HOLY FAMILY NURSING AND MIDWIFERY TRAINING COLLEGE, BEREKUM

A CLIENT /FAMILY CENTERED MATERNITY CARE STUDY

ON

MADAM ELLEN ANDREW

BY

MS. ANTWI SERWAA INDIRA

4122220043

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

AUGUST 2024

Contents

PREFACE

Client and family Centered Maternity care is a standardized approach of rendering care to an anticipating mother and her family through pregnancy, labour and puerperium. The aim of this study is to help know the client better to be able to respect her cultural and religious beliefs, traditions and values. This care is based on a thoughtful understanding of the client as a unique person with specific problems or needs that must be addressed. Basically, include the physical, emotional and psychological aspect of nursing to the expectant mother and her family. The study makes it possible for the student midwife to put into practice the knowledge and skills she has acquired during her training.

The family centered maternity care study is an academic work which gives the student midwife the opportunity to nurse a client throughout pregnancy, labor and puerperium using the knowledge and skills acquired during the three-year training program.

The study helps the midwife to use new trends in midwifery like the opportunity to use partograph in monitoring client during labour. This partograph is a tool developed by World Health Organization (WHO), which when used correctly helps curb the menace of maternal death in the country. The active management of third stage of labour also introduced to limit the occurrences of postpartum hemorrhage. Additionally, it helps the midwife to put into practice the safe motherhood initiative which has been adopted in order to improve quality of health through antenatal care, labour and postnatal care.

A client centered maternity care helps to foster a good interpersonal relationship between clients and the student midwife and also strengthen the trust that exists between them.

The care study is a partial fulfillment of the requirement by the Nurses and Midwives Council of Ghana in awarding a Midwifery Certificate to the graduate at the end of the program to enable one to practice as a midwife in Ghana or any other country in the world.

ACKNOWLEDGEMENT

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

My heartfelt appreciation also goes to the principal, Ms. Monica Nkrumah for her support throughout study period, my Supervisor Madam Diana Owusu Serwaa for her keen supervision and corrections to make this script a success and to the entire tutorial staffs and the non-teaching staffs of Holy Family Nursing and Midwifery Training College God bless you all.

Special thanks to my client and 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.

My Sincere gratitude goes to the midwife in-charge, Mrs. Ivy Kyerewaa of African Libera Health Centre and her staffs 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 go to my parents, Mr. and Mrs. Antwi and Rev Fr Raphael Annan for supporting me spiritually through the three-year course of study.

My honest appreciation goes to Madam Gifty Ofori-Amanfo and Nathaniel Antwi for your time, encouragement, motivation and support both psychologically and spiritually, may the good Lord bless you. 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

A client family-centered maternity care study is a systematic holistic care to expectant mothers, their family and community as a whole, based on thoughtful understanding with specific needs and problems.

1. The care study started from pregnancy, labour and puerperium and during this period the clients physical, psychological, spiritual and social changes were considered with. The framework of her family and community. The care study was carried on Madam Ellen Andrew a 21 years old expectant mother, gravida 2 Para 1(G2P1). She was 37 weeks when she was met at Africa Libera Health Centre at the antenatal unit for review and she was selected for the care study since she qualified for the criteria, thus she has given birth to one child per vaginal without any complication and carried the pregnancies to term. She was first met on the 15th of August, 2023 at the antenatal unit when she came for antenatal review and that was the day the care study started.

Madam Ellen's problems identified during pregnancy, labour, puerperium environment and managed. The condition from the beginning till the end of the interaction was satisfactory. Madam Ellen had a successful pregnancy, delivered spontaneously on the 9th September 2023 to a live female baby. Puerperium was also successful and client and baby were handed over to the midwife in-charge of Africa libera Health Centre in good condition for continuity of care.

The four chapters outlined in the script, includes Chapter one, which talks about assessment of client histories in order to gain knowledge about the client, Chapter two talks about the antenatal care given to the client, chapter three talks about labour and chapter four talks about puerperium. The care and management rendered at each stage has been outlined, and a care plan was drawn at the end of pregnancy, labour and puerperium to identify and solve problems of the client and

also to prevent complication from occurring. Summary, conclusion, bibliography, appendices, and signatories are also included.

LITERATURE REVIEW

Pregnancy

Pregnancy: The state of carrying a developing embryo or foetus within the female body. This condition can be indicated by positive results on an over-the-counter urine test, and confirmed through a blood test, ultrasound, detection of fetal heartbeat, or an X-ray. Pregnancy lasts for about nine months, measured from the date of the woman's last menstrual period (LMP). It is conventionally divided into three trimesters, each roughly three months long (Davis, 2021). The most important tasks of basic fetal cell differentiation occur during the first trimester, so any harm done to the foetus during this period is most likely to result in miscarriage or serious disability. There is little to no chance that a first-trimester foetus can survive outside the womb, even with the best hospital care. Its systems are simply too undeveloped. This stage truly ends with the phenomenon of quickening: the mother's first perception of fetal movement. It is in the first trimester that some women experience "morning sickness," a form of nausea on awaking that usually passes within an hour. The breasts also begin to prepare for nursing, and painful soreness from hardening milk glands may result (Davis, 2021).

As the pregnancy progresses, the mother may experience many physical and emotional changes, ranging from increased moodiness to darkening of the skin in various areas. During the second trimester, the foetus undergoes a remarkable series of developments. Its physical parts become fully distinct and at least somewhat operational. With the best medical care, a second-trimester foetus born prematurely has at least some chance of survival, although developmental delays and other handicaps may emerge later. As the foetus grows in size, the mother's pregnant state will begin to be obvious. In the third trimester, the foetus enters the final stage of preparation for birth. X It increases rapidly in weight, as does the mother (American College of Obstetricians

and Gynaecologist, 2018). According to Davis (2021), conception to about the 12th week of pregnancy marks the first trimester. The second trimester is weeks 13 to 27 and the third trimester starts about 28 weeks and lasts until birth. Women gain weight all over their bodies while they are pregnant. Fetal weight accounts for about 7 1/2 pounds by the end of pregnancy. The placenta, which nourishes the baby, weighs about 1 1/2 pounds. The uterus weighs 2 pounds. A woman gains about 4 pounds due to increased blood volume and an additional 4 pounds due to increased fluid in the body. A woman's breasts gain 2 pounds during pregnancy. Amniotic fluid that surrounds the baby weighs 2 pounds. A woman gains about 7 pounds due to excess storage of protein, fat, and other nutrients. The combined weight from all these sources is about 30 pounds (Davis, 2021). The World Health Organization (WHO) envisions a world where "every pregnant woman and newborn receives quality care throughout the pregnancy, childbirth and the postnatal period" (Tunçalp, et al., 2019). Antenatal care (ANC) can be defined as the care provided by skilled health-care professionals to pregnant women and adolescent girls in order to ensure the best health conditions for both mother and baby during pregnancy (World Health Organization, 2016). According to the World Health Organization (2016), the components of ANC include: risk identification; prevention and management of pregnancy-related or concurrent diseases; and health education and health promotion. ANC reduces maternal and perinatal morbidity and mortality both directly, through detection and treatment of pregnancy-related complications, and indirectly, through the identification of XI women and girls at increased risk of developing complications during labour and delivery, thus ensuring referral to an appropriate level of care (World Health Organization, 2016). In addition, as indirect causes of maternal morbidity and mortality, such as HIV and malaria infections, contribute to approximately 25% of maternal deaths and near-misses (9), ANC also provides an important opportunity to prevent and manage concurrent diseases through integrated service

delivery (World Health Organization, 2016). Through this form of preventive health care, women can learn from skilled health personnel about healthy behaviours during pregnancy, better understand warning signs during pregnancy and childbirth, and receive social, emotional and psychological support at this critical time in their lives. Through antenatal care, pregnant women can also access micronutrient supplementation, treatment for hypertension to prevent eclampsia, as well as immunization against tetanus (United Nations Children's Fund (UNICEF), 2023

Labour

Labour consists of a series of rhythmic, involuntary or medically induced contractions of the uterus that result in effacement (thinning and shortening) and dilation of the uterine cervix (Artal-Mittelmark, 2023). The World Health Organization (WHO) defined normal birth as "spontaneous in onset, low-risk at the start of labour and remaining so throughout labour and delivery. The infant is born spontaneously in the vertex position between 37 and 42 completed weeks of pregnancy. After birth, mother and infant are in good condition" (WHO, 2020). The stimulus for labour is unknown, but digitally manipulating or mechanically stretching the cervix during examination enhances uterine contractile activity, most likely by stimulating release of oxytocin by the posterior pituitary gland (Artal-Mittelmark, 2023). Normal labour XII usually begins within 2 weeks (before or after) the estimated delivery date. In a first pregnancy, labour usually lasts 12 to 18 hours on average; subsequent labours are often shorter, averaging 6 to 8 hours (Artal-Mittelmark, 2023).

As discussed by Artal-Mittelmark (2023) rupture of the chorioamniotic membranes or bloody show is diagnostic for onset of labour. Labour begins with irregular uterine contractions of varying intensity; they apparently soften (ripen) the cervix, which begins to efface and dilate. As

labour progresses, contractions increase in duration, intensity, and frequency. As specified by Marshall and Raynor (2014), the onset of labour is a process, not an event; therefore, it is very difficult to identify exactly when the painless (sometimes painful) contractions of pre-labour develop into the progressive rhythmic contractions of established labour.

Traditionally, three stages of labour are described: the first, second and third stage, but this is a rather pedantic view, as labour is obviously a continuous process. It has also been acknowledged that there are more than three stages of labour, namely the latent, active and transitional phases, and these not only encompass specific physical changes but should also account for the emotional effects observed in women during this time (Marshall & Raynor, 2014).

1. **The 1st stage**—from onset of labor to full dilation of the cervix (about 10 cm). Begins with regular rhythmic uterine contractions to the full dilatation of the cervix and is managed by a partograph. The first stage lasts for about twelve to fourteen hours in primi gravida and six to twelve hours in multigravida (Artal-Mittelmark, 2022).
    a. The **latent phase of labour** is prior to the active phase stage of labour and may last 6–8 hours in primigravidae when the cervix dilates from 0 cm to 4 cm dilated. The latent phase of labour is so subjective and poorly understood that a normal range is difficult to measure. According to Marshall and Raynor (2014), the cervical canal shortens from 3 cm long to <0.5 cm in length during this time. A woman may believe herself to be labouring, whereas sound midwifery judgement and understanding of the physiology of the first stage of labour may lead the midwife to the diagnosis of the latent phase of labour. Both the woman and midwife being aware of the latent phase of labour, and allowing this time to pass with no intervention, can prevent the medical diagnosis of poor progress or failure to progress later in labour. In a hospital setting, it is good practice not to commence the partograph until active labour has commenced.

Assessing the active phase of labour has been highlighted as essential in reducing interventions in normal labour (Marshall & Raynor, 2014).

b. The **active phase** within the first stage of labour is the time when the cervix usually undergoes more rapid dilatation. This begins when the cervix is at least 4 cm dilated and, in the presence of rhythmic contractions, progressively dilates to 10 cm or full dilatation. When in labour, contractions will often be accompanied or preceded by a blood-stained mucoid show: that is, the release of the operculum from the cervical canal as effacement and dilatation progresses. Occasionally, the membranes will rupture, at which stage the midwife may seek assurance that there are no significant changes in the fetal heart rate due to the rare complication of cord prolapse and that meconium is not present in the liquor, indicating fetal compromise (Marshall & Raynor, 2014).

c. The **transitional phase** of the first stage of labour is from when the cervix is around 8 cm dilated until it is fully dilated or until expulsive contractions associated with the second stage of labour are felt by the woman. There is often a brief lull in the intensity of uterine activity at this time. Many women may feel the urge to push during transition. In addition to physiological responses, women can experience a range of experiences and emotions. The woman may verbalize her distress, direct it at her birth partner(s), alternatively she may be quiet and contemplative (Marshall & Raynor, 2014).

2. The second stage of labour has traditionally been regarded as the phase between full dilatation of the cervical os, and the birth of the baby (Marshall & Raynor, 2014). On average, it lasts 2 hours in nulliparas (median 50 minutes) and 1 hour in multiparas (median 20 minutes). It may last another hour or more if conduction (epidural) analgesia

or intense opioid sedation is used. For spontaneous delivery, women must supplement uterine contractions by expulsively bearing down. In the 2nd stage, women should be attended constantly, and fetal heart sounds should be checked continuously or after every contraction. Contractions may be monitored by palpation or electronically (Artal-Mittelmark, 2022). During the 2nd stage of labor, perineal massage with lubricants and warm compresses may soften and stretch the perineum and thus reduce the rate of 3rd- and 4th-degree perineal tears (Aasheim, et al., 2017).

3. The **third stage** can be defined as the period from the birth of the baby to complete expulsion of the placenta and membranes. It involves the development of the relationship between mother, baby and father, the separation, descent and expulsion of the placenta and membranes, the control of haemorrhage from the placenta site, and sometimes, the initiation of breast-feeding. Although traditionally labour is divided into three distinct component parts to aid comprehension, it should be viewed as one continuous process. With this in mind, it is important to understand that the physiology of the third stage depends, in part, on what has happened during pregnancy as well as during the first and second stage of labour, and on the woman's basic level of health and wellbeing. The midwife's knowledge and evidence-based skills play a crucial role in ensuring that the care received by the woman works with, not against, physiological processes. The placenta may shear off during the final expulsive contractions accompanying the birth of the baby or remain adherent for some time. The third stage usually lasts between 5 and 15 minutes, but any period up to 1 hour may be considered normal (Marshall & Raynor, 2014).

Puerperium

The words “postpartum” and “postnatal” are sometimes used interchangeably. In this report we use the word “postpartum”, except in sections exclusively dealing with the infant. In those sections the word “postnatal” is used. The postpartum period (also called the puerperium) according to Western textbook definitions starts shortly after the birth of the placenta (American College of Obstetricians and Gynecologist, 2018).

Following the birth of a baby, placenta and membranes, the newly birthed mother enters a period of physical and emotional/psychological recuperation. Skin-to-skin contact is advocated immediately following birth and during the postnatal period as there is clear evidence of benefit to the mother and father. The puerperium starts immediately after birth of the placenta and membranes and continues for 6 weeks. In many cultures around the world 40 days for recuperation is a time-honored practice. A general expectation is that by 6 weeks after birth a woman’s body will have recovered sufficiently from the effects of pregnancy and the process of parturition. However, there has now been a recognition that the return to a non-pregnant state of health and wellbeing can take much longer (Marshall & Raynor, 2014).

According to Marshall and Raynor (2014), after the birth of a baby and expulsion of the placenta, the mother enters a period of physical and psychological preparation and this period, called the puerperium starts immediately after delivery of the placenta and membranes and continues for a period of 6 to 8 weeks. Puerperium is a period after childbirth where the uterus and other organs and structures which were affected by pregnancy returns to their non-gravid state. This period is also divided into three;

1. Immediate puerperium: this is the first 24 hours after delivery.
2. Early puerperium: is between the second and the seventh day after delivery.

3. Late puerperium: this is the period from the second week to the sixth week after childbirth.

During this time a number of physiological and psychological changes take place which are;

The reproductive organs return to the non-pregnant state.

1. Lactation is established
2. Bounding between infant and parents is also established

The mother recovers from the stresses of pregnancy and delivery, and assumes responsibility for the care and nurture of her infant. The main aim of management during puerperium is to;

1. Manage minor disorders in both mother and baby.
2. Counsel and teach on nutritional needs of the puerperal mother.
3. Counsel, teach and encourage the mother to breastfeed exclusively for six months and how to properly fix baby to breast.
4. Counsel and teach mother on importance of rest and sleep, ambulation and exercise as well as family planning.

The transition to parenthood involves major adjustments within a family and some mothers will welcome and actively seek help and support from a midwife during the postnatal period, but some women, for a range of reasons, may not. Women from different cultural backgrounds may have traditions that conflict with the current management of postpartum care consider that they already have sufficient skills and experience. Not being able to speak or understand English may also prevent a woman from seeking help. Although a visit to the home might have been planned, there will also be times when women are not at home when the midwife visits. It is important to keep in mind individual circumstances and whether these might have any bearing on a no-access visit. For example, parents with a disability such as hearing loss or poor mobility might not hear a doorbell. It is, therefore, important to make arrangements for contact to be made by alternative

means (e.g. using a visual alarm or telephone to alert the woman of the visit beforehand). The midwife needs to recognize situations where the mother perceives she has different priorities from those routinely provided by the healthcare services (Marshall & Raynor, 2014)

WHY CLIENT WAS CHOSEN

Madam Ellen was seen at Africa Libera Health Centre as a client on one of her usual antenatal visits to the clinic. On our first contact, Madam Ellen was seen feeling so heavy and very sweaty, so an approach was made, and was complaining of heartburns and backache. Education was given to Madam Ellen on some of the minor disorders in pregnancy and how to manage them whiles at home. She was advice to have a good rest, avoid standing for a long time and eat foods that contains less or no spices. Upon going through her antenatal booklet, she was qualified to be used for the care study, thus a multiparous woman of G2P1 with no complication in her previous pregnancy, labour, and puerperium and also in her 37^{th} week of gestation.

Introduction of self was made as a student midwife from Holy Family Nursing and Midwifery Training College, Berekum, who is on clinical practice and the interest to select her for a study, of which She agreed and said she was glad.

Since she accepted and therefore fit into the criteria for selection of the study, education and explanation of the care was given to her, routine procedures were carried out, and the midwife in-charge after her assessment approved of client to be used. Direction to her house was given and home visit appointment was booked.

CHAPTER ONE

ASSESSMENT OF CLIENT/FAMILY

1.0 INTRODUCTION

This chapter entails information about the client, her family and community. It gives an account of the assessment on the client, her family and the community in which she lived.

1.1 PERSONAL AND SOCIAL HISTORY

Madam Ellen is a 21-year-old G2:P1A lady who comes from Nkoranza in the Bono East Region, Ghana. She stays near a drinking water factory in her area (Amangoase). She is dark in complexion and 153cm tall. She speaks Twi and Dagaare. She has been in a relationship with Mr. Richard Andrew for 6 years but has been married for 3 years now. She is blessed with a 3 years son called Godfred Andrew. Madam Ellen had her education up to primary six and is currently a house wife. Madam Ellen is a Christian and worships at St. Theresah's catholic church and she is very religious and for this reason she does not smoke or take in alcohol. Her next of kin is Richard Andrew. Mr. Richard Andrew, her husband is a 37 years old man, a native of Nkoranza, who had his formal education up to Junior High level. He is also a Christian and worship with Saint Stephen catholic Church and a farmer as his occupation. His hobbies are watching football and listening to music whiles his wife likes to play Ludo and listen to music as a hobby. Madam Ellen and her son patronize health care services from the Africa Libera Health Center.

1.1 FAMILY HISTORY

Madam Ellen said there are no hereditary diseases like sickle cell disease, diabetes, hypertension, heart disease, asthma or mental illness in her family. She reported of a history of twin pregnancies in the family and no congenital abnormality in the family. Her parents are Madam Agnes and Mr. John Ofori of which her father passed on. She has four siblings of which she is the first child among them and they are all workers. Death occurs naturally in their family.

1.3 MEDICAL HISTORY

Madam Ellen said she has not been on admission at the hospital before but receives medical treatment on out-patient basis, whenever she is ill.

According to her, she has no existing condition like hypertension, sickle cell, heart disease, diabetes, asthma, glucose 6 phosphate dehydrogenase (G6PD) defect, mental illness, TB, respiratory disease, heart disease, epilepsy, HIV infection, alcohol, smoking, syphilis, respiratory disease, multiple pregnancies, birth defects, mental health disorder.

She has no known allergies to food or any drugs. She has never been transfused nor donated blood before.

1.4 SURGICAL HISTORY

Madam Ellen has not been involved in any road traffic accident neither has she undergone any surgical operation on the pelvis, spine, reproductive tract, caesarean section, laparotomy and infertility treatment before. She has no history of abortion. She has never undergone any blood donation exercise nor has been transfused before.

1.5 MENSTRUAL HISTORY

Madam Ellen had her menarche at the age of fourteen (14). Her menstrual cycle is 28 days lasting usually for 6 days and she does have dysmenorrhea during this period according to her. She often buys drugs at pharmacy for the dysmenorrhea and uses sanitary pads during her menstrual period. Client's last menstrual period was 5/12/2022

1.6 CLIENT'S LIFESTLE AND HOBBIES

Madam Ellen wakes up around 5:30am and does her devotion. She cleans the compound after her devotion and brushes her teeth. After that she prepares breakfast and takes her son to school. She comes back and bath after which she rests till noon and prepares lunch. She waits for the son to come back from school at 2pm and goes to the market to buy foodstuffs to prepare for supper. She usually prepares supper around 4pm and eats around 6pm. She rests after eating which she uses this time to watch news on television. She baths after watching the news and makes sure the son does the homework and study. She listens to music and sleeps at 9:30pm. She usually does her household duties as a wife. Bathing and bowel movement are twice daily and empty's the bladder four to five times daily in her current state. She eats three square meals a day. She usually eats porridge and bread in the morning, ampesi and garden eggs stew as lunch, and fufu with salmon soup for supper. Her favourite food is ampesi and garden egg stew with eggs. Her hobbies are watching television, listening to music and playing Ludo.

1.7 PAST OBSTERTIC HISTORY

Pregnancy

Madam Ellen has had two pregnancies and alive male child (G2P1). She has no history of abortion, it being spontaneous nor induced. Madam Ellen began her first antenatal clinic session at Africa libera Health Center during pregnancy at ten (10) weeks gestation for her first child. She carried her pregnancy to term without any complication like ante-partum hemorrhage, urinary tract infection, malaria or anemia in pregnancy except some minor disorders of

pregnancy like heart burns, frequency of micturition, lower abdominal pains for both pregnancies. She also had no pregnancy induced diseases like hypertension and diabetes. Her first child was three years before she got pregnant again. She had two doses of tetanus toxoid and five doses of sulfadoxine pyrimethamine for her first pregnancy and 3rd doses of tetanus toxoid and five doses of sulfadoxine pyrimethamine for her current pregnancy. she became pregnant 3 years after her last pregnancy.

Labour

At term she had a spontaneous vaginal delivery to her son at Monarich Health Center. Labour did not last for long and it was without any complications such as postpartum hemorrhage. She said placenta and membranes were fully expelled shortly after she was given an injection on the thigh. Blood loss was minimal. She couldn't recall the exact weight of the baby but she described her baby to be neither fat nor thin, the baby had no abnormalities and her condition after birth was good.

Puerperium

Client said her puerperium was without any complications such as secondary post-partum hemorrhage or infection. She practiced exclusive breastfeeding for 6months and continued with complementary feeds like wean mix, other foods taken by the family and weaned her baby after 2 years. Her baby received care and all immunizations during her post-natal visits to the postnatal clinic and child welfare clinic. Both mother and baby did not suffer any ailment during puerperium. She received support from her husband's mother and her sister during puerperium. She used lactational amenorrhea and menstrual calendar- based method as her family planning method.

1.8 PRESENT OBSTETRICAL HISTORY

Madam Ellen G2P1 reported to Africa Libera Health center antenatal clinic for registration on the 19/06/23 with 29 weeks gestation since she was already booked at the Maternal and Child Health hospital at Kumasi. She said her last menstrual period was on 5/12/22, thus her expected date of delivery was calculated to be 12/09/2023 according to the scan and when calculated it was still the same 12/09/2023. Detailed information about her personal, menstrual, obstetrical, lactation, medical, surgical, family and contraceptive histories were taken. Her weight was 64 kilograms and height 153cm.

Vital signs checked and recorded as follows.

- Temperature - 36. 4 ˚C
- Pulse - 82 bpm
- Respiration - 22 cpm
- Blood pressure - 110/66 mmHg
- Urine test showed negative for both protein and sugar. Client's laboratory investigations were also done and recorded below as;
- Haemoglobin level - 10.0g/dl
- Blood group - O
- Rhesus factor - Positive
- HIV status - Negative
- Hepatitis B - Negative
- G6PD - No defect
- Sickling - Negative

- Stool (cyst, protozoa, ova) - No abnormality detected
- Syphilis (VDRL) - Non reactive

Physical examination conducted revealed no abnormalities. Symphysio-fundal height was 29cm when palpated. Client complained of lower abdominal pains as stated in her record card. Client received her 3rd dose of tetanol diphtheria immunization on her first visit. She was served with routine drugs as below;

- Tab.Multivitamin 1 daily x30
- Tab Folic Acid 5mg 1 daily x30
- Tab Ferrous sulphate 1 daily x30
-

Client made her next appointment on 14/07/23.

On 14/07/23 at 33 weeks' gestation, and her third appointment was 15/08/2023 at 37 weeks of gestation. She has also received education on nutrition, rest, sleep, exercise, danger signs of pregnancy as per her card. She made complains like Frequency of micturition and lower abdominal pains and was manage as such. Explanation was made to her that it was one of the physiological changes that occur in later part of pregnancy as a result of the descending fetal head exerting pressure on the bladder. She was told to drink more water in the day but less during the night as this might help reduce the frequency of urination at night.

Client had visited the ANC three times before she was met. Madam Ellen was a healthy pregnant woman on the first day of contact.

.

CHAPTER TWO

ANTENATAL CARE

2.0 INTRODUCTION

This chapter talks about the antenatal care given to Madam Ellen during her pregnancy period. It includes first contact with the client, first antenatal home visit, subsequent visits to the clinic by client, subsequent home visit as well as the nursing care plan drew for problems identified.

2.1 FIRST CONTACT WITH THE CLIENT.

The first contact with Madam Ellen was on Tuesday 15th August, 2023. The client was a regular attendant of Africa Libera health center. Madam Ellen was 37 weeks pregnant, and this was her third visit to the facility a visit after her previous visits to the ANC at the maternal and child health hospital in Kumasi. She was warmly welcomed and offered a seat. On our first contact, Madam Ellen was seen feeling so heavy and very sweaty, so an approach was made, and was complaining of heartburns and backache. Education was given to Madam Ellen on some of the minor disorders in pregnancy and how to manage them while at home and the importance of visiting the ANC. She was advice to have a good rest, avoid standing for a long time and eat foods that contains less or no spices. Upon going through her antenatal booklet, she was qualified to be used for the care study, thus a multiparous woman of G2P1 with no complication.

Her antenatal booklet was collected and read to note the previous recordings. 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, the client was found to have met the criteria. Madam Ellen was assisted through the routine laboratory investigation after vital signs were checked and recorded. Her haemoglobin level was 11.4g/dl and her HIV screening result was negative.

Her vital signs and weight were checked and recorded as:

- Temperature - 36.4 degree Celsius
- Pulse - 80 beats per minute
- Respiration - 21 cycles per minute
- Blood Pressure - 117/76millimeters of mercury
- Weight - 65Kilograms

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.

URINE TESTING**:** Protective clothing like apron and gloves were worn. The quantity, color, odour, smell and sediments were noted. Instructions were read on the reagent bottle. 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 color on the container. There was no change in color of the strip indicating a negative result of both glucose and protein and the PH, when compared closely with the corresponding color chart on the container.

Findings were recorded and discussed with both midwife in-charge and client.

The procedure involved in physical examination was explained to her and she consented. Privacy was provided by closing doors and nearby windows and curtains drawn and hand washing was done.

HEAD TO TOE EXAMINATION

Madam Ellen was assisted to sit on the bed, lie on her right side and then assume a supine position after client has been assisted to undressed, examination was started.

HEAD AND NECK**:** on examination from the head there were no scars on the scalp. The hair was check for brittleness, dandruffs, lice, infection and also distribution of hair but that moment her hair was combed and styled nicely and neatly. Few educations were done and she was congratulated. The face was also examined for the presence of edema, chloasma and rashes but no abnormalities were detected and the skin looked smoothed and facial color was well distributed. Her eyes were examined and there was no pallor, jaundice and discharges from it. The nose was examined with no discharges, the mouth was examined with no dental carries, and tooth decay, halitosis during conversation, no cracks or sores were found on the lips, the gum and tongue were inspected for pallor and they were normal. Her ears were examined with no pain and discharges from it. Her neck had no enlarged thyroid gland, palpable lymph nodes or distended veins.

BREAST EXAMINATION**:** Client was informed on examining the breast and she consented. On breast examination both breasts were present, the shape and size were normal, the areolar was very dark in color, and the skin of the breast was smooth with the nipple well projected. The breast nearer was covered and the other one farther was exposed to be examined. The client was asked to put the hand of the part to be examined under her head and with the left hand supporting the breast, the right hand was used to palpate the breast systematically in a circular manner using the inner aspect of the fingers for masses, enlarged axillary lymph nodes but no abnormality was detected. The nipple was also squeezed gently with cotton wool and expressed fluid was examined for it color and it was clear with no foul smell and same procedure was performed on the other breast. While doing the breast examination she was told to be observant, since she

would have to repeat what was done at home to detect abnormalities of the breast after every menstruation. She was made comfortable and covered up. Findings were explained to client.

UPPER EXTRIMITIES**:** after client was informed about the continuation of examination, Client was asked if she had tingling and tightness in an attempt to make a fist, and she answered negative. Her upper extremities were examined for equality, extra digit, presence of edema, nail beds for pallor and there were no abnormalities. Her nails had also been cut and kept clean.

The Client was informed about the next step and client was assisted into a left lateral position.

ABDOMINAL PALPATION: Before abdominal examination, palms were rubbed together to provide warmth to prevent inducing contractions.

INSPECTION: There were no scars on the abdomen. The abdomen had an ovoid shape with the signs of pregnancy like striaegravidarum running through the midline of the abdomen. There were fetal movements.

MEASURING OF SYMPHYSIO-FUNDAL HEIGHT**:** the zero end of the measuring tape was placed on the fundus of the uterus and the tape extended to the upper boarder of the symphysis pubis and the symphysio-fundal height measured 35cm and gestational age of 37 weeks 3days.

Fundal palpation: hands were warmed by rubbing them together to avoid inducing contractions. Standing on the right side of the client, both hands were placed just below the xiphisternum and down the abdomen until the upper part of the fundus were felt. The fundus was occupied by a soft round mass indicating the buttocks.

LATERAL PALPATION: with one hand stabilizing the right side of the uterus, the other hand was moved gently on the left side where rough parts were felt indicating the fetal limbs palpated. This was repeated at the right side and a smooth round part was palpated indicating the fetal back.

PELVIC PALPATION: Upon facing the client's lower limbs and placing the palms of both hands on either side of the lower abdomen below the umbilicus pointing downwards and inwards, the head was palpated in the lower pole of the uterus. On palpation the lie was longitudinal, presentation was cephalic and the position was right occipito-anterior.

DESCENT**:** the anterior shoulder was located 2.5cm below the umbilicus and with the ulna border just above the symphysis pubis, five fingers occupied the space indicating descent of $5/5^{th}$.

AUSCULTATION; The fetal heart was auscultated by warming and placing fetal stethoscope (fetoscope) on the area where the back was located; the ear was placed against the fetoscope, making sure hands were not touching the fetoscope and the fetal heart beat was counted. Comparing the rate with the maternal pulse and counting how many beats were heard for one minute, it was 148bpm with regular rhythm.

VULVA EMINATION**;** Permission was sought to inspect her vulva after hand washing was done. Client's vulva was inspected after the examination light was turned towards the genital area for clear view. The vulva was well shaved and clean. The perineum, labia and clitoris were inspected and it was clean, they had no abnormalities such as swollen tissue, rashes, warts or blisters and there was no indication of female genital mutilation, and no abnormal discharges found. Hands were washed and dried. Findings were communicated to her and she was congratulated for her co-operation.

LOWER EXTRIMITIES: Client was asked to lie on her back again for examination of the lower extremities. There was no pain found in the calf, her toe nails were short and clean, there was no varicose vein, extra digit or edema on the lower extremities. The legs were checked for equalities and nail bed for pallor. She was congratulated for a neat and healthy body.

BACK**:** her back was examined for any abnormalities of the spine and sacral region for edema and for varicose veins of which no abnormality was detected. The skin was in good condition and costovertebral angle tenderness was absent.

She was thanked and was helped to turn to her left side before getting off the bed and to do so any time she rises from bed. She was assisted to dress up. Madam Ellen was offered a seat and was asked if she had any complains, of which she gave heartburns and backache. She was encouraged to continue maintaining personal hygiene and also to have enough rest and sleep. She was told to get all her items needed for delivery ready and well packed this was done after being educated on the signs of labour. Finally, education on the need to attend antenatal on time was reinforced. Signs of labour were explained to her as she was in her late weeks and under direct observation madam Ellen was served with sulphadaxine pyrimethamine (SP) and was given her routine drugs as below;

- Tab.Multivitamin 1 daily x30
- Tab Folic Acid 5mg 1 daily x30
- Tab Ferrous sulphate 1 daily x30

We discussed home visitations and she gave directions to her house after which contacts were exchanged and she was seen off. The date for her next appointment (22th August, 2023) was given to her.

HOME VISITS

2.2 FIRST ANTENATAL HOME VISIT

The first home visit to Madam Ellen was on the 16th of August, 2023 by foot according to directions given. Upon arrival at the vicinity, it was identified that Madam Ellen lives in a U-shape house near a drinking water company. The visit was purposefully to know the client, her house, assess the community in which she lived, make more investigations about her family

background and check if she was prepared for her birth. After a warm welcome and exchange of pleasantries, client introduced me to her co-tenants and son, her husband was not around since he had gone to work. She then led the way to her room and a seat was offered with a sachet of water.

CLIENT'S PHYSICAL ENVIRONMENT

During the conversations, the following observations were made; it was observed that the room was a spacious single room partitioned with a white and blue long curtain and was well kept and the chairs and table arranged neatly in the room, the floor was covered with carpet, they have a wooden bed with an insecticide treated net hanging loosely over it. She was encouraged to sleep in it with the family every day. The room had adequate lighting and ventilation. Their clothes were nicely folded into their various bags. She was congratulated and asked to keep it up. In other to inspect her washroom, client was asked of a place to urinate of which she did, and it was observed that the place was neat, after inspecting the washroom, a quick glance through the house was made and the house portrayed a tidy environment.

The house is built with cement and painted in ash and made up of seven single rooms, fourteen windows and a pouch in front with a wooden trap door on each room and has good ventilation system. She uses her pouch as a kitchen where she cooks and the pouch was neatly kept and her utensil was well arranged in a cabinet. There is a toilet and bath in the house which is shared with the people living in the house. Their source of light is electricity and pipe borne water is their source of water and they keep their refuse in a waste bin and dispose of it into a Zoom lion waste collector container. Client was asked about who has being cleaning the bath house and the toilet and was told it was cleaned twice a week by tenants according to turns. She was advised on the use of antiseptic solution in and on the toilet seat before using, since she was at risk of urinary tract infection, and also to wash her hands with soap under running water after visiting

the toilet. She was asked about her preparations towards delivery and her layette was inspected, everything on the delivery list was intact and was neatly arranged and she had a blood donor (her sister). She was encouraged to arrange with her sister since he is a business man who could transport her to the hospital when labour sets in. She had also prepared an amount of money and added it to her suit case. Her support person was her sister. Client had her sister and sister's number which she can call when needed.

Education was given to her on the signs of true labour which were painful regular and rhythmic uterine contractions which will be felt as tightening discomfort or actual pain, a blood-stained mucoid discharge from the vagina, there may be rupture of membranes. She was encouraged to visit the health center immediately she experienced any of these signs and take her drugs as prescribed. Enquiry about her frequency of micturition was made, of which she said it has resolved. Client was further asked if she had any problem and she said she has been experiencing backache. Explanation was made to her that it was one of the physiological changes that occur in the later part of pregnancy. It was further explained to her that, it could be due to the weight of the pregnant uterus and product of conception or relaxation of muscles and ligament by progesterone and relaxin hormones.

Education to lie on a left lateral position, support herself with pillow when sitting and to apply warm compress to the back. Madam Ellen understood and promised to adhere to the education as she did when she had the discomfort from the frequent micturition on 19/06/2023 which was her first visit to the ANC. Later during the interactions her husband called on phone and he was informed of the presence of the midwife. The phone was handed over and an introduction was made again to him, he was very happy that education was given to his wife on her pregnancy. Client's husband was encouraged to support client in the performance of household chores and taking care of their very active son.

PSYCHOSOCIAL HISTORY

Madam Ellen, the husband, the son and family have a cordial relationship with each other, she was a warm and friendly relationship with the tenants, other family members staying around the house and neighbours. Her friends most of the times visit her at home and she also visit them at her leisure time. She is very free and likes to crack jokes. She has respect for people and likes to make new friends. She is sociable and neither smokes nor takes in alcohol. Madam Ellen attends her church service every Sunday. She takes her daily prayers very seriously.

The family was encouraged to continue eating nutritious diet and to always drink clean and safe water. Afterwards permission was sought to leave the house and to visit again some other time. She was reminded of her next visit to the health center.

2.3. SECOND ANTENATAL HOME VISIT

Madam Ellen was visited at home on 20th August, 2023 at 9:00 am. Madam Ellen was greeted and a seat was offered. Client was asked of her health and that of the family, of which she confirmed they were doing well. The aim of the visit was to inquire about her health, to assess if client had adhered to the education given to her and her preparation towards birth. During the interaction with her, Madam Ellen said the heartburns reported on her second ANC visit has resolved since she adhered to the counsel given to her and she was feeling fatigue. Education to practice exclusive breast feeding after birth was done. Madam Ellen complained of fatigue but explanation was given that it was one of the physiological changes that occur in the later part of pregnancy. It was further explained that, it was due to the weight of product of conception and inadequate rest. Madam Ellen was encouraged to take have adequate rest during the day and avoid strenuous activities. Madam Ellen said her sister would accompany her to the clinic if labour commences. Educations on the signs of true labour were reinforced and she was

encouraged to report as soon as she notices any of the signs. Permission was sought to leave and she was told to call when labour begins or if any problem occurs.

At 8:00pm, on 20th August, 2023, client was asked how she was coping with the fatigue on phone and she said she was doing well.

2.4 SECOND ANTENATAL VISIT TO THE CLINIC

Madam Ellen next antenatal visit was on the 22th of August, 2023. She arrived very early and was welcomed and her health and that of her family was asked of which she responded they were all doing well. She was neatly dressed with a cheerful face and she was asked of how she was coping with the backache, which she said, she was adapting to it. She was then taken through the routine care; urine sample was taken to test for the presence of protein and glucose of which was tested negative. Her vital signs/weight was checked and recorded as;

Blood pressure - 118/71 millimeters of mercury

Temperature - 36.6 degree Celsius

Pulse - 82 beat per minute

Respiration - 22 cycles per minute

Weight - 67 kilograms

Permission was sought to examine her. Having urinated earlier, privacy was provided and she was helped onto the bed on her left side. Hands were washed with soap under running water and dried. On physical examination from head to toe, no abnormality was detected. Hands was rubbed together to make them warm and abdominal examination were performed with the following findings; the abdomen was spherical and little fetal movements detected. The linear nigra running through the midline of the abdomen and the symphysio fundal height was measured to be 36cm. On fundal palpation an irregular soft mass was felt which indicated that the fetal buttocks of the upper pole of the uterus. On lateral palpation the right side of the

abdomen revealed a smooth curved mass indicating the back of the fetus. On pelvic palpation a smooth hard mass was felt indicating fetal head at the lower pole of the uterus. It was therefore concluded that, the presentation was cephalic and position was right occipito-anterior with the descent of 5/5th.

On auscultation the fetal heart rate was 132 beats per minute with regular rhythm.

Client was assisted to get up from the bed and a seat was offered to her. Hands were washed and dried. Findings were documented and communicated to her. She was asked of any complaints or questions and she said she was having heart burns and lower abdominal pains. It was explained to her that it was the action of progesterone on the smooth muscle causing relaxation of the gastric sphincter leading to reflux of gastric contents and compression on the abdominal nerves as fetal head descents respectively. Client was encouraged to eat less spicy and oily foods, sit up for a period of time after eating and also lie on her side and lie down with many pillows to raise her up. In the absence of further questions, she was encouraged to continue with her routing drugs.

2.5 NURSING CARE PLAN ON ANTENATAL

Problems Identified

1. On 19/06/23 Frequency of micturition.
2. On 15/08/23 fatigue
3. On 16/08/23 Backache
4. On 22/08/23 heart burns.
5. On 22/08/23 lower abdominal pain

Short Term Objectives

1. Client will cope with frequency of micturition within 24 hours.

2.Client's backache will subside within 48 hours.

3. Client's heart burns will resolve within 48hours.

4. Client's fatigue will resolve within 48hours.

5. Clients can cope with lower abdominal pain within 7hours

LONG TERM OBJECTIVE

Client will be healthy throughout pregnancy without any complication

NURSING CARE PLAN FOR ANTENATAL

DATE / TIME	NURSING DIAGNOSIS	NURSING OBJECTIVE /OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTIONS	DATE/ TIME	EVALUATION	SIGN
19/06/23 at 12:30pm	Frequency of micturition related to reduced bladder volume during pregnancy as evidenced by client complaining of visiting the washroom 3 times in an hour	Client frequency of micturition will subside within 24 hours understanding and coping with condition as evidence by client verbalizing that she can cope with the frequent micturition. 2. Midwife observing client coping with the frequent micturation	1. Reassure client that her condition can be managed. 2. Educate client on the causes of frequency of micturition. 3. Educate client to decrease intake of natural diuretics. 4. Teach client to lean forward when voiding. 5.Educate client to keep a clean covered chamber pot at bedside. 6. Educate client to use tissues to wipe vulva after urinating. 7. Educate client to use panty liners if she can afford.	1. Client was reassured that; her condition can be managed 2. Client was educated that the causes of frequent micturition is as a result of reduced bladder volume due to pressure on the bladder by the uterus as the fetus grows 3. Client was educated to decrease intake of natural diuretics green tea and coffee. 4. Client was taught to lean forward when voiding. 5. Client was educated to keep a clean covered chamber pot at bedside. 6. Client was educated to use tissues to wipe the vulva after urinating. 7. Client was educated to use panty liners if she can afford.	20/06/23 at 12:30pm	Goal was fully met as client reported that she can cope with frequency of micturition. 2.Midwife observed client coping with frequent micturation	A.S.I

NURSING CARE PLAN FOR ANTENATAL

DATE / TIME	NURSING DIAGNOSIS	NURSING OBJECTIVE /OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTIONS	DATE/ TIME	EVALUATION	SIGN
16/08/23 at 10:30am	Backache related to the relaxation of muscles and ligaments by hormone progesterone and relaxin.	Madam Ellen's pain will reduce within 24 hours as evidenced by; 1.Client verbalizing that the pain has reduce. 2. Midwife observing client with a cheerful facial expression	1. Reassure client that the pain will reduce. 2. Educate client on the cause of backache. 3. Encourage client to support herself with pillows beneath the knees and abdomen. 4. Encourage client to lie on a left lateral position. 5. Encourage client to apply warm compress at the lower back.	1.Client was reassured pain will reduce 2. Client was educated that the cause of her backache is a result of relaxation of the joints and ligament by the hormone relaxin which put strain on the pelvis 3. Client was encouraged to support herself with pillows beneath the knees and abdomen. 4. Client was encouraged to lie in a left lateral position. 5. Client was encouraged to apply warm compress at the lower back.	17/08/23 at 10:30am	Goal was fully met as 1. Client verbalize that pain has reduced. 2. Midwife observing client has no sign of pain	A.S.I

NURSING CARE PLAN FOR ANTENATAL

DATE/TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
15/08/23 at 9:00am	Fatigue related to stress from under taking household chores	Client's fatigue will resolve within 48hours as evidence by 1. Madam Ellen verbalizing that she is feeling rested. 2.Midwife observing client looking cheerful and energetic	1. Reassure Madam Ellen of competent nursing care and physical support from family members. 2. Encourage a support person to assist in household chores. 3. Educate client to have rest and sleep in between activities. 4. Encourage client to reduce household activities. 5. Encourage client to adopt more comfortable position when like left lateral when sleeping	1. Madam Ellen was reassured of competent nursing care, emotional and physical support from family. 2. Client's sister was encouraged to assisted in household chores. 3. Client was educated to have rest and sleep in between activities 4.Client was encouraged to reduce household activities 5. Client was encouraged to adopt more comfortable position like left lateral when sleeping.	17/08/23 at 9:00am	Goal was fully met as client informed the midwife that her fatigue had resolved and midwife observing client does not feel tired.	A.S.I

NURSING CARE PLAN FOR ANTENATAL

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
22/08/23 at 9:00am	Heartburns related to reflux of stomach contents by weakened pyloric sphincter of the stomach as evidenced by client complaining of burning sensation around her chest.	Client's heart burns will resolve within 48hours as evidenced by client verbalizing that the heartburns has resolved and midwife observing client showing no signs of heartburns.	1.Reassure client of quality care. 2. Educate client on physiology of heart burns. 3. Educate client to reduce the intake of fatty and spicy foods. 4. Encourage her to use more pillows when sleeping. 5. Encourage client have early supper 6. Encourage her to sit up at least 2-3 hours after eating	1.Client was reassured of quality care. 2. Client was educated on physiology of heart burns that it is caused by reflux of stomach acid due to relaxed pyloric sphincter by the hormone progesterone. 3. Client was educated to reduce the intake of fatty and spicy foods 4. Client was encouraged to used more pillows when sleeping. 5. Client was encouraged to have early supper 6. Client was encouraged to sit up at least 2-3hours after eating.	24/08/23 at 9:00am	Goal fully met as client verbalizing that her heartburns had resolved. 2.Midwife observing client is relieved from signs and symptoms of heartburns.	A.S.I

NURSING CARE PLAN FOR ANTENATAL

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVE/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTIONS	DATE/ TIME	EVALUATION	SIGN
29/08/2023 at 8:00am	Lower abdominal pain related to fetus exerting pressure on the lower pole of the uterus.	Client will be able to cope with lower abdominal pain within 7 hours as evidenced by client verbalizing that she can cope with lower abdominal pain. Midwife recording stable vital signs to rule out signs of pain(tarchycardia)	1. Reassure client that the lower abdominal pain will reduce soon after delivery. 2. Educate client on the causes the lower abdominal pain. 3. Encourage client to reduce house chores. 4. Encourage client to exercise like walking and mildly massage the affected part. 5. Encourage client to have enough rest and sleep.	1. Client was reassured that the lower abdominal pain will reduce after delivery. 2. Client was educated on the causes of lower abdominal pain. 3. Client was encouraged to reduce house chores. 4. Client was encouraged to exercise and mildly massage the affected part. 5. Client was encouraged to have enough rest and sleep.	29/08/23 at 3:00pm	Goal was fully met as client reported that she could cope with lower abdominal pain. And midwife observing client is relieved from signs and symptoms of heartburns.	A.S.I

CHAPTER THREE

LABOUR

3.0 INTRODUCTION

This chapter describes the management of labour in four stages thus; first, second, third and fourth stage and immediate care of the newborn, subsequent care, examination of the newborn and care plan for the management of the problems encountered during this period.

3.1 ADMISSION AND MANAGEMENT OF FIRST LABOUR

Admission

During an afternoon shift on the 9th of September 2023, Madam Ellen arrived at the labour ward at 12:10pm accompanied by her sister and husband, after her husband called on phone to give information about her wife experiencing lower abdominal pain and waist pain. Her husband and sister were aske d to relax at the reception. Assessment was done to rule out the urge to push before client was taken through the admission process. History of labour was taken from client and she said labour started around 10:00am, show was noticed at home 10:20am and the contractions became frequent. Madam Ellen said she had not seen any trickling of water or blood but could feel increased fetal movements. Enquires were made to know if she took any medications or herbs since the pain started but she answered no. She had her last bowel movement in the morning at around 7:30am of that day. Client was reassured of competent care to be rendered after which she was made comfortable in bed and privacy maintained. Client layette was arranged by her bedside and she was encouraged to empty her bowel and bladder when she had the urge. Madam Ellen was reassured of competent care to be given as well as education on procedures to be performed and the stages of labour. She was also reassured that she will not be left alone but she will be accompanied by her sister

Her vital signs were checked and recorded as follows;

Temperature - 36.7 ^{0}C

Pulse - 96bpm

Respiration - 22cpm

Blood Pressure - 130/80mmHg

Privacy was provided and explanation was given on procedure for physical examination from head to toe. Consent was sought from client and she agreed. Madam Ellen was asked to empty her bladder and take midstream urine to test for protein and glucose which when tested was negative for protein and glucose. Client passed 150mls of straw-colored urine. Client was assisted to undress and cover herself with a piece of cloth and assisted onto the examination bed. Hands were washed with soap under running water, dried and warmed. The head- to- toe examination was done under the supervision of the midwife in-charge. The hair, sclera, conjunctiva, nose, mouth, ears, neck were without any abnormality. The face was a bit tensed because of the painful contractions. The breast was firm on the chest with no engorgement or inversion of the nipple and the arms were proportionate in length, the nails were also short and clean.

On abdominal inspection, the abdomen was globular in shape, there was linear nigra on the abdomen and no straie gravidarum or previous scar was observed, Symphysio - fundal height was 39 centimeters with gestation of 40 weeks, the fundus was palpated and a soft mass was identified as the fetal buttocks, lateral palpation was done to find the back and limbs of the fetus which revealed a smooth fetal back to be at the right side of the abdomen and limbs on the left side as it felt rough. On pelvic palpation, the lie was longitudinal, position was right occipito-anterior, and presentation was cephalic. Descent was determined by locating the anterior

shoulder 2.5 cm below the umbilicus and symphysis pubis which admitted four fingers. Descent was four-fifth ($4/5^{th}$) palpated above the pelvic brim.

On auscultation, the fetoscope was rubbed on the palm to warm it before placing it on the abdomen to listen to the fetal heart beat for a full minute which read as 140 beats per minute with regular rhythm and good volume.

The uterine contractions were timed for 10minutes and it recorded 2 in 10 minutes lasting 35 seconds approximately. On her lower extremities, there was no varicose vein found on the legs. There was no pallor, edema nor jaundice. The hands were warmed again by rubbing them together.

VAGINAL EXAMINATION

Permission was asked to perform vaginal examination and she consented. Procedure for vagina examination was explained to her in order to promote comfort and seek her cooperation. A sterile tray was set containing two gallipots, one containing savlon antiseptic solution, the other gallipot with sterile cotton wool swabs, a pair of surgical gloves and a receiver for used swabs and all was covered with a sterile towel.

Privacy was ensured. Hands was washed with soap under running water and dried with a clean towel.

Client was then helped into a lithotomy position with her knees flexed and thighs apart. Examination gloves were worn and soiled pad removed and then discarded with the left hand. A pair of surgical gloves was worn. The vulva was well shaved though soiled with the blood-stained mucous (show). It had no abnormalities. A sterile cotton wool swab was picked with the right hand dipped into the gallipot containing savlon solution. The swab was dropped from the right hand into the left hand and used to swab the labia majora and the minora using different swab for

each stroke. With the left hand parting the minora, the last swab in the right hand was used to clean the vestibule from anterior to posterior. Client was informed that, the middle finger followed by the index finger will be put into her vagina to assess the condition of the vagina and cervix and that she will feel a bit uncomfortable. With the labia minora still separated, the right middle finger was inserted into the vagina gently but firmly pressing downward whilst the index finger was added into the vagina in order to relax the vagina wall and muscles.

On vaginal examination, the vagina was warm and moist, the sacrum was well curved, the ischial spines were blunt, the sacral promontory was not reached and cervix was thin, soft, elastic and cervical os was 5cm dilated at 4:15pm. The presenting part was well applied to the cervix with intact membranes. Moulding was not present. The pubic arch was wide, and the rectum was empty. On withdrawal of the fingers, observation was made on the examining fingers and they were clear and not offensive. The vulva was cleaned and a clean perineal pad was applied. Client was made comfortable with the help of the midwife-in-charge. All instruments used were decontaminated in 0.5% chlorine solution. Hands were washed and dried after the gloves were discarded.

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 sister was identified as the unskilled personnel. The doctor on call was notified about the client's admission. 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 delivery, of which she agreed.

Room was well lighted and ventilated. Madam Ellen 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 including cot sheets were also made available. Delivery items were also made available.

MANAGEMENT OF FIRST STAGE OF LABOUR

Madam Ellen 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 Ellen 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.

Madam Ellen 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, moulding, blood pressure were checked every four (4) hours. Temperature was checked every two (2) hours. Urine test for protein and glucose 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 4:15pm fetal heart rate was 140bpm, contractions were 3 in 10 lasting 35 seconds and maternal pulse was 78bpm cervical os 5cm dilated, membranes-intact, no moulding. Descent was $3/5^{th}$. Vital signs checked and recorded: T-36^{OC} BP-100/60mmHg. A 100 mls of urine

At 4:45pm fetal heart rate was 138bpm, contractions were 3 in 10 lasting for 36 seconds and maternal pulse was 76bpm. At 5:15pm Fetal heart rate was 136bpm, contractions 3 in 10 lasting 35seconds and maternal pulse was 79bpm. At 5:45pm fetal heart rate was 136bpm, contractions were 4 in 10 lasting 36 seconds and maternal pulse was 74bpm. She was assisted to lie on her left side and breathe through her mouth since she was complaining of severe waist pain. She was reassured that she will soon have her baby and all discomforts will be resolved and a sacral massage was given to reduce the pain. She was encouraged to assume a favorable position not harmful to the fetus and the physiology of uterine contraction was explained to her. At 6:15pm fetal heart rate was 136bpm contractions were 4 in 10 lasting 38 seconds, temperature was 36.2^{oc} maternal pulse was 76bpm, blood pressure was 130/87mmHg, urine was taken to test for protein and glucose and they all showed negative and amount as 100mls. At 6:45pm fetal heart rate was 138bpm contractions were 4 in 10 lasting 42 seconds, maternal pulse was 78bpm. At 7:15pm fetal heart rate was 142bpm, contractions were 4 in 10 lasting for 55 seconds. Maternal pulse was 82bpm. At 7:45pm fetal heart rate was 140bpm, contractions were 4 in 10 lasting 58 seconds, maternal pulse 84bpm.

Preparation for vaginal examination was done at 8:15pm. Fetal heart rate was 135bpm contractions were 5 in 10 lasting 45 seconds, maternal pulse was 88bpm. Client was sweating a lot and was cleaned with a wet towel. She was also given iced water to calm herself. Descent was $1/5^{th}$. Membranes ruptured spontaneously with clear liquor. Vaginal examination was done to

exclude cord prolapse. cervical os was 9cm dilated with moulding (++). Progress of labour was communicated to her and she was reassured. It was observed that client had removed pad onto bed. She was quickly made aware not to do that since she could be infected. She was encouraged to wash her hands and discard pad if fallen

Delivery trolley was set paying attention to sterility. It contained the following items;

Top shelf

- A sterile bowl for savlon solution
- A delivery pack containing;

  Two sterile towels

  Two artery forceps

  Two dissecting forceps
- An episiotomy pack containing;

  Episiotomy scissors

  Needle holder

  Dissecting forceps
- Receiver for placenta
- Sterile gauze swabs and cotton wool swabs in a gallipot
- Clean sucker.

Bottom shelf

- Pre-packed sterile gloves
- Warm towels and blanket
- Jug to measure blood loss
- Perineal pads,
- Syringes and needles
- Cord clamp
- Baby identification band
- Antiseptic lotion
- Fetoscope
- Drainage bag and catheter
- A drug tray containing injection Oxytocin, Lidocaine, water for injection, injection vitamin K, and Tetracycline eye drop
- Two clean cot sheets.

Oxygen source and suctioning machine were all in good working condition.

Client complained of being anxious. Client was encouraged to change her position at regular intervals, and walk around bed side, of which she did. At 8:45pm fetal heart rate was 140bpm, contraction 5 in 10 lasting 45 seconds and maternal pulse was 90bpm. At 9:15pm fetal heart rate was 132bpm, contractions were 5 in 10 lasting 45 seconds and maternal pulse was 82bpm. 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 and the client that the cervix was fully

dilated descent was 0/5th. All findings were explained to her and recorded on the partograph sheet. The midwife in charge confirmed full dilation of the cervix.

3.2 MANAGEMENT OF THE SECOND STAGE OF LABOUR

Client was positioned in the second stage room at 9:20pm. She was asked which position she preferred and she responded that she wanted to lie in a dorsal position. She was helped on to the delivery bed and asked to lie on her side.

A sterile trolley was pushed near the delivery bed at the right side of her. Client was reassured to allay her anxiety. Protective clothing was worn (mackintosh apron, safety boots, goggles, and nose mask). Hands were washed and dried and a pair of sterile gloves worn. Client was draped and full dilatation of cervical os was confirmed. A perineal pad was applied to the anus to prevent faecal matter from contaminating the delivery field hence infecting the baby and FH was checked with each contractions. Client was encouraged to bear down with contractions and rest in between. The fingers of the left hand were placed on the advancing head to aid the smallest diameter of the head distends the perineum. At the onset of crowning, she was asked to stop pushing and pant. The fingers were spread equally over the vertex to restrain any sudden expulsive effect. She was asked to take a deliberate breath to aid pushing. The head was delivered by extension, allowing the sinciput, face and chin to glide slowly over the perineum to be delivered. The baby's eyes were cleaned with sterile cotton wool swabs from the inner canthus to the outer canthus to prevent infection using one swab for each eye. The mouth and nose were also wiped gently with sterile gauze. Neck was felt for cord but there was none. Restitution took place followed by external rotation of head allowing the shoulders to lie in the anterior-posterior diameter of the pelvic outlet, the hands were placed on the sides of the baby's head over the ears and with gentle downward traction the anterior shoulder was delivered towards the mothers' anus followed by upward traction toward the mother's abdomen to deliver

the posterior shoulder. The rest of the body was delivered through lateral flexion along the curve of carus onto the mother's abdomen. At exactly 9:53pm a live female infant was delivered and she cried loudly. The client was congratulated for her effort and cooperation. Baby was wiped, placed on mothers' abdomen for skin-to-skin contact and covered. Her sister and husband were informed of her successfully delivery.

IMMEDIATE CARE OF THE BABY AT BIRTH

Immediately the head was delivered, sterile gauze was used to clean the baby's face, mouth and nose. The eyes were cleaned with sterile cotton wool from inside out. The baby was delivered onto the mother's abdomen. The baby cried immediately after delivery and she was congratulated. The baby was wiped with a clean cloth paying attention to the skin folds. Wet linen was changed. The baby was shown to the mother for confirmation of sex which she identified as female and the baby was put to breast to initiate breastfeeding whiles on the mother's abdomen for skin-to-skin care.

A brunette and baby's socks was put on as well as cloth for warmth. The cord was clamped 3cm from the baby's abdomen, and 2cm from the first clamp with artery forceps and was cut in between the two forceps with a sterile scissors covered with sterile gauze to prevent splash of blood. This was done to separate the baby from the mother. The first and fifth-minute Apgar score was 9/10 and 10/10 respectively. An identification band with the name of the mother, sex, date and time was placed at the baby's wrist. Client was congratulated.

APGAR SCORE		FIRST MINUTE	FIFTH MINUTE
Appearance	-	1	2
Pulse/heart rate	-	2	2
Grimace/reflex	-	2	2
Activity/muscle tone	-	2	2
Respiration	-	2	2
TOTALS	-	9/10	10/10

3.3 MANAGEMENT OF THE THIRD STAGE OF LABOUR

The procedure was explained to her. The presence of undiagnosed second twin was checked and there was none. Ten (10) unit of oxytocin was injected intramuscularly at the thigh to aid contraction of the uterus and separation of the placenta by the midwife in-charge. Controlled cord traction was the method used in delivering of the placenta in order to prevent having retained placenta or products of conception. The cord was re-clamped with an artery forceps closer to the perineum and the tip end placed in a receiver in between the thighs. The left hand was placed on the fundus and as soon as there was contraction, the left palm was placed just above the symphysis pubis to support the uterus, with the palm facing the fundus of the uterus. This was done to prevent inversion of the uterus. With the right hand, the clamped cord was held. When the uterus was contracted, a very gentle pull was applied on the cord in a downward motion. The downward pulling was continued until the placenta was visible in the vulva. The two hands were used to receive the placenta and it was gently twisted to tease out the membranes completely at 9:58pm(5minutes). The placenta was placed in the receiver and inspection was quickly made to be sure that the membranes and lobes were intact. The uterus was massaged to

stimulate contraction and expel clots. Gauze was wrapped around the first and second fingers of both hands to inspect the vulva, vaginal walls and the cervix were all intact with minimal lacerations at the perineal area. Blood loss per vaginum was about 150mls. Client was well cleaned and perineal pad was applied over the vulva and she was made comfortable in bed to rest at the labour ward. She was encouraged to urinate frequently whenever she had the urge for proper contraction of the uterus and help in involution of the uterus to prevent postpartum hemorrhage. All items used were decontaminated in 0.5% chlorine solution and hands was dipped into the chlorine solution to make it less infectious before removing gloves and discarded appropriately.

EXAMINATION OF THE PLACENTA AND MEMBRANES

Protective clothing was worn and a thorough inspection of the placenta and membranes was done to ensure no part of it have been retained during its delivery when sent to the sluice room. allowing the membranes to hang loosely downwards. The cord was of normal size and the cut edge was cleaned with cotton wool which revealed two arteries and one vein. It was surrounded by Wharton's jelly. The cord insertion was central, it had no false or true knots. The placenta was placed on a flat surface with the maternal surface facing upward. Through inspection, the color was dark red and the cotyledons were intact. There were no infarcts or extra lobes on the maternal surface. The fetal surface was shinny and smooth with its color being bluish grey. The branches of the cord vessels were seen radiating on its' surface. The placenta was put in 0.5% chlorine solution to make it less infectious and it was held by the cord. It was then disposed appropriately. The working surface was wiped with 0.5% chlorine solution and decontaminated the delivery instruments in 0.5% chlorine solution for 10 minutes, washed with soap and water, rinsed, allowed to air dry and packed to the central sterilization supply department (CSSD) for

sterilization. Findings were recorded on the labour ward sheet, delivery book and summary of delivery in the antenatal booklet. The partograph was also completed.

3.4 MANAGEMENT OF THE FOURTH STAGE OF LABOUR

The fourth stage of labour refers to the first six (6) hours after the delivery of all products of conception. During this period, the baby and mother were closely monitored to detect any complication that may arise and be managed accordingly.

Mother

At 10:53pm madam Ellen was assisted to the lying-in-ward to an already prepared warm bed after one-hour uninterrupted skin to skin care at the labour ward. Her vital signs and condition of the uterus were checked every 15 minutes for the first one hour. Client's immediate post - delivery vital signs were checked and recorded as follows;

Temperature	-	36.4^0c
Pulse	-	84bpm
Respiration	-	20cpm
Blood Pressure	-	120/70 mmHg

The uterus was palpated and it was well contracted and symphysio-fundal height was 16 centimeters. She was encouraged to urinate frequently as this will aid contraction of the uterus and involution. Her perineum was observed and the pad for amount of lochia which was bright red, moderate and not offensive. Madam Ellen was encouraged to change her pad frequently when soaked and to wash her hands before and after changing pad and before handling baby. For the first six hours she was given porridge with bread after which she continued breastfeeding. She was also encouraged to massage her uterus, change pad and to void if she has the urge.

Baby

Prevention of diseases of the new born

This was done after one (1) hour uninterrupted skin to skin care. The procedure to be carried out on the baby was explained to the mother. Hands were washed and dried with a clean towel. The baby was put on a clean, warm and flat surface in the presence of mother. Chloramphenicol eye drop was instilled on the inner canthus of the eye with the hand pressing on the cheek. Cord was inspected for bleeding but was seen fresh and in good condition without any bleeding. The umbilical cord was cleaned with sterile cotton wool swabs soak in methylated spirit and kept dry. Vitamin K1 was given also as a prophylaxis for prevention of hemorrhagic disease of the newborn after examination of the newborn due to the pain it causes.

SUMMARY OF LABOUR

Date and time of delivery - 9 September, 2023 at 9:53pm

Type of Delivery - Spontaneous Vaginal Delivery

Time injection oxytocin was given - 9:53pm

Time of Expulsion of Placenta and membranes - 9:58pm

Drugs given - Injection Oxytocin 10 units

DURATION OF LABOUR

1st Stage - 6 hours, 15minutes

2nd Stage - 15minutes

3rd Stage - 5 minutes

Total time - 6 hours, 35minutes

CONDITION OF MOTHER

Condition of mother - Stable

Perineum - Intact

Fundal Height - 16cm

Blood Pressure - 118/60mmHg

Pulse Rate - 82bpm

Respiration rate - 22cpm

Temperature - 36.4ºC

Blood lost - 150

CONDITION OF BABY

Heart rate - 148bpm

Respiration - 48cpm

General condition of baby - Satisfactory

Sex of Baby - Female

Baby's Weight - 3.0kg

Congenital Abnormalities - None detected.

Baby's Full Length - 49cm

Head circumference - 31cm

Meconium - Passed

Urine - Passed

PROBLEMS IDENTIFIED

3.7 NURSING CARE PLAN DURING LABOUR

- Anxiety
- Lower abdominal pain
- Waist pain
- Excessive sweating
- Risk of infection

SHORT TERM OBJECTIVES

- Client will be allaying of anxiety within 30 minutes
- Client will cope with lower abdominal pain till she delivers
- Client will cope with waist pain within 2 hours.
- Client will remain well hydrated and comfortable within 2 hours and at the end of labour
- Client will show no signs of infection within 24 hours.

LONG TERM OBJECTIVE

Client will go through labour successfully with healthy baby without complication to both mother and baby.

NURSING CARE PLAN DURING LABOUR TABLE

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES /OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTIONS	DATE / TIME	EVALUATION	SIGN
09/09/23 at 12:15pm	Anxiety related to unknown outcome of labour as evidenced by client showing signs of anxiety such as shivering, sweating and increased B.P.	Madam Ellen will be allayed from anxiety within 30 minutes as evidenced by 1. Madam Ellen verbalizing she is no longer anxious. 2.Midwife observing client with a cheerful facial expression.	1. Reassure client of competent care to be rendered in the management of the condition. 2 Encourage her to voice out all her needs and fears. 3. Provide answers to questions accordingly and appropriately. 4. Involve client in her care 5. Keep Madam Ellen informed of the progress of labour. .	1. Madam Ellen was reassured of competent care to be rendered in the management of the condition. 2. Madam Ellen was encouraged to voice out all her needs and fears 3.Client was provided with answers to question accordingly and appropriately. 4. Madam Ellen was involved in her care. 5. Madam Ellen was informed of the progress of labour.	09/09/23 at 12:45pm	Goal was fully met as client anxiety was allayed and she had a relaxed facial expression. 2.Midwife observing client with a cheerful face	A.S.I

NURSING CARE PLAN ON LABOUR

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES /OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTIONS	DATE/TIME	EVALUATION	SIGN
9/09/23 at 4:45pm	Lower abdominal pain related to painful uterine action as evidenced by descent of the fetal head.	Madam Ellen will cope with lower abdominal pain within 30 mins till she delivers as evidenced by Madam Ellen verbalizing that she can cope with pain 2. Midwife observing client coping with the relaxation techniques such as breathing techniques and resting in between contractions	1. Reassure Madam Ellen that she will be relieved after delivery. 2. Explain physiology of the lower abdominal pain to Madam Ellen. 3. Encourage Madam Ellen to adopt comfortable position and ambulate. 4. Communicate progress of labour to Madam Ellen. 5. Encourage Madam Ellen to do deep breathing exercise during contractions. 6. Provide diversional therapy by conversing with client.	1. Madam Ellen was reassured that will be relieved after delivery. 2. Physiology of lower abdominal pain was explained to the Madam Ellen that it is as a result of excessive uterine contractions. 3. Madam Ellen was encouraged to adopted comfortable position and ambulated. 4. Progress of labour was communicated to client. 5. Madam Ellen was encouraged to do deep breathing exercise during contractions. 6. Diversional therapy was provided to client by conversing with her.	9/09/23 at 5:15pm	Goal fully met as Madam Ellen coped with the lower abdominal pain and cooperated during labour and midwife observed client cope with relaxation techniques	A.S.I

NURSING CARE PLAN ON LABOUR

DATE / TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES / OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTIONS	DATE / TIME	EVALUATION	SIGN
9/09/23 at 7:30pm	Waist pain related to relaxation of the bones and ligament by hormone relaxin.	Madam Ellen will cope with waist pain within 20 minutes as evidenced by client verbalizing that she is coping with waist pain and performing deep breathing exercise during uterine contractions. 2. Midwife observing client relieved from waist pain	1. Reassure Madam Ellen that she will be relieved after delivery. 2. Explain physiology of waist pain to Madam Ellen. 3. Massage sacral region during contraction to relieve pain. 4. Encourage client to adopt comfortable position and ambulate (left lateral). 5. Communicate progress of labour to client. 6. Provide diversional therapy by conversing with client.	1. Madam Ellen was reassured that she will be relieved after delivery 2.The physiology of waist pain was explained to the Madam Ellen that it is due to pressure exerted on the pelvic muscles during uterine contractions. 3.Sacral region was massaged during contractions to relieve her pain 4. Madam Ellen was encouraged to adopt a comfortable position and ambulate (left lateral) 5. The progress of labour was communicated to client 6. Diversional therapy was provided to client by conversing with her	9/09/23 at 7:50pm	Goal was fully met as 1.client coped with waist pain and performed deep breath exercise till, she delivered. 2.Midwife observing client is relieved from waist pain	A.S.I

NURSING CARE PLAN ON LABOUR

DATE / TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES / OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTIONS	DATE / TIME	EVALUATION	SIGN
9/9/23 at 7:45pm	Impaired body comfort related to excessive sweating as evidenced restlessness.	Madam Ellen will remain comfortable (within 30 minutes) and throughout labour as evidenced by midwife observing that Madam Ellen feels comfortable and not sweating excessively. 2. Client feeling relaxed	1. Reassure client of competent care to promote comfort. 2. Explain the cause of the sweating. 3. Serve Madam Ellen cold water to drink at frequent interval. 4. Give ice cubes to client to sip 5. Mop the face and body of client with wet towel. 6. Improve ventilation by open windows and putting on fans.	1. Client was reassured of competent care to promote comfort. 2.The cause of the sweating was explained to the client that it is as a result of restlessness and discomfort. 3. Madam Ellen took cold water frequently 4. Ice cube was given to the Madam Ellen to sip 5. Madam Ellen's face and body was mopped with wet towel. 6. Windows was opened and fan put on	9/9/23 at 8:15pm	Goal fully met as midwife observing client feeling comfortable and felt relaxed. client verbalizing she feels comfortable	A.S.I

NURSING CARE PLAN FOR LABOUR

DATE / TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES / OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTIONS	DATE / TIME	EVALUATION	SIGN
9/09/23 at 8:30pm	Potential risk for infection as evidenced by mishandling of perineal pad	Madam Ellen will be free from infection within 24 hours as evidenced by; 1. Madam Ellen verbalizing that she does not feel sick 2. The midwife observing that she shows no signs of infection.	1. Reassure Madam Ellen that she will be free from infections. 2. Encourage client to wash her hands before and after touching perineal pad. 3. Educate Madam Ellen on the need to change perineal pad whenever soaked to prevent infections. 4. Educate Madam Ellen to discard pad if fallen. 5. Teach Madam Ellen how to fix pad properly.	1. Madam Ellen was reassured that she will be free from infections. 2. Client was encouraged to wash her hands before and after touching perineal pad. 3. Madam Ellen was educated to change her soaked perineal pad to prevent infections. 4. Madam Ellen was educated to discard fallen perineal pad. 5. Madam Ellen was taught to fixed pad properly.	10/09/23 at 8:30pm	Goal fully met as; Madam Ellen verbalized that she does not feel sick. 2.Midwife recording stable vital signs	A.S.I

CHAPTER FOUR

PUERPERIUM

4.0 INTRODUCTION

This chapter gives detailed information on the care rendered to the client, the baby and family from the day of delivery till two weeks postnatal**.**

MANAGEMENT OF FOURTH STAGE OF LABOUR

4.1 Day of delivery

Madam Ellen delivered on 9th September, 2023 at 9:53pm to a live female baby. Client and her baby were transferred to the lying-in ward after hours of close observation when their conditions were satisfactory. Her immediate post-delivery vital signs at 10:53pm recorded as follows;

Mother's Vital Signs

Temperature - 36.4^0C

Pulse - 82bpm

Respiration - 22cpm

Blood Pressure - 118/60 mmHg

On palpation the uterus was well contracted and the symphysio-fundal height measured 16 cm just below the umbilicus. The lochia was red in color and flow was moderate. On examination, no abnormality was detected. She was encouraged to change her sanitary pad when wet to avoid the risk of infection and for comfort. She was encouraged to report any excessive bleeding and also to urinate frequently to enable the uterus to contract firmly. Emphasis was placed on fluid and adequate diet to help replace worn out tissues and promote growth by encouraging husband and other family members to provide adequate water and food like protein (meat, egg, beans,

milk etc.), fruit (orange, apple, banana etc.) and vegetable (kontomire etc.). At 11:00pm, client complained that when her baby suckles, she experiences pain. Madam Ellen was reassured and was encouraged to continue breastfeeding which will help in the involution of the uterus. Madam Ellen was served with 1gm of paracetamol. Baby was put to breast and she suckled effectively. Madam Ellen was educated to breastfeed baby exclusively on demand and wash hands before breastfeeding baby. She was served by her sister with rice and ground nut soup.

Examination of the newborn

At 12:00am baby was put on a clean warm and flat surface. Baby was then exposed systematically as it was examined from head to toe in the presence of the mother. On appearance, baby was seen pink and active. The head was examined for shape and size, widened sutures, bulging or depressed fontanels, any edematous swelling, (caput succedaneum) no abnormalities were found. A tape measure was used to encircle its head starting from the occipital protuberance to the supraorbital ridges to measure the head circumference and it was 31centimeters. The ears were examined for size, shape, and patency, softness of the cartilage, alignment and discharges. The eyeballs were examined for presence and color, pallor, jaundice and deformities. The nose was examined for shape, size, patency, deviated septum and discharges. The buccal cavity was inspected for false teeth, tongue tie, color of tongue and gum, cleft palate using the little finger to feel for palate for any sub mucous cleft, the neck for nodules, rigidity and congenital goiter but no abnormality was detected. On the chest, respiratory movement was normal, nipples were in alignment without discharges, and breast had no mass. The upper extremities were inspected for equality, number of palmer creases clubbed fingers, extra or loss digits. Baby's ability to perform Moro and grasp reflexes was also checked and was present. The abdomen was examined for

shape, size, with no bleeding from the umbilical site and abnormalities such as omphalocele, gastroschisis were absent.

The lower extremities were inspected for equality, clubbed feet, extra/loss digits, none was detected. Congenital hip dislocation was also checked using the Ortolani's test and there was no dislocation since a 'clunk' sound was not heard. With baby lying on one side, its back was examined for abnormalities like spinal bifida, meningocele, oedema which were absent. The genitalia were inspected with the labia majora covering the minora and the urethral orifice was patent as it passed urine. The anus was also examined and it was patent as baby passed meconium. Baby was weighed and it was 3.0 kilograms and length was 49 centimeters. Vitamin K (1mg) was injected intramuscularly at the thigh of the baby to prevent hemorrhagic diseases of the baby. The baby was monitored for cord bleeding and there was none. Gloves were removed and disposed aseptically before washing and drying hands. All the findings were communicated to the parents and recorded afterwards. The baby was then dressed nicely in a warm sheet and given to the mother for breastfeeding while observing suckling reflex. Client was educated on the importance of exclusive breast feeding for the first six months of birth.

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

Temperature	36.1degrees Celsius
Heart rate	148bpm
Respiration	48cpm

Baby's condition was satisfactory. The baby and mother were then transferred to the postpartum room for further monitoring.

SUBSEQUENT CARE OF THE BABY

Baby bath and cord dressing

After 6hours of delivery, permission was sought from mother to bath the baby of which she consented. Hand was washed with soap under running water and dried with towel. Brief examination was done and no abnormality was detected. The baby passed meconium and urine which was normal. The cord was inspected for bleeding and discharge but there was none. Baby's vital signs was checked and recorded as,

Baby's Vital Signs

Temperature - 36.1 ℃

Apex beat - 148bpm

Respiration - 48cpm

Weight - 3.0kg.

REQUIREMENT NEEDED FOR BABY BATH

Top Shelf

1. Sterile cotton swab
2. Sterile water in a galipot
3. Sterile galipot

Bottom shelf

1. Soap
2. Sponge
3. Cream / powder / oil
4. Basin

5. Towels: 1 big towel and 3 small ones
6. Cot sheet 2
7. Apron
8. Gloves
9. A clean baby dress, cap and socks
10. Mackintosh
11. 2 jugs containing hot and cold water each
12. Two receptacles for used water and dirty linen
13. A receiver for used swab
14. Chlorhexidine gel
15. Sterile cotton in a gallipot or wrapped.

A plastic apron was put on. Hands were washed with soap under running water and dried with clean towel. Both cold water and hot water were mixed together and the temperature of the water was checked using the elbow. Gloves were worn and the baby was put on a protected flat surface and was undressed. Baby was then wrapped with a cot sheet with the head exposed for it to be bathed. The eyes were cleaned with clean cotton wool swabs soaked in clean water from inner canthus to outer canthus and the face cleaned with damp face towel and dried. The nape of the baby's neck was supported with one hand. The head was supported and the baby's ears plugged with two fingers. The head was then washed with soapy sponge. Baby was then lifted off flat surface, supporting the nape of the neck and the body resting in the elbow, to the edge of

the basin and soap rinsed off baby's hair and dry. Baby was then put on protected flat surface and exposed. The arms and front of trunk were washed paying attention to the skin folds. The back of the baby was turned with one arm supporting the chest and with a hand holding the distal arm of the baby. The back was washed down to the feet, paying attention to the skin folds. Baby was supported firmly and immersed in warm water, with head above water and rinsed thoroughly. She was then placed on the flat surface covered by a big bath towel. A small towel was used to dry the baby, paying attention to skin folds. Baby oil, as well as, powder was applied on the baby. The baby was wrapped with clean dry cot sheet after which the cord was exposed. The gloves were removed, hands were washed with soap and water and a sterile gloves worn. The cord was inspected for bleeding but there was none. Six sterile cotton wool swabs were used to dress the cord. The tip of the cord was held with sterile cotton wool swab soaked in chlorhexidine gel, then swabbed 5cm away from the base and after that the base of the cord was cleaned with separate cotton wool swabs soaked in methylated spirit. The whole cord was cleaned from the base upwards and lastly the tip was also cleaned with separate cotton wool swab soaked in methylated spirit. The cord was left exposed to air dry. Baby was dressed after diaper was put on. The baby was wrapped with clean dry cot sheet to maintain her temperature and given to her mother. Findings were communicated to the mother and she was thanked for her co-operation and she was accompanied to the bedside. The working surface and the instruments were decontaminated with 0.5% chlorine solution for 10 minutes; it was then washed. The gloves were removed and hands washed and dried and the procedure was documented

Mother was informed that the baby will be immunized against tuberculosis and poliomyelitis

4.2 FIRST DAY POST DELIVERY (DAY OF DISCHARGE)

On 10th September, 2023, was the first day after delivery and Madam Ellen and her baby were very healthy with cheerful looking face when they woke up around 6:00am. All procedures to be carried out on both mother and baby were explained. Perineal pad was inspected and blood flow was small and red in colour (rubra) without odour, and enquiries about her bladder habit was asked, of which she said it was resuming to normal. She brushed her teeth, emptied her bowel and had warm bath. Madam Ellen was served with porridge and bread as her breakfast. She complained of lower abdominal pain and sleeps less in the night which she said was due to breastfeeding of the baby at night therefore does not have enough sleep at night. She was encouraged on good and enough breastfeeding during the day and to ensure the atmosphere is calm at night this will enable the baby to sleep at night so that she can also rest. She was also educated to sleep in the afternoon when the baby too is asleep, she was reassured and encouraged to sleep when baby sleep. It was explained to client the important of feed baby at regular intervals. She was made comfortable in bed. Her vital signs were checked and recorded as follows;

Madam Ellen's assessment was recorded as follows;

Temperature	36.3^{o}c
Pulse	80bpm
Respiration	22cpm
Blood Pressure	118/91mmHg
Lochia	Rubra
Fundal Height	15cm
Condition of the uterus	contracted
Breast	Lactating

Madam Ellen's symphysio-fundal height was 15 centimeters above the symphysis pubis. Her lochia was red (rubra) in colour when checked and amount was minimal and not offensive after permission was sought to inspect it. Madam Ellen was then assisted to perform Kegel exercise to strengthen the perineal muscles. She was served with tea and bread by the mother as breakfast.

The baby was also examined with permission from the mother after hand washing with soap under running water and dried with towel. On examination, there was no abnormality detected. The baby passed meconium and urine which was normal. The cord was inspected for bleeding and discharge but there was none. Vital signs of the baby were checked and recorded. The baby was topped and tailed and the cord was dressed with cotton swabs and chlorhexidine gel and given to mother to breastfeed. On observation, mother positioned baby well and baby also had a good suckling and swallowing reflex. The baby's assessment was recorded as follows;

Temperature	36.4^{o}c
Apex beat	143bpm
Respiration	45cpm
Skin color	Pink
Cord condition	Clean dry
Cord bleeding	None
Suckling	Good
Weight	2.9kg
Stool color	Meconium

All findings were communicated to mother. Later in the day around 8:30am, the baby was given the immunization against tuberculosis with bacilli calmatte Guerin (BCG) by the community health nurse from the Reproductive and Child welfare Clinic but polio '0' (OPV0) which

prevents the baby against poliomyelitis was not given since it was a day after delivery. The BCG was given intradermal on the right upper arm of which the mother was informed that it will form a blister and scar later and she was advised not to apply anything to the site in other to ensure effectiveness of the vaccine and 2 drops of Polio '0' vaccine (OPV0) was given at the back of the tongue. Client was told to come with the baby to take the rest of the immunization at the time scheduled in order to protect the baby from any of the childhood preventable diseases like Measles, Tetanus, and Diphtheria and among others.

Preparation for discharge

She was told that, she would be discharged that day. She was educated on healthy adequate nutritious diet like fish, ground nut, and green leafy vegetables to help in the production of more breast milk and improve her immunity as well. This could help repair worn out tissues. She was also educated on personal hygiene, the various family planning method available and post-natal exercises. The essence of the exercise was explained to her that it would help the pelvic organs to strengthen the pelvic muscles and gaining her shape back. Furthermore, she was educated on demand feeding and exclusive breast feeding.

Madam Ellen was educated to breastfeed whenever the baby demands it. She was health insured therefore her medicines were collected for her from the pharmacy with health insurance card and some money paid for other billings. Routine drugs were served as prescribed. Madam Ellen was reminded of her counsel and was informed of her discharge. Madam Ellen's drugs were given to her and the dosage and time for taking the drug were explained to her again as follows:

Capsule Amoxicillin - 500 milligram tab for 7 days

Tablet Metronidazole - 400 milligrams tab for 7 days

Tablet Paracetamol - 1gram tab for 5 days

She was educated on when the fontanelles will close naturally and therefore no hot water should be applied with the intention of helping it to close earlier.

She was helped to pack her belongings and was educated on intended post-natal visits for a period of one week which was explained to her that she would be visited at home for seven days for continuity of care. Madam Ellen was educated on and how to manage some common breast problem such as cracked nipple and breast engorgement. She was also encouraged not to apply anything on the cord aside the use of chlorhexidine gel. She was encouraged to register the baby at the birth registry and informed of continuity of care. Madam Ellen was then discharged at 10:00am and went home accompanied by her sister

POST NATAL VISITS

4.3 FIRST POSTNATAL HOME VISIT

On 10th September, 2023 at 4:50pm, client and family were visited as promised. Madam Ellen was at home with her sister and son. Greetings were exchanged on arrival. Client was asked if they are faring well and she confirmed she was doing well. Madam Ellen's previous complain of interrupted sleep during her first day post-delivery was asked and said she was able to sleep better than previous night. Permission was sought to do the examination of which she agreed. After hand washing, symphysio-fundal height was measured. The reading was 15 centimeters above the symphysis pubis. The perineal pad was checked and the color of the lochia was bright red and not offense V.E. Client's vital sign checked and recorded as follows;

Temperature	36.9^{o}c
Pulse	79bpm
Respiration	20cpm
Blood pressure	100/70mmHg
Lochia	Rubra

Condition of the uterus	Contracted
Breast	Lactating

She was asked whether she has any problem and she responded no. Head to toe examination was done on the baby and there was no abnormality. Baby's assessment was as follows;

Observation	Evening
Temperature	37.2^{o}c
Apex beat	145bpm
Respiration	45cpm
Skin color	pink
Cord condition	dry and clean
Cord bleeding	None
Suckling	Good
Weight	2.9kg
Stool colour	meconium

She was encouraged to breastfeed on demand and frequently. Client was thanked and informed that she will be visited the following day.

4.4 SECOND POSTNATAL HOME VISIT

On the 11th September 2023 at 7:50am in the morning and5:30pm in the evening, another visit was made to Madam Ellen. The main aim of the visit was to know if the mother and baby were in good health. Madam Ellen was examined, her breast was lactating well and her uterus was well contracted, her symphysio-fundal height was 14cm. Perineal pad was inspected and lochia was bright red in color (rubra), the flow was moderate and not offensive. She was congratulated after the examination. Madam Ellen's assessment was recorded as follows;

The reading was 14 centimeters above the symphysis pubis. The perineal pad was checked and the colour of the lochia was bright red and not offensive. Client's vital sign checked and recorded as follows;

READINGS(MOTHER)	MORNING	EVENING
Temperature	36.4^{o}c	36.7 ^{o}c
Pulse	81bpm	70bpm
Respiration	20cpm	18cpm
Blood pressure	110/80mmHg	110/70mmHg
Lochia	Rubra	Rubra
Fundal height	14cm	14cm
Condition of the uterus	Contracted	contracted
Breast	Lactating	Lactating

She was asked whether she had any problem or complains and she responded no. Head to toe examination was done on the baby but there was no abnormality found. The baby was assessed and recorded as follows;

RECORDINGS (BABY)	MORNING	EVENING
Temperature	37.0^{0}c	37.0^{0}c
Apex beat	130bpm	132bpm
Respiration	48cpm	46cpm
Skin color	Pink	Pink
Cord condition	Dry and clean	Dry and clean
Cord bleeding	None	None
Suckling	Good	Good

Weight	2.8kg	2.8kg
Stool color	Meconium	Greenish brown

The baby was then dressed nicely with cap and socks and wrapped loosely in a warm sheet and made comfortable in bed. Madam Ellen was asked if she has any complains and she said her breast was heavy, she was encouraged to breastfeed baby more frequently. At 5:30 pm in the evening, client and family was visited again. Madam Ellen was assisted to position and fix baby well to the breast while breastfeeding. Madam Ellen was again educated to breastfeed baby frequently and also make sure one breast is completely empty before giving the other one to the baby. Madam Ellen was also educated on the need to apply cold compresses on the breast and the need to put on a well-fitting brassiere to help relieve the engorgement. Madam Ellen was educated to continue to express as often as necessary milk to make her comfortable until engorgement stops and findings were recorded. The baby's vital sign was checked and recorded after which was bathed and cord was dressed. Permission was then sought to leave and she was informed of the next visit. Assessment of the baby were recorded.

4.5 THIRD POSTNATAL HOME VISIT

On the 12th September,2023 at 7:30am and 5:00pm in the evening, a visit was paid to Madam Ellen and her family, they were all in good health but client looked moody. She was encouraged to share her problems and to be happy for what God has done for her and her family. Madam Ellen was examined from head to toe and the uterus was well contracted. The symphysio-fundal height was 13cm. The perineal pad was inspected for lochia and the color was bright red (rubra), the flow was moderate with no odour. The breast was also lactating well. Madam Ellen said the baby can now hold the breast and breastfeeding well. Client's assessment was recorded as follows;

RECORDINGS (MOTHER)	MORNING	EVENING
Temperature	36.5^{o}c	36.8
Pulse	82bpm	82bpm
Respiration	20cpm	20cpm
Blood pressure	110/60mmHg	110/80mmHg
Lochia	Rubra	Rubra
Fundal height	13cm	13cm
Condition of the uterus	Contracted	contracted
Breast	Lactating	Lactating

The baby was topped and tailed in the present of the mother while singing a lullaby to her and cord dressed for the second time. Cord looked dry. Baby passed greenish brown stool and urinated during bathing. The baby was assessed and recorded as follows;

RECORDINGS(BABY)	MORNING	EVENING
Temperature	36.9^{o}c	37.2 ^{o}c
Apex beat	130bpm	142bpm
Respiration	48cpm	48cpm
Weight	2.7kg	2.7kg
Skin color	pink	pink
Cord condition	clean and dry	clean and dry
Cord bleeding	None	None

Suckling	present	Good
Stool color	Greenish brown	Yellowish

At 5:00pm in the evening, mother and baby were visited. Madam Ellen was assessed and record was taken after assessment made. Baby was bathed and her cord was dressed. Vital signs of baby were checked and recorded. Client complained that elder child has been angry and has refused to eat since they were discharge home. It was explained to her that, the elder child feels neglected and she was encouraged to care for him and to allow him to play with baby under her supervision to avoid sibling rivalry. Client was also informed her about the change of visit to daily bases. Permission was sought to leave and it was granted.

4 .6 FOURTH POSTNATAL HOME VISIT

On 13th September, 2023 Madam Ellen and family were visited at 7:15am. The aim of the visit was to know how they were faring. All the family members were around on arrival. Every member of the family was in good health after asking and their environment was clean upon assessment. Madam Ellen verbalized that the pains she felt in her breast had subsided greatly and they also felt lighter as she adhered to the education given to her during my previous visit. She was congratulated and encourage to practice educations given to her. Head to toe examination was done and was detected that the engorged breast has resolved and there was no abnormality detected on Madam Ellen. Her perineal pad was inspected for lochia and the flow was moderate, pink in color (serosa) and not offensive. Symphysio-fundal height was measured and it was 12cm and recorded as follows;

Temperature	$36.2^{o}c$
Pulse	80bpm

Respiration	20cpm
Blood pressure	110/90mmHg
Lochia	Rubra
Fundal height	12cm
Condition of the uterus	contracted
Breast	Lactating

Madam Ellen's mother was assisted to top and tail the baby and after that she was taught how to use chlorhexidine gel in dressing the cord. The baby passed yellowish stool and urinated during the procedure. She wrapped the baby loosely in a sheet and made her comfortable in bed. Baby's vital signs and other observations were recorded as follows;

Observation	Morning
Temperature	$36.6^{o}c$
Apex beat	132bpm
Respiration	40cpm
Cord	Shrinking
Cord bleeding	None
Suckling	present
Weight	2.7kg
Stool colour	Yellowish

Client said that the elderly child is happy and now play with the baby. After that she was asked if there were any complains and she had no complains. She was informed of the next home visit

and permission was asked to leave. They expressed their gratitude for the visit and was accompanied outside the house.

4.7 FIFTH POST NATAL HOME VISIT

On the 14thSeptember, 2023 at 7:00 am, she was visited once again. On arrival, Madam Ellen was brushing her teeth. The rest of the family members were asked how they were doing and they responded they were fine by God's grace. Hot water was already available for bathing but she requested that, she would like to perform some pelvic exercises before bathing. The symphysio-fundal height was 11 centimeters. The perineal pad was examined and the color was pink (serosa) without any offensive odour and no abnormalities detected at the perineum. Madam Ellen's assessment was recorded as follows;

Temperature	36.5^{o}c
Pulse	83bpm
Respiration	23cpm
Blood pressure	120/80mmHg
Lochia	Serosa
Fundal height	11cm
Condition of the uterus	Contracted
Breast	Lactating

Madam Ellen topped and tailed her baby under supervision. Baby's cord was dressed with chlorhexidine gel and it looked dried and about to slough off, baby was dressed nicely and wrapped in white cloth and made comfortable in bed. Madam Ellen said the baby has already passed yellowish brown stool and urinated. Baby was assessed and the observations were

recorded as follows; temperature 36.7˚C and weight 2.8kg, apex beat 134bpm and respiration 48cpm.

Temperature	37.0^{o}c
Apex beat	134bpm
Respiration	48cpm
Skin color	pink
Cord	Dried and about to slough off
Cord Bleeding	None
Suckling	present
Weight	2.8kg
Stool color	Yellowish brown

Madam Ellen's mother and sister was encouraged to assist client in the care of the baby and was educated not to apply anything on the stump to prevent infection but should always leave it clean and dry. She complained of perineal pain when she was asked if there is any problem. Permission was asked to leave.

4.8 SIXTH POSTNATAL HOME VISIT

Madam Ellen was visited again on 15th September, 2023 at 7:30am. Everybody in the house was in good health. Madam Ellen was seen happy and was smiling all around as she has adequate support and love from her relatives and friends as well. Every procedure to be carried on was explain to her. The symphysio- fundal height was 10cm. The perineal pad was examined and the color was pink (serosa) without any offensive odour. Head to toe examination was carried out without any abnormalities detected.

Temperature	36.6^{o}c
Pulse	70bpm
Respiration	20cpm
Blood pressure	110/60mmHg
Lochia	Serosa
Fundal height	10cm
Condition of the uterus	Contracted
Breast	Lactation

The baby's cord was off, she was bathed and the stump dressed with chlorhexidine gel. Yellowish-brown stool and urine were passed during bathing. The baby's weight was 2.9kilograms, her temperature was 36.8˚C, her apex beat was 128 bpm, and her respiration was 40cpm. She was wrapped loosely in a warm baby sheet. Baby's assessment was recorded as follows;

Temperature	36.8^{o}c
Apex beat	128bpm
Respiration	40cpm
Skin color	pink
Cord	Off
Cord bleeding	Absent
Suckling	Present
Weight	2.9kg
Stool color	Yellowish brown

She reported of no complains. They were informed about the next day to be the first postnatal visit to the hospital and the last post-natal home visit to them. They were not really happy about the last visit announcement, but they were assured of meeting again at the postnatal clinic. They were bid goodbye.

4.9 SEVENTH POST NATAL HOME VISIT

The last post-natal home visit was on the 16th September, 2023 at 7:46am after the first postnatal visit to the clinic. On arrival, Madam Ellen had her daughter on her laps while singing lullaby. Greetings were then exchanged and routine examinations started after permission was soughted.

Madam Ellen's symphysio- fundal height was 9cm. Her perineal pad was inspected and the lochia was pink (serosa) and not offensive with the flow reduced in amount. On examination, there was no abnormality detected on her. Madam Ellen's assessment was recorded as follows:

Madam Ellen's assessment was recorded as follows;

Temperature	36.4^{o}c
Pulse	72bpm
Respiration	20cpm
Blood pressure	110/70mmHg
Lochia	Serosa
Fundal height	9cm
Condition of the uterus	Contracted
Breast	Lactation

Hot water was available for bathing the baby. The baby was bathed and the stump dressed with chlorhexidine gel. Yellowish brown stool and urine had been passed before bathing. The baby's

weight was 3.1kg, her temperature was 36.7˚C, her apex beat was 130 bpm, and her respiration was 48cpm. She was wrapped loosely in a warm baby sheet. Baby's assessment was recorded as follows;

Temperature	36.3^{o}c
Apex beat	136bpm
Respiration	52cpm
Skin color	Pink
Cord	Healing
Cord bleeding	No
Suckling	Present
Weight	3.1kg
Stool color	Yellowish brown

Madam Ellen said she took fufu and light soup as super. She was encouraged to continue feeding the baby on demand and also to fix baby properly onto the breast when feeding her. By so doing, her breast will not be engorged and her nipple will not develop sore. Madam Ellen's husband's was encouraged to help her to take warm baths and also on the need to massage the breast. They were then discharged from home visits. The family was thanked for their understanding and cooperation. Emphasis of that visit being the last was made again. They also expressed their gratitude.

4.10 FIRST POST-NATAL VISIT TO THE CLINIC

On 18th September, 2023, Madam Ellen and her baby visited to the clinic around 8:00am. They were warmly welcomed and a seat was offered to them. Madam Ellen was looking cheerful and neatly dressed. The baby was also looking very active, nice and healthy. Her permission to check her vital signs and weight and was recorded as below;

Mother's Vital Signs

Temperature	-	36.2 degrees Celsius
Pulse	-	74beats per minute
Respiration	-	19 cycles per minute
Blood pressure	-	110/80 millimeters of mercury
Weight	-	62 kilogram

Baby's Vital Sign

Temperature	-	36.9 degrees Celsius
Pulse	-	132 beat per minutes
Respiration	-	42 cycles per minutes
Weight	-	3.3kilogram

Since it was her first postnatal clinic visit, there was the need to send her to the Laboratory for further investigations. Madam Ellen was therefore given a specimen bottle for 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 Ellen with her consent to be sent to the laboratory for haemoglobin to be tested. The samples were then sent to the laboratory. The results were as follow

Haemoglobin 11.6 g/dl

Urine protein Negative

Glucose Negative

The results were explained to her and she expressed signs of joy upon hearing that all results were normal and smiled also.

Madam Ellen was sent to the palpation room where privacy was provided by drawing the curtains and closing doors and windows. She was helped to assume a comfortable position with which she chose to lie laterally on her left 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 was no discharged from the eyes, nose and ears. No abnormality was found in the mouth and neck as the mouth buccal cavity looked pink with no odor and neck was free from any palpable masses as well as free from distensions of blood vessels. On examination of the breast, it was lactating well but engorgement was detected. No abnormality such as sub involution, tenderness, enlargement of liver and spleen was detected on the abdomen. The symphysio-fundal height measured was 8cm.

With the lower extremities, certain condition such as edema was looked out for. It was detected that she showed no abnormality of that sort.

The perineum was intact and there was no offensive vaginal discharge and the lochia was white in color (alba). All findings were communicated to her after the procedure. She was then thanked for her co-operation and helped to dress up.

Head to toe examination was also performed on the baby to look out for absence of abnormalities. On the head, the anterior and posterior fontanelles was palpated for pulsation and it was present and normal. A few skin rashes on the baby's forehead which looks like heat rash. Madam Ellen was reassured that its normal for babies to develop skin rashes as their skin is sensitive to a different environment and encouraged to dress the baby according to the weather. In so doing, she should ensure baby wears clean and dry cotton clothing, wash her hands before and after handling the baby and ensure diapers are changed frequently. There were absent of discharges from the eye and nose. The skin was nice, very pink and with no rashes. The chest movement was normal as well as the extremities. The umbilical cord was healed. Findings were communicated to the mother and she was congratulated for taking good care of the child and herself. She was educated on various family planning methods, when to resume sex and the need to feed the baby exclusively for 6 months especially in the night. She was also encouraged to register the baby at the birth registry. Education was given to her on the need to attend child welfare clinic in order to monitor the growth of her baby, early detection of infection or disease and the need to complete all the immunization. Client was encouraged to continue practicing of exclusive breastfeeding and practice the pelvic floor muscle exercise. Both mother and baby were in good health and documentation was done on all findings.

She was reminded of the six weeks' post-natal visit to the clinic. She was thanked for cooperation. Madam Ellen and family was handed over to the midwife in charge. Madam Ellen was sad of what was said but she was promised to be checked on from time to time through phone calls and was seen off.

4.11 SECOND POST-NATAL VISIT TO THE CLINIC

According to the midwife in charge, on the 30th October, 2023 at 8:00am. Madam Ellen came to the clinic for six weeks visit. They were warmly welcome and they appeared very healthy. General examination was conducted 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	36.8ºc
Pulse	75bpm
Respiration	20cpm
Blood Pressure	110/60mmHg
Weight	60kg

Madam Ellen was given a urine sample container to provide small amount of urine to be sent to the Laboratory for urine analysis. She was educated on the need of the procedure and to provide midstream urine for the examination. A sample of blood was also taken from Madam Ellen with her consent and sent to the Laboratory to be tested for her hemoglobin level. The results from the Laboratory were as follows;

Haemoglobin-	12.2 g/dl
Urine protein	Negative
Glucose	Negative

The results were explained to her and she expressed her joy upon hearing the results.

Madam Ellen was sent to the palpation area where privacy was provided by drawing the curtains. She was helped to assume a comfortable position 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 was no discharge 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 edema was looked out for. It was detected that she showed no abnormality.

She was asked if she has resumed menstruation but she said no. she was educated on the need to start a family planning method to prevent unwanted pregnancy. Her baby was also examined from the 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 smooth with no rashes. The chest and upper extremities were normal. The umbilical stump was inspected and it had healed and was off. The lower extremities were normal. Weight of baby was 5.0kg

The baby`s vital signs and weight were as follows:

Temperature	36.7ºC
Respiration	38cpm
Apex heart beat	132bpm

Weight 4.0kg

Madam Ellen and her baby were handed over to the midwife in charge for the six weeks' immunization against diphtheria pertussis, tetanus, haemophilus influenza type B and hepatitis B.(pentavalent).

She was encouraged to ask questions but she asked none and made no complaints either. She was reminded on exclusive breastfeeding, rest and sleep, exercise and nutritious diet, which would help in lactation. Madam Ellen and her children were able to cope with their new sibling. She was finally handed over to the public health nurse for continuity of care but she was asked to report to the facility any time she encountered any health-related problem.

She was thanked for her cooperation and understanding during our interaction and was bid farewell.

4.12 NURSING CARE PLAN DURING PUERPERIUM

PROBLEMS IDENTIFIED

- On 09/09/23 Afterpain
- On 10/09/23Insufficient sleep
- On 12/09/23 risk for mood changes
- On 14/09/23 perineal pain

SHORT TERM OBJECTIVE

- Client's after pain will reduce within 48hours.
- Client will be able to sleep for 2hours daily and 6hours in the night within 24hours.
- Client's perineal pain will reduce within 48hours
- Client will express joy and happiness within 24hours.

LONG TERM OBJECTIVES

Client and baby will go through puerperium successfully without any complications

CARE PLAN DUIRING PUERPERIUM

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
09/9/23 at 1:00am	Afterpain related to involution of the uterus as evidenced by sharp abdominal pain	Client's after pain will reduced within the next 48hours as evidenced by Client verbalizing the pain has reduced. 2.Midwife observing signs of the pain relief (cheerful face)	1. Reassure client that the pain is temporary. 2. Explain the cause of the pain to allay anxiety. 3. Encourage client to apply warm compress at her lower abdomen. 4. Encourage client to continue breastfeeding. 5. Serve prescribed analgesics.	1. Client was reassured that pain is temporary. 2. The cause of the pain was explained to the client to allay anxiety that it is as a result of uterine contractions 3. Client was encouraged to apply warm compress on the lower abdomen. 4. Client was encouraged to continue with breastfeeding. 5. Client was served prescribed analgesics.	11/09/23 at 1:00am	Goal was fully met as 1.Client reported that the pain had reduced and midwife observed client is relieved from pain.	A.S.I

NURSING CARE PLAN DURING PUERPERUIM

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
09/9/23 at 5:30am	Insufficient sleep related to caring for baby at night as evidenced by restlessness.	Client will have at normal sleeping pattern of 6-8 hours during the night and 2 hours during the day within 24 hours as evidenced by 1.Client verbalizing that she can sleep at night. 2.Client's sister confirming that client gets enough rest at night.	1. Reassure client that baby's demand is important so she should be assisted. 2. Encourage client to sleep when baby sleeps. 3. Educate client and family to reduce the number of visitors. 4. Teach client how to breastfeed in a lying down position. 5. Educate client to feed baby adequately before going to bed	1. Client was reassured that baby's demand is important so she will be assisted. 2. Client was encouraged to sleep when baby sleeps. 3. Client and family was educated to reduce the number of visitors. 4. Client was taught how to breastfeed in a lying down position. 5. Client was educate to feed baby adequately before going to bed.	10/09/23 at 5:30am	Goal fully met as client reported she had slept 6hours at night and 2 hours during the day. 2.Client's sister confirmed that client was not exhausted or tired.	

NURSING CARE PLAN DURING PUERPERIUM

DATE/ TIME	NURSING DIAGNOSIS	OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
13/09/23 8:00am	Breast pain related to engorgement as evidenced by swollen and tenderness of the breast.	Client breast pain will relieve within 30 minutes as evidence by 1.client verbalizing that the pain has relieved 2.Midwife observing the engorgement has subsided.	1. Reassure client that pain would subside. 2. Encourage client to maintain good personal hygiene 3. Encourage client to have warm bath 4. Encourage client to breastfeed the baby by lying down or sitting on a cushion 5.Educate client to empty one breast before the other. Administer prescribed analgesics	1. Client was reassured that the pain would subside. 2. Client was encourage to maintain good personal hygiene 3.Client was encouraged to have a warm bath 4.Client was encouraged to breastfeed the baby by lying down or sitting on a cushion 5.Client was educated to empty one breast before Prescribed analgesics was administer.	13/09/23 8:30am	Goal fully met as client reported that the pain has resolved.	A.S.I

NURSING CARE PLAN DURING PUERPERUIM

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
12/09/23 at 7:30am	Risk for mood changes (postpartum blues) as evidenced by hormonal action in the body	Client will express joy and happiness within 24 hours as evidenced by: 1. Client verbalizing that she feels very happy and loved. 2. Relatives observing that client expresses joyful facial expression.	1. Reassure client of competent care in management of the condition. 2. Encourage client to engage in recreational activities such as listening to music and reducing stress 3. Educate client's partner and relatives to take part in the care of the newborn such as changing his diapers when soiled and caring for the older sibling. 4. Assist the client to rethink about the image of motherhood. 5. Listen to the client and provide encouragement	1. Client was assured of competent care in the management of the condition. 2. client was encouraged to engage in recreational activities such as listening to music and lessen stress. 3. Education was given to client's partner and relatives to take maximum part in the care of the client, the baby and the older sibling 4. Client was assist to rethink about the image of motherhood. 5. Client was listened to and the words of encouragement was provided for her	13/09/2023 at 7:30am	Goal was fully met as she was seen happy and smiling all over.	A.S.I

Termination of care

On the 18th of December ,2023 madam Ellen was called around 5pm to tell her that the care rendered to her at home will end on her visit to the facility and was also reminded that she will be visiting the facility the next day.

On the 19th December, 2023 about 9:30am Madam Ellen came to the facility with her baby accompanied by her sister, she was welcomed and made comfortable .She went through the routine postnatal care and everything was normal. It was explained to Madam Ellen that the care rendered at home has come to an end since the period of study is over. She was handed over to the midwife in charge for the continuity of care with all necessary information needed. 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 anytime needed. The midwife in charge said she will hand over madam Ellen to the Public Health Nurses at the Reproductive and Child Health Unit for continuity of care.

She was reminded of her day of visit and the care that will be rendered to her. She and her entire family were thanked for availing themselves and helping to bring this study to a successful end. Madam Ellen expressed her gratitude for the care given to her. She and the family were bid farewell. On 20th December 2023, at 10:20am madam Ellen was called to check on she and her baby of which she said they were fine, she was reminded of her visit to the facility. She was once again thanked for the opportunity given to carry out the study on she and the family.

SUMMARY AND CONCLUSION

Madam Ellen a 21-year-old Gravida two Para one (G2P1) was the client used for the Family Centered Maternity care study conducted at Africa Libera Health Centre in the Bono-East region. She made her first antenatal visit on 19th June, 2023 in her early pregnancy. She was met on 14th August, 2023 during her usual antenatal clinic visit with gestation of 37 weeks and was given individualized care both at the clinic and home visits. Minor problems identified were managed using the nursing process. Client finally had a spontaneous vaginal birth to a live healthy female child on the 9th of September, 2023 at 9:53pm with no complication to both mother and baby.

Client and baby were cared for during puerperium, through continuous home visits for a week. On 10th September, 2023 thus the first postnatal clinic visit, they were handed over to the Public Health Nurses at the Reproductive and Child Health Unit for continuity of care.

In conclusion, this care study is an opportunity to put into practice all the theoretical knowledge acquired in classroom with the help of the clinical in-charge.

It has helped me to conduct a very good delivery.

It has also helped me to build a trustworthy relationship with the client and the family.

It has helped me to know how to care for a client in their own environment.

It has helped me to know how to help client make decision on their own and solve problem

BIBLIOGRAPHY

World Health Organization. (2016). *Maternal, newborn, child and adolescent health.* Geneva: World Health Organization.

American College of Obstetricians and Gynaecologist. (2018). Definition of term pregnancy. Obstet Gynecol, 123, 1139-1140.

Artal-Mittelmark, R. (2023, September). Management of normal labour. Retrieved October 3, 2023, from MSD Manual Professional Version: https://www.msdmanuals.com/professional/gynecology-and-obstetrics/normal-labor and-delivery/management-of-normal-labor

Davis, C. P. (2021, March 29). Definition of pregnancy. Retrieved October 3, 2023, from RxList: https://www.rxlist.com/pregnancy/definition.htm

Marshall, J. E., & Raynor, M. D. (2014). Myles textbook for midwives (17th ed.). Oxford: Churchill Livingstone.

United Nations Children's Funnd (UNICEF). (2023, July). Antenatal care. Retrieved October 3, 2023, from https://data.unicef.org/topic/maternal-health/antenatal-care/

World Health Organization. (2016). Maternal, newborn, child and adolescent health

APENDIX I

COMPLETE DIAGNOSTIC MEASURES

ANTENATAL CARE

DATE	SPECIMEN	INVESTIGATION	NORMAL RANGE	FINDINGS	REMARKS
19/04/23	Blood	Haemoglobin level	11.4g/dl-16g/dl	11.4g/dl	Normal
		Sickling	Negative	Negative	Normal
		Rhesus factor	Positive/Negative	positive	Normal
		HIV/AIDS	Negative	Negative	Normal
		Grouping	A, B, AB, O	O	Normal
		Hepatitis	Negative	Negative	Normal
		Stool	Negative	Negative	Normal
		VDRL	Negative	Negative	Normal
		G6PD	Negative	Negative	Normal
	Urine	Protein	Negative	Negative	Normal
		Glucose	Negative	Negative	Normal
19/05/23	Urine	Protein	Negative	Negative	Normal
		Glucose	Negative	Negative	Normal

DATE	SPECIMEN	INVESTIGATION	NORMAL RANGE	FINDINGS	REMARKS
19/06/23	Urine	Protein Glucose	Negative Negative	Negative Negative	Normal Normal
14/7/23	Urine	Protein Glucose	Negative Negative	Negative Negative	Normal Normal
15/8/23	Urine Blood	Protein Glucose Haemoglobin level	Negative Negative 11.4g/dl-16g/dl	Negative Negative 11.4g/dl	Normal Normal Normal
22/08/23	Urine	Protein Glucose	Negative Negative	Negative Negative	Normal Normal

LABOUR

DATE	SPECIMEN	INVESTIGATION	NORMAL RANGE	FINDINGS	REMARKS
09/09/23	Blood	Haemoglobin level	11.4g/dl-16g/dl	12.4g/dl	Normal
	Urine	Protein	Negative	Negative	Normal
		Glucose	Negative	Negative	Normal

PUERPERIUM

DATE	SPECIMEN	INVESTIGATION	NORMAL RANGE	FINDINGS	REMARKS
18/09/23	Blood	Haemoglobin level	11.4g/dl-16g/dl	11.6g/dl	Normal
	Urine	Protein	Negative	Negative	Normal
		Glucose	Negative	Negative	Normal

APPENDIX II

PHARMACOLOGY OF DRUGS FOR THE MOTHER

NAME OF DRUG	CLASSIFICATION	DOSAGE	ROUTE	ACTION AND USES	ACTUAL EFFECT	SIDE EFFECTS	SIDE EFFECT EXPERIENCE
Tablet Sulphadoxine Pyrimethamine	Anti-Malaria	3 tablets start at 23weeks 6days/ after quickening and repeated at 4 weeks' interval till delivery	Oral	Prevention of malaria	Malaria was prevented in pregnancy	Nausea, itching, headache	None
Injection oxytocin	uterotonic	10 units	Intramuscular	Intramuscular	Uterine contraction was effective	Vomiting, rise in blood pressure	None
Tablet Ferrous Sulphate	Haematonic	10 milligram Once daily	Oral	Helps in the formation of hemoglobin	Hemoglobin increased	Gastrointestinal disturbance and blood stool	Dark Stool
Tab multivitamin	Vitamin preparation	200 milligram for 30days	Oral	Formation of red blood cells	Increase appetite	Gastrointestinal disturbance	None

NAME OF DRUG	CLASSIFICATION	DOSAGE	ROUTE	ACTION AND USES	ACTUAL EFFECT	SIDE EFFECTS	SIDE EFFECT EXPERIENCE
Tablet Folic Acid	Vitamin Preparation	5milligram Once daily	Oral	Proper formation and function of red blood cell	Hemoglobin level increased	Nausea and vomiting	None
Paracetamol	Analgesic	1000 milligram 3 times daily.	Oral	Help the relieve of pain	Pain was relieved	Prolong use causes damage to the liver.	None
Tetanus Diphtheria	Anti-Tetanus	0.5 milligram	Intramuscular	Protect mother and fetus against tetanus infection	Client was protected from tetanus infection	Mild fever and malaise	None

PHARMACOLOGY OF DRUGS FOR THE BABY

NAME OF DRUG	CLASSIFICATION	DOSAGE	ROUTE	ACTION AND USES	ACTUAL EFFECT	SIDE EFFECT	SIDE EFFECT EXPERIENCE
Vitamin K	Coagulant	0.5 milligram	Intramuscularly	Production of prothrombin	No bleeding	None	None
Chloraphenicol	Antibodies	2 drops	Instillation	To prevent infection	Infection of the eye was prevented	None	None
Oral polio vaccinse	Antigen	2 drops	Orally	Production of antibodies to prevent poliomyelitis	Poliomyelitis. Under observation	There may be diarrhea	None
Injection Bacillus Calmette Guerin	Antigen	0.5 milligrams	Intradermal	Production of antibodies to prevent tuberculosis	Tuberculosis. Under observation	Blister formation and slight fever	None
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
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
Rotarix 1	Antigen	1.5 ml	Oral	Prevention of gastroenteritis	Under observation	None	None

APPENDIX III

ANTENATAL RECORDS

DATE	WEIGHT (KG)	BLOOD PRESSURE (MMHG)	URINE FOR SUGAR AND PROTEIN	GESTA-TIONAL AGE IN WEEKS	FUNDAL HEIGHT (CM)	PRESEN-TATION AND POSITION	DESCENT	FETAL HEART RATE BEAT PER MINUTE	COM-PLAINTS	TREATMENT	REMA-RKS
19/04/23	60	120/70	Negative Negative	21	-	-	-	Positive	Headache	Cap iron III polymaltose Tetanol Diphtheria injection 1st dose Sulphadoxine pyrimethamine	Healthy
19/05/23	62	100/70	Negative Negative	25	26	Cephalic	-	Positive	No complain	Cap iron III polymaltose 2nd Sulphadoxine pyrimethamine	Healthy
19/6/23	64	110/66	Negative Negative	29	29	cephalic	-	Positive	Lower abdominal pains	Cap iron III Polymaltose 3rd Sulphadoxine pyrimethamine	Healthy

14/7/23	65	117/76	Negative Negative	33	32	cephalic	-	Positive	Frequent Urinating	Cap iron III Polymaltose 4th Sulphadoxine pyrimethamine	Healthy
15/8/23	65	117/76	Negative Negative	37	35	cephalic	-	Positive	Heart Burns	Cap iron III polymaltose	Healthy
22/8/23	67	112/71	Negative Negative	39	37	cephalic	-	Positive	Low abdominal pains	Cap III polymaltose	Good

WHO Modified Partograph

Registration No. S136/22 Name(Last, First) ANDREW ELLEN Age 21
Date 9/09/2023 Parity/Gravida 15/12/22 LMP G2P1A EDD 2/9/2023 Gestation(wks) 41WKS
ROM: 9/09/2023 Labour Duration (hrs) 6hrs Facility/Clinic Name Africa Liberia Health Center

FETAL HEART RATE

LIQUOR MOULDING

CERVIX (CM)

Plot X

DESCENT Plot C

HOURS

TIME

Alert

Action

DoD - 9/09/2023
ToD - 9:53pm
Sex - Female
A/S - 9/10, 10/10
L - 49 cm
H/C - 31cm
Bwt - 3.0kg
EBL - 150mls
Placenta - cct
Perinium - intact
D/L - 6hrs 5
Delivered by Indira Serugga Antubi

CONTRACTIONS PER 10 MINS

Oxytocin U / L
Drops / minute

DRUGS & IV FLUIDS

BLOOD PRESSURE

TEMPERATURE

36.0 36.2

100 100

LABOR NOTES
Madam Ellen G2P1^ at 41weeks gestation was seen at the ward with complains of waist pain, Vital Signs was checked with the following recordings, B.P - 120/70mmHg P-91bpm R-19cpm, T-36.8°C
V.E was repeated with cervical os at 5cm dilated. Client delivered at 9:53pm. Assessment was done on baby with the following recordings; Wt-3.0kg HT-49cm, H/C-31cm, T-36.1

Please circle or write responses.

DELIVERY

DATE: 9/09/2023 TIME: 9:53pm METHOD: (Spontaneous) / Vacuum Extraction / C/S / Other
PERINEUM: (Intact) / Episiotomy / Laceration
ANESTHESIA: (None) / Local / General

THIRD STAGE

Active Management: (Yes) / No Medication: Time 9:53pm Type/Dose 10 units of Oxytocin
PLACENTA: TIME: 9:58pm (Complete) / Incomplete
Intact
BLOOD LOSS AMOUNT: (Small (Less than 250 cc)) / Moderate (250-499 cc) / Large (more than 500 cc) / Significant for mother

BABY

Weight: 3.0kg
Sex: Male / (Female)
Baby Position: (Vertex) / Breech / Other

APGAR

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

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

FOURTH STAGE MONITORING

Frequency	Time	B/P.	Pulse	Fundus	Bleeding	Bladder
Every 15 minutes first 2 hours	10:53pm	118/60	82	16	No Bleeding	100mls
	11:08pm	120/70	84	Contracted	No bleeding	
	11:23pm	118/71	80	Contracted	No bleeding	Empty
	11:38pm	100/70	79	Contracted	No Bleeding	
	11:53pm	110/80	81	Contracted	No bleeding	
	12:08pm	110/80	82	Contracted	No bleeding	Empty
	12:23pm	118/71	83	Contracted	No bleeding	
	12:38am	110/70	83	Contracted	No bleeding	100
Every 30 minutes For 1 hour	1:08am	110/60	72	Contracted	No bleeding	
	1:38am	110/70	72	Contracted	No bleeding	Empty

Birth Attendant _____ Date _____

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

MATERNITY CHART

MADAM ELLEN ANDREW

21 WARD: MATERNITY

5136/22 BED NO.: 1

	9/9/23	10/9/23	11/9/23	12/9/23	13/9/23	14/9/23	15/9/23	16/9/23
Days in Hospital	D0D	D1	D2	D3	D4	D5	D6	D7
Hour AM		6:00	7:50	7:30	7:15	7:00	7:30	7:46
PM	10:53	4:50	5:30	5:00				

Temperature

°C °F

KEY
Temperature
Symphysio-fundal height

Pulse (BPM)

	Pass	Pass	Pass	Pass	Pass	Pass	Pass
	Pass	Pass	Pass	Pass	Pass	Pass	Pass
AM	110/60	118/91	110/80	110/80	110/90	120/80	110/60
PM							

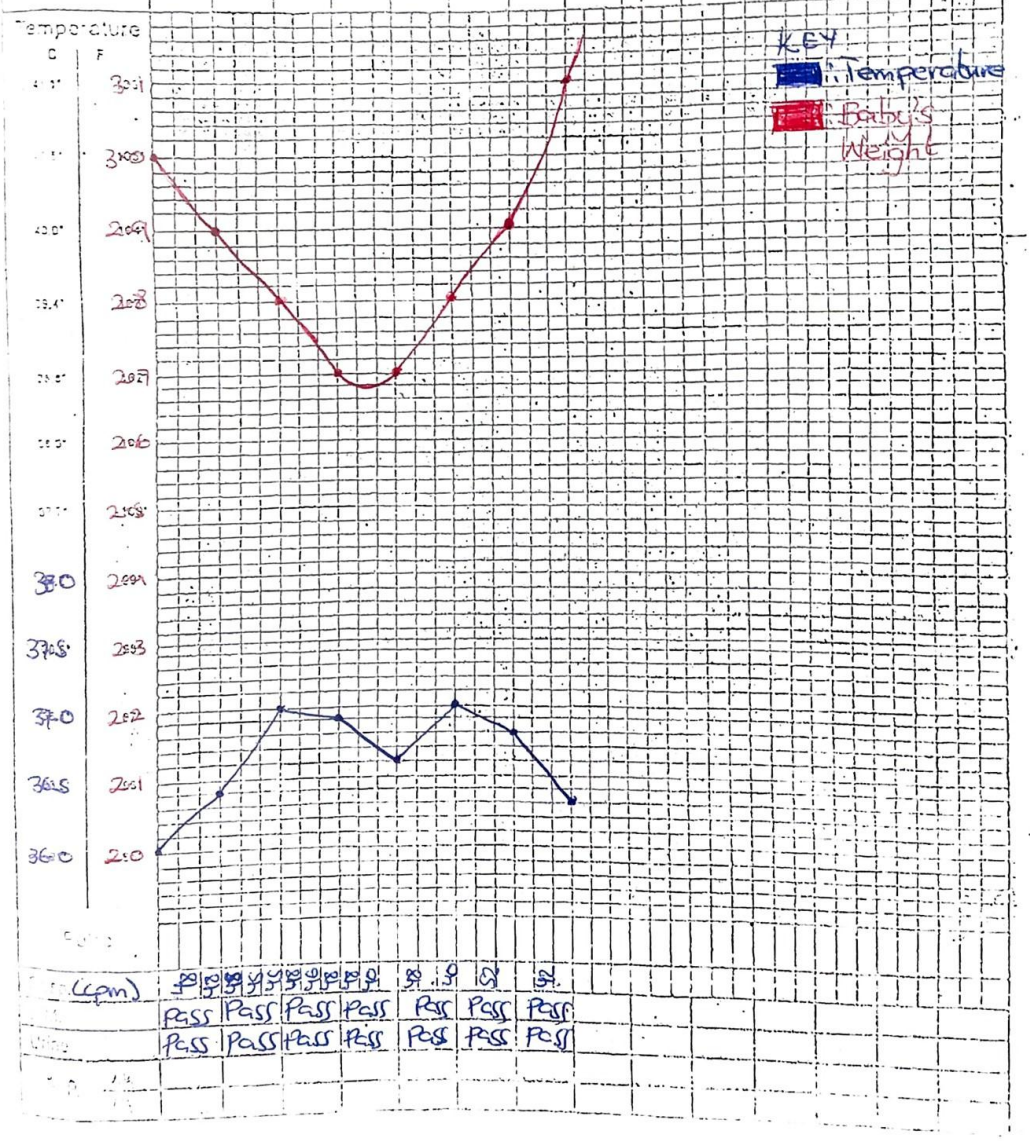
TEMPERATURE CHART

NAME: BABY OF ELLEN ANDREW

AGE: 21 WARD: MATERNITY

H.NO.: S136/22 BED NO.: 1

Date	9/09/23	10/9/23	11/9/23	12/9/23	13/9/23	14/9/23	15/9/23	16/9/23
Day in Hospital	D0	D1	D2	D3	D4	D5	D6	D7
Day of D.								
Hour AM		6:00	7:50	7:30	7:15	7:00	7:30	7:46
Hour PM	6:53	4:50	5:30	5:00				



Pulse (bpm)							
Urine	Pass	Pass	Pass	Pass	Pass	Pass	Pass
Stool	Pass	Pass	Pass	Pass	Pass	Pass	Pass

NEW BORN CHART

Name: Baby of Ellen Andrew No: 5136/22 Birth Weight: 3.0kg

Sex: Female Mother's No: 5136/22 Length: 49

Nature of Delivery: Spontaneous Vaginal Bleeding Diagnosis:

Date of Birth: 9/09/2023 Time: 9:53pm Date of Discharge: 10:00am

Date	9/09/23		10/9/23		11/9/23		12/9/23		13/9/23		14/9/23		15/9/23		16/9/23							
No. of Days	1		2		3		4		5		6		7		8							
Weight	3.0kg		2.9kg		2.8kg		2.7kg		2.7kg		2.8kg		2.9kg		3.1kg							
	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM
Temperature		36.1	36.4	37.2	37.0	37.0	36.9	37.2	36.6	37.0	36.8		36.8		36.3							
Stools		Meconium	Meconium	Meconium	Greenish Brown	Greenish Brown	Greenish Brown	Greenish Brown	Yellowish Brown	Yellowish Brown	Yellowish Brown		Yellowish Brown		Yellowish Brown							
Urine		Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass		Pass		Pass							
Remarks	Head Neck Trunk Genitalia Limbs > No abnormality Detected																					

NEW BORN EXAMINATION FORM

ame: Baby Ellen Andrew Date of Assessment: 9/09/23 Time: 10:00pm

ate of Birth: 9/09/23 Time of Birth: 9:53pm Sex: ☐ M ☑ F Age at time of Assessment (days/hrs) 17hrs

estational Age ☐ ☐ Mode of Delivery: ☑ Vaginal Assisted Vaginal C-Section

PGAR: 1min 8 5min 10 Birth Weight: ☐ 2.6kg ☐ Length 49 cm Head Circumference: 31 cm

mperature at time of Assessment: 36.1 °C Urine passed: Yes No Meconium passed: Yes No

ame of Assessor (Midwife/Doctor): Indira Serwaa Antoi

Respiration

ate

Rate < 30 b/m *
Rate < 60 b/m *
30-60 b/m
Retractions *
Grunting *
Stridor *

Activity/Movemnet

Spontaneous symmetric movements
Reduced/Absent Movement in ≥1 limb *
No Movement

Tone

Normal
Floppy *
Increased *

Colour

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

Cord

Normal
Red. draining pus
Bleeding

Cry

Normal
Shrill *
Absent *

7. Suck
☑ Good
☐ Weak
☐ Absent

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

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

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

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

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

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

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

16. Clavicle
☑ Normal
☐ Swelling/Fracture

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

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

19. Femoral pulse
☑ Present
☐ Not palpable*

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

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

22. Limbs
☑ Normal
☐ Abnormal

23. Genitalia

Male Genitalia
☐ Normal
☐ Undescended testes
☐ Abnormal meatus
☐ Hernia
☐ Other:

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

24. Anus
☑ Patent
☐ Imperforate*

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

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

May indicate severe disease that requires urgent referral

Diagnoses (if known)

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

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

NEW BORN EXAMINATION FORM

Name: Baby Ellen Andrew Date of Assessment: 10/09/23 Time: 8:30

Date of Birth: 9/09/23 Time of Birth: 9:53pm Sex: ☐ M ☑ F Age at time of Assessment (days/hrs) 1day

Astational Age ☐ ☐ Mode of Delivery: ☑ Vaginal Assisted Vaginal C-Section

APGAR: 1min 9 5min 10 Birth Weight: ☐ 3.0kg ☐ Length 49 cm Head Circumference: 31 cm

Temperature at time of Assessment: 36.2 °C Urine passed: Yes No Meconium passed: Yes

Name of Assessor (Midwife/Doctor): Indira Ferwaa Anhwi

1. Respiration

Rate_____

- ☐ Rate < 30 b/m *
- ☐ Rate < 60 b/m *
- ☑ 30-60 b/m
- ☐ Retractions *
- ☐ Grunting *
- ☐ Stridor *

2. Activity/Movemnet

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

3. Tone

- ☑ Normal
- ☐ Floppy *
- ☐ Increased *

4. Colour

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

5. Cord

- ☑ Normal
- ☐ Red. draining pus
- ☐ Bleeding

6. Cry

- ☑ Normal
- ☐ Shrill *
- ☐ Absent *

7. Suck

- ☑ Good
- ☐ Weak
- ☐ Absent

8. Head swelling

- ☐ Caput succedaneum
- ☐ Cephalhaematoma
- ☐ Subgaleal hemorrhage
- ☑ No swelling

9. Sutures

- ☑ Normal
- ☐ Overlapping
- ☐ Fused
- ☐ Widely Separated *

10. Fontanel

- ☑ Normal
- ☐ Sunken *
- ☐ Raised *
- ☐ Wide (>5cm)*

11. Eyes

- ☑ Normal
- ☐ Subconjunctival bleed
- ☐ White pupil or cornea
- ☐ Eye discharge
- ☐ Other

12. Ears

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

13. Mouth

- ☑ Normal
- ☐ Cleft palate
- ☐ Cleft Lip
- ☐ Other:_____

15. Neck

- ☑ Normal
- ☐ Swelling
- ☐ Webbed
- ☐ Other:_____

16. Clavicle

- ☑ Normal
- ☐ Swelling/Fracture

17. Chest

- ☑ Normal (Shape/movement)
- ☐ Abnormal_____

18. Heart rate

Rate: _____

- ☑ Normal (100-160)
- ☐ <100 *
- ☐ >160*

19. Femoral pulse

- ☑ Present
- ☐ Not palpable*

20. Abdomen

- ☑ Normal
- ☐ Distended*
- ☐ Scarphoid*
- ☐ Abdominal defect*
- ☐ Maases:_____
- ☐ Other _____

21. Back (spine)

- ☑ Normal
- ☐ Abnormal Swelling *
- ☐ Hairly patch over spine
- ☐ Abnormal dimple
- ☐ Abnormal curvature

22. Limbs

- ☑ Normal
- ☐ Abnormal_____

23. Genitalia

Male Genitalia

- ☐ Normal
- ☐ Undescended testes
- ☐ Abnormal meatus
- ☐ Hernia
- ☐ Other: _____

Female Genitalia

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

24. Anus

- ☑ Patent
- ☐ Imperforate*

25. Resuscitation provided

- ☐ One
- ☐ Suction/stimulation
- ☐ Bag and mask
- ☐ Endotracheal Tube
- ☐ Ventilator/CPAP

26. Services provided

- ☑ Vitamin K1 given
- ☑ Eye care provided
- ☑ Cord care provided
- ☑ Breastfeeding initiated
- ☑ Breastfeeding established
- ☑ Immunization (BCG/Polio
- ☑ BCG ☑ Polio Immunizati
- ☑ Antibiotics in mother
- ☐ Antenatal corticosteroids

*May indicate severe disease that requires urgent referral

Diagnoses (if known)_____

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

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

SIGNATORIES

THE STUDENT

NAME: MS. ANTWI SERWAA INDIRA

SIGNATURE.....

DATE:.....7/06/2024.....

THE MIDWIFE IN-CHARGE

NAME: MS IVY KYEREWAA

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

DATE:.....7/06/2024.....

THE SUPERVISOR

NAME: MS DIANA OWUSU SERWAA

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

DATE:.....7/06/2024.....

THE PRINCIPAL

NAME: MONICA NKRUMAH

PRINCIPAL
HOLY FAMILY NURSING AND MIDWIFERY TRAINING COLLEGE
BEREKUM

SIGNATURE:.....

DATE:.....10/06/2024.....

95