HOLY FAMILY NURSING AND MIDWIFRY TRAINING COLLEGE

BEREKUM

A CLIENT / FAMILY CENTERED MATERNITY CARE STUDY ON

MADAM MARY AFOSAA

BY

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SUBMITTERED TO THE NURSING AND MIDWIFERY COUNCIL OF GHANA INPARTIAL FULFILMENT TOWARDS THE AWARD OF LICENSE TO PRACTICEAS A PROFESSIONAL REGISTERED MIDWIFE.

(DIPLOMA)

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PREFACE

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

The maternity care study helps the student midwife to acquire knowledge which can be used to solve any problem associated with pregnancy, labor and puerperium. The competence of the student midwife is also tested in the practical aspect through the maternity care study which the student uses to identify both short- and long-term problems, set objectives for these problems and give intervention that will help her solve them. The main reason for carrying out this care study is to reduce maternal and infant mortality rate and to promote the health of the baby and mother, including the family. It is in this view that the World Health Organization (WHO) develops the partograph in managing the first stage of labor. Using this tool assists the midwife to identify any complication of labor for prompt intervention.

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

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INTRODUCTION

Family centered maternity care study which involves rendering holistic obstetric care to a specific client and her family from the first day we met during antenatal period through to labour and puerperium. The care study was conducted on Madam Mary Afosaa, 26 years old woman who is gravid 3 para 2 alive at the time of the study. She comes from Nkwabeng in the Bono East region.

The interaction with her started on the Wednesday, 16th August, 2023 during her sixth visit to the facility and she was 36 weeks + 6 days pregnant. She had a spontaneous vaginal delivery to a baby girl on 4th September, 2023. Care was rendered to her during pregnancy thus her antenatal visits through to labour and puerperium. Interactions with her ended nine days after delivery. The client was healthy throughout the beginning to end of the end of my interactions with her.

The study is divided into four (4) sections based on chapters as follows:

Chapter one (1) consists of client's social history, medical, surgical, past obstetrical, present obstetrical, family, menstrual history and habits of daily living.

Chapter two (2) consists of care delivered in the antenatal period. The chapter ends within care plan which outlines care given based on the nursing process.

Chapter three (3) narrative of the care given during the first, second and third stages of labour. It ends with a care plan.

Chapter four (4) explains the care provided during puerperium. It consists of daily visits to the client and family. The chapter also explains client's visit to the family for postnatal care. It also ends with a care plan.

This script also contains literature review, summary and conclusion to the whole study. It contains signatories which makes the work genuine.

LITERATURE REVIEW

This literature review gives information about what authors of different books report on pregnancy, labour and pueriperium.

PREGNANCY

According to Tiran, D. (2012) pregnancy is from conception to delivery of the fetus; normal duration is 280 days (40 weeks or 9 months and 7 days), counting from the first day of the last to delivery or 265 days from conception to delivery.

According to Marshall and Raynor (2014) pregnancy is divided into three trimesters. The first trimester is from conception until 12 weeks of gestation. The phase is associated with changes such as breast tenderness and feeling nauseated. The second trimester starts from 13 weeks to 25 weeks where pregnancy is noticed physically as the woman's body make-up changes to adjust to the pregnancy. The third trimester is from 26 weeks to 40 weeks, a period when the fetus continuous to grow and become matured for delivery. Care must therefore be taken once pregnancy has been confirmed so that the woman carries the pregnancy to term successfully.

According to Weller (2014), pregnancy is being with a child, the condition from conception to expulsion of the foetus. The normal period is 280 days or 40 weeks counted from the first day of the last menstrual period.

Myles (2014) describes pregnancy as a unique experience for every woman and each pregnancy the woman experiences will be new and uniquely different, nausea and vomiting, constipation, heartburns, headache, leg cram are minor disorders of pregnancy. Changes in the urinary system during pregnancy occur as a result of enlarging uterus affecting all the parts of the urinary tract at various times with the hormones of pregnancy having an even greater influence than mechanical effects. Progesterone relaxes the walls of the ureters, and allows dilatation and kinking. In some women this can result in stasis of urine resulting in marked infection

King (2014) states that, the prenatal period covers the time from the first day of the last menstrual period to the start of true labour, which marks the beginning of the intrapartum period. Prenatal period is divided into trimesters, the first trimester is 1to 12 weeks because organogenesis is completed at the end of twelve weeks (12) and the risk for spontaneous abortion is significantly reduced at this time. Second trimester is 13 to 28 weeks, third trimester extends from weeks 28 to 40. The term 'post- date' is typically used to describe a pregnancy beyond forty weeks (40)

According to Oduro-Kwarteng (2015), pregnancy is the condition of having a developing embryo or foetus in the uterus as a result of the union of an ovum and spermatozoa. Pregnancy can occur any time after a female begins to menstruate (menarche) in conjunction with ovulation until she reaches menopause where ovulation ceases.

LABOUR

According to Jacob (2013), labour is the process that involves a series of integrated uterine contractions that occur over time, and work to propel the product of conception (foetus, placenta and amniotic fluid) out of the uterus through the birth canal.

Konar (2013) states that, labour is the process by which the fetus, placenta and membranes are expelled through the birth canal. The events of labour are divided into four stages: First stage starts from the onset of true labour pains and ends with full dilation of the cervix. It is in other words the 'cervical stage' of labour. Its average duration is twelve hours (12) in prim gravida and (6) in multipara. Second stage starts from dilation of the cervix (not from the rupture of membranes) and ends with expulsion of the fetus from the birth canal. It mostly lasts up to 30 minutes in multiparous and 60 minutes in nulliparous women. Third stage begins after delivery of the fetus and ends with the expulsion of the placenta and membranes. Its average duration is

about 15 minutes in both primigravida and multipara. Fourth is the stage of observation for at least one (1) hour after expulsion of product of conception. During this period, general condition of the patient and the behavior of the uterus are to be carefully monitored.;

Marshall& Raynor (2014) stated that labour in the physical sense as the process by which the fetus, placenta and membranes are expelled through the birth canal. Normal labour occurs between 37 to 40 weeks of gestation. Labour begins when there are regular, painful contractions and with cervical dilatation. Signs and symptoms of labour are painful regular contractions, show, progressive dilation of the cervix, and sometimes ruptured membranes. First stage of labour begins with cervical dilatation which begins with rhythmic contractions until the cervix is fully dilated. This stage is in two phases, the latent phase is 0 - 3cm and the active phase starting from 4cm – 10cm when the cervix is fully dilated with both phases lasting from 8-12hours. Second stage of labour begins with the expulsion of the foetus from the birth canal. It begins when the cervix is fully dilated and the woman feels the urge to expel the foetus. It is however complete when the baby is born. This last from 30 minutes to 1 hour. The third stage is the separation and the expulsion of the placenta and its membranes as well as arrest of haemorrhage. From the above, it can be deduced that labour is a physiological phenomenon which can be managed by the midwife with the use of partograph, aseptic delivery process and active management of third stage of labour (control cord traction).

Myles (2014) describes labour as the process by which the fetus, placenta and membranes are expelled through the birth canal. It also explained that the first stage of labour can be divide into 3 stages namely;

- The latent phase which is prior to the active phase of first stage of labour and may last for 6-8hours in primigravida when the cervix dilates from 1cm to 3cm and to cervical canal shortens from 3cm long to less than 0.5cm long.

- The active phase which is the time the cervix undergoes more rapid dilation. This begins when the cervix is 4cm dilated and the presence of rhythmic contractions, is completed when the cervix is fully dilated (10cm).
- The transitional phase which is the stage of labour when the cervix is from around 8cm dilated until it is fully dilated or the until the expulsive contractions of second stage are felt by the woman. There is often a brief lull in the intensity of uterine activity at this time.

According to Tiran (2015), normal labour occurs spontaneously after 37 weeks' gestation with vertex presentation of single foetus, completed within 24 hours without maternal and foetal trauma; physiology depends on interaction between uterus, maternal pelvis and foetus.

PUERPERIUM

According to Jacob (2013), puerperium is a period following childbirth during which the body tissues especially the pelvic organs reverse back approximately to the pre-pregnant state both anatomically and physiologically, he further explained that, the post-partum period is divided in immediate puerperium that is the first 24 hours early puerperium from the end of all 24 hours up to 7 days. Remove 8 from the end of 7 days up to 6 weeks.

Konar (2013) states that, lochia is the vaginal discharge for the first fortnight during puerperium. The discharge originates from the uterine body, cervix and vagina. Depending upon the variation of the colour of discharge, it is named as;

- ❖ Lochia rubra; red, 1-4 days
- ❖ Lochia serosa; pink or pale brownish, 5-6 days
- ❖ Lochia alba; pale white, 10-15 days

Konar (2013) also added that, the average amount of discharge for the first 5-6 days is estimated to be 250ml, normal duration extends up to 3 weeks.

American Academy of paediatrics (2014) cited in their provider guide: Essential Care for Every Baby that all babies must be given eye care by instillation of tetracycline/chloramphenicol eye drop/ointment to prevent eye infection and also administering of vitamin K injection to prevent haemorrhage disease of the new born as well as cord dressing.

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

Oduro-kwarteng (2015), defines puerperium as a period that start immediately after delivery of the placenta to 6-8 weeks. This period is characterized by a lot of physiological changes, some of which include the following; lactation is well established, the productive organs return to the non-pregnant state.

According to Tiran (2015) puerperium is a period of six to eight weeks following childbirth during which the uterus and other organ structures return to their non-pregnant state.

Myles (2014) stated that puerperium starts immediately after delivery of the placenta and membranes and continues for six weeks after which all the systems in the woman's body will recover from the effects of pregnancy and return to their non -pregnant state. Myles strikes the difference between exercise and healthy activity verses rest, relaxation and sleep. Exploring each person's level activity will encourage advice in relation to appropriate exercise and by association, nutritional intake and rest or relaxation and sleep. Undertaking regular pelvic floor exercise is of benefit to the woman's long-term health. Myles mentioned that, regardless of whether women are breastfeeding, they may experience tightening, and enlargement of their

breast towards the 3rd or 4th day. Hormonal influences encourage the breast to produce milk. For women who are breastfeeding the general advice is to feed the baby and avoid excessive handling of the breast. Simple analgesics may be required to reduce the discomfort.

WHY CLIENT WAS CHOSEN

Madam Mary Afosaa was seen at Africa Libera at New Zongo, Nkoranza as a client on one of her usual antennal visits. During interaction, client was worried of having severe waist pains and severe heartburns. Upon her complains, Madam Mary Afosaa was educated on the causes of waist pain and the physiology of heartburns in pregnancy. She was also educated on how to manage these problems. After going through her antenatal booklet, she was qualified to be used for the care study, thus a multiparous woman with no complication in her previous pregnancy, labour and puerperium and also in her 36weeks +6 days gestational weeks. An opportunity was taken to introduce myself to her as a student midwife from Holy Family Nursing and Midwifery Training College, Berekum, who is on clinical practice and the interest to select her for the study. She agreed to be used for the study and she was thanked for understanding.

CHAPTER ONE

CLIENT PARTICULARS

1.0 INTRODUCTION

Assessment of client and family is the gathering of information from client which involves the client past and present obstetric, medical, surgical, menstrual, personal and family histories.

1.1 PERSONAL AND SOCIAL HISTORY

Madam Mary Afosaa is a 26 years old woman. She is Gravida 3 Para 2 (G3P2) all alive and comes from Nkwabeng in the Bono East region. She stays at Nkoranza specifically Kasadjan. She is 155 centimeters tall, 54.0kg in weight at booking and dark in complexion. She speaks Twi (native language) and English. Her educational level is at Junior High School. She is a trader by occupation. She is married to Mr. Appiah who comes from Techiman in the Bono East Region of Ghana. He is a trader and both the couple are Christians who worships with the Assemblies of God Church at Kasadjan. Madam Mary neither smoke nor drink alcohol. According to madam Mary, her mother is her next of kin.

1.2 FAMILY HISTORY

Madam Mary is the first child of three children born to Mr. and Mrs. Nyamekye. She stated that both parents are all alive and in good health. According to client, the family has no history of hypertension, no history of any hereditary diseases like mental illness, asthma, diabetes, sickle cell, jaundice and any congenital abnormality like cleft palate and lip, missing digits or extra digits. Client said there is history of multiple gestation in her family. Client husband's family has no history of the above diseases as well. She lives with her partner and their two children.

1.3 MEDICAL HISTORY

According to Madam Mary, she has no know medical condition like hypertension, sickle cell disease, diabetes, Jaundice, respiratory diseases (tuberculosis, cough and asthma), epilepsy and mental illness. She also has no known allergic reaction to food and drugs. Client also said she sometimes suffers from minor ailments like headache, general body pains and takes in over the counter drugs like Paracetamol from the community pharmacy or sometimes seeks healthcare at the out-patient-department of the Municipal Hospital, Nkoranza. She said she has neither donated nor received blood transfusion in her life.

1.4 SURGICAL HISTORY

Madam Mary stated that, she has never undergone any surgical procedure and has also never sustained any injury either through a road traffic accident or domestic accident that affected her pelvis. Upon examination, she had no scar indication surgical procedure.

1.5 MENSTRUAL HISTORY

According to Madam Mary she had her menarche at the age of fifteen (15). She states that she bleeds moderately with no dysmenorrhea for six (6) days. She uses a sanitary pad and changes it when soaked. Her regular menstrual cycle is twenty-eight (28) days. Madam Mary could not remember her last menstrual period and a scan was ordered and expected date of delivery was 7th September 2023 by scan.

1.6 CLIENT'S LIFESTYLE AND HOBBIES

Madam Mary wakes up around 5:30am, prays for about 10 minutes, brushes her tooth with tooth paste, empties her bowel and bladder. She goes about her daily domestic chores such as sweeping the compound, her room and sees to other household chores if any. She takes her bath and that of her daughters and prepares them for school. She prepares breakfast for the

family before escorting her daughters to the bus station. She then prepares and leave for work. Madam Mary eats at least three times a day.

According to client, she mostly leaves the work place at 4:00pm to the house to prepare supper for the family. After supper, she washes her cooking utensils, assist her daughters in doing their homework and prepares them for bed around 7:00pm. She finishes with the other house chores, takes her bath and go to bed around 8:00pm. On weekends she performs her house chores and either goes to funeral or wedding ceremonies. Madam Mary's favorite food is fufu with palm nut suop. She likes to watch television on her leisure time. She is a kind and generous woman. She does not drink alcohol nor smokes. She is an extrovert.

1.7 PAST OBSTETRIC HISTORY

PREGNANCY

Madam Mary is Gravida 3 Para 2 alive with no history of spontaneous or induced abortion. Madam Mary stated that, she has never had any complication in pregnancy such as anemia in pregnancy, pregnancy induced hypertension (PIH), pre-eclampsia, diabetes in pregnancy and vaginal bleeding which was confirmed in her Antenatal records book but did experienced some minor disorders of pregnancy such as ptyalism, backache and was managed. She attended Antenatal care (ANC) regularly at Africa Libera, New Zongo, Nkoranza and has received four doses of tetanus diphtheria injection in the previous pregnancy and took all the doses of sulphadoxine pyrimethamine. Madam Mary also stated that the interval between her pregnancies is 3years.

LABOUR

According to client, labour starts spontaneously in her pregnancies and so there was no induction or augmentation of labour. Her children were delivered per vaginum and they cried immediately after delivery but cannot remember the duration of labour. Placenta and its membranes were completely delivered shortly after delivery of the babies with minimum

blood loss and perineum was intact. Client said her children are with no abnormalities like cleft lip and palate, spinal bifida. According to Madam Mary, the birth weight of her first child was 3.5kg and the second child was 3.3kg and they are all female. There was no complication such as post-partum haemorrhage, retained placenta amongst others.

PUERPERIUM

Madam Mary said she went through puerperium successfully without any complication like puerperal infection or breast engorgement but experienced after pains of which she said resolved within some few days. She was in good health after delivery and she started breastfeeding her children immediately after birth. Her daughters were immunized against the childhood preventable disease and client practiced exclusive breastfeeding for six months and initiated complementary feeds. She breastfed for one year eight months before weaning the children completely. Madam Mary attended postnatal visits and was educated on family planning, the importance of child welfare clinic, nutrition and personal hygiene. Client was asked about her family planning method and she said she uses the natural family planning method and her daughters are in good health state. She further added that her support person was her husband and sister.

1.8 PRESENT OBSTETRIC HISTORY

Madam Mary's first visit to the hospital was 20th February, 2023 during which she was 11weeks and 4 days gestation. Client could not remember her last menstrual period and a scan was ordered which her expected date of delivery was 7th September, 2023 by ultrasound scan.

On Madam Mary's first antenatal clinic visit, her history was taken and recorded which included personal, family, medical, surgical and obstetrical histories. Laboratory investigations were also taken and physical assessment was done and recorded. Results of investigation which were carried out were as follows;

Haemoglobin level	-	12.2 grams per decilitre
Sickling test	-	Negative
Blood group	-	O
Rhesus factor	-	Positive
Hepatitis B	-	Negative
G6PD	-	No defect
PMTCT	-	280
Syphilis (VDRL)	-	Negative
Stool R/E	-	No abnormality detected
Urine R/E	-	Negative
BF for Malaria	-	Negative

Other observations made and recorded are as follows;

Temperature	-	36.1^{o}C
Pulse	-	82 beats per minutes
Respiration	-	18 cycles per minutes
Blood pressure	-	100/70 millimetres of Mercury
Weight	-	54 kilograms
Height	-	155 centimeters

Client's physical and abdominal examination were done and no abnormalities were detected. She also said she had no complains, therefore she was served with the following routine drugs;

Tablet folic acid 5 milligram (1 daily) for 30 days

Tablet ferrous sulphate 200 milligram (1 daily) for 30 days

Tablet multivitamin 200 milligram (1 daily) for 30 days

She received her fifth dose of tetanus diphtheria immunization on 10th March, 2023 which was confirmed in her antenatal book. Client said she was educated on the need to reduce

stressful work and have enough rest, sleep, leisure activities and was advised to be a regular attendant and was informed about her next visit. She was also asked to report to the facility anytime she had a problem.

CHAPTER TWO

ANTENATAL CARE

2.0 INTRODUCTION

Antenatal care refers to care given to a pregnant woman from the time conception is confirmed until the beginning of labour. Basically, this chapter deals with the first encounter with the client

During the antenatal period, client's subsequent visits to the antenatal clinic, subsequent antenatal home visits as well as the nursing care plan for client during the antenatal period.

2.1 FIRST CONTACT WITH CLIENT

Madam Mary was met for the first time on Wednesday, 16th August, 2023 when she was 36 weeks+ 6 days pregnant and it was her sixth visit to the antenatal clinic at Africa Libera, New Zongo, Nkoranza around 10:00am. Introduction was made as Adams Hamdiya Abrafi, a student midwife from Holy Family Nursing and Midwifery Training College, Berekum who has been stationed there for clinicals and to write a care study on a chosen client. The desire to take her as a client was expressed to her and she agreed and was glad. All the procedures to be carried out on her were explained to her understanding and she agreed for them to be done. Her vital signs, weight together with some laboratory investigations done on her were recorded as below.

Temperature	-	36.1^{o}C
Pulse	-	82 beats per minutes
Respiration	-	18 cycles per minutes
Blood pressure	-	100/70 millimetres of Mercury
Weight	-	54kilograms

Haemoglobin level - 11.2 g/dL

Urine testing

Specimen bottle was given to Madam Mary to collect urine to be checked for the presence of protein and glucose by the use of a urine reagent strip. It was explained to her that midstream urine was needed. Mackintosh apron was worn, hands were washed with soap under running water, dried and disposable gloves were also worn. The urine collected was checked for colour, sediments and blood products but none were present. It was smelt for bad odour but there was none. The urine was then placed on a flat surface. The reagent bottle was read and a strip was taken out. The strip was then dipped into the urine and removed immediately. The edge of the strip was tapped against the side of the urine container. It was then compared with the reagent bottle colour chat. The result for both protein and glucose were negative. Hands were washed with soap under running water and dried with a clean towel. Results were recorded in the antenatal book. After the procedure, physical examination from head to toe was explained to her and her consent was sought. Client was assisted unto a couch for the examination. Privacy was provided; hands were washed with soap under running water and dried with a clean towel.

Head-to-toe examination

REQUIREMENTS FOR HEAD-TO-TOE EXAMINATION

1. Sterile cotton wool swab in a sterile gallipot with a lid
2. Receiver for used cotton wool swabs
3. Fetoscope
4. Tape measure
5. A watch with a second hand
6. A pen and a client's folder

Client was examined from head-to-toe, under supervision of the midwife in-charge.

Head and neck

Client's hair was neatly braided. Lice and dandruff were absent on the scalp. There was no edema and rashes on the face or the eyelids. The sclera was checked for jaundice and the conjunctiva for pallor but none was detected. The nose and the ears were examined for pain and discharge but none was present. The lips were examined for dryness, pallor, sore and cracks but none was detected. There was absence of halitosis, the gum was inspected for bleeding which was absent and the tongue was neither pale nor coated. The neck was inspected and palpated for enlarged lymph nodes and distended veins but none was present.

Breast examination

Both breasts were exposed and inspected for the size and shape and the condition of the skin. One breast was covered and she was asked to put the hand of the part to be examined under her head. The breast was palpated thoroughly in a circular manner with the inner aspect of the fingers and there were no masses, lump, cracks or sore nipple. The areola was press for lumps. The nipple was squeezed gently for fluid (colostrum) and was examined for any abnormal discharge but was normal and it was cleaned with dry cotton. Same procedure was performed on the other breast and no abnormality was detected. Client was encouraged to wear a well-fitting brazier to support the breast and enhance comfort. She was also educated and taught how to perform self-breast examination.

Extremities

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

Back

The back was examined for spinal or vertebrae abnormalities such as costo-vertebral angle for tenderness, kyphosis, scoliosis but none was detected.

Abdominal Examination

The procedure and the reason for this examination were explained to the client's understanding. She was assisted to lie in a dorsal position with arms by her side to relax the abdominal muscles. Hands were rubbed together to warm it in order to help prevent pre-mature induction of contraction. Items used for the examination were shown to her to allay fear.

Abdominal Inspection

The shape of the abdomen was ovoid and medium in size. There was the presence of linea nigra and straie gravidarium. No scars were found on the abdomen which indicates no signs of previous surgical procedure performed on the abdomen such as caesarean section and myomectomy. There was evidence of fetal movement.

Measuring of Symphysio-fundal height The zero end of the tape measure was placed on the fundus of the uterus and was extended to the upper boarder of the symphysis pubis and the Symphysio-fundal height obtained was 35cm and her gestational week was 36 weeks and 6 days.

Abdominal Palpation

On abdominal palpation, hands were rubbed to generate warmth. The palms were placed on either side of fundus for fundal palpation. The fingers were curved around the fundus to determine what lies in the upper pole. The abdomen was palpated for tenderness, masses, enlarged spleen and liver, suprapubic tenderness but none was present. She was asked if there is pain and she replied negatively.

Fundal Palpation

Upon facing the head of the woman on her right-hand side, the fundus was palpated with both palms and the fetal buttocks were felt in the upper pole of the uterus.

Lateral Palpation

On lateral palpation, hands were placed on each side of the uterus, midway between the symphysis pubis and the fundus, the uterus was stabilized with one hand and examined with the other and the entire area was palpated from the abdominal midline to the lateral side and from the symphysis pubis to the fundus in a rotatory manner. A smooth curve was felt which indicated the back, the process was then repeated on the other side of the abdomen and an irregular mass and movement were felt which indicated the limbs. This helps to locate where to place the fetoscope to listen to the fetal heart sound.

Pelvic Palpation

Position was changed to face the feet of client. She was asked to bend the knees slightly and breathe in slowly. Palms were placed on either side of the lower abdomen just below the level of the umbilicus and fingers directed inwards and downwards toward the symphysis pubis with thumbs almost meeting. The head was palpated as hard mass occupying the lower pole. The presentation was cephalic and the lie was longitudinal.

Descent

The anterior shoulder was located first using two fingers. The upper border of the symphysis pubis was also located. Five fingers were admitted between the anterior shoulder and upper boarder of the symphysis pubis indicating descend of $5/5^{th}$ above the pelvic brim.

On Auscultation

The fetoscope was warmed by rubbing it in palm and was placed at the area where the back was located to listen to the fetal heartbeat. While listening to the heart rate, one hand was placed at the maternal radial pulse to ensure that it is not the maternal pulse being listened to. As soon

as the fetal heart beat was heard, client's hand was left. The fetal heart rate was checked for one minute noting the rhythm and volume and was recorded as 139 beat per minute.

Vulva examination

Permission was sought to inspect the genital area and she agreed. Hand were washed and dried. The vulva was inspected for edema, scar, genital warts, rashes, ulcer of the vulva, abnormal discharges and varicose veins but none was present. The mons pubis was well shaved. Client was encouraged to continue practicing good vulva hygiene. Client was asked to assume lateral position and sit up before getting out of bed. Hand washing was done and dried with clean dry towel. All findings were recorded in client's antenatal book and communicated to her. Client was advised on good nutrition and exercise. She was asked not to lift heavy objects and sit in between activities . She was advised to have enough rest and sleep. She complains of waist pain and severe heartburns. Madam Mary was educated on the cause of waist pain and physiology of heartburns due to the relaxation of the cardiac sphincter of the stomach causing reflux of acidic contents into the lower esophagus and was educated to minimize the intake of spicy foods, stay away from nauseated things and eat in bit. She was made aware that it was a normal physiology which will resolve after delivery. She was served with the following routine drugs;

Tablet folic acid 5 milligram (1 daily) for 30 days

Tablet ferrous sulphate 200 milligram (1 daily) for 30 days

Tablet multivitamin 200 milligram (1 daily) for 30 days

Client was asked to report to the clinic if any abnormality if she detects any abnormality. Education was given on birth preparedness and complication readiness. Since client agrees to be used for the study, an appointment was booked for home visit on the Friday, 17th August, 2023. Direction to her house was taken and contacts were exchanged. Permission was sought from the Midwife in-charge to escort her to the entrance of the maternity home.

2.2 FIRST ANTENATAL HOME VISIT

The first visit to Madam Mary's house was on Thursday, 17th August, 2023 around 5:20pm. The journey was easy due to the directions given by the client. The aim of the visit was to observe the environment where she lives, her source of water and light, the number of people she shares her room with, where she attends natures call (toilet), how she disposes off her refuse and also how she relates with her family members and her neighbours.

Upon arrival, a warm welcome was given and a seat was offered in client's room. She offered a bottle of cold drinking water. She was asked how, herself, her family were faring which she responded they were all fine. She was asked whether she was doing something but the response was no so conversation started

PHYSICAL ENVIRONMENT

During the interaction, it was identified that she lives in a single room with her husband.

The room was well kept and the furniture neatly arranged, it had adequate lightening, the windows were well arranged for proper ventilation, she was congratulated and asked to keep it up. Again, she was asked whether she sleeps under an insecticide treated bed net and she said yes. She was again educated on the importance of sleeping under an insecticide treated net. The room was not very neat since there was a partition on which some dirty clothes were hanged loosely. Also, their clothes were not well packed into their various bags.

She was advised to fold and pack the clean clothes nicely into their various bags and also not to hang any clothes whether dirty or neat on the partition since mosquitoes hide in them and come out at night to bite them. She was also advised to buy a laundry basket and keep the dirty clothes in them. Madam Mary had a kitchen. The kitchen was neatly kept; she has a kitchen cupboard in which she had neatly arranged her utensils. There were no dirty dishes found in

the kitchen. Her toilet and bathroom were well kept because she scrubs every day. A dustbin with a well-fitting lid was seen outside the house which she said she empties it every morning into the public refuse dump which is some few meters away from their house. She fetches water from her house.

Madam Mary was educated on the importance of maintaining good personal hygiene and encouraged to continue with her medication. She was asked to bring her layette for inspection; everything was intact as thought and she was congratulated on that. She was asked to identify a companion to help her when her time was due and was educated on complication readiness that is to get the contact of a taxi driver. She was asked whether she had any complaint that day and she complained of headache which was explained to her as a result of not taking enough rest and was educated to minimize the rate of doing house chores and take a time to relax. She was told to add her National Health Insurance identification card as well as her antenatal care book to the layette. She was thanked and permission was sought to leave. She was informed about the next visit to be 20th August, 2023.

PSYCHOSOCIAL

Madam Mary lives with her partner and relates well with her neighbors. Client said whenever there is a problem concerning the neighbor, she organized them to bring in their views on how to solve the issue. Madam Mary attend funerals, weddings and other ceremonies when the need arises with her husband. An introduction was made to a few neighbor who was around as a student midwife who will be taking her through pregnancy, labour and puerperium.

2.3 SECOND ANTENATAL HOME VISIT

The second home visit to Madam Mary's house was on Saturday, 20th August, 2023 at 3:20pm. She was met in the house chatting with some of her relatives who had visited her. They were greeted and a warm welcome was given and a seat offered. The wellbeing of the family was

inquired and she said they were all doing well by God's grace.

The aim of the visit was to inquire about her health whether some changes have been made on how to keep and arrange her bedroom well and neat. Client was asked about her previous complains and she said was better now. She was asked to make her layette ready and have a purse with her insurance card and money in it. Client was educated on birth preparedness and complication readiness that is, client should contact a taxi driver in case of emergency and get a blood donor. She was then congratulated and asked to keep it up. Education on rest and sleep as well as true labour signs was given to her and she was told to report to the clinic anytime she sees any of the signs. She was also encouraged to arrange with a taxi driver who would take her to the hospital when in labour. She was allowed to ask questions and appropriate answers were given. She complained of constipation. The physiology was explained to her as a result of the increasing weight of the gravid uterus and was educated to take more fluid and roughage diet, then she was educated on true sign of labour such as appearance of show, regular rhythmic contractions anytime she experiences that she should not hesitate to come to the heath facility. Permission was sought to leave, she was thanked and reminded of her next visit to the clinic again on 23rd August, 2023, of which she came and was taken care of at the antenatal clinic and no abnormality was detected and was doing well. Client was reminded of her next visit to the clinic again on 30thAugust,2023.

2.4 SUBSEQUENT VISIT TO THE CLINIC

On 30th August, 2023, Madam Mary visited the clinic at 10:00am. She was offered a chair and welcome. An enquiry was made about her heartburn and waist pain which she said was much better. But complained of not getting enough sleep at night as a result of frequent micturition at night, she was encouraged to take a warm bath and void before going to bed. The physiology of frequency of mitriction was also explained to her. She was asked about the signs of true labour to know if she recalled the education on the previous visit which she was able to mention

almost all of them. She was then congratulated. Client was examined from head-to-toe and no abnormality was detected and her gestation was 38 weeks and 6 days. Vital sign and other assessment are as follows;

Temperature	-	36.4^{o}C
Pulse	-	78bpm
Respiration	-	21cpm
Blood pressure	-	100/68mmHg
Weight	-	64 kg
SFH	-	37 centimeters
Descent	-	5/5th
Fetal heart rate	-	140bpm

Urine was tested for protein and glucose and was negative. She was educated to take in a lot of water, have enough sleep or rest and eat foods rich in energy and vitamins. She was educated on perineal hygiene. All findings were communicated to her and recorded in her antenatal care book. She was encouraged to take in her routine drugs and report to the facility if any labour signs or danger signs are seen.

2.6 ANTENATAL CARE PLAN

Nursing care plan seeks to identify problems and assisting to solve the ones involving the client and family.

PROBLEMS IDENTIFIED DURING ANTENATAL PERIOD

1. 16/8/2023 Client complained of heart burns
2. 16/8/2023 Client complained of waist pains
3. 17/8/2023 Client complained of headache
4. 20/8/2023 client complained of constipation
5. 30/8/2023 Client complained of insomnia

SHORT TERM OBJECTIVES

1.Client heart burns will reduce and be relieved within 48 hours

2.Client will be relieved of waist pains within 48 hours

3.Client's headache will resolve within 24 hours

4.Client will regain her normal bowel movement within 48 hours

5.Client will be able to sleep at least 6 hours within 24 hours at night

LONG TERM OBJECTIVES

Madam Mary will go through pregnancy successfully without any complications to both mother and fetus.

ANTENATAL CARE PLAN

Table 1: Nursing Care Plan for Madam Mary

Date and Time	**Nursing Diagnosis**	**Objective/Outcome Criteria**	**Nursing orders**	**Nursing Interventions**	**Date and Time**	**Evaluation**	**Sign**
16/8/23 At 10:00am	Heartburns related to regurgitation of stomach content	Client's heartburns will reduce within 48 hours as evidence by; 1. Client reporting that the intensity of heartburns has subsided 2.Client husband reporting that client heartburn has subside	1. Reassure client 2. Explain the physiology of heartburns to client. 3.Educate client to avoid spicy foods. 4. Educate client to sit upright after eating. 5. Educate client to wait a while after eating and before sleeping.	1. Client was reassured. 2. The physiology behind heartburns was explained to her. 3. Client reduced the intake of spicy foods. 4. Client was advised to sit upright during and after eating. 5. Client sat for a while after eating and before sleeping	18/8/2023 At 10:00am	Goal fully met as evidence by client verbalizing that heartburn is absent.	H.A.A

Table 2: Nursing Care Plan for Madam Mary Continue

Date and Time	Nursing Diagnosis	Objective/Outcome Criteria	Nursing orders	Nursing Interventions	Date and Time	Evaluation	Sign
16/8/2023 At 10:00am	Altered body comfort (Waist pains) related to effects of pregnancy hormones on the musculoskeletal system causing it to reflux	Client waist pain will reduce within 48 hours as evidenced by; 1.Client reporting that the intensity of waist pain has subside 2.client sister verbalizing that waist pain has subside	1. Reassure client to cope with pains. 2. Encourage client to have enough rest. 3. Explain the physiology behind waist pain to client. 4. Teach client the body mechanics. 5. Encourage client to wear low heel shoes.	1. Client was reassured to cope with the waist pain. 2. Client had enough rest. 3. The physiology behind waist pain was explained to client. 4. Client was taught to squat when picking items from the floor. 5. Client wore low heel shoes.	18/8/2023 At 10:00am	Goal fully met as evidenced by client verbalizing the rationale behind waist pains and she coped with a reduced waist pain.	H.A.A.

Table 3: Nursing Care Plan for Madam Mary Continue

Date and Time	Nursing Diagnosis	Objective/Outcome Criteria	Nursing orders	Nursing Interventions	Date and Time	Evaluation	Sign
17/8/2023 At 5:20pm	Headache related to stress.	Client headache will resolve within 24 hours as evidenced by; 1.Client's verbalizing that the pain has resolved 2.client sister verbalizing that pain has resolved.	1. Reassure client. 2. Educate client to have enough rest. 3. Monitor vital signs. 4. Administer prescribed analgesics. 5. Educate client to drink enough water during day time.	1. Client was reassured that the headache would resolve within 24 hours. 2. Client was educated to have enough rest in between activities. 3. Vital signs were checked to rule out hyperthermia. 4. Prescribed paracetamol 1g was administered to client. 5. Client was educated to drink enough water during day time.	17/8/2023 At 5:20pm	Goal met as client was relieved of headache.	H.A.A.

Table 3: Nursing Care Plan for Madam Mary Continue

Date and Time	Nursing Diagnosis	Objective/Outcome Criteria	Nursing orders	Nursing Interventions	Date and Time	Evaluation	Sign
20/8/2023 At 3:20m	Constipation related to inadequate fiber intake.	Madam Mary will regain her normal bowel movement once a day within 48 hours as evidenced by 1.Client verbalizing that she has no difficulty in emptying her bowel. 2. Client's sister confirming that client emptied her bowel	1. Reassure client. 2. Encourage client to take enough water. 3. Encourage client to take in fruit and vegetables. 4. Encourage client to take at least about 500mls of fluids on empty stomach preferably in the morning. 5. Advice client on active exercise.	1. Client was reassured on free bowel movement 2. Client drunk at least 8 cups of water daily 3. Client took in fresh fruit and vegetables e.g., Kontomire, orange etc. 4. Client drunk at least 500mls of warm or cold fluids on empty stomach preferably in the morning. 5. Client walked around as a form of exercise.	22/8/2023 At 3:20am	Goal fully met as client verbalized that she empties her bowel once daily.	H.A.A.

Table 4: Nursing Care Plan for Madam Mary Continue

Date and Time	Nursing Diagnosis	Objective/Outcome Criteria	Nursing orders	Nursing Interventions	Date and Time	Evaluation	Sign
30/8/2023 At 10:20am	Altered sleep pattern related to frequency of micturition	Client will be able to sleep for at least 6 hours at night within 24 hours as evidenced by; 1.Client verbalizing that she had 2 hours rest during the day and 6 hours sleep at night within 48 hours. 2.Client husband confirming that she had 2 hours rest during the day.	1. Reassure client. 2. Explain the physiology of frequent micturition. 3. Advise client to keep bedpan at bedside. 4. Encourage client to void before going to bed. 5. Encourage client to take in small amount of fluid prior to bed.	1. Client was reassured. 2. Physiology of frequent micturition was explained. 3. Client was advised to keep bedpan at bedside when sleeping. 4. Client voided before going to bed. 5. Client took in small amount of fluid prior to bedtime,	31/8/2023 At 10:20am	Goal fully met as evidence by client verbalizing that she had 2 hours rest during the day and 6 hours sleep at night.	H.A.A.

CHAPTER THREE

LABOUR

3.0 INTRODUCTION

The content of this chapter describes the management of the first, second, third and fourth stages of labour, the immediate and subsequent care performed on the newborn, problems identified and the care plans drawn for the management of the problems encountered during labour and delivery.

3.1 ADMISSION AND MANAGEMENT OF FIRST STAGE OF LABOUR

On Sunday, 3rd September, 2023, Madam Mary arrived at the labour ward at 11:30pm accompanied by her sister. Madam Mary, together with her sister were warmly welcome and offered a seat. Client had a history of waist pain, lower abdominal pain, having seen a bloody mucoid discharge and was feeling uncomfortable that compelled her to rush to the facility. Before examination, the antenatal card was collected and quickly glanced through with the Midwife-in-charge to know her gestational age. According to client, she ate rice and stew as supper. She added that she has not taken any medication apart from the routine drugs received during the antenatal care. Items for delivery were collected and labelled, these include; perineal pad, rubber, baby's cot sheet, socks, cap, mittens and diaper. The physiology of the stages of labour were explained to client. Her sister was asked to wait outside and was reassured that Madam Mary was in the hands of competent student midwife as well as staff midwife who was the supervisor. Client was taken to the delivery room and was made comfortable in a well laid bed.

Procedures to be done were explained to her and consent was gained. Client's vital signs checked and recorded as follows;

Temperature	-	36.2^{o}C
Pulse	-	80bpm
Respiration	-	22cpm
Blood pressure	-	120/80 mmHg

Client was served with a bedpan to empty her bladder and also to bring a midstream urine sample for testing. The amount of urine emptied was 150mls clear umber urine. The midstream urine was tested for protein and glucose and it was both negative. Client was helped unto the couch; hands were thoroughly washed with soap under running water and dried with a clean towel. It was explained to client that, the examination was done to check the position and presentation of the fetus, check the fetus condition and check if the fetus is descending into the pelvis. Consent was sought to examine her from head-to-toe. On examination, jaundice, anemia nor edema was not detected.

On abdominal examination

Inspection: the abdomen was ovoid in shape and medium in size with on scars of previous caesarean section observed but there was linea nigra and striae gravidarum present on the abdomen.

Measuring of the Symphysio-fundal height:

The symphysio-fundal height was measured from the fundus to the symphysis pubis which measured 37cm and the gestational age was 39 weeks and 3 days. With clean and warm hands, the abdomen was palpated. The abdomen was not tender to touch as well as no enlarged spleen or liver could be identified.

On fundal palpation: Standing on the right-hand side of the client while facing her, palms were rubbed together and gently fundus was palpated. The upper pole of the uterus was occupied with the fetus buttocks.

On lateral palpation: Fetus presented with limbs on the left-side and back at the right-side of the mother's abdomen.

On pelvic palpation: the fetal head occupied the lower pole of the uterus. The lie was longitudinal and the presentation was cephalic.

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

On auscultation: The fetoscope was warmed and placed on the abdomen where the back of the fetus was located and each heart beat was counted for a period of one minute and in all 141 beats per minute was record with regular and good volume. Contractions were time for ten minutes and recorded as 3:10 lasting 35 seconds.

Vaginal Examination:

Requirement

1. Two sterile gallipots, with each containing cotton wool swab and savlon respectively.
2. Receiver for used swap.
3. Sterile gloves
4. Perineal pad.

Permission was sought for vaginal examination and it was explained to Madam Mary. Client was asked to lie in a lithotomy position with knees flexed thighs parted. Hands were washed and dried and a pair of sterile gloves were worn. With left hand, a soiled pad was removed and discarded. On inspection, there was no scar from previous birth, rashes, warts, varicose vein, lesions or sores and edema. Show could be seen from the vagina orifice and was not offensive. On examination at 12:00 am, with the right hands, cotton wool swabs were dipped into savlon lotion. Swab was dropped from the right hand into the left hand per stroke. Labia majora was wiped from the anterior to posterior and used swabs were disposed into the receiver. Labia

minora was wiped also from the anterior to posterior with used swabs into the receiver. The vestibule was parted using the left hand, a swab was used to wipe the vestibule from anterior to posterior. Client permission was sought and middle finger of the right hand was gently inserted into the vagina but firmly pressing downwards, the index finger was also inserted for examination. The vagina felt warm and moist, cervix was soft but tough, effaced and cervical dilation was 5 cm with membranes intact with the presenting part well applied to cervix, no moulding. The sacral promontory was not reached, the ischia spines were blunt. The sacrum was well curved. A fist was made and it fitted into the intertuberous space. She was cleaned and a perineal pad was applied to the perineum. The used cotton wool swabs were disposed and the gallipots and receivers were immersed in 0.5% chlorine solution. Client was asked to sleep on her left lateral side. Gloves were removed by inverting them inside out and disposed off into a metal container. Hands were thoroughly washed dried. She was helped out of bed. Dilatation board was used to explain how far she had gone with labour and advised on deep breathing exercises as she complained of lower abdominal pains. She was also encouraged to ambulate and to empty her bladder frequently when she felt the edge to. Findings were communicated to her and was encouraged to ask questions.

3.2 PREPARATION FOR BIRTH

In preparation for birth, the Midwife-in-charge who would supervise labour and delivery and also assist in the care of the baby was identified as the skilled helper whereas the unskilled helper happened to be the client's sister, who accompanied her to the clinic and would run errands when the need arises. Emergency plan was reviewed, which includes communicating with the physician assistant to be alert and attend to any emergency when needed. Client's sister was asked to inform a taxi driver to be alert in case of emergency. The delivery room area was cleaned and good source of light was ensured and an emergency portable light was present and functioning. Preparation of the area for ventilation and certain windows and doors

were closed to provide privacy and warmth. A dry, flat and safe surface was prepared for receiving the newborn. The resuscitation tray was checked, cleaned and all equipment and instruments were assembled and tested for their function. Client's hand and abdomen was washed when second stage was eminent to prepare skin-to-skin care to prevent infection to the newborn. The delivery pack and emergency drugs like magnesium sulphate, oxytocin among others were made available.

3.3 MANAGEMENT OF FIRST STAGE OF LABOUR

Contractions were becoming frequent and strong. Deep breathing exercise was encouraged during contractions and also discouraged from pushing to prevent edematous cervix. Client was assigned to assume a comfortable position (lithotomy).

At 4:00am, hand hygiene was performed, sterile gloves were worn and vaginal examination was conducted. The cervix was 9 cm dilated as membrane ruptured spontaneously while removing examining fingers, the amniotic fluid was clear and moulding of one plus (++). Abdominal examination revealed, fetal heart rate of 142 bpm with descent of two-fifth. Contractions were 4 in 10 lasting 44 seconds. Findings were communicated to her and was asked to ambulate and to lie on her left side when tired to prevent the uterus from pressing on the inferior vena cava which can alter blood circulation to the fetus. She was asked if she had any complains and she complained of painful uterine contraction and was encouraged to relax and was reassured that, contractions aid in the dilatation of the cervix and that in no time she will be due. She was asked to change her pad when it is soaked and was educated on the need to change it frequently. Her sister who was waiting out was informed about the progress of labour. She was encouraged to sit with client and give her a sacral massage from time to time. Client complained of frequency of micturition, she was encouraged to empty her bladder whenever she had the urge to, as this help in the descent of the fetal head. She also complained of feeling nausea and salivating. The physiology behind the feeling of nausea and excessive

salivation was explained to the client and was asked to avoid things that makes her more nauseated and take more water. Madam Mary also complained of waist pain and the physiology was well explained to her. She was anxious. There was monitoring of maternal pulse, respiration, contractions and fetal heart rate at every 30 minutes. The temperature, blood pressure, descent and vaginal examination were done every 4 hourly and all results were plotted on the partograph.

Findings were recorded on the partograph as follows;

Temperature	-	$36.7^{o}c$
Pulse	-	79 beats per minutes
Respiration	-	21 cycles per minutes
Blood pressure	-	110/70 millimeters of Mercury
Fetal heart rate	-	142 beats per minute
Contractions	-	4 in 10 lasting 44 seconds
Descent	-	$0/5^{th}$
Urine	-	100 milliliters
Protein	-	Negative
Glucose	-	Negative

The trolley was cleaned and a sterile delivery pack with other clean items were made available on both top and bottom shelf as below;

THE TOP SHELF

a. Two sterile artery forceps
b. A sterile cord scissors
c. Two gallipots with cotton wool swabs and gauze
d. Cord clamp
e. Four sterile drapes

f. Sterile episiotomy set (2 dissecting forceps, suturing forceps, episiotomy scissors)

g. Receiver

LOWER SHELF

a. Cot sheets

b. Perineal pads

c. Measuring jug

d. Antiseptic solution

e. Mackintosh

f. Examination gloves

g. A receiver for placenta

h. Bed pan

i. Fetoscope

j. Lidocaine

k. Injection tray containing oxytocin, vitamin K, syringe and needle

l. Bulb syringe in bowel of water

m. Sterile gloves

3.4 MANAGEMENT OF THE SECOND STAGE OF LABOUR

Full dilatation of the cervix was confirmed by the midwife on duty at 5:00am and client was asked to assume any comfortable position she wished and she opted for the lithotomy position after showing her various types during the first stage of labour. Windows were closed and curtains were well drawn. She was then assisted to assume the position. Protective clothing such as mackintosh apron, face mask, goggles, boots and cap were worn. Hand washing was done and sterile gloves were worn. The vulva, perineum, pubis and the inner thighs of the client were swabbed with gauze soaked in savlon solution and client was draped with a sterile drape. A pad was applied over the anus and the perineum to prevent fecal matter from contaminating

the delivery field and she was asked to push with contractions. As the head advanced, flexion was maintained with two fingers placed on the head to allow the smallest diameter of the fetal head to distend the vulva. She was encouraged to rest if there were no contraction and was reminded that the body will be delivered onto her abdomen. When the head crowned, she was asked to pant and give only small pushes with contractions to prevent rapid expulsion of the fetal head which could result in perineal tears and intracranial injury.

By extension of the fetal head which is one of the movements used by the fetus as it passes through the birth canal, the sinciput, face and mentum swept the perineum and the head was born. The baby's face and eyes were gently wiped inside out with sterile gauze. The neck was felt for the cord around the neck but none was detected. Restitution was followed by external rotation of the head, which indicated internal rotation of the shoulders. The palms were placed on each side of the baby's head and she was asked to push gently. The anterior shoulder was delivered by downward traction and posterior shoulder by upward traction. With lateral flexion the rest of the body was delivered onto the mother's abdomen as the midwife-in-charge noted the time as 5:45am (Monday, 4th September, 2023). The baby cried immediately after delivery, liquor was wiped of the baby with a clean cot sheets, the wet sheet was changed and replaced with dry one to prevent heat loss. Baby was placed on mother's abdomen for skin-to-skin contact for one hour and covered with a cot sheet to prevent heat loss, provide warmth and promote bonding. First minutes Apgar score was 8/10.

3.5 IMMEDIATE CARE OF THE BABY

Immediately after the delivery of the baby, eyes were cleaned with sterile gauze from inner canthus outwards. Baby's mouth and nose were gently suctioned to clear the airway and to prevent aspiration of secretions. The baby was dried thoroughly with warm sheet and wet sheet removed and replaced with warm dry sheet to prevent hypothermia after delivery. The cord was clamped two fingers breadth away from the baby's abdomen and the second clamp was

placed three fingers breadth away from first clamp. The cord was cut within 2 minutes after it no longer pulsed with a sterile cord scissors. Mother identified the sex of the baby as a female when shown to her. The baby was placed on the mother's abdomen to ensure skin-to-skin contact and bonding. Breathing pattern was also monitored. First and fifth minute APGAR score were 8/10 and 9/10 respectively. Breastfeeding was initiated.

The Apgar score assessment was as follows:

INDICATOR	**FIRST MINUTE**	**FIFTH MINUTE**
Appearance	1	2
Pulse	2	2
Grimace	1	1
Activity	2	2
Respiration	2	2
Total	8/10	9/10

3.6 MANAGEMENT OF THE THIRD STAGE OF LABOUR

Client still in the lithotomy position, abdomen was palpated to exclude undiagnosed twin and there was none. 10 units of oxytocin was injected intramuscularly on the thigh by the midwife-in-charge, one minute after delivery of the baby which is to aid contraction of the uterus and separation of the placenta. The cut end of the cord was placed in the receiver and placed in-between the thighs near the perineum to receive the placenta and its membranes. Controlled cord traction was used in the delivery of the placenta. The cord was re-clamped closer to her perineum. The left hand was placed on the fundus to check for contractions and as soon as contractions was felt, the hand was repositioned above client symphysis pubis with palm facing the woman's umbilicus and the other hand held the clamped cord. Counter pressure was applied to avoid inversion of the uterus and with controlled cord traction, when the uterus contracted,

the cord was downwardly and steadily pulled to deliver the placenta. The process was repeated until placenta became visible at the vulva. The placenta was cupped by both hands and twisted to remove pressure on the fragile membranes. The placenta and its membranes were delivered completely at 5:50am (5 minutes). A quick examination of the placenta was done to ensure there was no retained products. It was placed in a receiver for further examination later at the sluice room. The uterus was massaged until it was well contracted and client was taught how to massage her uterus to expel blood clots. Expelled blood clots were added to the blood loss. Gauze was wrapped on the index and middle fingers of both hands to examine the vagina for laceration or tears. The cervix was also examined in clockwise manner to rule out any cervical tears, there were no laceration or tears on examination. Client was clean off liquor and blood with a clean pad after the examination. A new perineal pad was applied. She was made comfortable in bed with baby still on abdomen and covered with dry cloth. Blood loss was estimated as 200mls.

3.7 EXAMINATION OF THE PLACENTA AND MEMBRANES

Under a good source of light, a thorough inspection of the placenta and membranes were done in order to ensure that no part has been retained during delivery. The placenta was immersed in 0.5% chlorine solution. The cord had a normal size and cut edge of the umbilical cord had one vein and two arteries surrounded by Wharton's jelly. The cord insertion was central. The placenta was held by the cord with the membranes hanging. The membranes were examined for completeness by spreading out hands inside the membranes and was intact. The placenta was laid on a flat surface for further examination. The amnion was peeled from the chorion up to the umbilical cord to permit full visualization of the chorion. The branches of the cord vessels were seen radiating on the fetal surface. The fetal surface was shiny and bluish grey. The placenta was placed in the palm with the maternal surface facing downward. The lobes fitted together without any gab and edge also forming uniform circle at the maternal surface and this

indicated there was no missing lobe. There were no white patches (infarcts), no extra lobes nor edematous lobe on maternal surface. There was no abnormality detected. It was then decontaminated and disposed appropriately. The working area was wiped off with 0.5% chlorine solution. All the instruments used were kept in 0.5% chlorine solution for 10 minutes. The instruments were removed, washed, rinsed, dried and made ready for sterilization. All findings were recorded on the labor ward sheet, delivery book and summary of delivery in the antenatal booklet. The partograph was then completed.

3.8 MANAGEMENT OF FOURTH STAGE OF LABOUR

This is the period of six hours after delivery of the placenta during which both the mother and baby are monitored continuously in order to detect early complications, Madam Mary and her baby were monitored for six hours before transferring them to the lying-in-ward where they were closely observed for six hours after a successful completion of the third stage of labor. During this stage, the mother and the baby were assessed in every 15 minutes for 2 hours, 30 minutes for an hour and hourly for three hours which was recorded behind the partograph to detect any deviation from normal.

Post-delivery vital signs checked and recorded as follows;

Mother

Temperature	-	36.0^{o}C
Pulse	-	80 beats per minutes
Respiration	-	20 cycles per minutes
Blood pressure	-	110/70 millimeters of Mercury

Madam Mary was encouraged to massage her uterus to facilitate contraction. Blood clots were expelled and blood loss was 150mls, and the symphysio-fundal height was 18 centimeters. She was encouraged to void frequently and change perineal pad when soaked. Lochia was bright red (rubra) in colour with small flow and she was advised to show her soaked pad before she

discarded it for colour of lochia, amount of blood loss and odour. She was encouraged to have some rest. Client was transferred to the lying-in-ward and baby put to breast. Her sister was allowed into the lying-in to see her sister and the baby, she was happy when she saw them. Client and her support person were educated on the need for rest and sleep and also educated on the importance of breastfeeding and demonstration on proper positioning when breastfeeding was taught. Mother and her newborn were made comfortable in bed and also congratulated for her co-operation. She was encouraged to breastfeed the baby on his demand.

Baby

PREVENTION OF DISEASE IN THE NEWBORN

After the baby was born, two (2) drops of Chloramphenicol eye drop was instilled on each eye to prevent eye infection. Hand washing was done and sterile gloves were worn, cord was dressed with methylated spirit and sterile cotton wool to prevent any infection and to also keep the cord dry at all time. Injection 1mg of vitamin K was given intramuscularly to prevent bleeding. The baby was covered to provide warmth to prevent heat loss. The baby was given to his mother and was asked to put her to breast. Mother was educated on the need to use only methylated spirit given to her to dress the cord and avoid application of herbs, other creams and cow dungs on the cord to prevent infection of the cord.

3.9 EXAMNINATION OF THE NEWBORN

The procedure to be carried out on the baby was explained to the mother and consent sought. Handwashing was done under running water with soap and dried with a clean dry towel and examination gloves were worn. All nearby windows were closed and baby was put on a flat surface for examination in the presence of the mother. Baby was exposed systematically as it was examined from head-to-toe. Its general condition was checked to be normal and colour was pink on observation.

Skin

The baby was pink in colour. There were no rashes or birthmarks seen. Lanugo hair was present and skin was intact and smooth with little vernix caseosa.

Head and neck

The face was pink with no birth mark. The head was examined and there was no caput succedaneum. The fontanels were not bulging or sunken and were pulsating normally with no widened sutures. The mother was encouraged not to use any hot water on the head. She was educated that the posterior fontanelle would close within six (6) weeks and anterior fontanelle would also close within eighteen (18) months. The head circumference of the baby was measured using a tape measure to encircle the baby's head starting from the occipital protuberance to the supra-orbital ridges and it measured 34 centimeters. The ears were normal sized and shaped and the cartilage of the pinna was medium in texture. The eyes were in normal alignment. The sclera and conjunctiva were pink in colour with no discharges or jaundice. The ears were patent. The nose was of normal size and shape with a normal central septum. The nostrils were patent. The lips and tongue were pink, no tongue-tie, no false teeth and no cleft lip or palate were detected. Rooting, suckling and swallowing reflexes were evident. The neck was palpated for swellings and enlarged lymph nodes or congenital goitre but there was none.

Extremities

The upper extremities were equal with no extra digits, clubbing, webbing, or a missing digit. The capillary refill did not delay at all when finger was pressed. There were palmer creases and movement present. Grasping and Moro reflexes of baby were present. The lower extremities were equal. There was no extra digit, webbing, clubbing or forefoot adduction. There was no dislocation of the hip. Knee jerk and planter reflexes were normal.

Chest and Abdomen

The abdomen felt soft and round not distended and without any palpable masses. The cord was situated centrally and no bleeding was seen. The abdomen was of normal shape and size. The cord had one vein and two arteries. On the chest the trunk had a normal size. The breasts were normally situated with no engorgement or mass. The nipples were in alignment with no extra ones. Respiratory movement was normal.

Back

The back and spine were also examined for any abnormal curvature, swellings, and injuries but none was detected. There were no abnormalities of the back such as spinal bifida or meningomyelocele detected.

Genitalia and Anus

The vulva, labia, clitoris and vagina were examined for foreign bodies, patency and discharge. The urethra was inspected for patency. Anus was patent as the urethra as it passed urine and meconium respectively. Gloves were removed and disposed aseptically before washing and drying hands with a clean towel.

The length of the baby, weight and head circumference were checked and gloves were removed and disposed off according to infection prevention guidelines. Hands were washed and dried, weight and height checked and recorded as 3.5 kg and 50 cm respectively and head circumference was 34cm when measured. Vital signs were checked and findings were communicated to mother as follows;

Temperature - 36.7^{o}c

Apex heart beat - 141bpm

Respiration - 33cpm

3.10 SUMMARY OF LABOUR AND DELIVERY

CONDITION OF BABY AT BIRTH

After birth, baby was wrapped with warm cot sheet and was sent to mother side to start breastfeeding and her general condition was satisfactory. The following findings were obtained and recorded;

Temperature	-	36.7^{o}c
Apex heart rate	-	141 bpm
Respiration	-	33 cpm
Baby's weight	-	3.5 kg
Head circumference	-	34 cm
Length	-	50 cm
General condition of baby	-	Satisfactory
Meconium	-	Passed
Urine	-	Passed
Sex	-	Female

SUMMARY OF LABOUR NOTE

Date and time of delivery	-	4th September, 2023
Time of delivery		5:45am
Mode of delivery	-	Spontaneous vaginal delivery
Time of expulsion of placenta and membranes	-	5:50am
Drug given	-	Injection oxytocin (10 units)
Blood loss	-	200mls

DURATION OF LABOUR

Duration of 1st stage	-	5 hours 30 minutes
Duration of 2nd stage	-	45 minutes

Duration of 3rd stage - 5 minutes

Total duration of labour - 6 hours 20 minutes

CONDITION OF MOTHER AT BIRTH

General condition of the mother was stable as evidenced by the following findings;

Condition of mother - stable

Perineum - intact

Fundal Height - 18cm

Temperature - 37.0°c

Pulse - 87 bpm

Respiration - 21 cpm

Blood pressure - 110/70mmHg

Uterus - well contracted

Lochia - Red (Rubra)

CONDITION OF PLACENTA

Lobes - Intact

Membranes - Intact

Fetal surface - Normal (Greyish blue in colour)

Maternal surface - Normal (Dark red in colour)

State of placenta - Complete and healthy

Cord vessels - Two arteries and one vein

3.11 LABOUR CARE PLAN

PROBLEMS IDENTIFIED DURING LABOUR

4th September, 2023

1. Client complained of waist pains
2. Client complained of abdominal pains
3. Client complained of nausea and vomiting
4. Client complained of frequency of micturition
5. Client was anxious

SHORT TERM OBJECTIVES

1. Client's waist pain will be reduced and relieved within 5 hours and throughout labour
2. Client will cope with her lower abdominal pains within 5 hours
3. Client will be able to tolerate nausea and vomiting within 6 hours
4. Client will be able to cope with frequency of micturition within 6 hours
5. Client's anxiety will be allayed within 6 hours

LONG TERM OBJECTIVES

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

Table 6: Nursing Care Plan for Madam Mary

Date and Time	Nursing Diagnosis	Objective/Outcome Criteria	Nursing orders	Nursing Interventions	Date and Time	Evaluation	Sign
4/9/2023 At 12:00am	Waist pain related to relaxation of the pelvic joints of actions of the hormones in pregnancy.	Client will cope with waist pain within 5 hours as evidenced by; 1.Midwife visualizing that client is calm in bed and cooperating with the pains. 2. Client confirming that she is coping with pain.	1. Reassure client that she will be relieved of pain after delivery. 2. Explain the physiology of waist pain to client 3. Encourage her take enough rest in between contractions. 4. Encourage her to assume a comfortable position but harmless. 5. Massage client sacral region.	1.Client was reassured that she will be relived of her pain 2. The physiology of waist pain was explained to client 3. Client took enough rest in between activities 4. Client assumed a comfortable position but harmless 5. Client sacral region was massage by the midwife	4/9/2023 At 4:20am	Goal fully met as evidenced by midwife verbalized that client cooperated with pains.	H.A.A.

Table 7: Nursing Care Plan for Madam Mary Continue

Date and Time	Nursing Diagnosis	Objective/Outcome Criteria	Nursing orders	Nursing Interventions	Date and Time	Evaluation	Sign
4/9/2023 At 12:20am	Lower abdominal pains related to uterine contractions.	Client will cope with her lower abdominal pains within 5 hours as evidenced by; 1. She is coping well with the pain. 2.The midwife observing that client has a good facial expression	1. Reassure client to cope with the lower abdominal pains. 2. Explain the physiology of labour pains to her. 3. Put client in a comfortable position. 4. Encourage client to perform deep breathing and relaxation exercises 5. Engage client in conversation as a form of divisional therapy	1. Client was reassured that labour would soon end. 2. It was explained to her that the pain was due to the contractions and that is necessary for delivery of the baby. 3. Client was put in the left lateral position. 4. Client was encouraged to take deep breathing, in and out. 5. The midwife stayed with the client and interacted with her.	4/9/2023 At 4:20am	Goal fully met as client said that she coped well with the pains and midwife reported that client had a good facial expression.	H.A.A.

Table 8: Nursing Care Plan for Madam Mary Continue

Date and Time	Nursing Diagnosis	Objective/Outcome Criteria	Nursing orders	Nursing Interventions	Date and Time	Evaluation	Sign
4/9/2023 At 4:10am	Potential for fluid volume deficit (Dehydration) related to nausea and vomiting.	Madam Mary will be relieved from nausea and vomiting within 6 hours as evidenced by; 1. Client verbalizing that she no longer feels nauseated and vomiting. 2. Midwife witnessing that client has stopped vomiting	1. Reassure client. 2. Educate client on diet 3. Hydrate client to prevent dehydration. 4. Ensure oral hygiene. 5. Move away all nauseating objects from client.	1. Client was reassured. 2. Client was educated to take light diet. 3. Client was given oral fluids to replace fluid loss. 4. Client was given water to rinse her mouth after vomiting. 5. Nauseating objects such as soiled bed pan and vomitus were removed	4/9/2023 At 10:10am	Goal fully met as Madam Lydia verbalized that she no longer feels vomiting and nauseating	H.A.A.

Table 9: Nursing Care Plan for Madam Mary Continue

Date and Time	Nursing Diagnosis	Objective/Outcome Criteria	Nursing orders	Nursing Interventions	Date and Time	Evaluation	Sign
4/9/2023 At 4:10am	Frequency of micturition related to pressure of the presenting part on the bladder.	Client will cope with frequent micturition within 6 hours as evidenced by 1.Client verbalizing that she is able to cope with frequent micturition. 2.Clients' sister verbalizing that she is able to cope with frequent micturition.	1. Reassure client that condition is temporal and it will resolve after delivery. 2. Explain the physiology of frequent micturition to client. 3. Encourage client to urinate whenever she has the urge to. 4. Encourage client to lean forward when voiding. 5. Encourage client on perineal care.	1. Client was reassured that condition was temporal and it will resolve after delivery. 2. The physiology of frequent micturition was explained to client's understanding. 3. Client was encouraged to urinate whenever she had the urge. 4. Client was encouraged to lean forward when voiding. 5. Client was encouraged on perineal care.	4/9/2023 At 9:00am	Goal fully met as evidenced by client verbalizing that she has been relieved of frequent micturition	H.A.A.

Table 10: Nursing Care Plan for Madam Mary Continue

Date and Time	Nursing Diagnosis	Objective/Outcome Criteria	Nursing orders	Nursing Interventions	Date and Time	Evaluation	Sign
4/9/2023 At 4:20am	Anxiety related to unknown outcome of labour	Client's anxiety will resolve within 6 hours as evidenced by 1. Midwife observing that client is calm in bed. 2. Client being successful in labour	1. Reassure client. 2. Explain every procedure to client's understanding. 3. Allow client's relatives to be with her during labour. 4. Allow client to ask questions. 5. Stay by client to make her comfortable and feel cared for.	1. Client was reassured that labour will progress normally. 2. All procedures such as vital signs, vaginal examination, timing of contraction etc. were explained to client's understanding. 3. Client's sister was allowed to be with her during labour. 4. Client was allowed to ask questions and she was answered tactfully in language she understands. 5. Client was made comfortable and a chair was placed by her to engage her in conversation.	4/9/2023 At 6:15am	Goal fully met as midwife reported that client was relaxed in bed. Client said she was no more anxious.	H.A.A.

CHAPTER FOUR

PUERPERIUM

4.0 INTRODUCTION

This chapter describes the care and management given to both the mother and baby from day of delivery up to the second postnatal visit and care plan drawn for various problems identified.

4.1 DAY OF DELIVERY

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

She was encouraged to breastfeed on demand (1-2 hourly or 8-12 times daily) how to position and attach baby to breast properly and practice exclusive breastfeeding. Client was also encouraged to eat balanced diet and report any abnormal bleeding. Her vital signs were checked and recorded as follows:

Temperature	36.2˚C
Pulse	73bpm
Respiration	20cpm
Blood pressure	120/70mmHg

The symphysio-fundal height was 18centimetres. Lochia was bright red (Rubra) in colour and flow was in small amount with no offensive odour. Head to toe examination was conducted on the baby but no abnormalities detected.

4.2 SUBSEQUENT CARE OF THE BABY

This is a care given to the baby after delivery. It consists of bathing the baby, cord dressing and monitoring of vital signs.

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

Madam Mary was educated on exclusive and frequent breastfeeding at least 8 to 12 times a day and on demand, proper hand washing before and after handling the baby was encouraged. She was also educated on breastfeeding problems and how she would manage such problems like; breast engorgement, cracked nipple and sore nipple and to report if any problem arises. Client was educated on the newborn care such as cord care and also observe for any danger sign such as irregular breathing, jaundice, fever and report immediately to the nearest health facility.

BABY BATH

Requirements

Top Shelf

- 2 gallipots (one with cotton and the other one with sterile water)
- Cord dressing tray

Bottom Shelf

- Soap
- Sponge
- Cream/powder
- Basin
- Towels (big towel and 3 small ones)
- Cot sheets (2)
- Gloves
- A clean baby dress, cap and socks if available
- Mackintosh
- 2 jugs containing hot and cold water
- A receiver for used cotton wool swabs
- Methylated spirit for cord dressing

PROCEDURE

The procedure to be carried out was explained to the mother and it was done in her presence. A plastic apron was put on, hands were washed with soap under running water and dried with clean towel. Examination gloves were won, baby was kept safe on a flat surface. The water was mixed and temperature checked with elbow. Baby was undressed and wrapped with a cot and examined thoroughly. The head was exposed for it to be bathed. The eyes were cleaned with clean cotton wool swabs soaked in sterile water and the face was cleaned with a clamp face towel. The nape of the baby's neck was supported with one hand. The ears were plugged with two fingers to prevent water from entering the ears. The head was washed with a soapy sponge, rinsed and dried. The arms and front of the trunk (chest and abdomen were washed

paying attention to the skin folds). The baby was turned with one arm supporting the chest and with the other hand holding the distal arm of the baby, the back was washed down to the feet, paying attention to skin folds. Baby was supported firmly and immersed in a bath of warm water to rinsed thoroughly and dried. She was then place on the flat surface covered with a bath towel. Small towels were used to dry baby, paying attention to the skin folds. Baby was smeared with baby oil, powdered, a diaper was put on, baby dressed up and hair neatly combed and wrapped with a clean cot sheet.

CORD DRESSING

A tray was set aside containing (sterile glove, sterile gallipot, cotton wool swab and methylated spirit). Procedure for dressing of the cord was explained to the mother and procedure carried out still in her presence. Hands were washed and dried with a clean hand towel. Sterile gloves worn and cord exposed. The cord was observed if the clamp was loose, bleeding and pulsation. The tip of the cord clamp was held with one soaked cotton wool swab and the other hand held the rest of the cotton wool swab with methylated spirit.

Madam Mary was educated and taught how to clean the cord with methylated spirit. The skin around the base of the cord was cleaned some centimetres away from the base with cotton wool and discarded. The whole cord was clean upwards once each side. Hands were washed and dried. Baby was wrapped and given to the mother to breastfeed. Client was also advised to expose cord after dressing and to apply diaper below umbilicus.

Baby's vital signs checked and recorded as follows

Temperature	36.8 degree Celsius
Apex Heart rate	144 beat per minute
Respiration	37 cycles per minute
Weight	3.5 kilogram

4.3 FIRST DAY POST DELIVERY AND DISCHARGE

The first day post-delivery was on the 5th September, 2023. Mother and baby were seen lying in ward at 8:30 am to find out how they were faring. Madam Mary was asked about how she and the baby were faring. She replied they were both doing great except she complained of less sleep because the baby cried a lot during the night. She was encouraged to attend to the baby whenever it cries at night and have enough sleep when the baby is asleep. After client had emptied her bladder, brushed her teeth and taken her bath, she was served with her breakfast by her sister. A head-to-toe examination was done and no abnormalities were detected on both mother and baby. Baby was bathed and cord was dressed in presence of mother and she was taught how to dress the cord with six cotton wool swabs soaked with methylated spirit.

The uterus had contracted very well and the symphysiofundal height was measured as 16cm. The perineal pad was inspected and the lochia was bright red (rubra) with moderate flow and also not offensive.

First day postpartum checked done on client and recorded as follow;

Temperature	36.5 degree Celsius
Pulse	90 beat per minute
Respiration	24 cycles per minute
Blood pressure	110/80 millimeters of mercury

The baby had passed meconium and urine. No abnormalities detected on head-to-toe examination. Weight was 3.4 kilograms. Baby's vital signs and assessment were

Temperature	36.3 degree Celsius
Apex heart beat	141 beat per minute
Respiration	40 cycles per minutes

Baby received intradermal injection Bacilli Calmette Guerin (BCG) on the right upper arm for protection against tuberculosis and oral polio '0' vaccine was also given by the Community

Health Nurses. She was educated not to apply anything on the injection site or massage it. Client was told the site of injection could react by sore at the place, scar formation later which will be permanent, indicating that the child had been immunized against tuberculosis. Client was also educated on the need to continue with all the baby's immunization schedule at the child welfare clinic. Which was explained to her that it helps prevent the baby from contracting any of the childhood preventable diseases. She was educated to report back on any changed signs of the baby such as fever, difficulty in breastfeeding and breathing problems. Client was told on the need to register the baby at the birth and death unit. Mother was educated on personal hygiene, good nutrition, providing of warmth to the baby and prevention of infection by changing her perineal pad when they are soaked. She was discharged home. Prescribed medications were served according to the protocol of the clinic;

a. Tab Paracetamol 1 gram three times daily x 5 days.
b. Tab Metronidazole 400mg three times daily x 7 days
c. Cap Amoxicillin 500 three times daily x 7 days
d. Iron III Polymaltose complex 15ml daily x 30 days
e. Tab folic acid 5mg once daily x 30 days

She was helped to pack her things and was informed on intended post-natal visits for a period of one week which was explained to her that she will be visited at home for seven days, morning and evening for the first three days then once daily from the fourth day which she agreed.

4.4. FIRST POSTNATAL HOME VISIT (2nd DAY OF DELIVERY)

On 6th September 2023, at 7:30am and 5:30pm Madam Mary was visited in her house. Both mother and baby looked healthy on arrival. The family was much pleased to be visited. Explanation was given to Madam Mary that, the baby and herself would be examined from head-to- toe to detect any abnormality for early treatment, she was asked to empty her bladder in order not to interfere with the procedure. She was examined from head-to-toe to make sure

everything was normal. The general examination revealed no abnormalities. Breasts were soft and colostrum was expressed. The uterus was well contracted and the symphysio fundal height measured 14 cm. The perineum was clean when inspected, lochia drainage was red (rubra) with small flow and no clots were seen. It did not have any offensive smell. Madam Mary complained of backache and perineal pain. She was told to lean her back to a straight surface when breastfeeding and also to position baby well when feeding and it was also demonstrated to her when Madam Mary was asked to demonstrate how she breastfeeds her baby and she breastfed it using poor posture and wrong attachment of baby to the breast. Her vital signs were taken and recorded as;

Observation	**Morning**	**Evening**
Temperature	36.1^{o}C	36.2^{o}C
Pulse	82bpm	84bpm
Respiration	20cpm	23cpm
Blood pressure	110/70mmHg	120/70mmHg

Permission was sought to top and tail the baby in front of mother to observe and it was granted. Baby was examined from head-to-toe thoroughly and there was no abnormality detected. The baby had passed meconium and urine when the diaper was removed and it was inspected before top and tail. As the baby was being topped and tailed, it was also demonstrated to Madam Mary. The cord was also dressed with cotton wool soaked in methylated spirit; it was cleaned and kept dry, and there was no bad odour.

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

Observation	**Morning**	**Evening**
Temperature	36.7^{o}C	36.9^{o}C
Pulse	128bpm	132bpm
Respiration	41cpm	43cpm

Weight	3.3kg	3.3kg

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

4.5 SECOND POSTNATAL HOME VISIT (3RD DAY OF DELIVERY)

On the 7th September, 2023, the second visit was made to the client house at 7:00am and 5:40 pm morning and evening respectively. Madam Mary was greeted and welcomed me warmly and offered a seat. She was asked of her health and that of her family's as well. She said her condition had improved. Baby was doing well. Permission was sought to inspect her perineal pad. Perineal area was clean the lochia was red (rubra), not offensive and the flow was moderate. Head to toe examination was also done and all findings were normal. The uterus was firm and well contracted and symphysio-fundal height was 12 cm.

The baby was topped and tailed paying attention to the skin folds and general examination was carried out and no abnormalities were present. The cord was orderly dressed with no abnormality detected on it and was getting dried. The baby passed stools and urine that night according to mother, baby's weight was 3.2 kilograms. She was educated to feed the baby well. Permission was sought to leave and they bade me farewell and shown appreciation.

OBSERVATION ON MOTHER (7TH SEPTEMBER, 2023).

OBSERVATION	MORNING	EVENING
Temperature	36.4℃	36.5℃
Pulse	80 bpm	85 bpm
Respiration	21 cpm	22 cpm
Blood pressure	110/80mmHg	100/90mmHg
Lochia	Rubra	Rubra
Fundal Height	12cm	12cm

Condition of Uterus	Contracted	Contracted
Breast	Lactating	Lactating

OBSERVATION OF BABY (7TH SEPTEMBER, 2023)

OBSERVATION	**MORNING**	**EVENING**
Temperature	36.6℃	36.8℃
Apex Heart Beat	136 bpm	144 bpm
Respiration	44 cpm	48 cpm
Skin Colour	Pink	Pink
Cord Bleeding	No	No
Cord	Shrinking	Shrinking
Suckling	Yes	Yes
Weight	3.2 kg	3.2kg
Stool Colour	Greenish brown	Greenish brown

4.6 THIRD POSTNATAL HOME VISIT (4TH DAY OF DELIVERY)

On the 8th September, 2023, the third home visit was made to Madam Mary's house at 8:00am and 4:40pm morning and evening respectively. Greetings were exchanged. Mother and baby were doing well so as other members of the family. Permission was sought to begin the examination and also the baby's bath. Her perineal and perineal pad was checked, the place was clean and lochia was rubra (red) with scanty flow without any offensive smell. Her breast was lactating well but engorged. Symphysio fundal height was 10 cm when measured. Her vital signs were checked and recorded as

OBSERVATION	MORNING	EVENING
Temperature	37.0℃	36.9℃
Pulse	88 bpm	84 bpm
Respiration	20 cpm	23 cpm
Blood pressure	120/80mmHg	110/80mmHg
Condition of Uterus	Contracted	Contracted
Breast	Lactating but engorged	Lactating but engorged

Baby had a good general condition with no rashes, jaundice absent, cord stump was healing with no bleeding. Baby was able to suckle well. They baby was top and tailed. The cord was neatly dressed. The baby also passed brownish yellow stools and urine. Baby's vital signs and weight were taken and recorded as follows;

OBSERVATION	MORNING	EVENING
Temperature	36.9℃	36.7℃
Apex Heart Beat	138 bpm	140 bpm
Respiration	44 cpm	42 cpm
Skin Colour	Pink	Pink
Cord Bleeding	No	No
Cord	Shrinking	Shrinking
Suckling	Not well	Yes
Weight	3.2kg	3.2kg
Stool Colour	Brownish Yellow	Brownish Yellow

4.7. FOURTH POSTNATAL HOME VISITS (5TH DAY OF DELIVERY)

On the 9th September, 2023, Madam Mary and her baby were visited at their house at 7:00am to continue with the postnatal care. Their health status was required and was told they are all fine. Client stated of pain in her breast was subsiding. Lochia was pink (serosa) with scanty flow without any offensive odour on inspection of the perineal area. Head-to-toe examination was done and all findings were normal. Symphysiofundal height was measured and it was 8cm. Madam Mary was educated on continue breastfeeding on demand as she complained of heaviness in the breast which was as a result of fullness. She was also educated to apply warm compress on them to reduce pain and was to make sure one breast is emptied before the other and to wear a well fitting brassier.

Baby was top and tailed paying attention to the skin folds and the general condition carried out with no abnormalities detected. The cord was orderly dressed with methylated spirt and no abnormality found and it has dried up. The baby had already passed stools and urine with stool colour of bright yellow. Her weight was 3.3kg.

OBSERVATION ON THE MOTHER (9TH SEPTEMBER, 2023)

OBSERVATION	**MORNING**
Temperature	37.0℃
Pulse	79 bpm
Respiration	22 cpm
Blood pressure	110/80mmHg
Lochia	Serosa
Fundal Height	8 cm
Condition of Uterus	Contracted
Breast	Lactating but slightly engorged

OBSERVATION ON BABY (9TH SEPTEMBER, 2023)

OBSERVATION	MORNING
Temperature	36.8℃
Apex Heart Beat	139 bpm
Respiration	42 cpm
Skin Colour	Pink
Cord Bleeding	No
Cord	Shrinking
Suckling	Present
Weight	3.3kg
Stool Colour	Yellow brown

4.8. FIFTH POSTNATAL VISIT (6TH DAY OF DELIVERY)

The fifth postnatal home visit was made on the 10th September, 2023 at 8am. Greetings were exchanged on arrival with client and her family after which a seat was offered. According to client, all her complains were been resolved. On inspection of the mother, she was not pale, breasts were not engorged, nipples were not sored and lactating well. Lochia was inspected and the colour was pink (serosa) without any bad odour and flow was scanty. No abnormalities detected after head-to-toe examination. The symphysio fundal height was 6 cm when measured. Head-to-toe examination was done on the baby and no abnormalities detected. Baby was examined from head to toe and no abnormality found. Its cord had fallen off the previous evening. The stump was then dressed and the area was cleaned with methylated spirit. Baby passed urine and a yellowish stool. The weight was 3.4kg.

OBSERVATION ON MOTHER (10TH SEPTEMBER, 2023)

OBSERVATION	MORNING
Temperature	36.6℃
Pulse	79 bpm
Respiration	20 cpm
Blood pressure	110/80mmHg

OBSERVATION ON BABY (10TH SEPTEMBER, 2023)

OBSERVATION	MORNING
Temperature	36.6℃
Apex Heart Beat	140bpm
Respiration	44 cpm
Skin Colour	Pink
Weight	3.4kg

4.9. SIXTH POSTNATAL HOME VISIT (7TH DAY OF DELIVERY)

The sixth postnatal home visit was made at 7:30am on 11th September, 2023. Mother and baby were both in a healthy condition and client said her fullness of breast has resolved. No abnormalities were found on head-to-toe examination. Breast was soft and well lactating. Lochia was pink (serosa) in colour and flow was scanty without offensive odour. Symphysio fundal height measured and reassured as 4cm.

OBSERVATION ON MOTHER (11TH SEPTEMBER, 2023)

OBSERVATION	MORNING
Temperature	36.5℃
Pulse	84 bpm
Respiration	19 cpm
Blood pressure	112/85mmHg
Lochia	Serosa

OBSERVATION ON BABY (11TH SEPTEMBER, 2023)

OBSERVATION	MORNING
Temperature	36.8℃
Apex Heart Beat	136 bpm
Respiration	41cpm
Weight	3.5kg

4.10 SEVENTH POSTNATAL HOME VISITS (8TH DAY OF DELIVERY)

The last visit for the week was on 12th September, 2023 at 7:00am. The condition of mother and baby was very good upon assessment. Head-to-toe examination was done after explaining the procedure to her. Permission was sought and perineal pad was inspected. Lochia was creamy white (Alba) but very little and not offensive. Nothing abnormal was detected. Symphysio fundal height was 2 centimeters when checked.

Baby was bathed by the client and cord stump dressed under supervision. Head-to-toe examination was done and no abnormality was found. Baby had passed urine and bowel movement was presence. Weight was 3.6kilograms.

All the findings were explained to the client and she was educated on the importance of visiting the clinic for the first week postnatal and the importance of immunizing the baby fully. She was thanked for her support and co-operation and farewell was done.

OBSERVATION ON MOTHER (12th SEPTEMBER, 2023)

OBSERVATION	**MORNING**
Temperature	36.9^0C
Pulse	79 bpm
Respiration	20cpm
Blood pressure	100/90 mmHg

OBSERVATION ON BABY (12TH SEPTEMBER, 2023)

OBSERVATION	**MORNING**
Temperature	36.9^0C
Apex heart beat	143 bpm
Respiration	43cpm
Skin colour	Pink

4.11 FIRST POSTNATAL VISIT TO THE CLINIC

On 13th September, 2023 at 10:00am, Madam Mary and her baby came to the facility. A seat was offered to client, she looked healthy. Procedure to be carried out was explained to her and she consented. Madam Mary was asked to empty her bladder before the head-to-toe examination. Midstream urine was taken and checked for protein and sugar and all tested negative. Head-to-toe examination was done and everything was within the normal range. Haemoglobin level was 13.0g/dl.

Her vital signs were checked and recorded as;

Temperature - 36.5^{o}C

Pulse - 76bpm

Respiration - 20cpm

Blood pressure - 125/72mmHg

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

Head to toe examination was done on her. On the head, hair was neat and tied with a ribbon, the conjunctiva was not pale, no discharges from the eyes, nose and ears. There was no abnormality detected in the mouth, and there was absence of enlarged nodes on the neck. Breasts were lactating well, no engorgement, sore or cracked nipples were detected. The abdomen was palpated and there was no tenderness, no scars, enlarged liver or spleen on examination and the uterus was felt. There was no oedema, varicosities nor tenderness in calf. The perineum was intact and there was no offensive vaginal discharge and the lochia was not present. She was thanked for the cooperation and helped to dress up.

Baby was also examined from head to toe. The fontanelles and sutures were not bulging or widening. The conjunctiva was not pale, neither was there jaundice of the sclera nor eye discharges. The ears and nose were inspected as well as the lips and mouth, but no abnormality was found. Baby had no rashes or bruises on the skin. The umbilical stump was neatly healed. Baby's weight was 3.6kg when checked. Vital signs were checked and recorded as follows:

Temperature - 36.2 degree Celsius

Apex heart beat - 135 beat per minute

Respiration - 44 cycles per minutes

Madam Mary was also reminded on the need to completely attend baby clinic to complete the child's immunization schedules and also attend six weeks postnatal clinic for examinations on

19th October 2023. Madam Mary had no complains nor questions. They were asked to visit the birth and death registry to register the child.

4.12 TERMINATION OF CARE

Explanation was given to Madam Mary on the need to be handed over to the midwife in-charge for continuity of care. Client was reassured of midwife in-charge's competency. Client and family were then handed over to the midwife in charge at the clinic for continuity of care. Madam Mary was promised to be checked on from time to time through phone calls and was seen off.

4.13 SECOND POSTNATAL VISIT TO THE CLINIC

According to the midwife in charge, Madam Mary visited the facility on 19th Octorber,2023 at scheduled with her husband and they all looked very healthy. General examination was conducted on the client and the baby as well as vital signs and no abnormalities were detected. Madam Mary and her baby were handed over to the child welfare clinic and family planning unit for the rest of vaccination to be given, polio 1 - 2drops, DPT Hib B 0.5mls intramuscularly at left lateral thigh (This gives protection against the five-childhood disease that is hepatitis B, diphtheria, pertussis and haemophilus influenza B), Pneumococcal vaccine 0.5mls at the right lateral thigh for protection against pneumonia and rotavirus vaccine 0.5mls orally given for protection against diarrhea. After the immunization, she was handed over to the public health nurses for continuous growth monitoring of baby and family planning.

4.14 CARE PLAN DURING PUERPERIUM

PROBLEMS IDENTIFIED DURING PUERPERIUM

Client complains of:

1. 4/9/2023 after pain.
2. 5/9/2023 inadequate sleep.
3. 6/9/2023 backache.
4. 6/9/2023 perineal pain.
5. 9/9/2023 breast engorgement

SHORT TERM OBJECTIVES

1. Client's after pain will subside within 72 hours.
2. Client insomnia will resolve within 24 hours.
3. Client's backache will subside within 48 hours
4. Client perineal pain will subside within 48 hours
5. Client's breast engorgement will subside within 48 hours

LONG TERM OBJECTIVES

Madam Mary and baby will go through puerperium successfully without any complication.

Table 11: Nursing Care Plan for Madam Mary

Date and Time	Nursing Diagnosis	Objective/Outcome Criteria	Nursing orders	Nursing Interventions	Date and Time	Evaluation	Sign
4/9/2023 At 12:00pm	After pains Related to involution of the uterus.	Client's after pain will resolve within 72 hours as evidenced by; 1. Client verbalizing that the pain has resolve. 2. Midwife observing that client's face looks cheerful.	1. Reassure client that her pain will resolve. 2. Encourage client to void frequently. 3. Encourage client to breastfeed frequently and on demand. 4. Encourage client to gently massage the lower abdomen. 5. Give prescribed analgesics.	1. Client was reassured that the condition will resolve after few days. 2. Client voided at least every two hours. 3. Client breastfed frequently and on demand. 4. Client massaged the lower abdomen. 5. Client was given paracetamol 1g daily before breastfeeding.	6/9/2023 At 12:00pm	Goal fully met as client said that she was relieved of pain.	H.A.A.

Table 12: Nursing Care Plan for Madam Mary Continues

Date and Time	Nursing Diagnosis	Objective/Outcome Criteria	Nursing orders	Nursing Interventions	Date and Time	Evaluation	Sign
5/9/2023 At 10:00am	Interrupted sleeping pattern (inadequate sleep) related to caring for baby at night	Client will have a normal sleeping pattern of 4 to 6 hours apart during the night and 4 hours during the day within 24 hours as evidenced by 1. client verbalizing that she can sleep at night. 2. Client husband observing that client can sleep at night.	1.Encourage mother to take a nap whenever baby sleeps 2. Encourage client to change baby's soiled napkins 3. Encourage client to feed baby on demand and adequately before going to bed. 4. Educate client relative to help in taking care of the baby. 5. Encourage client and her family to reduce the number of visitors.	1. Client took naps whenever baby slept 2. Baby's soiled napkins were changed frequently to make baby comfortable 3. Client fed baby adequately before going to bed. 4. Client relative assisted her in taking care of the baby. 5. Client and her family reduced the number of visitors in order for client to have enough sleep during the day.	6/9/2023 At 10:00am	Goal fully met as the client reported she can sleep 4-6 hours apart.	H.A.A.

Table 13: Nursing Care Plan for Madam Mary Continues

Date and Time	Nursing Diagnosis	Objective/Outcome Criteria	Nursing orders	Nursing Interventions	Date and Time	Evaluation	Sign
6/9/2023 At 10:00am	Backache related to poor feeding posture.	Madam Mary's back pain will reduce within 48hours as evidence by; 1. Client verbalizing that pain is normal. 2. Midwife observing that client is breastfeeding baby comfortably and in good posture.	1. Reassure client that backache will resolve. 2. Educate client on the correct positions used in breastfeeding. 3. Encourage client to support her breast. 4. Educate client on the use of warm compress. 5. Apply gentle massage over the area.	1. Client was reassured that her backache will resolve. 2. Client was educated to sit straight and support her back when breastfeeding. 3. Client wore a well-fitting brassiere. 4. Client applied warm compress on the side where she feels the pains. 5. Client applied gently massage over the area.	8/9/2023 At 10:00am	Goal fully met as client reports that her back pain was not felt anymore.	H.A.A.

Table 13: Nursing Care Plan for Madam Mary Continues

Date and Time	Nursing Diagnosis	Objective/Outcome Criteria	Nursing orders	Nursing Interventions	Date and Time	Evaluation	Sign
9/9/2023 At 10:00am	Breast engorgement related to poor attachment of the baby to breast or inadequate emptying of breast	Client' engorged breast will subside within 48 hours as evidence by; 1. Client verbalizing that she is relieved of breast engorgement. 2.Midwife observing that client is relieved of breast engorgement.	1. Reassure client that her breast engorgement will subside. 2. Demonstrate to client on correct attachment of the baby to the breast. 3. Educate and encourage client on gentle manual expression of breast milk and store it. 4. Encourage her to continue breast feeding the baby. 5. Encourage client to apply warm and cold compress on both breasts.	1.Client was reassured that her engorged breast will subside. 2.A demonstration was done on how to properly fix the baby to breast and store. 3.Client was educated and encouraged on a gentle manual expression of breast milk and its storage. 4.Client was encouraged to continue breast feeding the baby on demand and frequently. 5.Client applied warm and cold compress on both breasts.	11/9/2023 10:00am	Goal met as client reported that her breast engorgement has subsided.	H.A.A.

SUMMARY AND CONCLUSION

The Client/Family Centred Maternity Care Study was conducted on Madam Mary, a 26-year-old gravida 3 para 2 and her entire family through pregnancy, labour and puerperium and she went through these processes safely without any complications.

Madam Mary became a regular attendant to the clinic since 20th February, 2023. She was managed through pregnancy, labour and puerperium safely through which all minor disorders were taken care of using the nursing care plan and goals were met when evaluated. She had a spontaneous vaginal delivery to a life female baby on 4th September, 2023. Client and family were visited for the first seven days after delivery.

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

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

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

The care study is an important and managerial tool which gives opportunity to student midwives to put into practice theoretical knowledge acquired in classroom with the help of the clinical in charge. It has helped to deal with obstetric problems as midwifery professional.

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APPENDIX I

ANTENATAL RECORD

DATE	WEIGHT (KG)	BLOOD PRESSURE (MMHG)	URINE FOR PROTEIN/SUGAR	GESTATION AGE IN WEEKS	FUNDAL HEIGHT (CM)	PRESENTATION	DESCENT OF FETAL HEAD	FETAL HEART RATE (FHR)	TREATMENT GIVEN	COMPLAINS	SIGN
20/2/23	54kg	100⁄70	Negative⁄negative	11weeks + 4 days	-	-	-	-	Routine drugs	Doing well	VA
20/3/23	55kg	100/60	Negative⁄negative	15 weeks + 4 days	13	-	-	-	Routine drugs	Doing well	VA
17/4/23	57kg	100/60	Negative⁄negative	19 weeks + 4 days	15	-	-	140	Routine drugs.	Doing well	AA
14/6/23	58kg	90/60	Negative⁄ negative	27 weeks + 6 days	29	Cephalic	-	136	Routine drugs.	Feels well	VA
19/7/23	59kg	100/60	Negative⁄ negative	32weeks + 6 days	32	Cephalic	-	134	Routine drugs.	Doing well	PA
16/8/23	62kg	100/70	Negative/ negative	36weeks + 6 days	35	Cephalic	$5/5^{th}$	139	Routine Drugs	Doing well	LP
23/8/23	63kg	100/65	Negative/ negative	37weeks + 6 days	36	Cephalic	5/5	147	Routine drugs	Doing well	VA
30/8/23	64kg	100/68	Negative/ negative	38 weeks + 6 days	37	cephalic	5/5	140	Routine drugs	Doing well	VA

APPENDIX II

COMPLETE DIAGNOSTIC INVESTIGATION ON MADAM MARY

DATE	SPECIMEN	IVESTIGATION	NORMAL VALUES	FINDINGS	REMARKS
20/02/2023	Urine	Protein	Negative	Negative	Normal
		Glucose	Negative	Negative	Normal
	Blood	Haemoglobin level	11-16gms/dl	12.2 gms/dl	Normal
		PMTCT	Negative	280	Normal
		VDRL	Negative	Negative	Normal
		Rhesus factor	Negative/Positive	Positive	Normal
		Grouping	A, B, AB, O	O	Normal
		Sickling Test	Negative	Negative	Normal
		Hepatitis B	Negative	Negative	Normal
		G6PD	Negative	Negative	Normal
	Stool	R/E	Negative	No abnormality detected	Normal

COMPLETE DIAGNOSTIC INVESTICATION CONTINUED

DATE	SPECIMEN	INVESTIGATION	NOMAL RANGE	FINDINGS	REMARKS
20/3/2023	Urine	Protein	Negative	Negative	Normal
		Glucose	Negative	Negative	Normal
	Blood	Haemoglobin level	11-16gms/dl	12.1g/dl	Normal
17/4/2023	Urine	Protein	Negative	Negative	Normal
		Glucose	Negative	Negative	Normal
14/6/2023	Urine	Protein	Negative	Negative	Normal
		Glucose	Negative	Negative	Normal
	Blood	Haemoglobin level	11-16gms/dl	12.1g/dl	Normal
19/7/2023	Urine	Protein	Negative	Negative	Normal
		Glucose	Negative	Negative	Normal

COMPLETE DIAGNOSTIC INVESTIGATION CONTINUED

DATE	SPECIMEN	INVESTIGATION	NORMAL RANGE	FINDINGS	REMARKS
16/08/2023	Urine	Protein	Negative	Negative	Normal
		Glucose	Negative	Negative	Normal
	Blood	Haemoglobin level	11-16gms/dl	11.2gms/dl	Normal
23/08/2023	Urine	Protein	Negative	Negative	Normal
		Glucose	Negative	Negative	Normal
30/9/2023	Urine	Glucose	Negative	Negative	Normal
		Protein	Negative	Negative	Normal
	Blood	Haemoglobin level	11-16gms/dl	12.2gms/dl	Normal

APPENDIX III

PHARMACOLOGY OF DRUGS FOR THE MOTHER

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

PHARMACOLOGY OF DRUGS FOR THE MOTHER CONTINUED

NAME OF DRUG	CLASSIFI-CATION	DOSAGE	ROUTE	ACTION AND USES	ACTUAL EFFECT	SIDE EFFECT	SIDE EFFECT EXPERIENCED
Tablet paracetamol	Analgesics	1 gram three times daily for three	Orally	Helps to relieve pain	Pain was relieved	Prolong use causes damage to the liver	None observed
Injection oxytocin	Oxytocic drug	10 units	Intramuscularly	Stimulate uterine contractions	Good uterine contraction and control of bleeding	Nausea and vomiting	None observed
Tablet multivitamin	Vitamin preparation	200 milligrams daily	Orally	Increases appetite. Help in the formation of red blood cell	Increases appetite	Gastrointestinal disturbance	Constipation
Ferrous Tablet	Haematinics	200mg daily for 30 days	Orally	Aids in Red Blood Cell formation	Increase in hemoglobin level	Black stool, diarrhea and constipation	None
Iron III polymaltose complex	Haematinic	15mls for 30days	Orally	Required for the formation of blood cells in the process of haematopoiesis	Patient regained appetite for food	Gastrointestinal discomfort, vomiting, constipation	None

PHARMACOLOGY OF DRUGS FOR THE MOTHER CONTINUED

NAME OF DRUG	**CLASSIFI-CATION**	**DOSAGE**	**ROUTE**	**ACTION AND USES**	**ACTUAL EFFECT**	**SIDE EFFECT**	**SIDE EFFECT EXPERI-ENCED**
Metronidazole	Anti-infective	400mg tds for 30days	Orally	Infection of prevention	Infection was prevented	Dizziness, headache, nausea	None
Amoxicillin	Antibiotics	500mg tds for 30days	Orally	Prevention of bacteria	Client was prevented against bacterial infection	Vomiting, diarrhea, nausea.	None

APPENDIX IV

PHAMARCOLOGY OF DRUGS FOR THE BABY

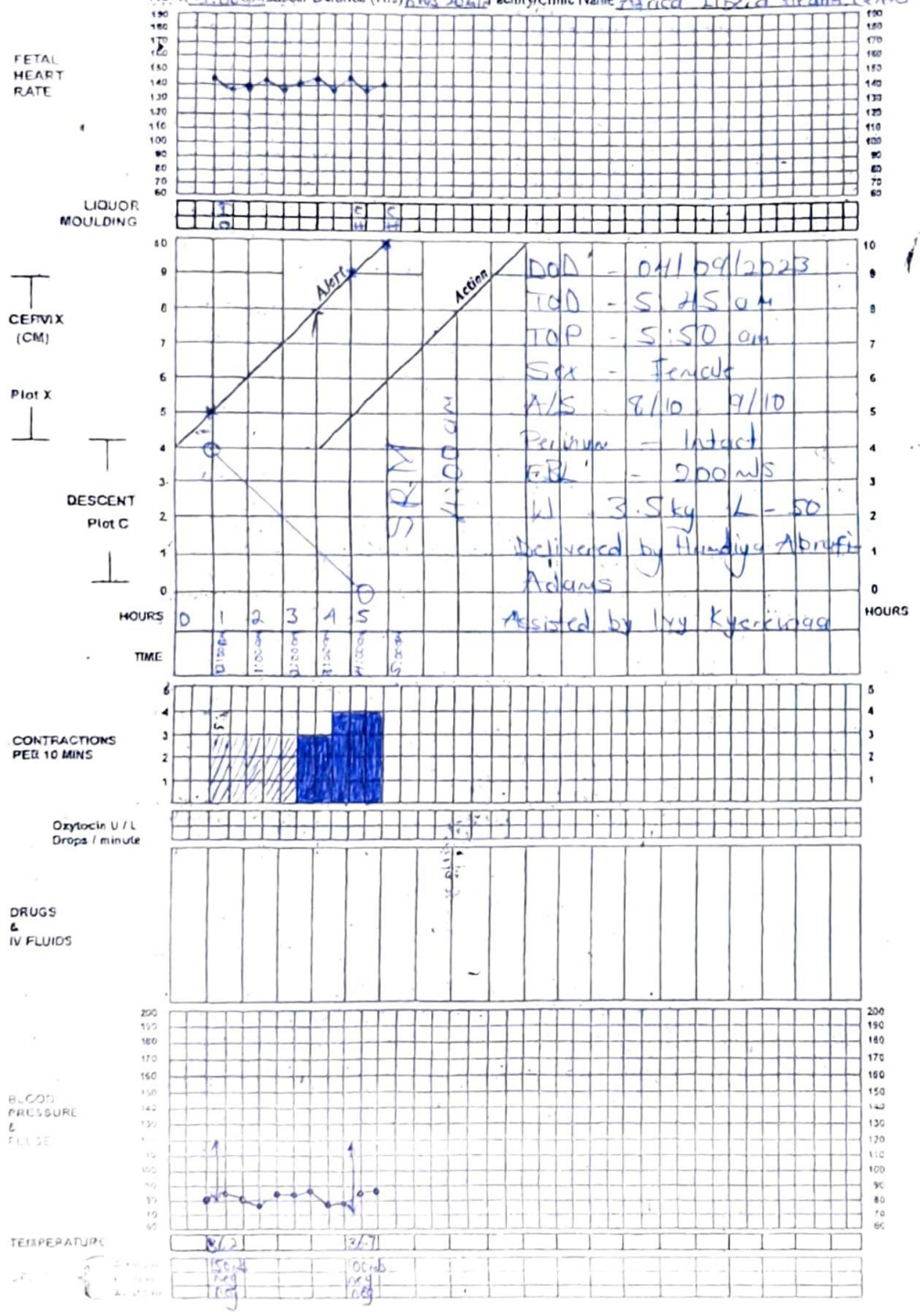
NAME OF DRUG	CLASSIFI-CATION	DOSAGE	ROUTE	ACTION/ USES	ACTUAL EFFECT	SIDE EFFECT	SIDE EFFECT EXPERIENCED
Vitamin K	Coagulant	1milligram	Intramuscular	Production of prothrombin	No bleeding	None	None observed
Chloramphenicol eye drop	Prophylaxis antibiotic	2-3 drops	Instillation	Prevents eye infection	Infection was prevented	Nephroxicity	None observed
Polio vaccine	Antigen	2 drops	Orally	Production of antibodies against poliomyelitis	Diarrhoea and fever may occur.	None	None observed
Injection Bacillus Chalmette Guerin (BGC)	Antigen	0.05 Milligram	Intradermal	Vaccinates neonates against tuberculosis	Tuberculosis prevention	Blister formation	None observed
Pneumococcal	Antigen	0.5 Milligram	Intramuscularly	Vaccinates neonates against pneumonia	Pneumonia prevention	Redness at the side of injection and fever	None observed

PHAMARCOLOGY OF DRUGS FOR THE BABY CONTINUE

NAME OF DRUG	CLASSIFI-CATION	DOSAGE	ROUTE	ACTION/ USES	ACTUAL EFFECT	SIDE EFFECT	SIDE EFFECT EXPERIENCED
Pentavalent vaccine	Antigen	0.5 milligram	Intramuscularly	Vaccinates neonates against diphtheria, pertussis (whooping` cough), tetanus, hepatitis B, haemophilus influenza type B	Prevention of childhood preventable diseases	Low grade fever	None observed
Rota virus vaccine	Antigen	1.5 milligrams (2 drops)	Orally	Prevention of gastroenteritis	Gastroenteritis prevention	None	None observed

WHO Modified Partograph

Registration No. 1041/23 Name(Last, First) Afosaa Mary Age: 26 years
Date: 04/09/2023 Parity/Gravida 2/3 LMP EDD 07/09/23 Gestation(wks) 39 + 3 days
ROM: 4:00am Labour Duration (Hrs) 6 hrs 20 mins Facility/Clinic Name Africa Liberia Healthy Center



LABOR NOTES

Madam Mary Labour progressed and has spontaneous Vaginal delivery to alive eight baby. APGAR score 1st minute 8/10 ✓ 9/10 for the 5th Minute ✓
Placenta and membranes were completely delivered at 5:50 am
Uterus was massage to expel clots, Perineum was intact
Skin to Skin contact and breastfeeding was initiated.

Please circle or write responses.

DELIVERY

DATE: 04/09/2023 TIME: 5:45 am METHOD: (Spontaneous) / Vacuum Extraction / C/S / Other
PERINEUM: (Intact) / Episiotomy / Laceration
ANESTHESIA: (None) / Local / General

THIRD STAGE

Active Management: (Yes) / No Medication: Time 5:46am Type/Dose 10 Units oxytocin injection
PLACENTA: TIME: 5:50 am (Complete) / Incomplete
BLOOD LOSS AMOUNT: (Small (Less than 250 cc)) / Moderate (250-499 cc) / Large (more than 500 cc) / Significant for mother

BABY

Weight: 3.5 kg
Sex: Male / (Female)
Baby Position: (Vertex) / Breech / Other

APGAR

Time	Color	Breath	Heart	Tone	Reflex	TOTAL
1min	1	2	2	2	1	8/10
5min	2	2	2	2	1	9/10

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

FOURTH STAGE MONITORING

Frequency	Time	B/P.	Pulse	Fundus	Bleeding	Bladder
Every 15 minutes first 2 hours	6:50am	110/70	80	1F cm	200mls	=
	7:05am	115/70	86	Well contracted	No active bleeding	100mls
	7:20am	110/75	84	✓	✓	=
	7:35am	120/70	79	✓	✓	=
	7:50am	110/70	80	✓	✓	=
	8:05am	120/70	78	✓	✓	300mls
	8:20am	110/70	82	✓	✓	=
	8:35am	110/70	81	✓	✓	=
Every 30 minutes For 1 hour	9:05am	110/75	85	✓	✓	
	9:35am	110/70	81	✓	✓	200mls.

Birth Attendant: Hamdiya Abrafi Adams Date: 04/09/2023
Assisted by Ivy Kyereboaa

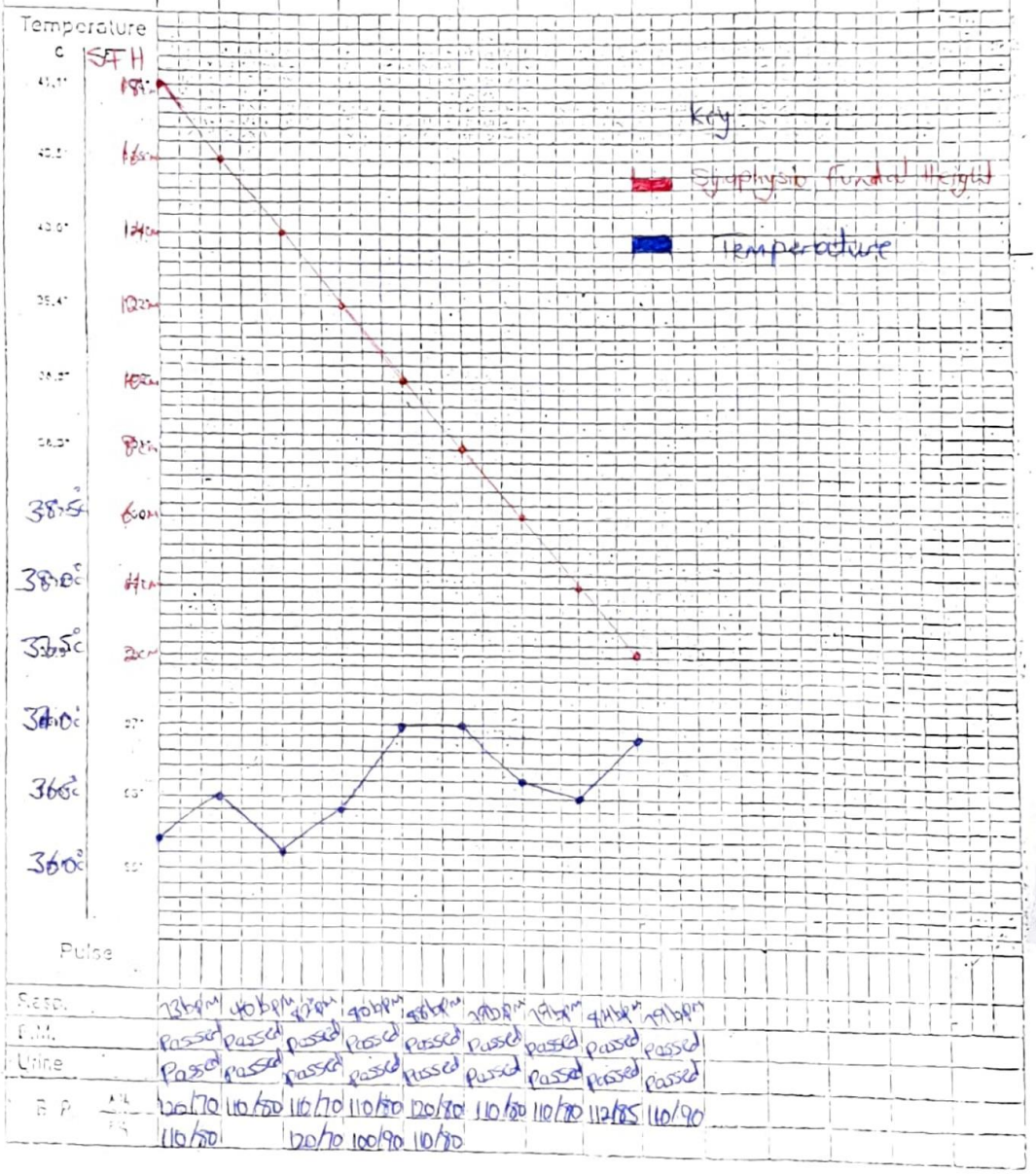
MATERNITY CHART

NAME: Madam Afosaa Mary

AGE: 26 years WARD: Labour Ward

IP NO.: 10H 1 23 BED NO.: 4

Date	4/9/23	5/9/23	6/9/23	7/9/23	8/9/23	9/9/23	10/9/23	11/9/23	12/9/23
Days in Hospital	DOD								
Days P. O.		D1	D2	D3	D4	D5	D6	D7	D8
Hour AM	9:45	8:30	7:30	7:00	8:00	7:00	8:00	7:30	7:00
PM	6:00		5:30	5:40	4:40				
Temperature C									
SFH									
Pulse									
Resp.	73bpm	40bpm	42bpm	40bpm	38bpm	39bpm	39bpm	41bpm	39bpm
B.M.	Passed	Passed	Passed	Passed	Passed	Passed	Passed	Passed	Passed
Urine	Passed	Passed	Passed	Passed	Passed	Passed	Passed	Passed	Passed
B.P. AM	120/70	110/60	110/70	110/80	120/80	110/80	110/80	112/85	110/90
PM	110/80		120/70	100/90	110/80				



NEW BORN EXAMINATION FORM

Name: Baby Adjoa Mary Date of Assessment: 04/09/2023 Time: 9:00AM

Date of Birth: 04/09/2023 Time of Birth: 5:45AM Sex: ☐ M ☑ F Age at time of Assessment (days/hrs) 1 hour

Astational Age 39 ☑ Weeks 3 ☑ Mode of Delivery: ☑ Vaginal Assisted Vaginal C-Section

APGAR: 1min 9/10 5min 10/10 Birth Weight: ☐ 3.5 kg ☐ Lenght 50 cm Head Circumference: 34 cm

Temperature at time of Assessment: 36.8 °C Urine passed: Yes No Meconium passed: Yes No

Name of Assessor (Midwife/Doctor): Hamdya Abrafi Adams

1. Respiration

Rate 37

- ☐ 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 Seperated *

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: 144 bpm

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

19. Femoral pulse

- ☑ Present
- ☐ Not palpable*

20. Abdomen

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

21. Back (spine)

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

22. Limbs

- ☑ Normal
- ☐ Abnormal_____

23. Genitalia

Male Genitalia

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

Female Genitalia

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

24. Anus

- ☑ Patent
- ☐ Imperforate*

25. Resuscitation provided

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

26. Services provided

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

*May indicate severe disease that requires urgent referral

Diagnoses (if known) Normal baby

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

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

NEW BORN EXAMINATION FORM

Name: Baby Aduoa Mary Date of Assessment: 05/09/2023 Time: 6:30 am

Date of Birth: 04/09/2023 Time of Birth: 5:45am Sex: ☐ M ☑ F Age at time of Assessment (days/hrs) 22 hrs

Astational Age 39 ☐ys 3 ☐ays ☐ Mode of Delivery: ☑ Vaginal Assisted Vaginal C-Section

APGAR: 1min 8 ☐ 5min 9 ☐0 Birth Weight: ☐3.5kg ☐ Length: 50 cm Head Circumference: 34 cm

Temperature at time of Assessment: 36.3 °C Urine passed: Yes ✓ No Meconium passed: Yes ✓ No

Name of Assessor (Midwife/Doctor): Hamdiya Abrafi Adams

1. Respiration
Rate 40
- ☐ 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: 141 bpm
- ☐ Normal (100-160)
- ☐ <100 *
- ☐ >160*

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

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

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

22. Limbs
- ☑ Normal
- ☐ Abnormal _____

23. Genitalia

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

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

24. Anus
- ☑ Patent
- ☐ Imperforate*

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

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

*May indicate severe disease that requires urgent referral

Diagnoses (if known) Normal baby

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

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

NEW BORN CHART

Name: Baby Adwoa Mary ..... No: 104/23 ..... Birth Weight: 3.5 kg .....

Sex: Female ..... Mother's No: ..... Length: 50 cm .....

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

Date of Birth: 04.09.2023 ..... Time: 5:45 am ..... Date of Discharge: 05/09/2023 .....

Date	04/09/23		05/09/23		06/09/23		07/09/23		08/09/2023		09/09/23		10/09/2023		11/09/2023		12/09/2023					
No. of Days	DOD		D1		D2		D3		D4		D5		D6		D7		D8					
Weight	3.5kg		3.4kg		3.3kg		3.2kg		3.2kg		3.3kg		3.4kg		3.5kg		3.5kg					
Temperature	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM
	36.8°C	36.8°C	36.3°C		36.7°C	36.4°C	36.4°C	36.8°C	36.4°C	36.7°C	36.8°C		36.6°C		36.8°C		36.9°C					
Stools	Passed	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		Passed					
Remarks	Head Neck Limbs Genitalia Trunk	} NO Abnormality Detected																				

TEMPERATURE CHART

NAME: Baby Adwoa Mary

AGE: Neo WARD: Labour Ward

IP NO.: 1041/23 BED NO.: 4

Date	4/9/23	5/9/23	6/9/23	7/9/23	8/9/23	9/9/23	10/9/23	11/9/23	12/9/23
Days in Hospital	DOD								
Days P. O.		D1	D2	D3	D4	D5	D6	D7	D8
Hour AM	9:45	8:30	7:30	7:00	8:00	7:00	8:00	7:30	7:00
PM	6:00		5:30	5:40	11:40				

Temperature

C	F
41.1°	106°
40.5°	105°
40.0°	104°
39.4°	103°
38.8°	102°
38.3°	101°
37.7°	100°
37.8°	99°
36.5°	98°
36.0°	97°
35.5°	96°
35°	95°

Key
- Weight of baby
- Temperature of baby

Pulse	144bpm	141bpm	128bpm	156bpm	138bpm	150bpm	140bpm	138bpm	148bpm
Resp.	37cpm	40cpm	41cpm	44cpm	45cpm	44cpm	44cpm	41cpm	43cpm
B.M.	Passed	Passed	Passed	Passed	Passed	Passed	Passed	Passed	Passed
Urine	Passed	Passed	Passed	Passed	Passed	Passed	Passed	Passed	Passed
B. P.									

SIGNATORIES

THE STUDENT MIDWIFE

NAME: HAMDIYA ABRAFI ADAMS

SIGNATURE: .....

DATE: 07 JUNE 2024

THE MIDWIFE IN-CHARGE (AFRICA LIBERA HEAITH CENTER)

NAME: MS. IVY KYEREWAA

SIGNATURE: .....

DATE: 07/06/2024

SUPERVISOR

NAME: Ms. CELESTINE AHIAWORNU

SIGNATURE: .....

DATE: 07/06/2024

THE PRINCIPAL

NAME: MONICA NKRUMAH

SIGNATURE: .....

DATE: 07/06/2024

PRINCIPAL
HOLY FAMILY NURSING AND
MIDWIFERY TRAINING COLLEGE
BEREKUM