>142</b>	<b>25</b>	<b>22</b>	<b>_</b>	<b>Insomnia</b>	<b>Routine drugs</b>	
<b>10/09/21</b>	<b>81</b>	<b>120/70</b>	<b>Negative/Negative</b>	<b>Cephalic</b>	<b>139</b>	<b>29</b>	<b>26</b>	<b>5/5th</b>	<b>No complains</b>	<b>Routine drugs</b>	
<b>05/11/21</b>	<b>85</b>	<b>110/70</b>	<b>Negative/Negative</b>	<b>Cephalic</b>	<b>140</b>	<b>37</b>	<b>35</b>	<b>5/5th</b>	<b>Constipation, heartburns</b>	<b>Routine drugs</b>	
<b>12/11/21</b>	<b>86</b>	<b>100/60</b>	<b>Negative/Negative</b>	<b>Cephalic</b>	<b>138</b>	<b>38</b>	<b>36</b>	<b>5/5th</b>	<b>No complains</b>	<b>Continue treatment</b>	
<b>19/11/21</b>	<b>86</b>	<b>110/70</b>	<b>Negative/Negative</b>	<b>Cephalic</b>	<b>137</b>	<b>38</b>	<b>36</b>	<b>5/5th</b>	<b>No complains</b>	<b>Continue treatment</b>	

**APPENDIX II**

**LABORATORY INVESTIGATIONS**

<b>DATE</b>	<b>SPECIMEN</b>	<b>INVESTIGATIONS</b>	<b>NORMAL VALUE</b>	<b>INVESTIGATION RESULT</b>	<b>REMARKS</b>
29/06/21	Blood	Haemoglobin level Sickling Blood grouping Rhesus factor Antibody screen, MPs HBSAG VDRL Syphilis PMTCT	11.5-14g/dl Negative AB, A, B, O Positive No Defect parasite seen Non-reactive Non-reactive Non-reactive Non-reactive	11.7g/dl Negative B positive Positive Negative Non-reactive Non-reactive Non-reactive Negative	Normal Normal Normal Normal Normal Normal Normal Normal
	Urine	Protein, Acetone Sugar	Negative Negative Negative	Negative Negative Negative	Normal Normal Normal
	Stool R/E	Worms	Negative	No ova detected	Normal
27/07/21	Urine	Protein Sugar	Negative Negative	Negative Negative	Normal
10/08/21	Stool	Worms	No ova Detected	No ova detected	Normal
22/09/21	Urine	Protein Sugar	Negative Negative	Negative Negative	Normal Normal
	Blood	Haemoglobin level	11.5-14g/dl	12.4g/dl	
31/10/21	Urine	Sugar Protein	Negative Negative	Negative Negative	Normal Normal
	Blood	Haemoglobin	11.5-14g/dl	12.2g/dl	Normal

### LABORATORY INVESTIGATIONS

24/10/21	Urine	Sugar Protein	Negative Negative	Negative Negative	Normal Normal
	Blood	Haemoglobin	11.5- 14g/dl	12.4g/dl	Normal
12/11/21	Urine	Sugar Protein	Negative Negative	Negative Negative	Normal Normal
	Blood	Haemoglobin	11.5-14g/dl	12.4g/dl	Normal

### APPENDIX III

#### PHARMACOLOGY OF DRUGS (MOTHER)

NAME OF DRUGS	CLASSIFICATION	DOSAGE	ROUTE OF ADMINISTRATION	ACTION & USE	ACTUAL EFFECTS	SIDE EFFECT OF DRUGS	SIDE EFFECT EXPERIENCED

Tablet folic acid	Haematinics	5 milligrams once daily	Orally	Proper formation and function of red blood cell	Haemoglob in level increased	Nausea and vomiting	None
Tablet multivitamin	Vitamin preparation	200 milligrams twice daily	Orally	Increased appetite. Helps in the formation of red blood cell	Increase appetite.	Gastro intestinal disturbances	None
Tablet ferrous sulphate	Iron supplement	200 milligrams 2 twice	Orally	Help in formation of haemoglobin and red blood	Haemoglob in level increased	Gastrointest inal disturbance	Dark stool

### PHARMACOLOGY OF DRUGS USED(MOTHER)

NAME OF DRUGS	CLASSIFICATION	DOSAGE	ROUTE OF ADMINISTRATION	ACTION & USE	ACTUAL EFFECTS	SIDE EFFECT OF DRUGS	SIDE EFFECT EXPERIENCED
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Tablet sulphadoxin epyrimetha mine	Anti-malaria and prophylaxis	3 tablets start from 16 weeks or quickening and repeated 4 weeks interval till she delivers.	Orally	Treatment and prevention of malaria	Malaria prevention	Itching, nausea, dizziness, headache	None
Injection tetanol	anti-tetanus	0.5 milligrams	Subcutaneously	Helps in the prevention of tetanus	Client protected against tetanus	slight fever and chills	None

#### APPENDIX IV

#### PHARMACOLOGY OF DRUGS USED (BABY)

NAME OF DRUGS	CLASSIFICATION	DOSAGE	ROUTE OF ADMINISTRATION	ACTION & USE	ACTUAL EFFECTS	SIDE EFFECT OF DRUGS	SIDE EFFECT EXPERIENCED
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Vitamin K	Group K vitamins (coagulant)	1.0mg	Intramuscular	Production of prothrombin which aids in clotting	No bleeding	None	None
Gentamycin eye drop.	Antibiotics	2 drops	Instillation	To prevent infection	Infection of the eye was prevented	None	None
Poliomyelitis	Antigen vaccine	2 drops	Orally	Production of antibodies	Baby is under observation	There may be diarrhea	None
Injection Bacillus Calmette Guerin	Antigen vaccine	0.5 Milligrams	Intradermal	Production of antibodies for prevention of tuberculosis	Baby is under observation	Blister formation	None

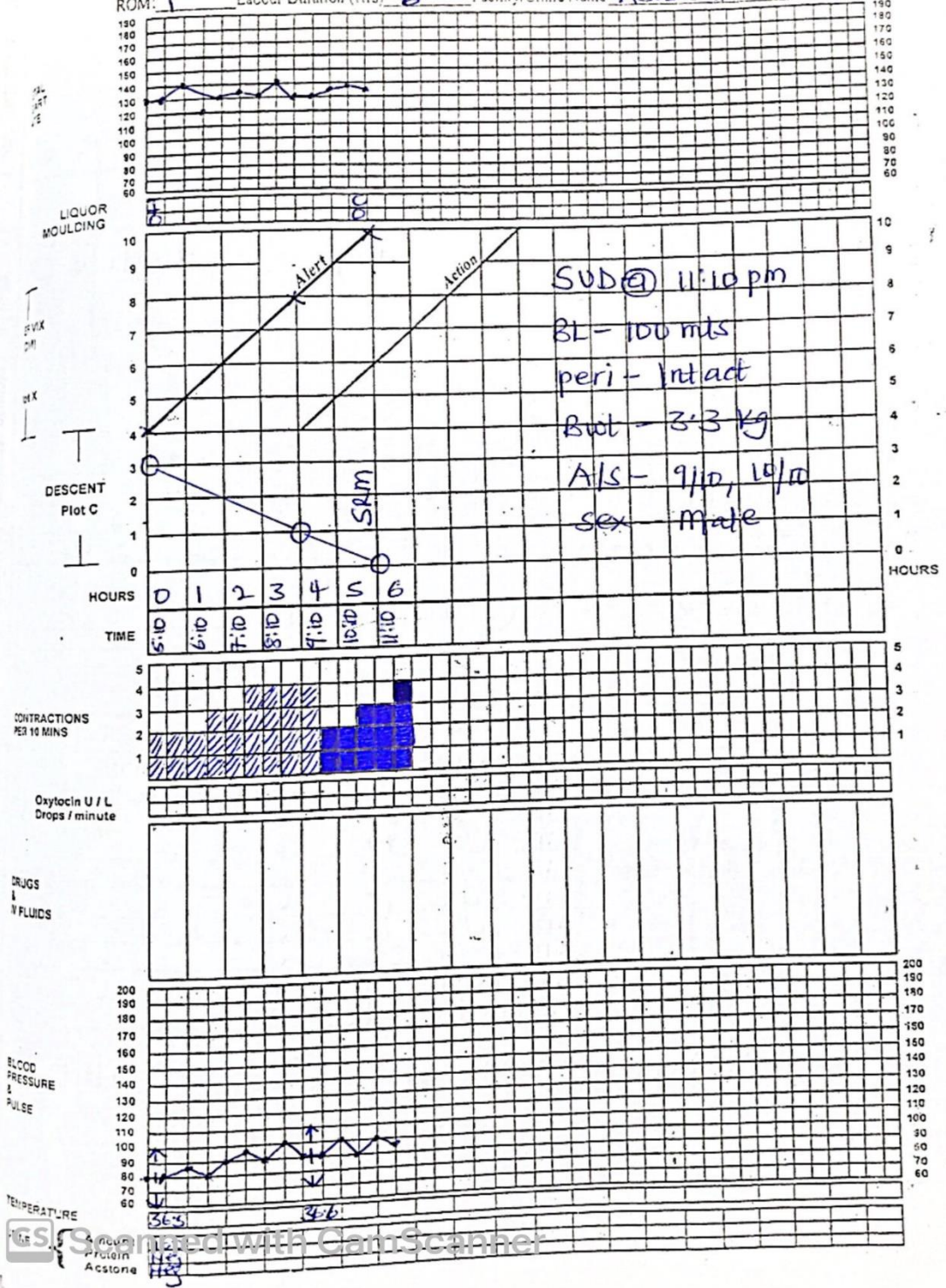
**PHARMACOLOGY OF DRUGS USED (BABY) CONTIUED**

Pneumococcal 1	Antigen	0.5 ml	Intramuscular right thigh	Vaccinates neonate against pneumonia	Under observation	Redness at the sight of injection and fever.	None observed
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Pentavalent 1 (5 in 1)	Antigen	0.5 ml	Intramuscular left thigh	Vaccinates neonate against diphtheria, pertussis (whooping cough), tetanus, hepatitis B, homophiles influenza B	Under observation	Low grade fever	None observed
Rotavirus 1	Antigen	1.5 ml	Oral	Prevention of gastroenteritis	Under observation	None	None

# WHO Modified Partograph

Registration No. 51/21 Name (Last, First) Twelwan Margaret Age 37 years  
 Date: 21/11/21 Parity/Gravida G3.P2 LMP 15/2/21 EOD 26/11/21 Gestation (wks) 38<sup>45</sup> weeks  
 ROM: 1 Labour Duration (hrs) 6 Facility/Clinic Name Asare Health Center



LABOR NOTES

Client had spontaneous vaginal delivery of 1st male child at 11:00. Placenta and its membranes delivered. Client vital signs checked and recorded. Baby examined. Birth weight 3.3 kg, Head circumference 36 cm, full length 50 cm, Apgar score 9/10, 10/10. Baby breast feeds. Both mother and baby are doing well and are being monitored.

Please circle or write responses.

DELIVERY

DATE: 21/11/21 TIME: 11:10 pm METHOD: Spontaneous / Vacuum Extraction / C/S / Other

PERINEUM: Intact / Episiotomy / Laceration

ANESTHESIA: None / Local / General

THIRD STAGE

Active Management: Yes / No Medication: Time 11:10 pm Type/Dose Oxytocin

PLACENTA: TIME: 11:15 pm Complete / Incomplete  
Small (Less than 250 cc)

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

APGAR

NEWBORN

Weight: 3.3 kg  
Sex: Male / Female  
Baby Position: Vertex / Breech / Other

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

COMPLICATIONS OF MOTHER / BABY: None / Other: HAD

FOURTH STAGE MONITORING

Frequency	Time	B/P	Pulse	Fundus	Bleeding	Bladder
Every 15 minutes first 2 hours	11:30	110/60	80	16cm	Small	Emptied
	11:45	100/70	78	contracted	Small	-
	12:00	110/80	82	✓	✓	-
	12:15	110/60	79	✓	✓	-
	12:30	120/80	80	✓	✓	Emptied
	12:45	100/70	75	✓	✓	-
	1:00	110/80	73	✓	✓	-
	1:15	100/60	82	✓	✓	-
Every 30 minutes For 1 hour	1:45	100/70	79	✓	✓	-
	2:15	100/70	87	✓	✓	Emptied

Birth Attendant: Asubonteng Claudia

Date: 21/11/21

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# MATERNITY CHART

THEWAA MARGARET

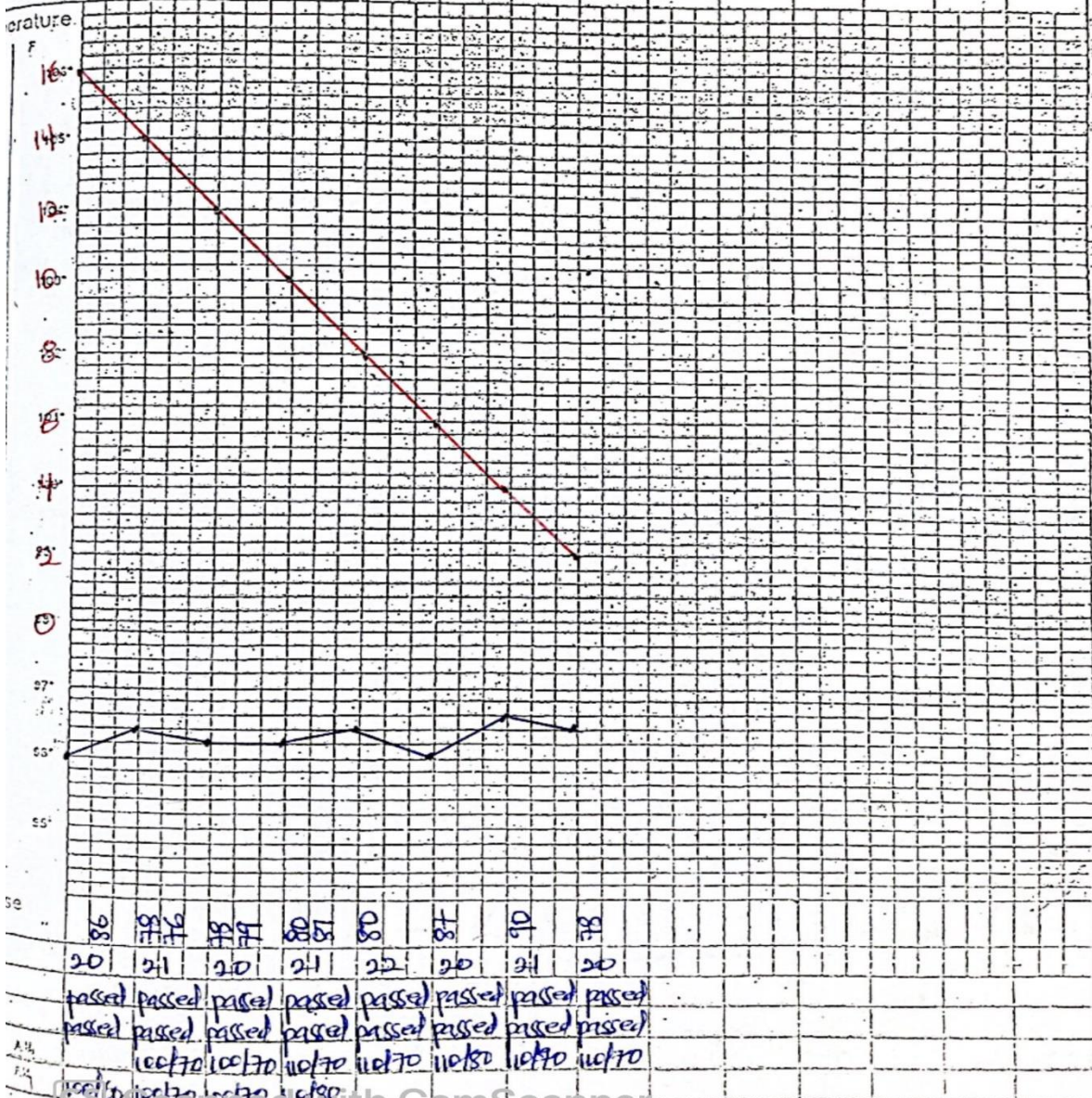
37 YEARS

WARD: LYING IN

4679/12

BED NO.: ONE

	01/11/21	02/11/21	03/11/21	04/11/21	05/11/21	06/11/21	07/11/21	08/11/21
In Hospital	D0	D1	D2	D3	D4	D5	D6	D7
P.O.	-	-	-	-	-	-	-	-
AM	7:00	7:00	8:00	8:00	8:00	8:00	7:00	8:00
PM	11:00	5:00	5:00	5:00				



NEW BORN EXAMINATION FORM

DISCHARGE

BABY AKWASI MARGARET Date of Assessment: 22/11/21 Time: \_\_\_\_\_  
 Birth: 21/11/21 Time of Birth: 11:10 pm Sex:  M  F Age at time of Assessment (days/hrs) 1 day  
 Mode of Delivery:  Vaginal  Assisted Vaginal  C-Section  
 Birth Weight:  3.2 kg  Length: 50 cm Head Circumference: 36 cm  
 Temperature at time of Assessment: 36.5 °C Urine passed:  Yes  No Meconium passed:  Yes  No  
 Assessor (Midwife/Doctor): ASUBONTENG CLAUDIA

<p>7. Suck</p> <input checked="" type="checkbox"/> Good <input type="checkbox"/> Weak <input type="checkbox"/> Absent	<p>8. Head swelling</p> <input type="checkbox"/> Caput succedaneum <input type="checkbox"/> Cephalhaematoma <input type="checkbox"/> Subgaleal hemorrhage <input checked="" type="checkbox"/> No swelling	<p>15. Neck</p> <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Swelling <input type="checkbox"/> Webbed <input type="checkbox"/> Other: _____	<p>22. Limbs</p> <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Abnormal _____
<p>9. Sutures</p> <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Overlapping <input type="checkbox"/> Fused <input type="checkbox"/> Widely Separated *	<p>10. Fontanel</p> <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Sunken * <input type="checkbox"/> Raised * <input type="checkbox"/> Wide (>5cm)*	<p>16. Clavicle</p> <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Swelling/Fracture	<p>23. Genitalia</p> <p>Male Genitalia</p> <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Undescended testes <input type="checkbox"/> Abnormal meatus <input type="checkbox"/> Hernia <input type="checkbox"/> Other: _____
<p>11. Eyes</p> <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Subconjunctival bleed <input type="checkbox"/> White pupil or cornea <input type="checkbox"/> Eye discharge <input type="checkbox"/> Other	<p>12. Ears</p> <input checked="" type="checkbox"/> Normal (size / shape/position) <input type="checkbox"/> Abnormal: _____	<p>17. Chest</p> <input checked="" type="checkbox"/> Normal (Shape/movement) <input type="checkbox"/> Abnormal _____	<p>Female Genitalia</p> <input type="checkbox"/> Normal <input type="checkbox"/> Fistula/meconium/urine through abnormal opening in vagina * <input type="checkbox"/> Large clitoria * <input type="checkbox"/> Other: _____
<p>13. Mouth</p> <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Cleft palate <input type="checkbox"/> Cleft Lip <input type="checkbox"/> Other: _____	<p>19. Femoral pulse</p> <input checked="" type="checkbox"/> Present <input type="checkbox"/> Not palpable*	<p>18. Heart rate</p> Rate: _____ <input checked="" type="checkbox"/> Normal (100-160) <input type="checkbox"/> <100 * <input type="checkbox"/> >160*	<p>24. Anus</p> <input checked="" type="checkbox"/> Patent <input type="checkbox"/> Imperforate*
<p>14. (Blank)</p>	<p>20. Abdomen</p> <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Distended* <input type="checkbox"/> Scarphoid* <input type="checkbox"/> Abdominal defect* <input type="checkbox"/> Maases: _____ <input type="checkbox"/> Other _____	<p>21. Back (spine)</p> <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Abnormal Swelling * <input type="checkbox"/> Hairly patch over spine <input type="checkbox"/> Abnormal dimple <input type="checkbox"/> Abnormal curvature	<p>25. Resuscitation provided</p> <input type="checkbox"/> One <input checked="" type="checkbox"/> Suction/stimulation <input type="checkbox"/> Bag and mask <input type="checkbox"/> Endotracheal Tube <input type="checkbox"/> Ventilator/CPAP
<p>14. (Blank)</p>	<p>26. Services provided</p> <input checked="" type="checkbox"/> Vitamin K1 given <input checked="" type="checkbox"/> Eye care provided <input checked="" type="checkbox"/> Cord care provided <input checked="" type="checkbox"/> Breastfeeding initiated <input checked="" type="checkbox"/> Breastfeeding established <input checked="" type="checkbox"/> Immunization (BCG/Polio) <input checked="" type="checkbox"/> BCG <input checked="" type="checkbox"/> Polio Immunization <input type="checkbox"/> Antibiotics in mother <input type="checkbox"/> Antenatal corticosteroids		

Indicate severe disease that requires urgent referral (if known) \_\_\_\_\_  
 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

## NEW BORN EXAMINATION FORM

Name: BABY AKWASI MARGARET Date of Assessment: 21/11/21 Time: \_\_\_\_\_  
 Date of Birth: 21/11/21 Time of Birth: 11:10 pm Sex:  M  F Age at time of Assessment (days/hrs) 1  
 Astational Age  Mode of Delivery:  Vaginal  Assisted Vaginal  C-Section  
 APGAR: 1min 9 5min 10 Birth Weight: 3.3 kg  Length: 50 cm Head Circumference: 36 cm  
 Temperature at time of Assessment: 36.5 °C Urine passed:  Yes  No Meconium passed:  Yes  
 Name of Assessor (Midwife/Doctor): ASUBOTENG CLAUDIA

<p><b>1. Respiration</b>                  Rate _____  <input type="checkbox"/> Rate &lt; 30 b/m *  <input type="checkbox"/> Rate &lt; 60 b/m *  <input checked="" type="checkbox"/> 30-60 b/m  <input type="checkbox"/> Retractions *  <input type="checkbox"/> Grunting *  <input type="checkbox"/> Stridor *</p> <p><b>2. Activity/Movement</b>  <input checked="" type="checkbox"/> Spontaneous symmetric movements  <input type="checkbox"/> Reduced/Absent Movement in ≥ 1 limb *  <input type="checkbox"/> No Movement</p> <p><b>3. Tone</b>  <input checked="" type="checkbox"/> Normal  <input type="checkbox"/> Floppy *  <input type="checkbox"/> Increased *</p> <p><b>4. Colour</b>  <input checked="" type="checkbox"/> Pink all over  <input type="checkbox"/> Pink body but blue hands/feet  <input type="checkbox"/> Blue all over *  <input type="checkbox"/> Pale *  <input type="checkbox"/> Jaundiced *</p> <p><b>5. Cord</b>  <input checked="" type="checkbox"/> Normal  <input type="checkbox"/> Red. draining pus  <input type="checkbox"/> Bleeding</p> <p><b>6. Cry</b>  <input checked="" type="checkbox"/> Normal  <input type="checkbox"/> Shrill *  <input type="checkbox"/> Absent *</p>	<p><b>7. Suck</b>  <input checked="" type="checkbox"/> Good  <input type="checkbox"/> Weak  <input type="checkbox"/> Absent</p> <p><b>8. Head swelling</b>  <input type="checkbox"/> Caput succedaneum  <input type="checkbox"/> Cephalhaematoma  <input type="checkbox"/> Subgaleal hemorrhage  <input checked="" type="checkbox"/> No swelling</p> <p><b>9. Sutures</b>  <input checked="" type="checkbox"/> Normal  <input type="checkbox"/> Overlapping  <input type="checkbox"/> Fused  <input type="checkbox"/> Widely Separated *</p> <p><b>10. Fontanel</b>  <input checked="" type="checkbox"/> Normal  <input type="checkbox"/> Sunken *  <input type="checkbox"/> Raised *  <input type="checkbox"/> Wide (&gt;5cm) *</p> <p><b>11. Eyes</b>  <input checked="" type="checkbox"/> Normal  <input type="checkbox"/> Subconjunctival bleed  <input type="checkbox"/> White pupil or cornea  <input type="checkbox"/> Eye discharge  <input type="checkbox"/> Other _____</p> <p><b>12. Ears</b>  <input checked="" type="checkbox"/> Normal (size / shape/position)  <input type="checkbox"/> Abnormal: _____</p> <p><b>13. Mouth</b>  <input checked="" type="checkbox"/> Normal  <input type="checkbox"/> Cleft palate  <input type="checkbox"/> Cleft Lip  <input type="checkbox"/> Other _____</p>	<p><b>15. Neck</b>  <input checked="" type="checkbox"/> Normal  <input type="checkbox"/> Swelling  <input type="checkbox"/> Webbed  <input type="checkbox"/> Other: _____</p> <p><b>16. Clavicle</b>  <input checked="" type="checkbox"/> Normal  <input type="checkbox"/> Swelling/Fracture</p> <p><b>17. Chest</b>  <input checked="" type="checkbox"/> Normal (Shape/movement)  <input type="checkbox"/> Abnormal _____</p> <p><b>18. Heart rate</b>                  Rate: _____  <input checked="" type="checkbox"/> Normal (100-160)  <input type="checkbox"/> &lt;100 *  <input type="checkbox"/> &gt;160 *</p> <p><b>19. Femoral pulse</b>  <input checked="" type="checkbox"/> Present  <input type="checkbox"/> Not palpable *</p> <p><b>20. Abdomen</b>  <input checked="" type="checkbox"/> Normal  <input type="checkbox"/> Distended*  <input type="checkbox"/> Scaphoid*  <input type="checkbox"/> Abdominal defect*  <input type="checkbox"/> Maases: _____  <input type="checkbox"/> Other _____</p> <p><b>21. Back (spine)</b>  <input checked="" type="checkbox"/> Normal  <input type="checkbox"/> Abnormal Swelling *  <input type="checkbox"/> Hairly patch over spine  <input type="checkbox"/> Abnormal dimple  <input type="checkbox"/> Abnormal curvature</p>	<p><b>22. Limbs</b>  <input checked="" type="checkbox"/> Normal  <input type="checkbox"/> Abnormal _____</p> <p><b>23. Genitalia</b>  <b>Male Genitalia</b>  <input checked="" type="checkbox"/> Normal  <input type="checkbox"/> Undescended testes  <input type="checkbox"/> Abnormal meatus  <input type="checkbox"/> Hernia  <input type="checkbox"/> Other: _____  <b>Female Genitalia</b>  <input type="checkbox"/> Normal  <input type="checkbox"/> Fistula (meconium/urine through abnormal opening vagina) *  <input type="checkbox"/> Large clitoria *  <input type="checkbox"/> Other: _____</p> <p><b>24. Anus</b>  <input checked="" type="checkbox"/> Patent  <input type="checkbox"/> Imperforate *</p> <p><b>25. Resuscitation provided</b>  <input type="checkbox"/> One  <input checked="" type="checkbox"/> Suction/stimulation  <input type="checkbox"/> Bag and mask  <input type="checkbox"/> Endotracheal Tube  <input type="checkbox"/> Ventilator/CPAP</p> <p><b>26. Services provided</b>  <input checked="" type="checkbox"/> Vitamin K1 given  <input checked="" type="checkbox"/> Eye care provided  <input checked="" type="checkbox"/> Cord care provided  <input checked="" type="checkbox"/> Breastfeeding initiated  <input checked="" type="checkbox"/> Breastfeeding established  <input checked="" type="checkbox"/> Immunization (BCG/Pe)  <input checked="" type="checkbox"/> BCG <input checked="" type="checkbox"/> Polio Immunization  <input type="checkbox"/> Antibiotics in mother  <input type="checkbox"/> Antenatal corticosteroids</p>
-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------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\*May indicate severe disease that requires urgent referral  
**Diagnoses (if known)** \_\_\_\_\_  
**Classification: (Overall assessment)**  Normal  Baby with a Problem  Danger Sign/ <1500g/ severe Jaundice  
**Plan:**  Routine Care  Problem. Continue supportive in-patient care  Urgent Referral / Advanced Care  Discharge

# TEMPERATURE CHART

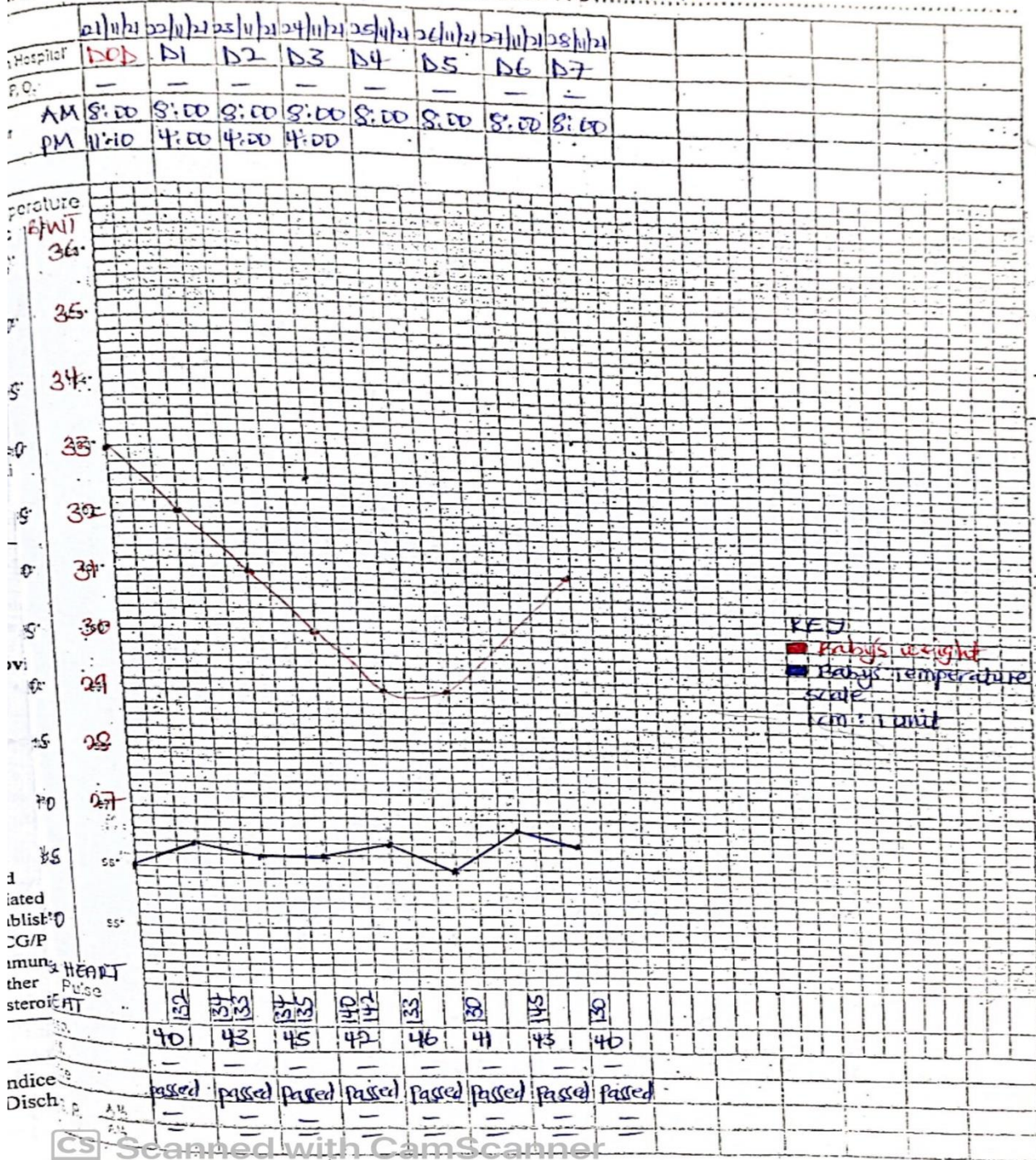
BABY AKWASI MARGARET

NEW BORN

WARD: LIVINGH

4211/21

BED NO.: ONE



### NEW BORN CHART

Name: BABY AKHNSI MARGARET No: 4211/21 Birth Weight: 3.3 Kg

Sex: MALE Mother's No: 4679/12 Length: 50 cm

Nature of Delivery: SPONTANEOUS VAGINAL DELIVERY Diagnosis: TERM BABY

Date of Birth: 21/11/21 Time: 11:10 PM Date of Discharge: 22/11/21

Date	21/11/21		22/11/21		23/11/21		24/11/21		25/11/21		26/11/21		27/11/21		28/11/21		29/11/21		30/11/21		
	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	
No. of Days	D1		D1		D2		D2		D3		D4		D5		D6		D7		D8		
Weight	3.3		3.2		3.1		3.0		3.0		3.1		3.1		3.2		3.3		3.4		
Temperature	36.5 <sup>00</sup>		36.5 <sup>00</sup>		36.8 <sup>00</sup>		36.7 <sup>00</sup>		36.6 <sup>00</sup>		36.6 <sup>00</sup>		36.6 <sup>00</sup>		36.7 <sup>00</sup>		36.7 <sup>00</sup>		36.5 <sup>00</sup>		
Stools	Passed		Passed		Passed		Passed		Passed		Passed		Passed		Passed		Passed		Passed		
Urine	Passed		Passed		Passed		Passed		Passed		Passed		Passed		Passed		Passed		Passed		
Remarks	HEAD NECK TRUNK GENITALIA NO ABNORMALITIES DETECTED																				

**SIGNATORIES**

**STUDENT**

NAME: MISS CLAUDIA ASUBONTENG

SIGNATURE ..... *Claudia* .....

DATE ..... 19/09/2022 .....

**MIDWIFE IN-CHARGE**

NAME: MRS CHRISTIANA ATIEMO

SIGNATURE ..... *Christiana* (RM) .....

DATE ..... 19/09/2022 .....

**SUPERVISOR**

NAME: MISS MARTHA KYEREMAA

SIGNATURE ..... *Martha* .....

DATE ..... 11/11/2022 .....

**PRINCIPAL**

NAME: MS. MONICA NKRUMAH

SIGNATURE ..... *Monica* (RM) .....

DATE ..... 11/11/2022 .....

GRADUATE CO-ORDINATOR - NURSING  
HOLY FAMILY NURSING & MIDWIFERY  
11/11/2022

