HOLY FAMILY NURSING AND MIDWIFERY TRAINING COLLEGE, BEREKUM

A CLIENT/FAMILY CENTERED MATERNITY CARE STUDY ON

MADAM OPPONG AMEYAA ELIZABETH

BY

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PREFACE

A family centered maternity care is the care and supervision given to the expectant mother and family throughout pregnancy, labor and puerperium.

It is based on a thoughtful understanding of the woman as a unique individual with peculiar needs which must be met within the context of the client's family. The care is extended to the members of the client's family as well as the community in which she lives.

Family centered maternity care gives each family member the education and support the family needs to welcome the new baby.

It enables the student midwife to utilize all the skills and knowledge acquired from the various subjects taught in school to give care to meet the peculiar needs of the pregnant woman and her family.

The care study also serves as a partial fulfillment of an academic requirement of the Nursing and Midwifery Council of Ghana to license a student midwife to practice upon completion of her course.

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INTRODUCTION

A family centered maternity care study is a tool that enables the student midwife to put into practice the knowledge and skills acquired in the course of her study or training.

The purpose and aim of this study is to help motivate learning positively. The study gives accurate information to the student midwife on professional standard care of client. This care given is based on identification of individual problems, analyzing them and some possible solutions provided.

This family centered maternity care study was carried out on Madam Elizabeth Oppong Ameyaa twenty-four years old woman, gravida 3 Para 2 alive during the period of pregnancy, labor and puerperium.

The interaction with her started on 9th November,2022 during one of scheduled visit at Emi's heath center as she was 37 weeks pregnant at that time. Interaction started when she was seen bearing a worried facial expression and was seen unconcerned. There are four chapters' outline in this script.

Chapter one talks about client's particulars such as social, family, medical, surgical, menstrual lifestyle, past and present obstetrical histories.

Chapter two talks about the antenatal care the client received and home visits made to client

Chapter three talks about labor and its management.

Chapter four is about puerperium which involves an elaborate care given to Madam Elizabeth, the baby and the family after delivery. At the end of each chapter, is a care plan table outlines the problems identified, nursing orders and intervention.

Finally, summary, conclusion and bibliography as well as the various appendix like antenatal records, pharmacology of drugs, complete diagnostic investigations, maternity chart, newborn chart and partograph.

LITERATURE REVIEW

PREGNANCY

Pregnancy: The state of carrying a developing embryo or fetus 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 [CITATION Dav21 \l 1033]. The most important tasks of basic fetal cell differentiation occur during the first trimester, so any harm done to the fetus during this period is most likely to result in miscarriage or serious disability. There is little to no chance that a first-trimester fetus 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[CITATION Dav21 \l 1033].

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 fetus 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 fetus born prematurely has at least some chance of survival, although developmental delays and

other handicaps may emerge later. As the fetus grows in size, the mother's pregnant state will begin to be obvious. In the third trimester, the fetus enters the final stage of preparation for birth. It increases rapidly in weight, as does the mother[CITATION Ame183 \l 1033].

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[CITATION Dav21 \l 1033].

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[CITATION Wor16 \l 1033]. 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

women and girls at increased risk of developing complications during labour and delivery, thus ensuring referral to an appropriate level of care [CITATION Wor16 \l 1033]. 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 [CITATION Wor16 \l 1033]. 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[CITATION Uni22 \l 1033].

LABOR

Labor 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[CITATION Art22 \l 1033]. The World Health Organization (WHO) defined normal birth as "spontaneous in onset, low-risk at the start of labor and remaining so throughout labor 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 labor 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[CITATION Art22 \l 1033]. Normal labor usually begins within 2 weeks (before or after) the estimated delivery date. In a first pregnancy,

labor usually lasts 12 to 18 hours on average; subsequent labors are often shorter, averaging 6 to 8 hours[CITATION Art22 \l 1033].

As discussed by Artal-Mittelmark (2022) rupture of the chorioamniotic membranes or bloody show is diagnostic for onset of labor. Labor begins with irregular uterine contractions of varying intensity; they apparently soften (ripen) the cervix, which begins to efface and dilate. As labor progresses, contractions increase in duration, intensity, and frequency. As sepcified 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 prelabour 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[CITATION Coo09 \l 1033].

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[CITATION Art22 \l 1033].
    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 laboring, 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 partogram until active labour has commenced. Assessing the active phase of labour has been highlighted as essential in reducing interventions in normal labour[CITATION Coo09 \l 1033].

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 bloodstained 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[CITATION Coo09 \l 1033].

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[CITATION Coo09 \l 1033].

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[CITATION Coo09 \l 1033]. On average, it lasts 2 hours in nulliparous (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[CITATION Art22 \l 1033]. 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 hemorrhage 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[CITATION Coo09 \l 1033].

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[CITATION Ame183 \l 1033].

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[CITATION Coo09 \l 1033].

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[CITATION Coo09 \l 1033].

WHY CLIENT WAS CHOSEN

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

Madam Elizabeth G3P2 reported to the facility on 9th November 2022 during one of her scheduled antenatal visits at the Emi's Heath Center. Client was 37 weeks pregnant at the time of the visit. Client was bearing a worried face and she was complaining of waist pains. She explained that her previous pregnancy was not like that. Client was educated that it is due to pregnancy to the descent of fetal head into the pelvis that is causing the waist pains.

Enquires were made from her after glancing through her antenatal book, and it was recorded that she had two previous deliveries at the Emi's Health Center. Client was a regular attendant to the antenatal clinic and was therefore chosen to encourage, motivate and ensure that she prepared well for the delivery and delivers at a health center when her time is due.

Client had a good obstetric history and immediate introduction of self was made as a student midwife from Holy Family Nursing and Midwifery Training College, Berekum on an eight weeks' clinical practice. She was informed that she would be taken as a client for care study and nursed during her pregnancy, labor and puerperium. Client was pleased to be used for the care study and readily agreed to it. All questions asked by client regarding the process was answered and all doubts cleared. She was thanked for her cooperation. The midwife in charge was informed about the selected client and she gave her permission.

Phone numbers were exchanged and direction to her house was given for home visits. Appointment was booked for home visits.

CHAPTER ONE

CLIENT'S PARTICULARS

1.0 INTRODUCTION

This chapter comprises of assessment of the client and her family, and also contains data from the client and her family. The information was obtained through observation and review of medical and maternal health records. Based on this information, the student midwife was able to give appropriate care to the client and her family taking into consideration physical, social, emotional, psychological and spiritual needs of the client.

1.1 SOCIAL HISTORY

Madam Oppong Ameyaa Elizabeth is a twenty-four-years-old gravida 3 Para 2 alive. She hails from Kato and stays at Kato and her house number is Kw-73/4near the Presbyterian park in the Bono Region of Ghana. She speaks Twi and English. She is dark in complexion, her height is 155cm and weighs 59kg at booking. She completed Junior High School (J.H.S) at Kato D/c Berekum. She is currently a trader. She is a Christian and fellowships with the Bethel Methodist Church Ghana, Berekum. Elizabeth next of kin is her husband, Mr. Gyabaa Solomon. She does not engage in smoking and drinking of alcohol.

She is married to Mr. Solomon Gyabaa a 29 years old man, who is a tiles setter. He lives at Kato and speaks Twi. He is a Christian and attends Lighthouse Chapel International, Berekum branch. He does not smoke or drink. Madam Elizabeth lives in a three-bedroom house owned by her parents. The house is built with concrete blocks and roofed with aluminum sheet.

1.2 FAMILY HISTORY

There is no history of any hereditary disease such as hypertension, diabetes, asthma, sickle cell, epilepsy or mental illness in her and her husband's family and she further narrated that there is no history of multiple pregnancy in her family and husband's family. Madam Elizabeth Ameyaa is the first born of two children. Madam Tima Janet and Mr. Moses Obeng are her parents. Mr. Solomon Gyabaa her husband is the third born of six children, all alive. Mr. Asante Emmanuel and Madam Serwaa Nancy are the parents of her husband. Death in both families occur naturally.

1.3 SURGICAL HISTORY

Madam Elizabeth Ameyaa has never undergone any surgical procedure, neither has she been involved in any accident or injury which might have affected her spine or pelvis. She has never been transfused with blood or it's components. On observation, no scar was seen which will indicate previous laparotomy such as caesarean section or appendectomy.

1.4 MEDICAL HISTORY

Client has never been admitted to the hospital. She receives medical treatment as an outpatient when she suffers minor illness at Emi health center Berekum, or she buys drugs from a licensed chemical seller when she falls sick. Client has never donated blood neither has she been transfused. She has no medical condition such as hypertension, sickle cell, diabetes, asthma, glucose-6 phosphate dehydrogenase (G6PD) defect, mental and heart diseases. She has never had any allergic reaction to any food or drug.

1.5 MENSTRUAL HISTORY

Madam Elizabeth Ameyaa Oppong had her menarche at age 12. She has a normal menstrual cycle of twenty-eight days with moderate blood flow of normal dark red colour and lasts for five days with no dysmenorrhea. Madam Elizabeth Ameyaa mentioned, she still had a menstrual flow of five days with no dysmenorrhea even after her first delivery. She also said she changes her pad twice daily during her menses. Madam Elizabeth last menstrual period was 17th February, 2022 and her expected date of delivery was calculated as 24th November, 2022.And ultrasound scan was done and her expected date of delivery was 24th November,2022.

1.6 PAST OBSTETRIC HISTORY

Pregnancy

Madam Elizabeth is gravida 3 para 2(G3P2AA). She said her pregnancies go to term before labor started. She said she has never had abortion whether spontaneous or induced. She did not experience any danger signs of pregnancy like pregnancy induced hypertension, antepartum hemorrhage, gestational diabetes and anemia among others but had occasional episodes of early morning sickness, fatigue and headache. She attended antenatal clinic for at least seven times and received all doses of Sulfadoxine Pyrimethamine and had 2nd dose of tetanus injection. The interval between her pregnancies is 2 to 3 years.

Labour

Madam Elizabeth said the mode of delivery of her children is spontaneous vaginal delivery for her two children, she delivered both of them at Emi health center kyiribaa, Berekum. She said her children weighed 2.5kg and 2.7kg respectively. Her first child was delivered on 6th January, 2014 and is a female and the second child was delivered on 20th November, 2017. She delivered

spontaneously per vagina without any episiotomy given or sustaining perineal tears. Babies cried at birth immediately they were delivered. She said during the third stage, there was no retained product of conception. She said blood loss after delivery was not much although she could not give accurate amount of blood loss. And there was no post-partum hemorrhage, post-partum psychosis, and fever after her deliveries.

Puerperium

Madam Elizabeth said her children never had any severe illness. She said she experienced after pain after delivery. She practiced exclusive breastfeeding for six months and added porridge to the breast milk during weaning of her children. She breastfed them for two years. According to her, she did not fall sick during puerperium and was always in good condition. Her mother helped her in taking care of the children and sometimes she got help from her grandmother. Her children received appropriate immunizations, hence, neither of them suffered from any of the childhood illness. She said, she has not practiced family planning in her life.

1.7 PRESENT OBSTETRIC HISTORY

Client's first visit to the Health Centre was on 11th April,2022 with twelve (12) weeks gestation. She said, her last menstrual period was 17th February and her expected date of delivery was 24th November, 2022 according to second scan and upon calculation. A comprehensive data was gathered by the staff midwife at booking about the personal, menstrual, obstetric, family, medical and surgical history and any history of the use of contraceptives or family planning. Vital signs were checked and recorded with the following parameters:

Temperature - 36.4 degree Celsius

Blood pressure - 110/60 millimeters of mercury

Pulse - 78 beats per minute

Respiration - 18 cycles per minute

Her weight and height was checked and recorded as 58.4 kilograms and 155 centimeters respectively. The following laboratory investigations were conducted as well and recorded with the following values:

Hemoglobin - 10.6 g/dl

Sickling - negative

Blood group - O

Rhesus factor - positive

Stool - no abnormality detected

Urine (Protein and Glucose) - negative

Syphilis - negative

HIV - negative

Hepatitis B (HBsAg) - negative

G6PD - no defects

Physical examination from head to toe revealed no abnormalities like varicosity, oedema and vaginal discharge. Madam Elizabeth had no complaints and was healthy.

The client was educated on nutrition, rest and sleep, and danger signs in pregnancy. Her symphysio-fundal height measured 10 centimeters and was given a dose of tetanus toxoid.

She was put on the following routine drugs:

Tablet folic acid – 5mg daily for 30 days

Tablet multivitamin dosage – 1 daily for 30 days

She was administered her first dose of Sulfadoxine Pyrimethamine at 27 weeks on 8th June, 2022. Client attended antenatal clinic five (5) times before meeting her for this study.

1.8 CLIENT'S LIFESTYLE AND HOBBIES

Madam Elizabeth said she often goes to bed around 9:00pm and usually wakes up around 5:30am in the morning. The first thing she usually does right from bed is to brush her teeth and clean her face. She also does same for her children. She said she brushes her teeth once daily with toothbrush and toothpaste and bath twice daily. She was encouraged to brush her teeth twice in a day thus, morning and evening. She sweeps her compound and tidy up her room and corridor. She prepares her children for school. She added that, she usually takes porridge and any other food she prefers as her breakfast, lunch, or supper. She prefers washing on weekends.

She said, she often visits the toilet in the morning and whenever she has the urge to empty her bowel. She voids when necessary. She prefers sleeping during her leisure time. She was encouraged to rest when she is tired from working. She watches television before she goes to bed.

CHAPTER TWO

ANTENATAL CARE

2.0 INTRODUCTION

This chapter highlights information about first contact with client, first and second antenatal home visit and clients' subsequent visit to the health centre. It also entails a care plan drawn to solve the client's problems identified during the period of antenatal care.

2.1 FIRST CONTACT WITH CLIENT

First contact with client was on the 9th November,2022 at 9:15am during one of her scheduled antenatal visits at the Emi heath center. Client was 37 weeks pregnant at the time of the visit and was attending her eighth antenatal visit. During the health education session at Emi health center at Berekum kyiribaa, Madam Elizabeth was seen bearing a worried facial expression and seems unconcerned. When approached, she revealed she was feeling very exhausted and fatigued since the previous day. Client card was taken and few questions were asked to rule out if there is any problem. It was realized client just had the normal physiological fatigue from the stress of pregnancy at the last trimester which is usually caused by pregnancy hormones. Client was taken through education on coping and relaxation techniques. She was a bit quite relieved after the education. During the interaction, it was observed that she fell within the criteria for selection of client for the client and family cantered care study. Client had a good obstetric history and immediate introduction of self was made as a student midwife from Holy Family Nursing and

Midwifery Training College, Berekum on an eight weeks' clinical practice. She was informed that she would be taken as a client for care study and nursed during her pregnancy, labor and puerperium. Client was pleased to be used for the care study and readily agreed to it. All activities to be performed on her were duly explained and her consent sought. She was thanked for her cooperation. The midwife in charge was informed about the selected client and she gave her permission.

Client's vital signs was checked and recorded as;

Temperature	36.6 degree Celsius
Blood pressure	80/60 millimeters of mercury
Pulse	67 beats per minute
Respiration	19 cycles per minute
Weight	69 kilogram

Laboratory investigation was also done and the following results were found

Hemoglobin level	12.4 grams per decilitre
Urine (protein and glucose	negative
HIV	negative

Urine testing

Client was given a specimen bottle and asked to provide midstream urine for protein and sugar. The urine collected was checked for colour, sediments and blood products but none were present. A chemically prepared strip was picked and dipped into the urine sample. The strip was immediately removed and the edge of the test strip tap against side of reagent container. There

was no change in colour of the strip indicating a negative result when compared closely with the corresponding colour chart on the container.

After vital signs and laboratory investigations were carried out client was examined from head to toe through the following procedure;

General Head to Toe Examination

She was first sent to the examination room and the procedure explained to her and consent sought. Privacy was provided and client was assisted onto the examination bed and taught to lie on her left side before lying on the back and encouraged to do that during subsequent visit. Her permission was sought to perform head to toe examination. Hands were properly washed with soap under running water and dried with clean dry towel.

Physical examination

Head and Face

The head was examined first during the physical examination. Client's hair was examined for cleanliness, lice, dandruff, ringworm, alopecia, skin infection and any other abnormalities and no abnormality was detected. Madam Elizabeth was congratulated and praised for keeping the hair clean and tidy and advised to keep it up.

Client's face was then inspected for oedema, rashes and chloasma and nothing abnormal was detected. Her eyes were also inspected for pallor of the conjunctiva, yellowish or jaundice of the sclera but no abnormality was detected.

The ears were also inspected for discharges and alignment with the eyes and nothing abnormal was detected.

The mouth was inspected for dryness, cracks and infection of the lips. The gums and tongue for pallor, sores or lesions and the teeth for decay but no abnormalities were detected. She was encouraged to brush her teeth two times daily and rinse her mouth after each meal.

The neck was palpated for enlarged thyroid gland, distended neck veins and enlarged lymph nodes and no abnormality was noted.

Breast examination

The procedure was explained to client and consent sought before breast was exposed. The breast was exposed to check for size, shape, dimpling and nipple retraction, and condition of the skin. Findings were normal. One breast was covered and she was asked to put the hand of the part to be examined under her head. The breast was palpated systematically in a circular manner using the inner aspect of the fingers and client was taught self-examination. Nipples were squeezed gently for fluid (colostrum) to be examined for odour, blood and cleaned with cotton wool swab and there was no fluid. The same was done for the other breast and no abnormality was noted. Client's breastfeeding history was inquired and client verified desire to breastfeed exclusively for 6 months as it was done for previous babies.

Client was reminded to examine breast at home after delivery as it was done at the facility frequently and any abnormal findings reported to the health center.

Upper Extremities

Madam Elizabeth was asked for tingling and tightness of the finger on making a fist, the palms and fingers were inspected for oedema, pallor of palms and nail bed and no abnormality was noted. The finger nails were well trimmed.

The back was examined for deformity of the spine (scoliosis), oedema of the sacral region and no abnormality was detected.

Abdominal examination

This procedure and reason for this was explained to the client's understanding. The purpose for this examination was to observe the signs of pregnancy, assess fetal size and growth, auscultate the fetal heart, locate fetal parts, and detect any deviation from normal. She was assisted to lie in dorsal position with arms by her side to relax the abdominal muscles. Hands was washed with soap and water and dried with clean dry towel. Standing on her right side the abdomen was exposed.

Inspection: During inspection of the abdomen it was observed to be ovoid in shape and medium in size. There was the presence of linea nigra and striae gravidarum. No scars were found on the abdomen which would indicate signs of pervious surgical procedure performed on the abdomen. Madam Elizabeth said she felt fetal movement.

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

Fundal palpation: The palms were warmed having explained the procedure to client. The woman was faced and the palms were placed on either side of the fundus after warming them. The fingers were curved around top of the fundus to determine what lies in the fundus or upper pole of the uterus. A soft part was felt in the fundus which indicated the buttocks. The fundus was at the xiphisternum.

Lateral palpation: This is done to determine the fetal back in order to locate the position. The hands are placed on either sides of the uterus at the level of the umbilicus. One hand was used to stabilize the uterus and the other hand was moved gently in a circular manner at the right side of the abdomen and the fetal limbs were palpated which were rough. This was repeated at the left side the abdomen and the fetal back was felt.

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

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

Auscultation: On auscultation, fetal stethoscope was warmed by rubbing it in the palms. It was placed on the area where the fetal back was located. The ear was placed against the fetoscope and the heart beat was listened to while comparing it with the maternal pulse. The heart beat was faster than the maternal pulse when counted for a minute as 135beats per minute and it was regular. As soon as the fetoscope was removed, fetal movement was observed. The lie was longitudinal, presentation was cephalic. Findings were communicated to the client.

Vulva and perineum

Client's permission was sought for vulva inspection and she agreed. A pillow was placed under her head and covered by blanket to provide warmth and modesty. The vulva was well shaved and clean. Hands were washed with soap and water and dried with clean towel, clean gloves worn on both hands and the vulva and the perineum was examined for abnormal discharges, rashes, warty growth and ulcers, episiotomy scars and varicose veins. The labia majora was examined for same size and shape, redness, swelling, and tenderness. Findings were normal. Madam Elizabeth was thanked for her cooperation and findings were communicated to her.

Lower extremities

The legs were inspected for size and equality and palpated for oedema, tenderness in the calf muscles, size and equality and no abnormality was detected. She was encouraged to rest in between sitting and standing, avoid prolonged standing and to perform regular exercise like walking to enhance proper circulation to prevent varicosity

All equipment used were decontaminated appropriately. The gloves were removed and also discarded. Hands were washed thoroughly with soap under running water and dried with clean dried towel.

Client was encouraged to have enough rest and sleep and also taught how to perform exercises in pregnancy such as pelvic rock which helps to relieve backache, head and shoulder lift which strengthens abdominal muscles, Kegel exercise strengthens pelvic floor muscles that makes delivery easier and rib cage lift which strengthens leg muscles and improves breathing. Client was also encouraged to take her drugs as prescribed. Health education was given on birth preparedness and complication readiness plan, and eating of nutritious diet (that is food that contains the three main groups of nutrients; body building food, energy given food and protective foods) to prevent anemia. The following drugs were given to Madam Elizabeth :

Tablet multivitamin 200mg once daily for 7 days

Tablets folic acid 5mg daily for 7 days

Tablets ferrous sulphate200mg once daily for 7 days

Client was informed of her next antenatal visit which was 16th November, 2022, since she was 37 weeks. An appointment for home visit was booked and phone numbers were exchanged. Clients was reminded to report any problem and was briefly taught the danger signs of pregnancy like severe headache, vaginal bleeding, swellings of the lower limbs, severe abdominal pains, excessive vomiting so as to help her identify any danger signs and report immediately. All activities carried out on the client and findings were recorded.

2.2 FIRST ANTENATAL HOME VISIT

The first visit to Madam Elizabeth house was on the 11th November, 2022 at 4:00 pm as it was booked. The purpose of the visit was to observe client's environment, establish rapport with client's family and neighbors, assess client health status and offer a comprehensive focus antenatal care to client.

Upon arrival, a warm reception was given and introduction to other members of the family was made. A quick assessment of the environment was done while being offered a seat. Client lives in their own house with her family thus, her mother, grandmother, sisters and their children. The house is built with concrete blocks, not painted, roofed with aluminum sheet and contains three bedrooms, a kitchen (made of wood), bathroom and a toilet facility. The floors of the rooms are cemented and covered with carpet and the windows made with louvre blades. Madam Elizabeth and her children occupy one room and sleep under insecticide treated mosquito net, while the other rooms are occupied by the rest of the family. The whole family shares the bathroom and

toilet facility. The room was well kept and furniture neatly arranged, it had adequate lightening, the windows were well arranged for proper ventilation and she was congratulated to keep it up. The family had a medium size plastic container covered with a sheet of aluminum into which they temporarily put their waste, and later empty at a nearby refuse dump for incineration. They use tap water from a nearby house about a minute walk from their house. They store the water in two plastic containers covered with lids.

Health education was given to client and her family on birth preparedness and complication readiness plan, infection prevention and good nutrition. Client's layette was inspected and all items such as baby's cloths, cot sheets, baby napkins or diapers, old clothes, among others, were available. Client had the telephone number of a taxi driver who will bring her to the facility in case her husband was not around when she was due. A support person was also identified as her mother who lived in the same house. There was good interpersonal relationship between client and her family. Client complaint of backache and leg cramps. The physiology was explained to her as a result of the increasing weight of the gravid uterus and the effect of hormone relaxation joint. Client was thanked for her time and hospitality and permission was then sought to leave.

2.3 SECOND ANTENATAL HOME VISIT

The second antenatal home visit to Madam Elizabeth's house was on the 14th November,2022 at 10:00 am as scheduled. The purpose of the visit was to inquire about their health. Madam Elizabeth and her family welcomed me warmly. An enquiry was made about the client and her family's health status and a positive response was given. However, client complained of leg cramps and constipation. She was reassured of a relief from pain and the physiology explained to her. Client was encouraged to apply gentle massage to the affected area and to put a pillow under

her foot to prevent plantar flexion of the ankle joints. On complain of constipation, Madam Elizabeth was educated that it was as a result of low intake of fiber foods and low intake of fluids. Client was encouraged to take adequate fiber foods and take in adequate fluids to prevent constipation.

Client was again educated on the true signs of labor such as appearance of ‘show’, and regular rhythmic painful uterine contractions. Client was asked to report to the clinic any time she sees any of the signs mentioned to her or any of the danger signs taught previously. Client’s environment was clean and tidy and the refuse had been emptied. Inspection of the client’s rooms was done and it was observed that the mosquito nets were well hanged. Madam Elizabeth was reminded of the next visit to the clinic on the 16th November,2022. She was thanked and bid farewell.

2.4 SUBSEQUENT VISIT TO THE CLINIC

On 16th November, 2022, 10:30am, Madam Elizabeth came to the clinic, which was the second (2nd) contact with her at the clinic but her ninth (9th) visit to the clinic. Client was warmly welcomed and offered a seat. Madam Elizabeth was asked about her general condition especially about the leg cramps and backache she complained of during the home visit. She confirmed she was well and pain from backache and leg cramps had reduced. Every procedure that was going to be carried on her was explained to her. Client’s vital signs and weight was checked and recorded as follows;

Temperature 36.5 degree Celsius

Pulse 68 beat per minute

Respiration 18 cycles per minute

Blood Pressure 90/40 millimeters of mercury

Weight 67 kilograms

Client's hemoglobin level was checked and recorded as 12.6 grams per decilitre. Client was asked to empty her bladder to promote comfort during physical examination and sample of the urine was tested for protein and glucose which tested negative. Hand washing was done with soap and water and dried with a clean dry towel before head to toe examination was done. Privacy was provided and she was helped unto the examination bed in a supine position. On physical examination, everything from head to toe was normal. On fundal palpation, the buttocks occupied the upper pole of the uterus. The lie was longitudinal. The position was right occipito-anterior. The head occupies the lower pole with descent of 5/5th; symphysio fundal height was 37 centimeters and gestational age was 38 weeks. On auscultation, fetal heart was 136 beats per minute with good volume and rhythm. All findings were communicated to her. Client complained of heartburns. Client was reassured and educated on the causes and prevention of heart burns. Client was encouraged to avoid going to bed immediately after meals and elevate the top part of the bed when lying down. Client was again encouraged to reduce the intake of fatty and spicy food. She was also educated to have adequate rest and to do minimal work.

Client was encouraged to come back in a week time for review. Madam Elizabeth was thanked for her cooperation, helped into a comfortable position. Hand washing was done and findings communicated to her.

Routine drugs were given to her which included:

Tablet multivitamin 200mg daily for 7 days

Tablet folic acid 5mg daily for 7 days

Tablet ferrous sulphate 200mg daily for 7 days

The next antenatal visit schedule was 23rd November,2022.

Madam Elizabeth was thanked for cooperating, reminded of next home visit, and escorted to the road side.

2.8 NURSING CARE PLAN

Problems Identified during Antenatal

- On 9/11/22 client complained of fatigue.
- On 11/11/22 client complained of backache.
- On 11/11/22 client complained of leg cramps.
- On 16/11/22 client complained of heart burns.
- On 18/11/22 Client complained of constipation

Short Term Objectives

• Client will cope with fatigue within 24 hours.

• Client will be relieved of leg cramps within 48 hours.

• Client's backache will reduce within 48 hours

• Madam Elizabeth will be relieved of heartburns within 24 hours.

• Client will regain her normal bowel habit (once daily) within 48 hours.

Long Term Objectives

Madam Elizabeth will carry the pregnancy to term with all support needed without any complication to her and the fetus.

TABLE 1: NURSING CARE PLAN DURING ANTENATAL CARE

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES/OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
9/11/22 9:15am	Readiness for enhanced knowledge as evidenced by client expressing desire to know more about her feeling exhausted and fatigue.	Madam Elizabeth will be able to cope with fatigue within 24 hours as evidence by: 1.Client verbalizing ability to cope with weight of product conception. 2.Mifwife observing client looking relaxed.	**1.**Reassure and educate client on fatigue. **2.**Encourage family members to assist in house chores. **3.**Encourage client to have adequate rest. **4.**Encourage client to do minimal work. **5.**Teach client energy conservation technique such as sitting whilst working.	1.Client was reassured and educated on fatigue. 2.Family members were encouraged to assist in house chores. 3.Client was encouraged to have adequate rest. 4.Client was encouraged to do minimal work. 5.Client was taught energy conservation techniques such as sitting while working.	10/11/22 4:00pm	Goal fully met as: 1.Client verbalized ability to cope with weight of product of conception. 2.Midwife observed client's relaxed facial expression.	K.P

TABLE 1: NURSING CARE PLAN DURING ANTENATAL CARE

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES/OUTCOME	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN

		CRITERIA					
16/11/22 10:00am	Leg cramps related to insufficient blood supply to the lower limbs as evidenced by pain in the calf muscles.	Client will be relieved of leg cramps within 48 hours as evidenced by; 1.Client verbalizing that she is relieved of leg cramps. 2.Midwife observing that client Is relieved of the leg cramps.	**1.**Reassure client that pain will be relieved. **2.**Educate client on the physiology of leg cramps. **3.**Encourage client to apply a gentle massage over the painful area. **4.**Advise client to apply warm compresses. **5.**Educate client to put a pillow at the foot of her bed to prevent plantar-flexion of the ankle joint.	1.Client was educated on relief measures. 2.Client was educated that her condition was due to limited blood supply to the limbs. 3.Client applied a gentle massage over painful area. 4Client applied warm compresses to the calf muscle. 5.Client used pillow at the foot of her bed to prevent plantar flexion of the ankle joints.	18/11/22 10:30am	Goal fully met as client verbalised that she was relieved of the leg cramps.	K.P

TABLE 1: NURSING CARE PLAN DURING ANTENATAL CARE

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
16/11/22	Impaired comfort related to backache as evidenced by pain at the back when stretching.	Client will cope with backache within 48hours as evidenced by; 1.Client verbalizing that the pain has reduced. 2.Client looking more cheerful on assessment.	1.Reassure client that the pain will reduce. 2.Educate client on the causes of low back pain. 3.Encourage client to support her back with pillows while lying down. 4.Encourage client to lie in the left lateral position. 5.Encourage client to apply warm compress to the lower back. 6.Advise client on rest and sleep.	1.Client was reassured that pain will reduce. 2.Client understood backache was as a result of pregnancy hormones. 3.Client supported her back with pillows while lying down. 4.Client lied in left lateral position. 5.Client applied warm compress to the lower back. 6.Client took a break to rest in between activities.	18/11/22 10:30 am	Goal fully met as client appeared relaxed.	K.P

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
16/11/22 10:30am	Heart burns related to reflux of gastric content into the oesophagus due to relaxed cardiac sphincters by progesterone as evidence by hotness in the throat.	Client will be relieved of heart burns within 24 hours as evidenced by; 1.Client verbalizing that she is relieved of heart burns. 2.Midwife observing that client expressed no sign of burning sensation.	1. Reassure and educate client on the cause of heartburns. 2.Encourage client to sit during activities rather than bending after eating. 3.Encourage client to sit for a while after meals before going to bed. 4.Encourage client to reduce spicy and oily foods. 5.Encourage client to elevate the head side of the bed by 6 inches. 6.Encourage client to take a lot of water.	1.Client was reassured and educated that heartburn was due to effect of pregnancy hormone. 2.Client stayed in an upright position after eating. 3.Client spent some time after eating before to bed. 4.Client reduced intake of spicy and oily foods. 5.Client elevated the head of the bed by 6 inches. 6.Client was able to take a lot of water.	17/11/22 3:35pm	Goal fully met as evidenced by 1.Client verbalized that she was relieved of heart burns. 2.Midwife observed that client was relieved of heart burns.	K.P

TABLE 1: NURSING CARE PLAN DURING ANTENATAL CARE

TABLE 1: NURSING CARE PLAN DURING ANTENATAL CARE

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
24/11/22 8:30am	Constipation related to relaxation of smooth muscle of the bowel as evidenced by difficulty in passing stool.	Madam Elizabeth will move her bowel once daily within 48 hours as evidenced by the client verbalizing that she has a normal bowel movement of at least once a day.	1.Reassure client that she will be relieved of constipation. 2.Encourage client to increase intake of fruit and vegetable. 3.Encourage client to increase fluid intake. 4.Encourage intake of fiber and roughages like orange and pineapple. 5.Encourage client to exercise.	1.Client was reassured of free bowel movement. 2.Client increased intake of fruits and vegetables. 3.Client increased fluid intake to at least 8 glasses of water in a day. 4.Client increased intake of fiber and roughages like orange and pineapple. 5.Client performed brisk walking.	26/11/22 5:20pm	Goal achieved as client said she had normal bowel movement of at least once a day.	

CHAPTER THREE

LABOUR

3.0 INTRODUCTION

This chapter describes the management of labour and immediate care of the new born, examination of the new born and the care plan drawn for the management of the problems encountered during this period.

3.1 ADMISSION AND MANAGEMENT OF LABOUR

On 23rd November 2022, client reported to the health centre at 1:00am with complains of lower abdominal pains and painful uterine contraction. Further enquiries made, indicated that client had seen blood stained mucus (show) at 11:00pm. She was accompanied by her sister to the facility. They were welcomed and were offered seat and further assured that she is in safe hands. She was reassured to allay anxiety as client was anxious. Her maternal health record book was taken and glanced through to confirm her information. Her last menstral period was on 17th February ,2022, and her calculated date of delivery was 24th November,2022. Her first expected date of delivery as shown by scan was 21st November,2022, and her second expected date of delivery was 24th November 2022. She was made comfortable in bed and all procedures to be carried out were explained to her and her consent was sought. Client's labour history was taken and recorded. Her vital signs were checked and recorded as follows:

Temperature 36.0 degree Celsius

Pulse 70 beats per minute

Respiration 20 cycles per minute

Blood Pressure 120/80 millimeters of mercury

A specimen bottle was given to client for the midstream urine collection for urine examination and a bed pan was also served. The amount of urine produced was 200mls. A urine reagent strip was used to test for glucose, acetone and protein and the result was negative and the colour of urine was amber, clear and not offensive. Hands were washed with soap under clean running water and dried with clean dry towel. Client drank 500mls of water. Having explained the procedure and her consent sought, head to toe general examination was conducted but no abnormality was detected. The abdomen was inspected.

Inspection: On inspection, client's abdomen was ovoid in shape and medium in size. Striae gravidarum, linear nigra and foetal movement were present but no scar was found. Client's abdomen was palpated, symphysio fundal height was 37cm, and gestational age was 39weeks the lie was longitudinal, presentation was cephalic, and descent was 3/5 palpable abdominally. Contractions was 3 in 10minutes lasting for 30seconds.On auscultation, the heart rate was 142 beats per minute with good volume and had a regular rhythm.

VAGINAL EXAMINATION

Madam Elizabeth was helped onto the lithotomy position. Hands were washed with soap and water and dried with a clean towel, sterile gloves were worn for vaginal examination. The vulva was then inspected for scars, sores, warts, oedema and clitoridectomy, abnormal discharge but none was present. The vulva was then swabbed with sterile cotton wool swabs soaked in savlon solution. After swabbing the vulva, the vagina was entered with the middle finger and then followed by the index finger at 2:00am.

On vaginal examination, the vagina was warm and moist, the cervix was soft, thin and the presenting part well applied to it. The membranes were intact; cervical dilatation was four (4) centimetres. Presentation was cephalic promontory of sacrum was not reached at 10centimeters. The sacrum was well curved, ischial spines were blunt and pubic arch was wide. Hands were removed and a fist was made and it fitted into the inter- tuberous diameter. Madam Elizabeth ’s perineum was cleaned and a perineal pad applied to the vulva.

Client was covered with a cloth and made comfortable in bed. She was also encouraged to ambulate and to lie on her left when she felt tired. Client was then informed that she was in true labour and would be managed. She was informed that vaginal examination will be done 4 hourly.

PREPARATION FOR BIRTH

Skilled and unskilled helpers were identified. The midwife in-charge who was supervising labour was the skilled helper. The sister of the client who was the unskilled helper was informed to be available in order to run errands when needed. The taxi driver was also informed that his service may be needed when there is emergency.

The area for delivery was prepared by drawing curtains down, making provision for lighting and switching on fans but she was told the fans will be switched of during delivery to provide warmth atmosphere for the baby. Madam Elizabeth had taken her bath before coming so her abdomen was cleaned with savlon and gauze and was assisted to wash and dry her hands.

It was ensured that resuscitation equipment were clean and prepared for resuscitation when necessary. The equipment needed for resuscitation were assembled and tested for functioning and they were in good condition. The equipment included head cover, scissors, Ambu bag and mask of different sizes, timer, suction device, stethoscope, source of light among others. Delivery trolley was set up.

The top shelf:

• Cord scissors

• Cord clamp

• 2 artery forceps

• 2 cot sheet

• Vitamin k injection

• Pair of sterile gloves

• Drapes

• 10 unit of oxytocin

• Episiotomy set

• 2 gallipots (one containing cotton swabs soaked in savlon solution and the other containing gauze)

Bottom shelf

• Measuring jug

• Placenta bowl

• Sucker in a bowl of water

• Cord clamp

• Disposable gloves

• Perinea pad

• Receiver for used swabs

• Bed pan

• Fetoscope

• Rubber mackintosh

• Syringe with needle

• Rubber apron

• Catheter and drainage bag

• Antiseptic lotion

3.2 MANAGEMENT OF FIRST STAGE OF LABOUR

Client was put on partograph on admission when active labor was confirmed. Foetal heart rate, contractions and pulse were checked every 30 minutes and vaginal examination, descent, blood pressure and temperature were done four hourly. Madam Elizabeth was encouraged to empty her bladder when she felt the urge as that will aid in the descent of the foetal head and effective contractions. She was also asked to change her perineal pad when it got soiled and proper way of handling to prevent contaminating herself with the soiled pad.

Her sacral region was massaged during contractions to reduce pain. She was cautioned not to push when she felt the pains because that would make the cervix oedematous and thereby prolonging labour. She was educated on the importance of deep breathing exercise and how to do it. She was asked if she felt hungry and she replied in the negative. Client's sister was offered a seat outside and she was reassured

She complained of severe lower abdominal pains, fatigue, nausea and she was later seen vomiting at 2:35am. All objects that promoted nausea were removed from the ward. Sacral massage was done. She was reassured and the physiology behind the pains was explained to her and educated on deep breathing exercise during contractions. She was encouraged to take light nutritious diet and normal fluids in bits to prevent dehydration and to help her during the second

stage of labour. She took a cup of mashed kenkey. Madam Elizabeth was also encouraged to adopt left lateral position to prevent supine hypotension syndrome.

At 6:00am the foetal heart rate was 142 bpm, uterine contraction was 4 in 10 minutes lasting 44 seconds temperature 36 degree, blood pressure 110/70, decent 1/5th cervical dilatation was 8cm. The amount of urine passed was 200mls which was tested for protein and acetone and the results were negative and she was encourage to urinate whenever she has the edge to. All findings were recorded on the partograph and client was informed of progress of labour using the dilatation board, she was informed delivery was imminent and during that period she will have the edge to defecate and therefore asked to call the midwife. At 6:30am membranes ruptured, liquor was clear and client complained that she wants to defecate. Vagina examination was done to exclude cord prolapse and to confirm full dilatation of the cervix.

Client was helped to wash her hands and abdomen cleaned with savlon solution and dried to prepare for skin to skin care.

At 8:00am Madam Elizabeth called, she had the urge to pass stools, vaginal examination was done and the cervix was 10cm dilated, descent was 0/5th, contractions was 5 in 10 minutes lasting 45 seconds and foetal heart rate was 143 bpm. The perineum bulged and the anus gaped. The in-charge was informed of the progress of labour and was asked to confirm it and she confirmed which marked the beginning of second stage of labour. The first stage lasted for 5 hours, 30 minutes.

3.3 MANAGEMENT OF SECOND STAGE OF LABOUR

Second stage of labour begins from full dilatation of cervix to the birth of the foetus. After carrying out vaginal examination, client was informed that she was due to deliver her baby.

Madam Elizabeth was asked about the position she preferred to deliver her baby with and she chose the lithotomy position and was helped to assume that position. All windows were closed and fans were turned off. Protective clothing was then worn, that is plastic apron, boots and face masks. Hand washing done and sterile gloves put on.

The vulva was cleaned with cotton wool swab soaked in savlon solution. She was draped with sterile sheets on both thighs, on the abdomen and under the buttocks to maintain a sterile field for the foetus. Madam Elizabeth was reminded that the baby would be delivered onto her abdomen and she agreed. With the second stage being confirmed by the last vaginal examination, she was asked to push with contractions and take a rest when the contractions wear off.

As she pushed and the head was advancing, a clean perineal pad was placed at the anal region to prevent the stool from contaminating the delivery field and getting in to contact with baby's face. The middle and index fingers of the right hand were placed on the foetal advancing head to aid flexion and to allow the smallest diameter of the foetal head to distend the vulva; this was done to prevent crack or tear of the perineum. With two contractions crowning took place and the woman was asked to stop pushing and pant with contraction in order to prevent sudden expulsion of the foetal head. Extension of the head occurred in which sinciput, face and chins swept the perineum and the head was born. The eyes were cleaned immediately with sterile gauze, cleaning from the inner canthus of the eyes outward using a swab at a time.

The neck was felt for cord around it and there was none. Restitution occurred and external rotation of the head which indicated internal rotation of the shoulders had occurred. The foetal head was held in both palms, each palm on the parietal bones and with little downward traction, the anterior shoulder was delivered. The posterior shoulder was also delivered with upwards traction as it was allowed to sweep the perineum and with lateral flexion, the trunk and the rest

of the body was delivered onto the mother's abdomen and for skin to skin contact as well as providing warmth and bonding. Immediately the time of delivery was noted as 8:30am. The baby started crying out very loudly. The baby was shown to mother to identify the sex. The breathing pattern of the baby was assessed whiles drying him and apgar score within the first minute was 8/10.

3.4 IMMEDIATE CARE OF THE BABY

Immediately the head was delivered, sterile gauze was used to clean the baby's face, eyes, mouth and nose. As soon as the whole body was delivered, the baby was placed on the mother's abdomen and dried thoroughly, paying attention to skin folds. Wet linen was changed and baby was placed skin to skin on the mother's abdomen, and covered with a clean warm sheet.

First Minute APGAR score:

Appearance 2

Pulse 2

Grimace 1

Activity 1

Respiration 2

Total 8/10

The cord was covered with gauze and cut in- between the clamps to separate the baby from the mother. The cord was then measured 2 finger breaths from the baby's abdomen and clamped with the cord clamp and measuring 3 finger breath above the clamp and cord was cut.

An identification band was placed at the baby's wrist with the mother's name, sex, date and time of delivery. The condition of the baby was very good as she was actively crying and responding to stimuli.

The first and fifth minute APGAR score recorded 8/10, 9/10 respectively.

Fifth Minute Apgar score

Appearance 2

Pulse 2

Grimace 2

Activity 1

Respiration 2

Total 9/10

The midwife in-charge helped fixed baby to breast to initiate breastfeeding and bonding.

3.5 MANAGEMENT OF THIRD STAGE OF LABOUR

This stage of labour deals with the total delivery of the placenta and membranes and control of haemorrhage. The in-charge gave 10 units of oxytocin intramuscularly at the thigh of Madam Elizabeth at 8:31am with the aim of contracting the uterus after palpating to exclude second twin. Controlled cord traction was the method used in delivering the placenta in order to prevent retained placenta or products of conception. The cord was clamped closer to the perineum. A receiver was placed in between Madam Elizabeth's thigh to receive the placenta and membranes. The left palm was placed on the uterus to feel for contraction. With counter pressure and with the palm facing the fundus of the uterus and at the same time, the dominant hand held the clamped cord. When the uterus contracted, control traction was applied on the cord in a downward motion

to deliver the placenta in the direction of the curve of carus. The steady traction was maintained until the placenta was visible at the vulva. The placenta was cupped in both hands and was twisted to deliver it with its membranes. The placenta and membranes were expelled completely at 8:35am. The placenta was placed in the receiver after quick examination was done to know whether the membranes and lobes were intact. The uterus was rubbed to stimulate contraction and expel clots. Client was taught how to perform uterine massage and also educated on how the uterus should feel after massaging. The perineum, vulva, vagina and the cervix were swabbed and examined for tears and lacerations under a good source of light but there was no tear. A clean pad was then used to clean the liquor and the blood from her body.

A clean perineal pad was also applied to the perineum and the client was asked to lie on her back and cross her legs so that any bleeding could easily be identified. She was thanked for her co-operation and efforts. She was informed to empty her bladder whenever she felt the urge in other to aid quick uterine contraction and prevent bleeding. Her sister was informed of a safe delivery of a baby girl and her mother who came later was also informed. They were both delighted.

Finally, the placenta and membranes were sent to the sluice room to be examined and discarded afterwards as per the protocol of the facility.

3.6 EXAMINATION OF THE PLACENTA

The placenta was placed in 0.5% chlorine solution and it was examined. The placenta was held by the cord with the membranes hanging and the membranes were examined for completeness and it was intact. The placenta was then laid on a flat surface for further examination. The amnion was peeled from the chorion up to the umbilical cord and was fully viewed, the lobes fitted together without any gab and edges also forming uniform circle at the maternal surface and

this indicated there was no missing lobe, there were no white patches on the maternal surface, there was also no blood vessels radiating into the membranes which indicated absence of succenturiate lobe.

The cord was situated at the centre of the placenta with one vein and two arteries were seen in the cord at the foetal surface with it bluish-grey colour, smooth and shiny. There was no abnormality detected. The placenta was discarded after decontaminating it according to the protocol of the facility.

The instruments and equipment used were soaked in 0.5% chlorine solution for ten minutes and washed, rinsed, dried and repacked for sterilization. Hands were dipped in chlorine solution before discarding the gloves.

3.7 MANAGEMENT OF THE FOURTH STAGE OF LABOUR

The fourth stage of labour is a period of close observation of mother and baby for the first six hours after delivery to detect any deviation from normal. Madam Elizabeth finished skin to skin at the labour room before being taken to the lying-in-ward for further observation to be carried out. This stage includes prevention of disease, examination of the new born, management of the mother's condition and the baby.

3.8 PREVENTION OF DISEASE

Chloramphenicol eye drops was instilled on the baby's eye as prophylaxis for any eye infection. The baby was covered to provide warmth to prevent heat loss, vitamin K 1.0milligram was given intramuscularly on the thigh to prevent bleeding.

Hands were washed and cord was dressed with methylated spirit and cotton. The baby was put to breast. She was further asked to report when she observes any bleeding, discharge and redness of the cord. Hands were washed with soap and water and dried with a clean towel.

Mother was advised to wash hands before and after handling baby.

3.9 EXAMINATION OF THE NEWBORN

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

Temperature	36.5 degree Celsius
Apex heartbeat	138 beats per minute
Respiration	40 cycles per minute
Weight	3.1 kilogram

The procedure (examination of the new born) was explained to client.

Head and Face

Examination gloves were worn and the baby was examined in the presence of the mother in a clean, warm environment, where nearby windows were closed. Baby was put on a covered flat surface and only the part to be examined was exposed. The general condition of baby was checked to be normal. The colour was pink, chest was moving normally and the baby was active. A detailed head to toe examination was carried out to detect any abnormality: The head and scalp were normal with no caput succedaneum, bulging or sunken fontanels. The eyes were examined for the presence of eye balls, for jaundice, discharge and redness but no abnormality was found.

Nose: The nose was inspected for size and shape and examined for deviated septum but the septum was normal. The nostrils were inspected for patency and discharges and the mucosa for colour and polyps. No abnormality was detected.

Mouth: The mouth was examined by pressing the angle of the jaw which opened the mouth and the tongue, gum and palate were inspected and there was also no false tooth noticed. The palate was high arched, intact and the vulva centrally placed. There was no cleft palate or cleft lip, or tongue tie.

Ears: The ears were inspected; the upper notch of the pinnae was at the same level with the canthus of the eye. External auditory meatus was patent and the cartilage in the pinnae was checked for it softness. The shape and size was also noted and no abnormality was detected.

Neck: The neck was inspected and palpated with no swelling such as congenital goitre, enlarged lymph node, rotation and flexion were good.

Chest and Abdomen: The chest was examined, the respiratory movement was regular and the respiratory rate was 38cpm. The space between the nipples was noted and the nipples were in alignment. The abdomen was round with no bleeding from the umbilical cord. The cord was examined and there was one vein and two arteries.

Upper Extremities: Hands and arms were inspected for symmetry, movement and paralysis, and the palm for the number of palmer creases. Shape and colour of nail beds were inspected for reflexes (grasping, Moro) and they were normal. Hands were again examined for clubbing, extra or missing digits, nail growth and webbing and no abnormality was detected.

Genitalia and Anus: The genital area was examined. The labia majora covering the labia minora. The clitoris was present, the urethra and anus were patent since the baby passed urine and meconium.

Lower Extremities: The length and movement of the limbs were also noted. The digits were counted to be normal and separate to exclude webbing. The feet were examined for any disability

such as talipes equinovarus. The lower limbs were also examined for congenital dislocation of the hip but no abnormality was detected.

Spine: The spine was also examined with baby lying in prone position. The back was palpated for swelling, dimpling, hairy patches to exclude spinal bifida.

The baby was weighed and the weight was 3.1kg, head circumference was 33centimeters, length 50centimeters.Vitamin K 1milligram was given to baby intramuscularly to prevent bleeding.

In all, there was no abnormality detected. The baby was classified as normal and routine care of the baby initiated. Gloves were removed and disposed aseptically before washing hands with soap under running water and dried with clean dry towel. The baby's skin was smeared with baby oil and wrapped. All findings were reported and recorded.

Baby's weight was 3.1 kilograms. Measurements of the baby were done and the head circumference 33 centimetres, chest circumference 31 centimetres, length of the baby was 50 centimetres.

MANAGEMENT OF THE MOTHER

Her vital signs were checked every 15 minutes for the first two hours, then 30 minutes for the third hour and hourly for the fourth, fifth and sixth hour's post-delivery. Madam Elizabeth 's vital signs were checked and recorded as follows;

Temperature	36.6 degree Celsius
Pulse	82 beats per minute
Respiration	20 cycles per minute
Blood pressure	110/60 millimetres of mercury

Client was asked to empty her bladder for fundal height to be measured and she was further informed that, emptying her bladder would provide comfort and ensure accurate measurement. Afterwards, a new perineal pad was applied on her vulva. She was helped to lie down comfortably. The uterus was well contracted with symphysio-fundal height measuring 18 centimetres. The lochia was red in colour (rubra) and moderate in amount with no offensive odour. The baby was then put to breast to stimulate the release of oxytocin to aid in the contraction of the uterus and also to help in the production of milk.

She was educated on the need to change her perineal pad frequently and any time it got soiled. She was encouraged to report any bleeding. She was further encouraged to eat any food of her choice. She ate mashed kenkey. Her relatives were allowed to visit mother and baby then mother and her baby's vital signs and other examinations were carried out and recorded to know their condition.

CONDITION OF MOTHER AND BABY

MOTHER

Temperature	36.6 degree Celsius
Pulse	82 beats per minute
Respiration	20 cycles per minute
Blood pressure	110/60 millimetres of mercury

Symphysio fundal height 18 centimetres

Lochia red in colour

Uterus well contracted and mother's condition was satisfactory.

BABY

Temperature 36.5 degree Celsius

Apex heartbeat 138 beats per minute

Respiration 40

Sex; Female

Birth weight 3.1 kilograms

Length of baby 50 centimetres

Baby passed meconium and urine. Baby's condition was good.

3.10 SUMMARY OF LABOUR

Date and time of admission - 23rd November,2022 at 1:00am

Date and time of delivery- 23rd November,2022 at 8:30am.

Type of delivery - Spontaneous Vaginal Delivery (SVD)

Time of expulsion of placenta and membranes - 8:35am

Blood loss - approximately -150 milliliters.

DURATION OF LABOUR

First stage of labour - 6 hours

Second stage of labour - 30minutes

Third stage of labour - 5 minutes

Total duration - 6 hours, 35minutes

Injection oxytocin - 10 units given on the left thigh after delivery of baby

CONDITION OF THE PLACENTA AND CORD

Cord insertion	-	centrally situated
Cord vessels	-	two arteries, one vein
Placenta and membranes	-	complete
Maternal surface	-	dark red
Fetal surface	-	grayish blue
Condition of placenta	-	healthy and normal

3.11 NURSING CARE PLAN FOR LABOUR

PROBLEMS IDENTIFIED

1. On 23rd/11/2022 Madam Elizabeth complained of lower abdominal pains.
2. On 23rd/11/2022 Madam Elizabeth was anxious due to unknown outcome of labour.
3. On 23rd/11/2022 Madam Elizabeth complained of nausea.
4. On 23rd/11/2022 Madam Elizabeth was seen vomiting.
5. On 23rd/11/2022 Madam Elizabeth complained of fatigue.

SHORT TERM OBJECTIVES

1. Client will cope with lower abdominal pains within 7 hours.
2. Client will be relieved of anxiety within 1 hour.
3. Client will be relieved of nausea within 1 hour
4. Client will be relieved of vomiting within 1 hour.
5. Client will be relieved from fatigue within 1 hour.

LONG TERM OBJECTIVES

Madam Elizabeth will go through labour successfully and deliver a healthy baby without any complications.

NURSING CARE PLAN FOR LABOUR

DATE/ TIME	NURSING DIAGNOSIS	OBJECTIVE/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
23/11/22 11:10am	Impaired comfort related to painful uterine contraction as evidenced by client experiencing lower abdominal pain.	Client will cope with lower abdominal pains within 7hours as evidenced by a. Client verbalizing that she is coping well with abdominal pains. b. Midwife visualizing that client is sleeping in between contractions	1. Reassure client. 2. Explain the process of labour to the client. 3. Encourage client on deep breathing exercise. 4. Encourage client to empty her bladder frequently. 5. Teach client partner on sacral massage.	1. Client was reassured that labour pain will subside. 2. The stages of labour were explained to the client. 3. Client was educated on deep breathing exercise and she was assisted to do so. 4. Client was encourage to empty her bladder frequently when she gets the urge to do so. 5. Client's partner was educated on sacral massage and she perform it on the client.	24/11/22 11:30pm	Goal fully met as a. Client said she was able to bear the pain. b. Midwife reported that client slept in between contractions.	K.P

NURSING CARE PLAN FOR LABOUR

DATE/ TIME	NURSING DIAGNOSIS	OBJECTIVE/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
23/11/22 11:15am	Risk for prolong labour as evidenced by client being anxious.	Client's anxiety level will be reduced within 1 hour as evidenced by a. Client verbalizing that she is no more anxious. b. Midwife observing that client has a relaxed facial expression.	1. Reassure client. 2. Educate client on the stages of labour.. 3. Explain every procedure to be carried out to the client. 4. Update client on progress of labour. 5. Allow client to ask questions.	1. Client was reassured that she was in the hands of competent midwives. 2. Client was educated on the stages of labour. 3. Every procedure carried on client was explained to her. 4. Client was updated on progress of labour by the use of dilation board. 5. Client was allowed to ask questions and were answered appropriately.	24/11/22 12:15pm	Goal fully met as client verbalizing she was no more anxious.	K.P

NURSING CARE PLAN FOR LABOUR

DATE/	NURSING	OBJECTIVE/	NURSING ORDERS	NURSING INTERVENTION	DATE/	EVALUATION	SIGN

TIME	DIAGNOSIS	OUTCOME CRITERIA			TIME		
23/11/22 11:35pm	Nausea related to the hormonal action as evidenced by client unable to tolerate meals.	Madam Elizabeth will be relieved of nausea within one hour as evidenced by Client reporting that she is no more nauseated.	1. Reassure client. 2. Educate client on the cause of nausea. 3. Encourage client to chew a piece of chewing stick. 4. Teach client on how to rinse her mouth with mouth wash. 5. Educate client on how to keep her surroundings clean from nauseated substances.	1. Client was reassured that nausea would subside. 2. Client was educated that nausea was due to hormonal actions in labour. 3. Client was encourage to chew a piece of chewing stick to reduce nausea. 4. Client was taught and assisted on how to rinse the mouth with mouth wash. 5. Client was educated on how to keep her surroundings clean from nauseated substances such us bed pain.	24/11/22 12:35pm	Goal fully met as client reported that her nausea had subside.	K.P

NURSING CARE PLAN FOR LABOUR

DATE/ TIME	NURSING DIAGNOSIS	OBJECTIVE/ OUTCOME	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN

		CRITERIA					
23/11/22 11:35	Risk for maternal exhaustion related to stress as evidenced by client feeling fatigue.	Madam Elizabeth will be relieved of fatigue within 7hours as evidenced by a. Client verbalizing that the fatigue has resolved. b. Midwife observing that client no longer fatigued.	1.Reassure client 2.Encourage client to rest and sleep. 3.Restrict visitor. 4.Encourage client to call for assistance when needed. 5.Encourage client to take in fluids and food.	1.Client was reassured that she will regain her strength. 2.Client was encourage to rest and sleep to help relieve her from fatigue. 3.Visitors were restricted to enable client to have enough rest. 4.Client was encouraged to call midwife to her aid when needed. 5.Client was encouraged to take in fluids and she ate mashed kenkey.	24/11/22 1:35pm	Goal achieved as client reported a feeling of wellbeing.	P.K

CHAPTER FOUR

PUERPERIUM

4.0 INTRODUCTION

This chapter provides details of the care given to the client and the baby from the day of delivery till six weeks' postnatal period. Care plan drawn for the management of problems encountered during puerperium. During this period, the reproductive organs return to their non-pregnant stage and lactation initiated. Also health education, counselling, assessment, support for infant feeding and immunization service for baby is done.

4.1 DAY OF DELIVERY

Madam Elizabeth was transferred to the postnatal ward after one hour of skin to skin contact with her baby, on the 23rd of 2022, where she was given a comfortable bed to sleep on. Both mother and baby were kept warm to prevent heat loss by closing doors, windows and baby was well wrapped.

Madam Elizabeth demonstrated how to fix the baby to breast. She was advised to have enough rest and sleep. The following were her vital signs:

Temperature	36.6 degree Celsius
Pulse	82 beats per minute
Respiration	20cycles per minute
Blood pressure	110/60 millimetres of mercury

The vital signs were checked every 15 minutes for 2 hours and 30 minutes for 1 hour and hourly for the next 3 hours after which it was checked for every 4 hours. Perineum was inspected for lochia which was red (rubra) with small flows and no odour. Symphysio-fundal height measured 18 centimetres. She was served with light soup and fufu.

4.2 SUBSEQUENT CARE OF BABY

Vital signs checked and recorded as:

Apex heart beat 138 beats per minute

Temperature 36.5 degree Celsius

Respiration 40 cycles per minute

Weight 3.1 kilograms

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

All findings were communicated to Madam Elizabeth.

BABY'S FIRST BATH

A trolley was set containing the following

1. Soap
2. Sponge
3. Cream/ powder/baby oil
4. Sterile cotton in a gallipot
5. Basin
6. Towels: 1 big and 3 small ones

7. Two cot sheets

8. Apron

9. Gloves

10. A clean baby dress, cap and socks

11. Mackintosh

12. 2 jugs containing hot and cold water each

13. Two receptacles for used water and dirty linen

14. A receiver for used swab

All windows and doors were closed, fans switched off and the lights switched on to make the room warm. Procedure was explained to Madam Elizabeth and was thanked for accepting. After gathering all items, the hot and cold water were mixed and temperature was tested with the back of the palm

Plastic apron was then worn, hands were washed with soap and under running water and dried with a clean towel. Sterile gloves were worn and the baby was positioned on a protected flat surface, she was undressed and covered with the towel leaving the face. The general condition was observed and baby had a pink skin colour covered with vernix caseosa. Baby`s eyes were cleaned with cotton wool swab soaked in clean water from the inner canthus out and then the face was cleaned with damp face toel and dried. The baby`s neck was supported with the hand, the ears were plugged with the thumb and middle finger to prevent water from entering the ears. The hair was washed with soap and sponge in a circular manner, rinsed, dried.

The baby was put back on the working surface and exposed, arms and front of the trunk were washed to the feet paying attention to the skin folds. He was then turned to the back and with one arm supported, the chest and the back was washed down to the feet paying attention to the skin

folds. Baby's body was immersed in a bath of warm water, with the head supported above the water and the body rinsed thoroughly. The baby was then placed on a cleaned cot sheet and a small, clean, dry towel was used to dry the body paying attention to the skin folds. Gloved hands were dipped into 0.5% chlorine solution and were removed and discarded. Baby oil was applied on the skin and baby was dressed leaving the umbilical cord exposed for dressing and the hair combed neatly. Hands were washed and dried with clean towel.

Cord Dressing

The cord was dressed by wrapping the baby in a towel to keep her warm. Mother was asked to protect him on the table. The tray containing dry cotton wool swabs in a gallipot containing antiseptic solution which was methylated spirit and a receiver for the used swabs was already set. The cord was then exposed. Hands were thoroughly washed again with soap and under running water and dried in a clean towel. Sterile gloves were worn. The cord was inspected for bleeding but there was none. The cord clamp was held with one swab in the non-dominant hand. The base of the cord was cleaned with another cotton wool swab in a circular manner and was discarded. One cotton wool swab was used to clean the anterior part from the base of the cord to the cord clamp, another one was also used to clean the posterior part from the base of the cord to the cord clamp. The area of the cord above the cord clamp was cleaned in the same manner as the base was cleaned. The sixth swab was used to clean the tip of the cord. The cord clamp was dried with the swab that was used to hold it. The cord was left exposed to air dry.

Baby was dressed, wrapped and, given to mother to breastfeed. The used items were discarded according to infection prevention protocol. Gloves were removed and discarded. Hands were washed with soap and water, dried with a clean towel before handling the baby.

4.3 FIRST DAY POST DELIVERY (DAY OF DISCHARGE)

The first day post-delivery for Madam Elizabeth was on the 24th November,2022. Client was asked about her sleep during the night and she said she slept well but had to wake up intermittently to breastfeed her baby. Her vital signs were then checked and recorded as follows:

Mothers vital signs

Temperature	36.0 degree Celsius
Pulse	70 beats per minute
Blood pressure	100/70mmhg
Respiration	19cycles per miute

Permission was sought for head to toe examination to be performed on her and was granted, and there was no abnormality detected. The breast was lactating well and the uterus was well contracted when palpated and measured 17cm. On perinea inspection, the lochia flow was small and the colour was red (rubra) with no odour. She was encouraged to ambulate to promote effective circulation and drainage of lochia. She took her baby after she was served with warm porridge and bread as breakfast. Baby was also examined with permission from the mother after hand washing was done with soap and under running water and dried with clean towel. A thorough head to toe examination was performed on the baby again but no abnormality was detected.

The cord was inspected for bleeding, odour and discharge but there was none. The baby was top and tailed with the cord dressed with methylated spirit. The baby was dressed nicely and wrapped in clean warm sheet. The baby`s weight was 3.0kilogram. The baby`s vital signs were checked and recorded as follows:

Temperature	36.7 degree Celsius
Pulse	150 beats per minute
Respiration	50 cycles per minute

Client was educated on how to position herself when breastfeeding and how to put the baby to breast. This was also demonstrated to Madam Elizabeth to enable her breastfeed well. She was asked to give return demonstration and she did that perfectly. She was informed that she would be discharged that day.

She was educated on the intake of nutritious diet which would help boost her immunity and repair worn out tissues. She was encouraged to maintain good personal hygiene and also informed to sleep whenever the baby is sleeping so that she can also have enough rest. She was educated on minor disorders in puerperium such as breast sores for the mother

Routine drugs were served as follows:

Tablet folic acid 5mg once daily for 7days.

Tablet multivitamin 200mg once daily for 7 days

Table ferrous sulphate 200mg once times daily for 7 days.

Madam Elizabeth was also advised on the importance of keeping the baby's cord clean and dry. She was educated to only use the methylated spirit given to her for cord dressing. She was encouraged to dress cord as was done. Madam Elizabeth was also educated on the importance of reporting to hospital anytime she notices danger signs like bleeding from the cord, offensive odour from the cord or high temperature of the baby. Madam Elizabeth was encouraged to continue sleeping under treated mosquito net together with the baby to prevent malaria.

She was also educated to breastfeed the baby on demand and also encouraged her sister and mother to help her take care of the baby. Client was encouraged to have adequate rest and sleep.

The information about visits to her house to continue the care up to the seventh day was emphasized and they were seen off. At 12pm, client and family were bid farewell.

4.4 FIRST POSTNATAL HOME VISIT (1ST DAY POST DELIVERY)

On the 24th November, 2022, at 4:00pm in the evening, Madam Elizabeth was visited in her house at Kato. We exchanged greetings and a warm welcome and seat was offered. She was asked about her health and that of her family and responded that they are all well.

Permission was sought from Madam Elizabeth to examine her which she agreed. After hand washing was done with soap under running water and dried. The perineal pad was checked and the colour of the lochia was bright red with no foul smell and scanty in amount.

The breast was lactating well. There were no observed abnormalities. Her vital signs were checked and recorded as follows

Temperature	36.1
Respiration	20 cycle per minute
Blood pressure	120/60 millimetres
Pulse	76 beat per minutes

Again permission was sought from the mother to examine the baby which was agreed. The baby was examined from head to toe with no abnormality detected.

Temperature	36.6 degrees Celsius
Respiration	44 cycle per minute
Pulse	122 beat per minute
Weight	3.0 kilogram

Madam Elizabeth complained of after pains and the physiology behind it was explained to her and was also reassured that it was a normal disorder. She was educated to gently massage the lower abdomen to help the uterus to contract. She was again educated to assume a prone position with pillow under her lower abdomen to help relieve her from the pain. She was encouraged to urinate frequently whenever is the urge to and to take the prescribed analgesics.

4.5 SECOND POSTNATAL HOME VISIT (2ND DAY POST DELIVERY)

Madam Elizabeth and her baby were visited on 25th November,2022 at 8:00am in the morning and 4:00pm in the evening. Both mother and baby looked healthy on arrival to their house. Greetings were exchanged and client was informed on the procedures to be carried out.

After hand washing was done with soap under running water and dried. The symphysio fundal height was 16 centimetres. The perineal pad was checked and the colour of the lochia was bright red with no foul smell and scanty in amount. The breasts were lactating well. There were no abnormalities observed. Her vital signs were checked and recorded as follows

	Morning	**Evening**
Temperature	36.2 degree Celsius	36.5degree Celsius
Blood pressure	120/80mmHg	112/78mmHg
Respiration	18 cycles per minute	24cycles per minutes
Pulse	78 beats per minute	82beat per minutes

The baby was examined from head to toe with no abnormality detected. The baby vital signs were as follows

	Morning	**Evening**
Temperature	37.0 degree Celsius	36.7 degree celcius
Respiration	40 cycles per minutes	44 cycles per minutes
Pulse	128 beat per minutes	132 beat per minutes
Weight	2.9kilogram	

The baby was toped and tailed, cord was dressed with methylated spirit and was dressed nicely, wrapped in a warm clean sheet and was given to the mother to breastfeed. Madam Elizabeth was encouraged to continue the practice of exclusive breastfeeding not to put anything on the cord apart from the methylated spirit and also wash hands before handling baby.

She was thanked and permission was sought to leave.

4.6 THIRD POSTNATAL HOME VISIT (3RD DAY POST DELIVERY)

On 26th November, 2022, at 8:00am and 4:00pm in the evening Madam Elizabeth was visited to asses both the mother and baby. We exchanged greetings and a warm welcome and seat was offered. She was asked about her health and that of her family and responded that they are all well and she was relieved from after pain.

Both mother and baby were examined for any abnormalities. Hand washing was done with soap under running water and dried. The symphysio-fundal height when measured was 15cm. The perinea pad was checked and the colour of the lochia was bright red with no foul smell and scanty in amount. The breasts were lactating well. There were no observed abnormalities. Her vital signs were checked and recorded as follows

	Morning	**Evening**
Temperature	36.6 degree Celsius	36.3 degree celsius
Blood pressure	108/70mmHg	110/70 mmHg
Pulse	84 beats per minute	80 beats per minute
Respiration	22 cycles per minutes	22 cycles per minutes

The baby was examined from head to toe and it was observed that baby had heat rashes. He was toped and tailed and his cord was dressed with methylated spirit. She was then dressed nicely, wrapped in a clean sheet, vital signs checked and recorded as follows

	Morning	Evening
Temperature	36.5 degree Celsius	36.6 degree celsius
Respiration	40 cycles per minutes	44 cycles per minutes
Pulse	130 beat per minutes	138 beat per minutes
Weight	2.8kilogram	

Baby was then given to the mother to breastfeed.

Education was given on prevention of infection. Client complained of fatigue and heat rashes on the baby's forehead. She was reassured, encouraged to sleep when baby is asleep, and get enough rest. Her mother was educated to assist in caring for the baby to enable Madam Elizabeth get enough rest. Madam Elizabeth was educated to take in nutritious diet as well to help her gain enough energy. She was also educated to dress baby in cotton cloth, and use baby soaps in bathing the baby. Both Madam Elizabeth and her mother were educated to wash hands with soap and water before and after handling the baby.

4.7 FOURTH POSTNATAL HOME VISIT (4TH DAY POST DELIVERY)

Fourth home visit was on 27th November 2022, at 8:00am. Client, baby and family were doing well. She showed a cheerful facial expression and said she no longer feel fatigue.

Purpose of the visit was made known to her. Permission sought for head to toe examination which was granted and no abnormalities detected. Her perinea pad was inspected for lochia and the flow was small, pink in colour (serosa) and was not offensive. Her symphysio fundal height measured was 14centimetres.Her vital signs were checked and recorded as follows

Temperature	36.4 degree Celsius
Pulse	84 beats per minute
Respiration	24 cycle per minute
Blood pressure	108/70 millimetres of mercury

The baby was toped and tailed and cord was dressed. The cord looked dry and about to slough off and the baby was nicely dressed and wrapped in a clean sheet and made comfortable in bed.

Temperature	36.0 degree Celsius
Pulse	130 beat per minute.
Respiration	44 cycle per minute.
Weight	2.8 kilogram

Client complained of backache. She was educated on the positions to assume when breastfeeding and was encouraged to wear well-fitting or supportive brassiere. Client was informed of the next visit.

4.8 FIFTH POSTNATAL HOME VISIT (5TH DAY POST DELIVERY)

Client was visited on 28th November, 2022 at 8:00am in the morning. On arrival, greetings were exchanged and she was asked about her health and that of the family and she responded that they are doing well. The purpose of the visit was explained her vital signs were checked and +recorded as follows,

Temperature	36.2 degree Celsius
Pulse	76 beat per minute
Respiration	18cycles per minute
Blood pressure	110/70 millimetres of mercury

Her perineal pad was inspected and the lochia was pink (serosa) with scanty flow and not offensive. Her symphysio fundal height was13 cm. The baby was top and tailed and the cord was dressed nicely. It looked very dry and it was reported that he passed yellowish stool. The baby was dressed and wrapped in a clean warm sheet and was given to the mother to breastfeed. Client was reminded of the practice of good personal hygiene.

Temperature	36.7 degree Celsius
Pulse	120 beat per minute
Respiration	42 cycles per minute
Weight	2.9 kilogram

Madam Elizabeth was asked if there was about her previous complaints and she gave positive response on that and any complain again, and she said there was none. She was thanked and permission was sought to leave.

4.9 SIXTH POSTNATAL HOME VISIT (6TH DAY POST DELIVERY)

On 29th November,2022, client and family were visited again in the morning at 8:30am. I was warmly welcomed and the health of the client and her family was inquired and I was given positive response. She verbalised that the baby's rashes had gone and she is relieved of the backache.

Permission was then sought and daily routine examination was carried out on both mother and baby from head to toe and no abnormality was detected in any of them. Their condition was very good and both looked healthy. Lochia was inspected and was serosa and amount drained was

scanty with no foul odour. Symphysio fundal height was 12cm and vital signs was checked and recorded as

Temperature	36.3 degree Celsius
Pulse	80beat per minute
Respiration	19 cycles beat per minute
Blood pressure	120/70 millimetres of mercury

On examination of the baby, the cord was seen to have fallen off and a baby bath was provided and the mother and sister were educated on how to properly bath the baby and avoid pouring hot water on the head and genital areas and also continue to keep the stump dry always and also not apply any herb. Baby's vital signs were checked and recorded as follows

Temperature	36.5 degree Celsius
Pulse	124 beat per minute
Respiration	42 cycles per minute
Weight	3.0 kilogram

It was observed that the rash on the body had gone. Madam Elizabeth complained of sleeplessness due to baby`s crying and feeding at night. She was reassured and her mother was also encouraged to help in taking care of the baby and was encouraged to feed baby on demand. She was also educated on the need to change baby's soiled napkin which might be the cause of the cry and was taught how to breastfeed whilst lying. She was thanked and permission to leave was sought.

4.10 SEVENTH DAY POSTNATAL HOME VISIT (7TH DAY POST DELIVERY)

At 8:30am in the morning of 30th November,2022, client and family were visited again. A warmly greetings were exchanged and the health of client and her family was inquired and positive response was given. Madam Elizabeth verbalized that she slept for 6 hours during the night and 2 hours during the day.

Permission was then sought and routine examination was carried out on both mother and baby from head to toe and no abnormality was detected in any of them. Mother was examined from head to toe and no abnormality was detected and was lactating well. Her perinea pad was inspected and lochia was scanty and pinkish in colour. The symphysio fundal height was 11cm. The baby was bathed and stump was clean. The vital signs were checked and recorded as follows:

Mother

Temperature	36.0 degree Celsius
Pulse	75 beat per minute
Respiration	18 cycles per minute
Blood pressure	110/70 millimetres per mercury

Baby

Temperature	36.8 degree Celsius
Pulse	126 beat per minute
Respiration	38 cycles per minute
Weight	3.1 kilogram

Client was asked whether she had complaints that day but she had nothing to report. She was thanked and reminded her of her next visit.

4.11 FIRST POSTNATAL VISIT TO THE CLINIC

Madam Elizabeth and her baby reported to the clinic on 1st December,2022, at 8:00am. She was welcomed and offered a seat. She was asked how they were faring and she responded that they were doing well. Procedures to be carried on her and the baby were explained and she consented. Midstream urine was collected from her for protein and sugar and it was negative.

Her haemoglobin checked and recorded as 13.1g/dl. Her vital signs were checked and recorded as follows:

Temperature	36.2 degree Celsius
Pulse	81 beats per minute
Respiration	21 cycles per minute
Blood pressure	90/60 millimetres of mercury
weight	57 kilograms

Madam Elizabeth was assisted to undress and lie on the bed for head to toe examination. Hands were washed and dried with clean towel. On examination, her hair was nicely braided and neatly kept. The eyes were inspected for pallor and discharges, the nose and ears were also inspected for discharges but nothing abnormal was detected. There were no swellings or lymph nodes around the neck. The breast was lactating well and was educated on breastfeeding the baby on demand to avoid breast engorgement.

On abdominal examination, uterus was not palpable. The extremities were free from oedema. On vulva inspection, the lochia had stopped flowing and the vulva was neatly kept with no odour.

No abnormality was detected on the lower extremities too. She was assisted out of the bed and all finding communicated to her.

The baby was also examined in the presence of Madam Elizabeth but no abnormality was detected. The baby`s weight was 3.2kg. baby`s vital signs was checked and recorded as follows:

Temperature	36.3 degree Celsius
Pulse	142 beats per minute
Respiration	40 cycles per minute
Weight	3.2 kilogram

Findings on the baby were communicated to her and she was congratulated of taking good care of the baby and herself. She was educated on various family planning methods and the benefits of practicing family planning, when to resume sex and the need to feed the baby exclusively for six months. She said she have been practicing lactation amenorrhea method since her first delivery and she is comfortable with it. Mother gave positive response on the use of family planning method.

She was also educated on the need to attend child welfare clinic in order to monitor the growth of her baby, any detection of diseases to complete all the immunization. She was reminded of the importance of rest, eating nutritious diet, maintaining good personal hygiene, baby care, breastfeeding and breast care.

Explanation was given to Madam Elizabeth on the need to be handed over to the midwife in-charge for continuity of care on the 23rd of December,2022. but client was reassured of the midwife in-charge’s competency. Client was reminded to continue and complete all the immunizations.

Finally, she was handed over to the midwife in charge for the continuity of care. She was congratulated and thanked for her cooperation and support.

4.12 SECOND POSTNATAL VISIT TO THE CLINIC (SIX WEEKS POSTNATAL EXAMINATION)

According to the midwife in charge, Madam Elizabeth reported to the clinic on the 1st January,2023 for six weeks visit. She was warmly welcome and she looked very healthy. General examination was conducted from head to toe as well as vital signs after permission was sought. Her vital signs were checked and recorded as follows

Temperature	36.9 degrees Celsius
Pulse	78 beat per minute
Respiration	20 cycle per minute
Blood pressure	100/60 millimetre of mercury

Urine testing was done and no abnormalities were found. .Haemoglobin level was checked and it was 13.2g/d

Head to toe examination was done on both mother and baby and no abnormalities detected

Baby's vital sign was checked and recorded as follows

Weight	5.0 kilogram
Temperature	36.9 degree Celsius
Pulse	128 beats per minute
Respiration	40 cycles per minute

4.13 CARE PLAN DURING PUERPERIUM

Madam Elizabeth complained of

• After pain on 24th Novenber, 2022

• Fatigue on 26th November, 2022

• Skin rashes on the baby's skin on the 26th November, 2022

• Backache on 27th November, 2022

• Sleeplessness on 28thDecember, 2022

Short Term Objectives

• Madam Elizabeth would be relieved of after pains within 48 hours

• Madam Elizabeth would be relieved of fatigue within 24 hours

• Baby would be relieved of skin rashes within 72 hour

• Madam Elizabeth would be relieved of sleeplessness within 24 hours

• Madam Elizabeth would be relieved of backache within 48 hours

Long Term Objectives

Client will go through puerperium successfully without any complication.

NURSING CARE PLAN FOR PUERPERIUM

DATE/ TIME	NURSING DIAGNOSIS	OBJECTIVE/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
24/11/22 8:00am	Impaired comfort related to involution of the uterus as evidenced by client experiencing after pain.	Client will be relieved of after pain within 48 hours as evidenced by 1.Client verbalizing that she will be relieved of after pain. 2.Midwife visualizing that client is relieved of the after pain.	1. Reassure client 2. Educate client to gently massage the abdomen. 3. Educate client to assume a prone position. 4. Encourage client to urinate frequently whenever there is the urge. 5. Serve analgesics.	1.Client was reassured that the pain is temporary and it will subside. 2.Client was educated to apply a gentle massage at the lower abdomen which will help the uterus to contract. 3.Client was educated to assume a prone position with pillow under her lower abdomen to help relieve her from the pain. 4.Client was encouraged to urinate frequently whenever there is the urge which will help the uterus to contract well. 5.1gram of tablet paracetamol was served as prescribed to reduce pain.	26/11/22 8:30am	Goal fully met as client said she is relieved of the pain.	P.K

NURSING CARE PLAN FOR PUERPERIUM

DATE/ TIME	NURSING DIAGNOSIS	OBJECTIVE/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
26/11/22 8:00am	Activity intolerance related to fatigue from physical demands of caring for the new born.	Client will be relieved of fatigue within 24 hours as evidenced by: 1.Client verbalizing that she is relieved of fatigue. 2.Midwife visualizing that client is relieved of fatigue.	1.Reassure client that she will regain her energy. 2.Encourage client to sleep during the day when baby is asleep. 3.Encourage client's mother to assist in the caring of the baby. 4.Encourage client to have enough rest. 5.Educate client to take in nutrious diets.	1.Client was reassured that she would regain her energy . 2.Client slept during the day when the baby was asleep. 3.Clients's mother assisted her in caring for the baby. 4.Client verbalized she had enough rest. 5.Client verbalized she took in enough nutrious diets such as palava sauce with rice.	27/11/22 8:00pm	Goal fully met as client verbalized that she is relieved of fatigue.	P.K

NURSING CARE PLAN FOR PUERPERIUM

DATE/	NURSING	OBJECTIVE/	NURSING ORDERS	NURSING	DATE/	EVALUATION	SIGN

TIME	DIAGNOSIS	OUTCOME CRITERIA		INTERVENTION	TIME		
26/11/22 8:00am	Skin rash related to warm environment.	Baby will be relieved of skin rashes within 72 hours as evidenced by: 1.Mother verbalizing that rashes are no more. 2.Midwife observing that there are no skin rashes on baby's skin.	1.Reassure mother that the rashes will go. 2.Explain the physiology of rash to the mother. 3.Encourage mother to dress baby with cotton cloth. 4.Encourage mother to use baby soaps when bathing baby. 5.Encourage mother to apply baby powder to the baby's skin. 6.Encourage mother to wash hands before and after handling the baby.	1.Client was reassured that the rashes would disappear. 2.Physiology of rash was explained to mother. 3.Mother used cotton cloths to dress the baby. 4.Mother used Johnson baby soaps when bathing baby. 5.Mother applied baby baby powder to baby's skin. 6.Client was encouraged to wash hands before and after handling the baby.	29/11/22 8:30am	Goal partially met as client verbalizing that skin rashes has reduced.	P.K

NURSING CARE PLAN FOR PUERPERIUM

DATE/ TIME	NURSING DIAGNOSIS	OBJECTIVE/ OUTCOME	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN

		CRITERIA					
M	Impaired comfort related to backache as evidenced by client experiencing pain at the back when stretching.	Client will be relieved of backache within 48 hours as evidenced by: 1.Client verbalizing that she is relieved from the pain. 2.Midwife visualizing that client scoring lower mark on comparative pain assessment scale.	1.Reassure client that she will be relieved of pain. 2.Teach client on how to position herself when breastfeeding. 3.Educate client on different types of position used in breastfeeding. 4.Encourage client to wear well-fitting or supportive brassiere. 5.Encourage client to attach baby properly during breastfeeding.	1.Client was reassured that she will be relieved of back pains. 2.Client was taught on how to support the back with pillows when breastfeeding baby. 3.Client was educated on the different types of positions used when breastfeeding. 4.Client was encourage to wear a well-fitting brasserie to support the breast. 5.Client was encourage to fix baby properly to breast.	28/11/22 8:30am	Goal fully met as client verbalizing back pains have been relieved.	P.K

NURSING CARE PLAN FOR PUERPERIUM

DATE/ TIME	**NURSING DIAGNOSIS**	**NURSING OBJECTIVES**	**NURSING ORDERS**	**NURSING INTERVENTIONS**	**DATE/TIME**	**EVALUATION**	**SIGN**
01/12/2	Disturbed	Madam Elizabeth	1.Reassure client that her	1.Client was reassured	2/11/22	Goal partially	P.K

2	sleep pattern {insomnia} related to baby's crying and feeding at night.	would be coping with sleeplessness within 24 hours as evidenced by: 1.Client verbalizing that she was able to sleep for about 6 hours in the night. 2.Midwife observing client slept for about 6 hours.	sleeping pattern will be restored to normal. 2.Encourage client to feed baby on demand. 3.Educate client to change baby's soiled napkins when necessary. 4.Teach client how to breastfeed whilst lying. 5.Encourage client relative to help her in taking care of the baby.	that her sleeping pattern will be restored to normal. 2.Client was encouraged to feed baby on demand. 3.Client was educated to changed baby's soiled napkins when necessary. 4.Client was taught how to breastfeed baby whilst lying. 5.Client's relative was encouraged to help her in taking care of the baby.	8:30am	met as client verbalizing that she slept for 6 hours during the night and 2 hours during the day.

SUMMARY AND CONCLUSION

The family centered maternity care study was conducted on Madam Oppong Ameyaa Elizabeth, a 24-year-old gravida 3 para 2 alive and her entire family. Care was given during antenatal, labour and puerperium periods and these processes were gone through successfully.

Madam Elizabeth first visit to the clinic was on 11th April, 2022 when she was 14 weeks pregnant and attended the clinic till delivery and the first contact with her was on 7th November, 2022 when she was 37 weeks pregnant.

She had spontaneous vaginal delivery of a life female child on the 23rd November, 2022 without any complications and went through a normal and safe puerperium. She and her family were cooperative, supportive and acted towards any form of education given to them. Through home visits, a close monitoring was made throughout puerperium and education given on how to care for herself and the baby and they were later handed over to the midwife in charged for continuity of care.

To sum up, this care study has given me the student midwife opportunity to put my theoretical knowledge into practice and has therefore boost the confidence level in me and has also help me to improve upon my ability in caring for other pregnant women whom I shall meet in the nearest future throughout pregnancy, labour and puerperium successfully.

I have learnt to care systematically for a pregnant woman and her family.

It has also broadened my knowledge on issues concerning pregnancy, labour and puerperium.

I have also learnt how to care for a pregnant woman in her own environment.

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APPENDIX I

MOTHER'S ANTENATAL RECORDS

DATE	WEIGHT [KG]	BLOOD PRESSURE	URINE FOR PROTEIN/SUGAR	GESTATIONAL AGE IN WEEKS	FUNDAL HEIGHT [CM]	PRESENTATION	DESCENT	FETAL HEART RATE
11/04/22	48.3	110/60	Negative/Negative	**E**	**P**	**-**	**-**	**-**
11/05/22	**50.1**	**110/60**	**Negative/Negative**	**12**	**-**	**-**	**-**	**FM+**
8/06/22	**52.0**	**110/60**	**Negative/Negative**	**16**	**12**	**-**	**-**	**FM+**
6/07/22	**53.4**	**110/60**	**Negative/Negative**	**20**	**19**	**cephalic**	**-**	**FM+**
8/08/22	**55.2**	**110/60**	**Negative/Negative**	**24+4**	**23**	**Cephalic**	**5/5**	**132**
5/9/22	**56.5**	**110/60**	**Negative/Negative**	**28+4**	**25**	**cephalic**	**5/5**	**134**
3/10/22	**57.8**	**110/60**	**Negative/Negative**	**32+4**	**31**	**cephalic**	**5/5**	**139**
17/10/22	**57.8**	**110/60**	**Negative/Negative**	**34+4**	**33**	**cephalic**	**5/5**	**135**
31/10/22	**58.6**	**110/60**	**Negative/Negative**	**36+4**	**35**	**cephalic**	**5/5**	**140**
14/11/22	**58.4**	**110/60**	**Negative/Negative**	**38+4**	**36**	**cephalic**	**5/5**	**138**

Malaria Prevention

Long Lasting insecticide date supplied Treatment Net{LLIN} **11TH APRIL 2023**

G6PD STATUS **No Defect/Full Defect/Partial Defect**

INTERMITTENT PREVENTIVE TREATMENT {IPTp} FOR MALARIA	**DATE GIVEN**	**GESTATIONAL AGE IN WEEKS**
IPT1	**8/06/22**	**16WEEKS**
IPT2	**6/07/22**	**20WEEKS**
IPT3	**8/08/22**	**24+4WEEKS**
IPT4	**5/09/22**	**28+4WEEKS**
IPT5	**3/10/22**	**32+4**

Tetanus-Diphtheria Immunization Schedule

Tetanus-Diphtheria Dose Date Given Batch Number

THIRD DOSE 11/05/22

Deworming : Given after 16weeks

DATE 08/06/22

APPENDIX II

COMPLETE DIAGNOSTIC INVESTIGATIONS

DATE	SPECIMEN	INVESTIGATION	NORMAL VALUES	FINDINGS	REMARKS
11/04/22	1.Blood	Haemoglobin level	11.3g/ldl-12.3g/dl	12.9g/dl	Normal
		Sickling status	Negative	Negative	Normal
		Grouping and rhesus factor	A, B, AB and O	O positive	Normal
		HIV status	Positive		
		Syphilis	Negative	Negative	Normal
		Hepatitis status	Non- reactive	Non defect	Normal
		G6PD status	Non-reactive	Negative	Normal
		Sugar	Negative	Non defect	Normal
	2.Urine	protein	Negative	Negative	Normal
			Negative	Negative	Normal
11/05/22	1.urine	Sugar	Negative	Negative	Normal
		Protein	Negative	Negative	Normal

8/06/22	Urine	Sugar	Negative	Negative	Normal
		Protein	Negative	Negative	Normal
6/07/22	1.Blood	Haemoglobin	11.3g/dl-12.3g/dl	12.6g/dl	Normal
	2.urine	Sugar	Negative	Negative	Normal
		Protein	Negative	Negative	Normal
8/08/22	Urine	Sugar	Negative	Negative	Normal
		Protein	Negative	Negative	Normal
5/09/22	Urine	Sugar	Negative	Negative	Normal
		Protein	Negative	Negative	Normal
3/10/22	Blood	Haemoglobin	11.3g/dl-12.3g/dl	12.1g/dl	Normal
	2.Urine	Sugar	Negative	Negative	Normal
		Protein	Negative	Negative	Normal
617/10/22	Urine	Sugar	Negative	Negative	Normal
		Protein	Negative	Negative	Normal

31/10/22	1.Blood	haemoglobin	11.3.g/dl-12.3g/dl	12.1g/dl	Normal
	2.Urine				
14/11/22	Urine	Sugar	Negative	Negative	Normal
		Protein	Negative	Negative	Normal

APPENDIX III

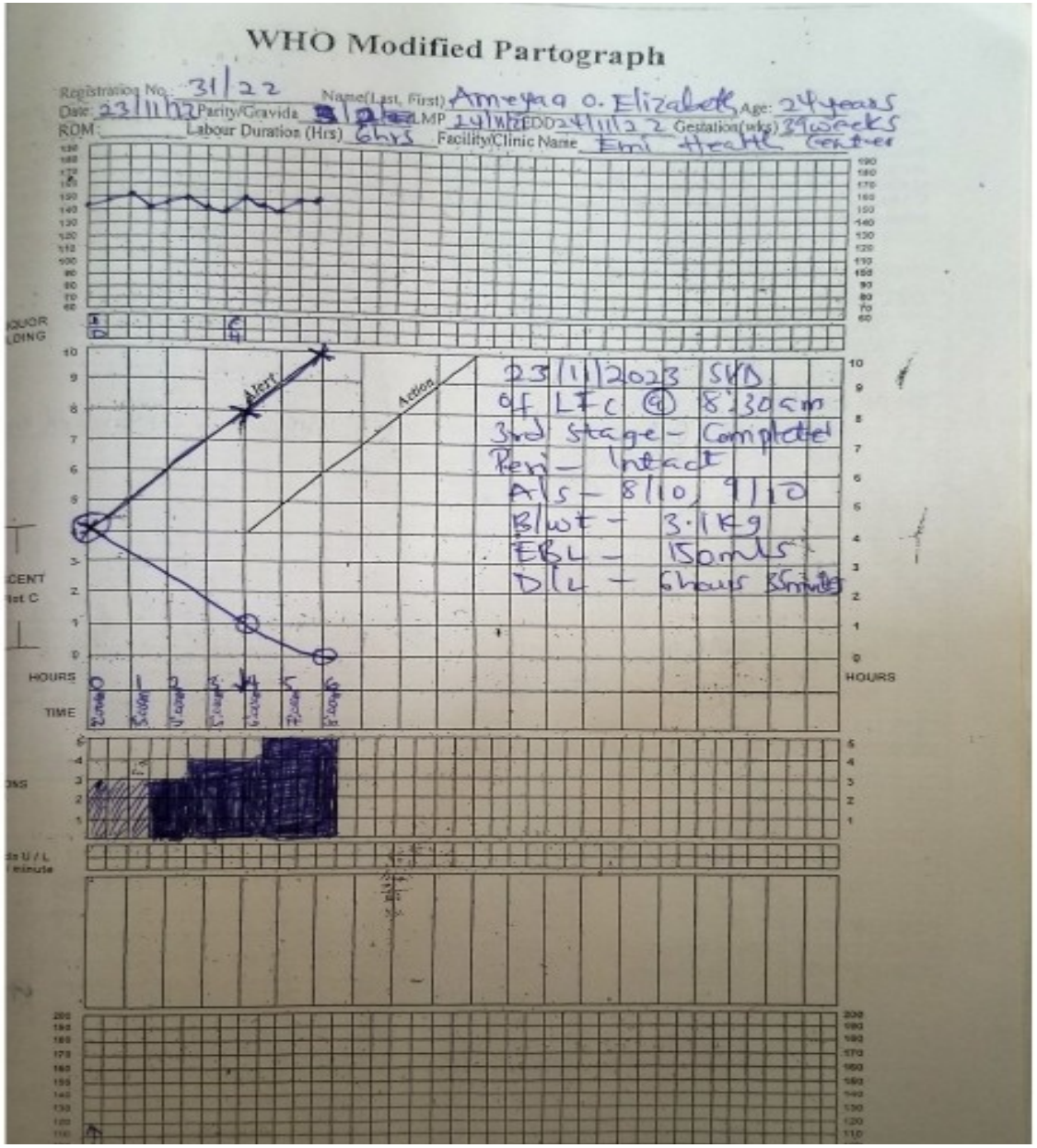
PHARMACOLOGY OF DRUGS (MOTHER)

DRUG	CLASSIFICATION	DOSAGE	ROUTE	ACTIONS AND USES	ACTUAL EFFECT	SIDE EFFECT
Ferrous Tablet	Haematinics	200mg daily	Orally	Aids in Red blood cell formation	Increase in haemoglobin level	Black stool, diarrhea and constipation
Folic Acid Tablet	Vitamin preparation	5mg daily	Orally	Helps in the formation of blood cell	Increase in hemoglobin level	Nausea , vomiting , diarrhea and constipation
Multivitamin Tablet	Vitamin preparation	200mg daily	Orally	Increases appetite and helps in the formation of Red blood cells	Increase in appetite	Gastrointestine disturbance
Paracetamol tablet	Antipyretics / analgesic	1g tds x3	Orally	Reduces mild to moderate pain	Client pain was relieved	Liver damage due to prolong use
Tetanus injection	Anti-tetanus drugs	0.5mg	Intra-muscular	Protect mother and fetus against infections	Client was protected against tetanus infection	Nausea , general ill feeling
Metronidazole tablet	Anti –infective	400mg tds x7days	Orally	Prevention of infection	Infection was prevented	Dizziness , headache , nausea.
Sulfadoxine-pyramethamine tablet	Anti –malaria prophylaxis	3 start 16 weeks or after quickening till delivery and was given monthly after last dose.	Orally	Prevention of malaria	Malaria was prevented	Urticarial rash , dizziness, nausea , stomatitis
Oxytocin injection	Oxytocin drug	10units	Intra-muscular	Increase uterine contraction and control bleeding	Client had good uterine contraction	Vomiting , uterine spasm, and raised blood pressure.

PHARMACOLOGY OF DRUGS (BABY)

DRUG	CLASSIFICATION	DOSAGE	ROUTE	ACTIONS AND	ACTUAL	SIDE EFFECT	SIDE EFFECT

				USES	EFFECT		EXPERIENCED
Vitamin k	Anticoagulant	1mg	Intra-muscular	Prevent haemolytic diseases	No bleeding	Risk of hemolysis in people with G6PD, rashes and brain damage	None observed
Gentamycin	Antibiotics	2 drops	Instillation	Prevent eye infection	Increase risk of plastic anemia	Ototoxicity and nephrotoxicoty	None observed
Bacillus calmett Guerin injection	Antigen	0.5mg	Intra-dermal	Immunity against tuberculosis	Under observation	Mild fever, swelling of injection site blister formation	None observed
Polio	Antigen	2drops	Orally	Production of antibodies to prevent poliomyelitis	Under observation	There may be diarrhea	None observed
Hepatis B vaccines	Antigen	0.5ml	subcutaneaous	Immunity against hepatitis B virus	Under observation	Fever	None observed
Diphtheria pertussis tetanus	Antigen	0.5ml	subcutaneous	Immunity against diphtheria pertussis tetanus	Under observation	Fever	None observed
Haemophilus influenza hepatitis B	Antigen	0.5ml	subcutaneaous	Immunity against haemophilus influenza hepatitis B	Under observation	Fever	None observed


WHO Modified Partograph
Registration No: 31/22
Name(Last, First): Ameya O. Elizabeth
Age: 24years
Date: 23/11/22
Parity/Gravida: 3/2
LMP 14/8/22 EDD 24/11/22
Gestation(wks): 39weeks
ROM:
Labour Duration (Hrs): 6hrs
Facility/Clinic Name: Emi Health Center
Alert
Action
23/1/2023 SVD
Of LTC @ 8:30am
3rd stage - Completed
Perj - Intact
A/S - 8/10, 9/10
B/wt - 3.1kg
EBL - 150mls
D/L - 6hours 35minutes
HOURS
TIME

LABOR NOTES

At 8:30am, alive female child was delivered, cleaned and put on mother's abdomen to initiate skin to skin contact, APGAR 8/10, 9/10 respectively within the first and fifth minutes. Cord clamped and cut. 10units of oxytocin was administered on the mother's thigh, placenta and its membranes delivered at 8:35am. EBL was 150mls and perineum was intact. Mother was cleaned and made comfortable in bed. Client and baby were under close monitering.

Please circle or write responses.

DELIVERY

DATE: 23/11/22 TIME: 8:30am METHOD: (Spontaneous) / Vacuum Extraction / C/S / Other

PERINEUM: (Intact) / Episiotomy / Laceration

ANESTHESIA: (None) / Local / General

THIRD STAGE

Active Management: (Yes) / No Medication: Time 8:31am Type/Dose Oxytocin (10units)

PLACENTA: TIME: 8:35am (Complete) / Incomplete

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

BABY

Weight: 3.1kg

Sex: Male / (Female)

Baby Position: (Vertex) / Breech / Other

APGAR

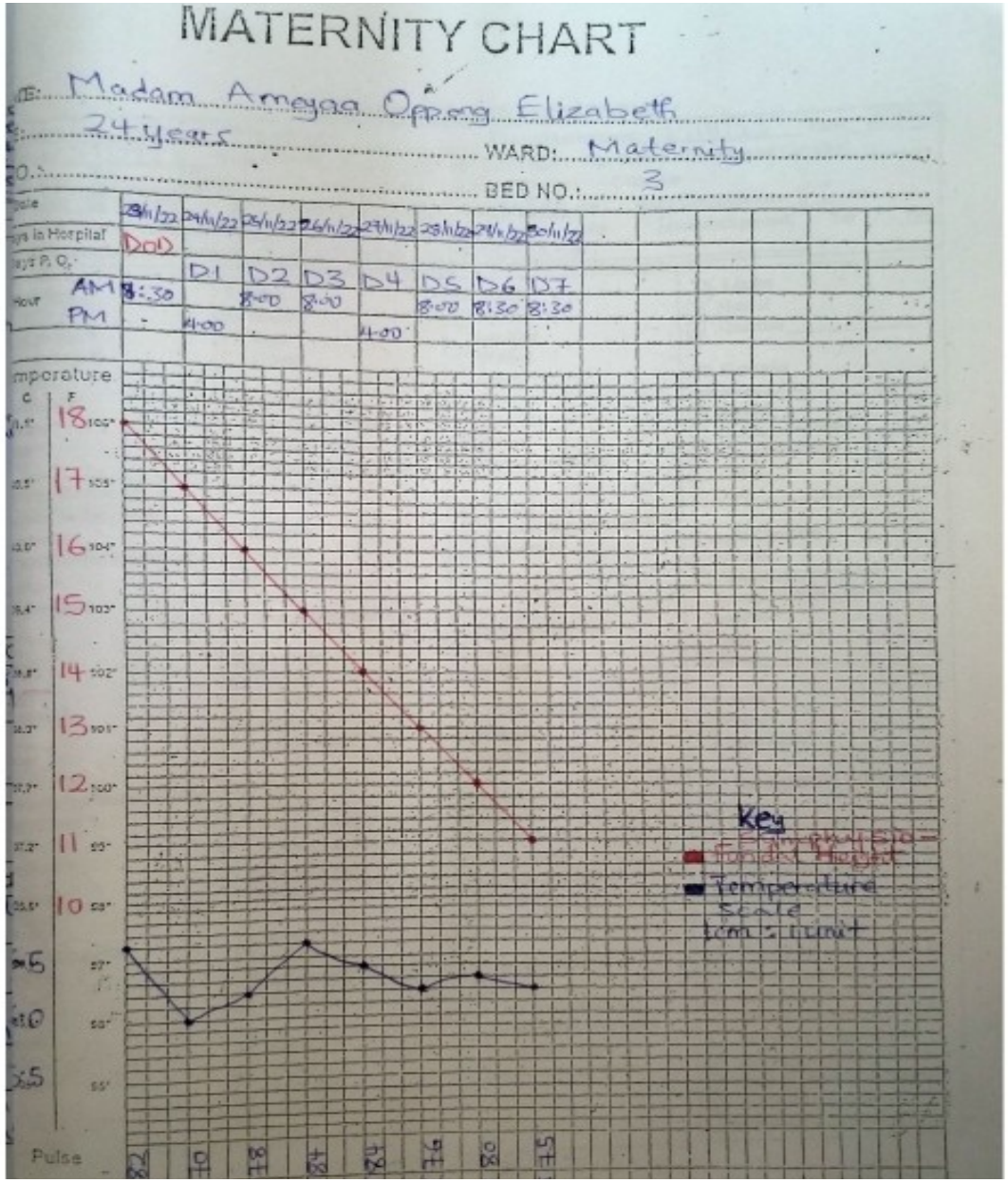
Time	Color	Breath	Heart	Tone	Reflex	TOT
1min	2	2	2	1	1	8
5min	2	2	2	1	2	9

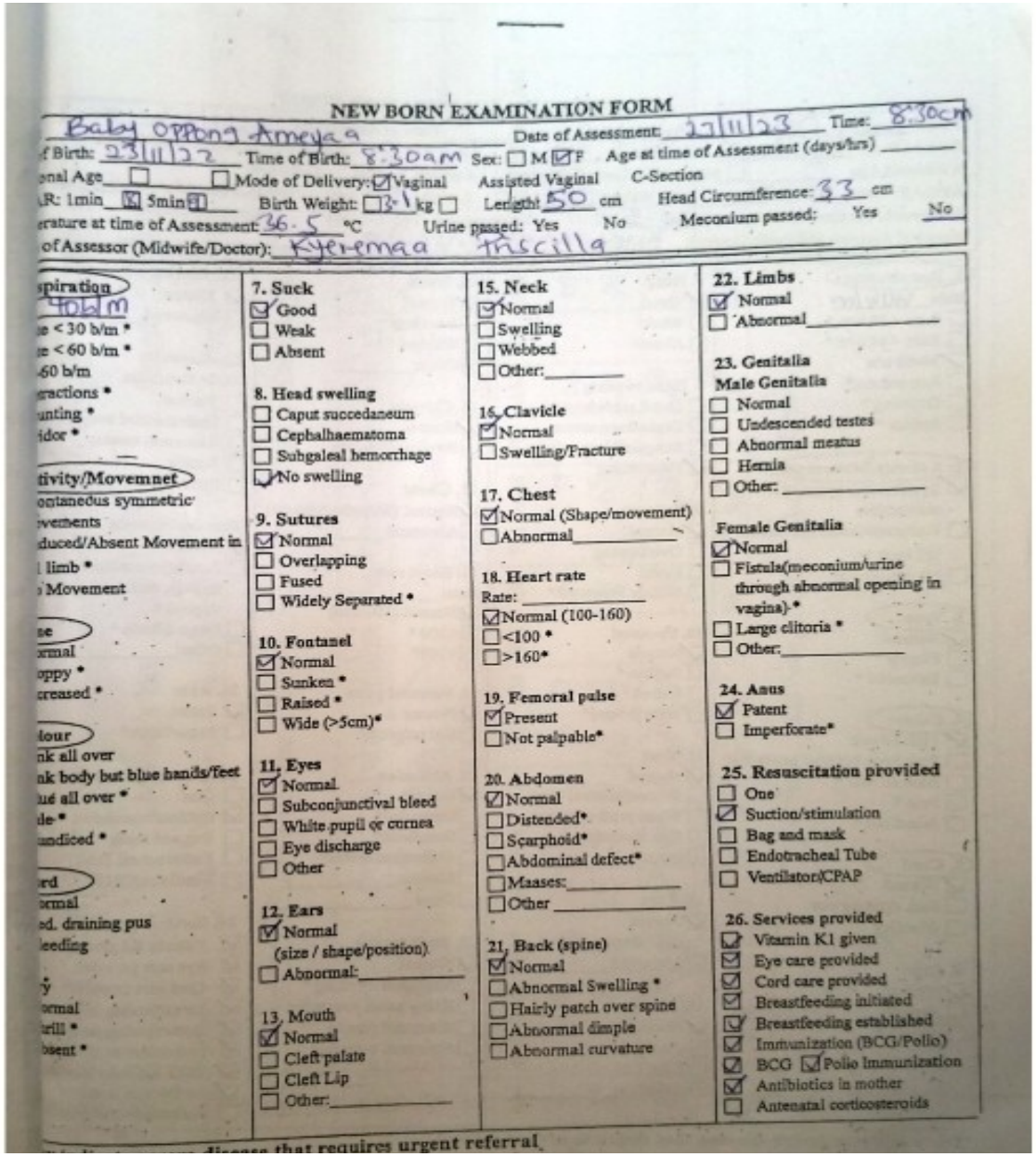
COMPLICATIONS OF MOTHER / BABY: (None) / Other:

FOURTH STAGE MONITORING

Frequency	Time	B/P.	Pulse	Fundus	Bleeding	Bladder
Every 15 minutes first 2 hours	8:45am	120/80	80	1F	No active bleeding	100mls
	9:00am	120/70	78	//	//	Nill
	9:15am	110/80	78	//	//	Nill
	9:30am	110/80	80	//	//	Nill
	9:45am	120/70	82	//	//	Nill
	10:00am	120/60	84	//	//	100mls
	10:15am	120/70	86	//	//	Nill
	10:30am	120/60	79	//	//	Nill
Every 30 minutes For 1 hour	11:00am	110/80	90	//	//	Nill
	11:30am	120/80	89	//	//	100mls

Birth Attendant Kyeremaa Priscilla assisted by Boatemaa Mavis (Midwife in charge) Date 23/11/22


MATERNITY CHART
Madam Ameyaa Oppong Elizabeth
24 Years
WARD: Maternity
BED NO.: 3
Temperature
Pulse
Key
Temperature
Pulse Rate
Temperature Scale
1cm : 1unit



NEW BORN EXAMINATION FORM

Baby OPPONG Ameyaa — Date of Assessment: 27/11/23 — Time: 8:30am

f Birth: 23/11/23 — Time of Birth: 8:30am — Sex: ☐ M ☑ F — Age at time of Assessment (days/hrs) _____

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

R: 1min ☒ 5min ☒ — Birth Weight: ☐ 3.1 kg ☐ — Length: 50 cm — Head Circumference: 33 cm

erature at time of Assessment: 36.5 °C — Urine passed: Yes — No — Meconium passed: Yes — No

of Assessor (Midwife/Doctor): Kyeremaa Priscilla

spiration
40b/m
e < 30 b/m *
e < 60 b/m *
-60 b/m
ractions *
unting *
idor *

tivity/Movemnet
ontanedus symmetric
vements
duced/Absent Movement in
limb *
Movement

se
rmal
oppy *
creased *

lour
nk all over
nk body but blue hands/feet
ué all over *
de *
ndiced *

rd
ormal
ed. draining pus
leeding

y
ormal
rill *
bsent *

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: _____

15. 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*
☐ Masses: _____
☐ Other _____

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

22. Limbs
☑ Normal
☐ Abnormal _____

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

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

diseases that requires urgent referral

NEW BORN EXAMINATION FORM

Name: Baby Oppong Ameyaa Date of Assessment: 23/11/23 Time: 8:30
Date of Birth: 23/11/23 Time of Birth: 8:30am Sex: ☐ M ☑ F Age at time of Assessment (days/hrs)
Astarional Age ☐ ☐ Mode of Delivery: ☑ Vaginal Assisted Vaginal C-Section
APGAR: 1min 8 5min 9 Birth Weight: ☐ 3.1 kg ☐ Length 50 cm Head Circumference: 33 cm
Temperature at time of Assessment: 36.5 °C Urine passed: Yes No Meconium passed: Yes
Name of Assessor (Midwife/Doctor): Kyeremag Priscilla

1. Respiration
Rate 40b/m
☐ 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: _____

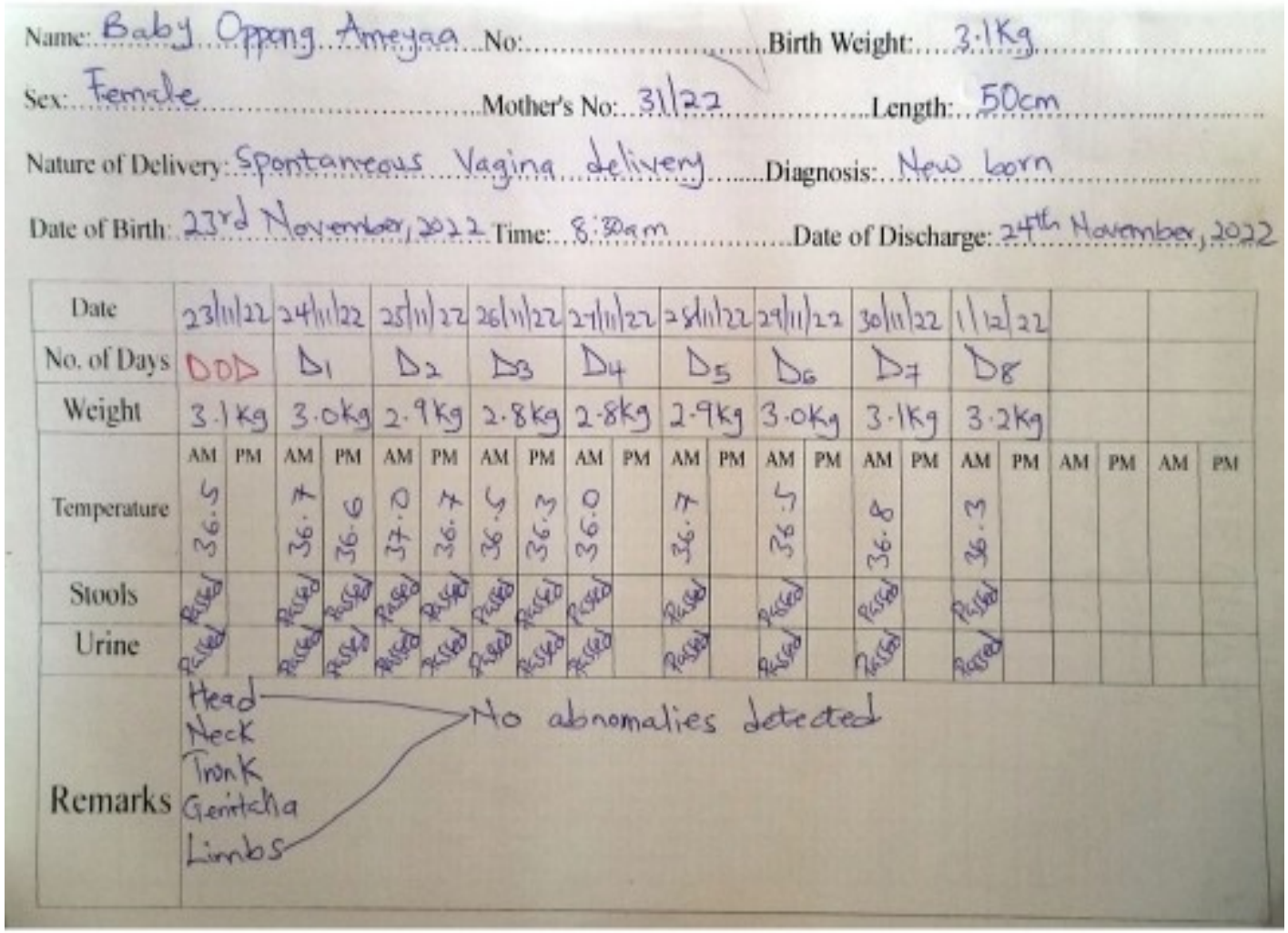
Female Genitalia
☑ Normal
☐ Fistula(meconium/urine through abnormal opening in vagina) *
☐ Large clitoria *
☐ Other: _____

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 Immunizat
☑ Antibiotics in mother
☐ Antenatal corticosteroids

*May indicate severe disease that requires urgent referral
Diagnoses (if known) _____



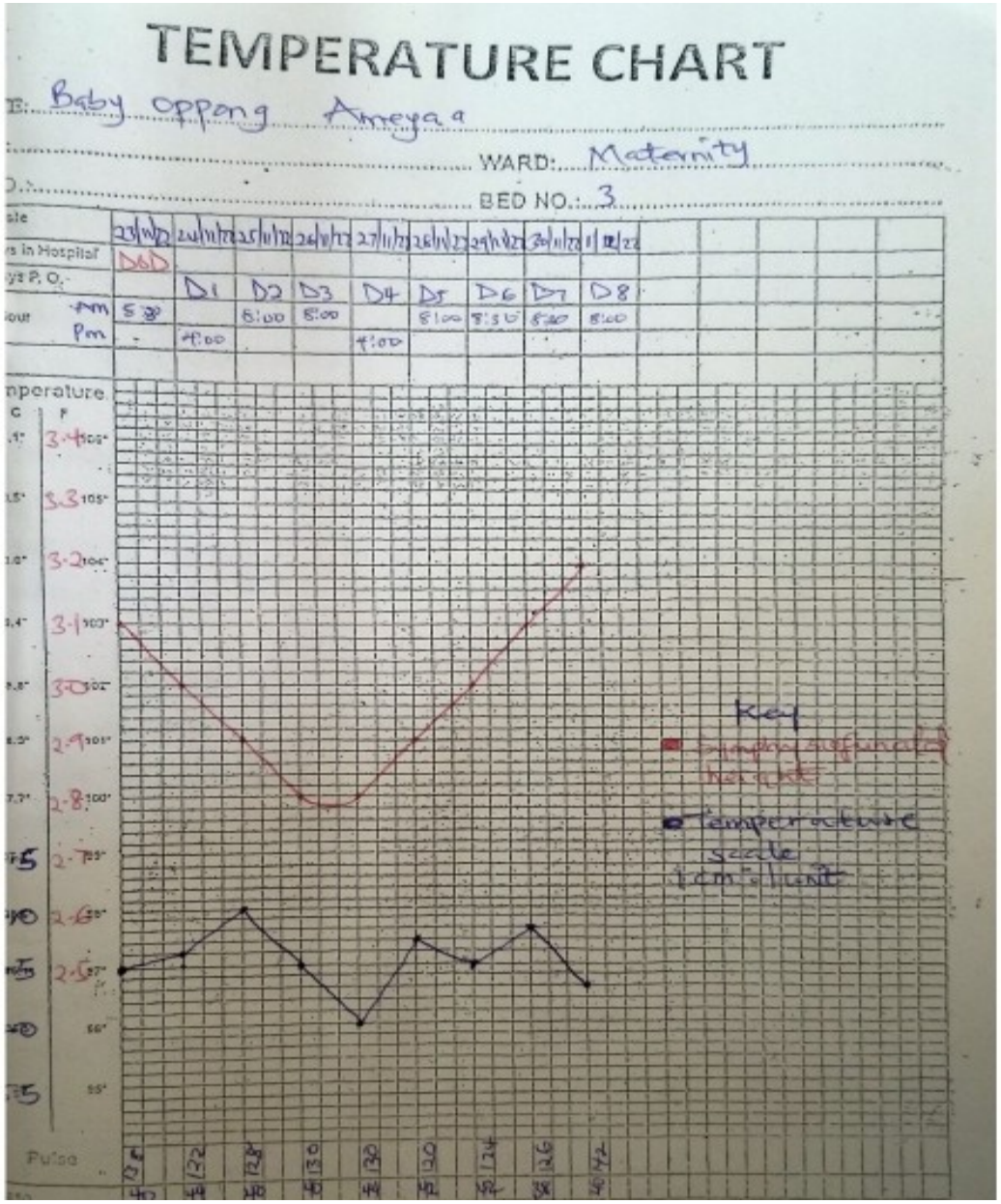
Name: Baby Oppong Ameyaa No: Birth Weight: 3.1Kg

Sex: Female Mother's No: 31/22 Length: 50cm

Nature of Delivery: Spontaneous Vaging delivery Diagnosis: New born

Date of Birth: 23rd November, 2022 Time: 8:30am Date of Discharge: 24th November, 2022

Date	23/11/22		24/11/22		25/11/22		26/11/22		27/11/22		28/11/22		29/11/22		30/11/22		1/12/22					
No. of Days	DOD		D1		D2		D3		D4		D5		D6		D7		D8					
Weight	3.1kg		3.0kg		2.9kg		2.8kg		2.8kg		2.9kg		3.0kg		3.1kg		3.2kg					
	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM
Temperature	36.5		36.7	36.6	37.0	36.7	36.5	36.3	36.0		36.7		36.5		36.8		36.3					
Stools	Passed		Passed	Passed	Passed	Passed	Passed	Passed	Passed		Passed		Passed		Passed		Passed					
Urine	Passed		Passed	Passed	Passed	Passed	Passed	Passed	Passed		Passed		Passed		Passed		Passed					
Remarks	Head Neck Trunk Genitalia Limbs — No abnormalities detected																					


TEMPERATURE CHART
Baby oppong Ameyaa
WARD: Maternity
BED NO.: 3
Key
Temperature scale
1 cm = 1 unit
Pulse

SIGNATORIES

THE STUDENT MIDWIFE

NAME: KYEREMAA PRISCILLA

SIGNATURE:

DATE: 12th June, 2023

THE MIDWIFE INCHARGE (EMI HEALTH CENTER – BEREKUM)

NAME: MISS AMARTEY EMILIA

SIGNATURE: (for)

DATE: 17/06/2023

THE SUPERVISOR

NAME: MS. UBAIDA ABDUL-KARIM

SIGNATURE:

DATE: 10/06/2023

THE PRINCIPAL

NAME: MONICA NKRUMAH

SIGNATURE: (A)

DATE: 17/06/2023