

REPUBLIQUE DU CAMEROUN

PAIX-TRAVAIL-PATTIE

MINISTERE DE L'ENSEIGNEMENT SUPERIEUR

DIRECTION DE L'ENSEIGNEMENT SUPERIEUR
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REPUBLIC OF CAMEROON

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**CAPITOL HIGHER INSTITUTE OF HEALTH
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P.O. BOX: 875, BAMENDA.

MOTTO: HOPE IS THE KEY

**A CASE STUDY REPORT ON POSTPARTUM
HAEMORRHAGE CARRIED OUT AT THE REGIONAL
HOSPITAL BAMENDA FROM 27 SEPTEMBER TO 29
OCTOBER 2016**

**SUBMITTED IN PARTIAL FULFILMENT OF THE REQUIREMENTS
FOR THE AWARDS OF HIGHER NATIONAL DIPLOMA (HND) IN
NURSING**

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April 2017

CERTIFICATION

This is to certify that the case study on POST PARTUM HAEMORRHAGE was carried out at the Regional Hospital Bamenda, North West Region from 27 September to 29 October 2016 by MAGDALINE AKWEN MAMBO

Name of Student Magdaline Akwen Mambo	Date 25 April 2017	Signature
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President of Jury Dr Mfonfu Daniel	Date 25 April 2017	Signature

DEDICATION

This piece of work is dedicated to my parents Mr/Mrs Mambo who made it possible for me to achieve this piece of work.

ACKNOWLEDGEMENTS

I will like to acknowledge the following people how helped me to achieve this piece of work.

Special thanks go to the proprietor of Capitol Higher Institute Mr Ngalah Edward for creating an institution and for choosing the Regional Hospital Bamenda, North West Region for me to carry out my case study internship.

Thanks go to the entire staffs of Capitol for giving me adequate lectures.

Great thanks go to the entire administration and staff of the Regional Hospital Bamenda for their assistance given to me to realize me objectives.

My immense gratitude go to my supervisor for her guidance to the end of the production of this piece of work.

Special thanks go to my parents for their endless support during this study.

Finally, thanks go to my friends and course mates who assisted me in writing this case report.

LIST OF ABBREVIATION

ABBREVIATION	FULL MEANING
DOA	Date Of Admission
DOD	Date Of Delivery
DOD	Date Of Discharge
BG	Blood Group
RH	Rhesus factor
LMP	Last Menstrual Period
EDD	Expected Date of Delivery
PPH	Postpartum Hemorrhage
C/S	Caesarean Section
BD	Twice Daily
IV	Intravenous
TAB	Tablet
S/C	Subcutaneous
OP	Operation
TID	Three times daily
KVO	Keep vein open
IU	International unit

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CHAPTER ONE - INTRODUCTION

1.1 INTRODUCTION

This is a case study report on POST PARTUM HAEMORRHAGE (PPH) carried out at the Bamenda Regional Hospital, North West Region from 27 September to 29 October 2016 at the Regional Hospital Bamenda in the postpartum ward.

1.2 MOTIVATION FOR THE CASE

I choose this topic in order to learn more about the disease because I had an aunt who died after giving birth due to PPH.

1.3 GENERAL OBJECTIVE

Successfully manage the case of POST-PARTUM HAEMORRHAGE as a member of the medical and nursing team; and to submit the report of this case study in partial fulfilment to obtain the HND in Nursing.

1.4 SPECIFIC OBJECTIVES

- Description of place of study (diagram or picture)
- Give a brief description of place of study
- Figure organigram of place of internship and source
- Identity the patient
- Describe the circumstances of arrival of the patient
- Admit the patient
- State the provisional diagnosis on admission, state source
- Administer any emergency medications

- Clerk / assess the patient
- Administer the medications prescribed by the medical officer, monitor and record side effects on the patients
- Describe nurses responsibility in the administration of drugs to patients
- Establish daily drug chart
- State results of confirmatory diagnostic tests
- Develop and implement nursing care plans
- Describe the evolution of the patient and vital signs
- Review the medications administered
- Write the discharge summary
- Identify positive findings, weaknesses, make recommendations; make conclusions

1.6 Brief description of place of study

The Bamenda Regional Hospital formally called Bamenda Provincial Hospital started in the 1904 in the premises presently occupied by the State Council for Mezam (up station)

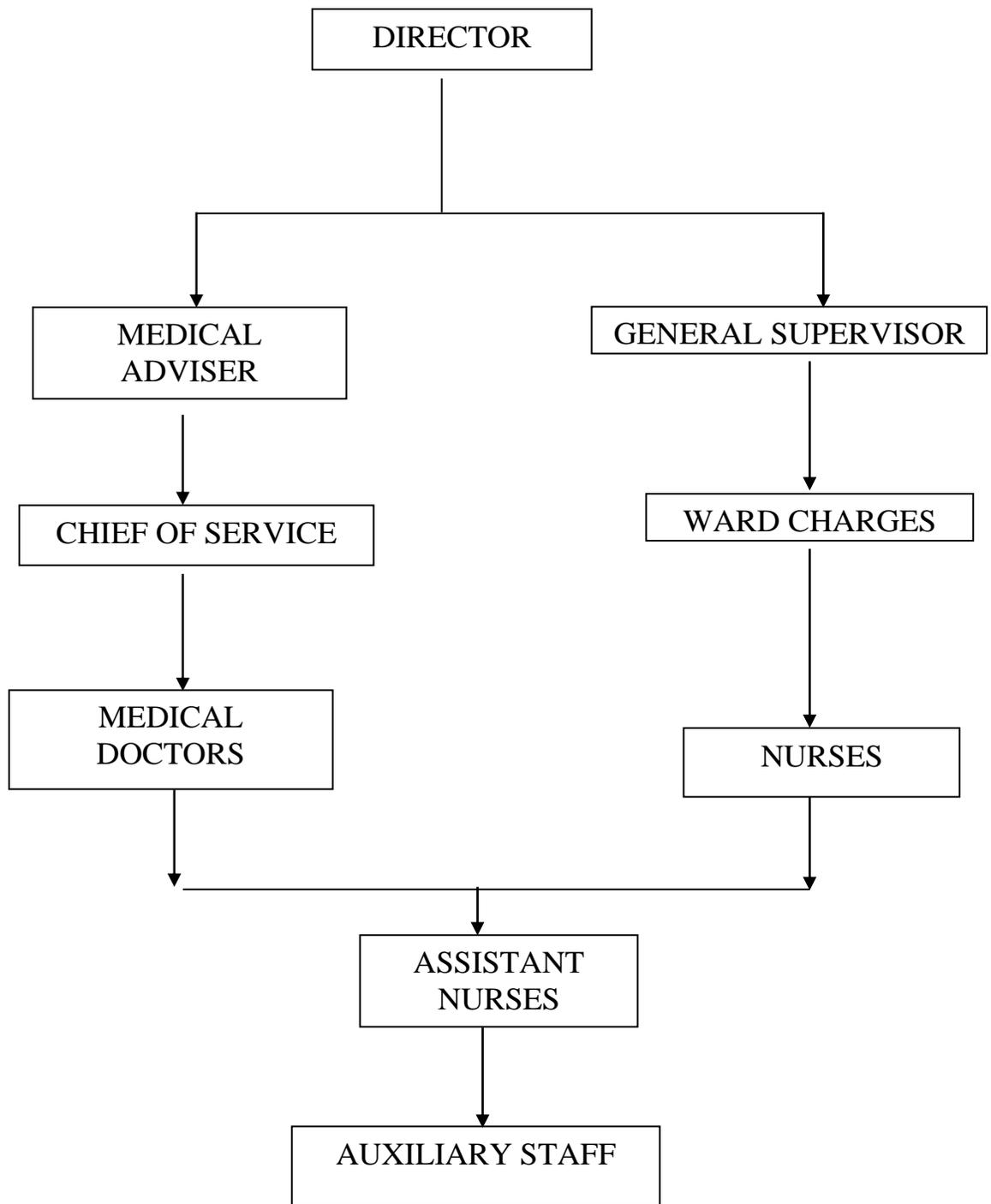
By the 5 April 1956 this hospital moved down to occupy its present position by his Excellency Sir James Roberson the governor general of the Federation of Nigeria

It was only by the presidential decree of 2008, changing province to region in Cameroon that Bamenda Provincial Hospital became to present day Bamenda Regional Hospital.

The Bamenda Regional Hospital, which act as a reference hospital in the North West Region is situated at about 100m away from the hospital round-about

junction. The hospital has 187 permanent personnel. It is made up of the following units.

- Female medical ward
- male medical ward
- Paediatric unit
- Gynaecological unit
- Laboratory
- Day hospital
- Mortuary
- Maintenance
- Information technology centre and hospital canteen
- OPD (Out Patient Department)
- Nursery
- Ophthalmology Department
- Physiotherapy Department
- Theatre
- Dialysis Department
- TB unit
- Casualty
- Reanimation unit



Source: General supervisor.

Fig 1: ORGANIGRAM OF THE HOSPITAL

CHAPTER TWO: LITERATURE REVIEW ON POSTPARTUM . HAEMORRHAGE

2.0 DEFINITION:

Postpartum Haemorrhage (PPH) is commonly defined as a blood loss of 500 ml or more within 24 hours after birth, while severe PPH is defined as a blood loss of 1000 ml or more within the same timeframe. (A. Metin Gülmezoglu et al, WHO)

Postpartum Haemorrhage is the most common cause of maternal death worldwide. Most cases of morbidity and mortality due to postpartum haemorrhage occur in the first 24 hours following delivery and are regarded as primary postpartum haemorrhage. Whereas any abnormal excessive bleeding from the birth canal occurring between 24hours and 12weeks postnatal is regarded as secondary postpartum haemorrhage (A. Metin Gülmezoglu et al, WHO)

Postpartum Haemorrhage is one of the most serious and alarming emergency that can occur after normal or assisted deliveries. The maternal mortality rate (MMR) in developed countries is 6 to 16 deaths per 1000, while in developing countries of West Africa; it is 629 per 1000life birth (lectures in class). The nurse/midwife is often the first professional present when haemorrhage occurs, so her prompt competent action will be crucial in controlling blood loss and reducing the risk of maternal mortality.

2.1 CAUSES OF POSTPARTUM HAEMORRHAGE

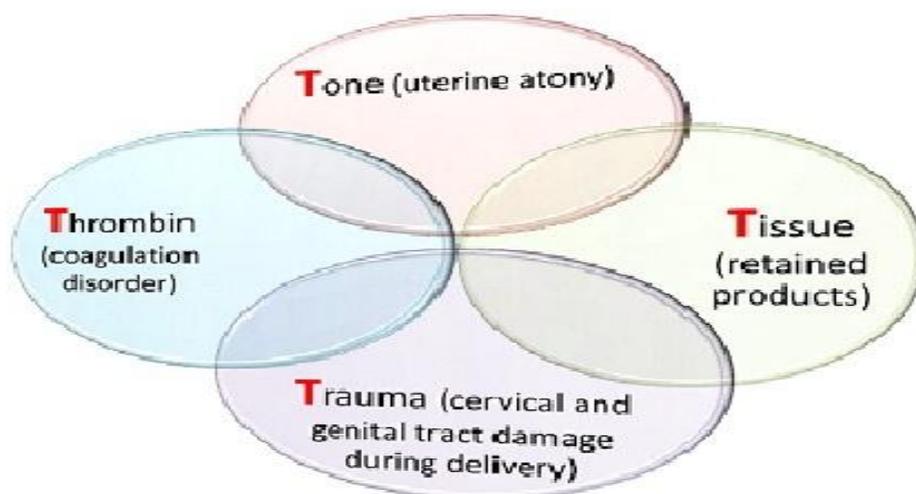
Causes of postpartum hemorrhage are uterine atony, trauma, retained placenta, and coagulopathy, commonly referred to as the "four Ts" according to

http://en.wikipedia.org/wiki/Postpartum_hemorrhage

- **Tone:** uterine atony is the inability of the uterus to contract and may lead to continuous bleeding. Retained placental tissue and infection may contribute to uterine atony. Uterine atony is the most common cause of postpartum hemorrhage.
- **Trauma:** Injury to the birth canal which includes the uterus, cervix, vagina and the Perineum which can happen when the delivery is not monitored properly. The bleeding is substantial as all these organs become more vascular during pregnancy.
- **Tissue:** retention of tissue from the placenta or fetus may lead to bleeding.
- **Thrombin:** a bleeding disorder occurs when there is a failure of clotting, such as

POSTPARTUM HAEMORRHAGE

4 T's RULE :



Speaker : Mabelle Baissari (PGY3); Moderator : Sahar Siddik (MD)
World Health Organization. The World Health Report 2005: Make Every
Mother and Child Count. Geneva, Switzerland: WHO Press, 2005; 62

with diseases known as coagulopathies.

- **Uterine Atony:** Atony describes a lack of normal tone. The postpartum uterus is a large, hollow organ with three layers of muscle. The middle layer has interlacing “figure eight” fibers. The uterine blood supply passes through this network of muscle fibers to supply the placenta.

After the placenta detaches, the uterus normally contracts and the muscle fibres compress bleeding vessels. If the uterus is atonic, however, the muscle fibers are flaccid and do not compress the vessels. Uterine atony allows the blood vessels at the placenta site to bleed freely and usually massively. (Maternity and paediatric nursing fourth edition)

- **Inversion of the uterus** (Frances Ganges et al, Prevention of Postpartum Hemorrhage Initiative (POPPHI)).

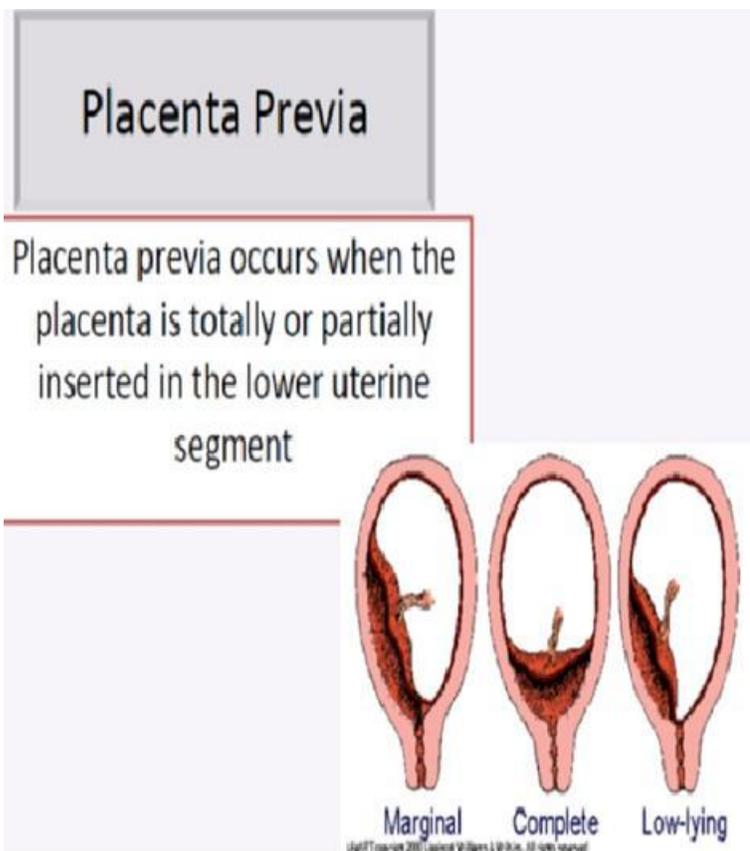
2.2 PATHOPHYSIOLOGY

Although most of the physiological processes in the third stage of labour remain unclear, they broadly help to explain the aetiology of atonic Postpartum Haemorrhage. In this section, the aetiology and accompanying pathophysiology are discussed.

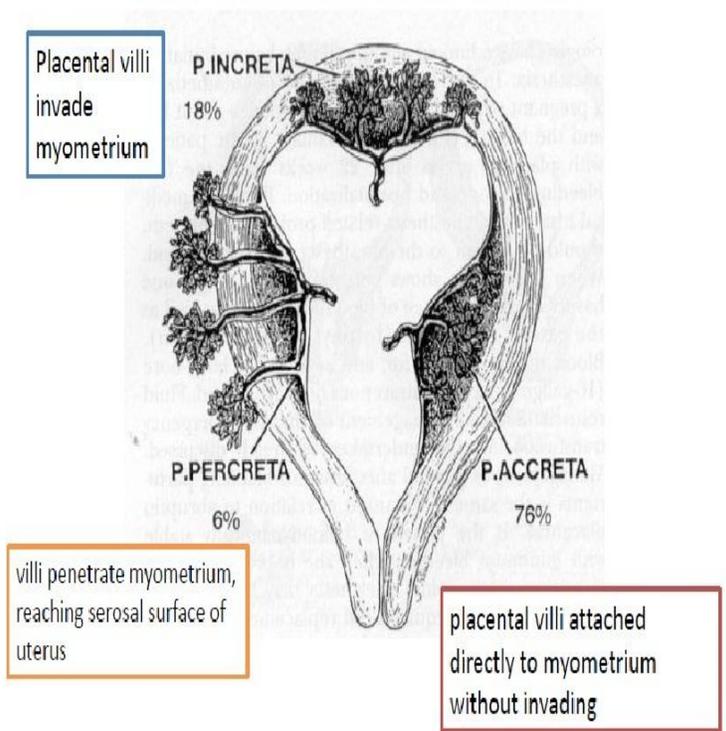
Uterine atony: The most common cause of Postpartum Haemorrhage is uterine atony, i.e. failure of the uterus to contract. Primary Postpartum Haemorrhage due to uterine atony occurs when the relaxed myometrium fails to constrict the blood vessels that traverse its fibres, thereby allowing haemorrhage. Since up to one-fifth of maternal cardiac output, or 1000ml/min, enters the uteroplacental circulation at term Postpartum Haemorrhage can lead to exsanguinations within a short time.

Whilst uterine atony is responsible for 75-90% of primary Postpartum Haemorrhage, traumatic causes of primary Postpartum Haemorrhage (including obstetric lacerations, uterine inversion and uterine rupture) comprise about 20% of all primary Postpartum Haemorrhage. Significant but less common causes of Postpartum Haemorrhage include congenital and acquired clothing abnormalities, which comprises around 3% of the total.

Failure of the uterus to contract may be associated with retained placenta or



Speaker : Mabelle Baissari (PGY3); Moderator : Sahar Siddik (MD)
 World Health Organization. The World Health Report 2005: Make Every Mother and Child Count. Geneva, Switzerland: WHO Press, 2005; 62



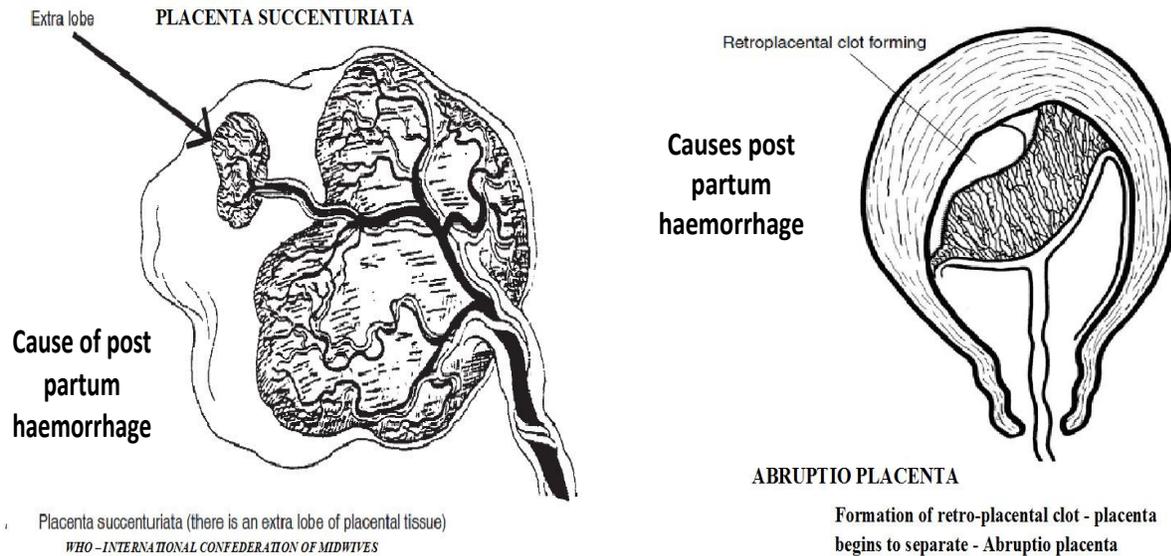
Placenta Accreta
 Abnormal placentation refers to abnormal attachment of the placenta to the uterine wall

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 World Health Organization. The World Health Report 2005: Make Every Mother and Child Count. Geneva, Switzerland: WHO Press, 2005; 62

placental fragments, either as disrupted portions or, more rarely, as a succenturiate lobe. The retained material acts as a physical block against strong the uterine contraction which is needed to contract placental bed vessels. In most cases,

however, dysfunctional postpartum contraction is the primary reason for placental retention. It is more likely for the so contraction failure often becomes self-perpetuating. The reasons for this contractile dysfunction are unknown.

The lower segment serves as an implantation sites. In both placenta praevia



and placenta praevia accreter, the placental bed (and thus the postpartum bleeding site) is in the lower segment. The presence of lower segment implantation makes hemorrhage and placental retention much more likely.

Although the existing evidence is scanty there are indications that aetiology of pathological bleeding is inextricably linked with the anatomical and physiological limitation of the lower segment.

2.4 CLINICAL FEATURE (SIGNS AND SYMPTOMS)

Signs and Symptoms may initially include,

- Visible bleeding above 500mls
- Maternal collapse with abnormal vital signs such as a drop in BP, increase pulse and respiration.
- As more blood is lost the woman may feel cold,

- Decrease in temperature
- Altered level of consciousness, restlessness and drowsiness
- An enlarged a tonic uterus as it fills with blood or blood clot. It feels bulgy on palpation (80ft and lacking tone)

2.5 DIAGNOSIS

- From the signs and symptoms such as recognition of excessive blood loss, low blood pressure, fast pulse and decreased temperature.
- Lab results will reveal a low haemoglobin levels.
 - Consider risk factors
 - Observe vaginal loss
 - Express blood from vagina following c/s
 - Remember
- Blood loss is consistently underestimated
- On-going trickling can lead to significant blood loss
- Blood loss is generally well tolerated a

2.6 TREATMENT

The principles of managing primary Postpartum Haemorrhage are

- Speed
- Skills
- Priorities - The priorities in managing Postpartum Hemorrhage are:
- Call for help (to assist in controlling bleeding)
- Make a rapid assessment of the woman's condition
- Find the cause of the bleeding
- Stop the bleeding

- Stabilize or resuscitate the woman
- Prevent further bleeding

In order to do those things which are most important, it is often necessary to;

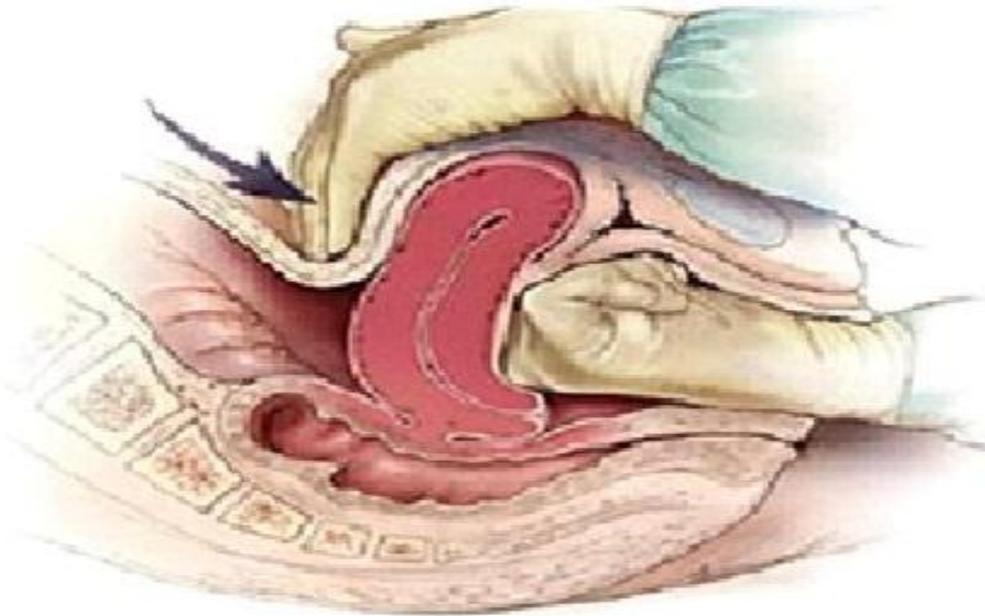
- Change the order of what is usually done (e.g. it is usual to examine a woman from head to toe. If she is already having a postpartum haemorrhage when you are called to her, you need to quickly assess her blood pressure, pulse, colour and levels of consciousness how much blood she has already lost and immediately feel her uterus to determine whether it is atonic haemorrhage. This can be done in a few seconds. Further detailed examination can be carried out later and would waste time now)
- **Remember; Delay means death.**
- Identify what must be done to save life.
The woman will die unless:
 - The bleeding is stopped
 - The woman is resuscitated or her condition is stabilized, this involves maintaining circulatory volume and managing shock.

Managing Atonic Postpartum Haemorrhage

Call for another health care professional available. Otherwise ask an individual who is culturally acceptable to the community and family to help you, in order to stop the bleeding. A third person should take care of the new-born.

1. Massage the uterus to promote a contraction and expel any clots, because

Management of postpartum haemorrhage



Bimanual compression

Speaker : Mabelle Baissari (PGY3); Moderator : Sahar Siddik (MD)
World Health Organization. The World Health Report 2005: Make Every
Mother and Child Count. Geneva, Switzerland: WHO Press, 2005; 62

blood clots trapped in the uterus will inhibit effective uterine contraction

2. Give oxytocin 10IU.IM
3. Assess the women's condition (pulse, blood pressure, colour, consciousness, uterine tone) and estimate how much blood has already been lost.
4. Start an intravenous infusion. Once the cannula is inserted take blood for cross-matching and haemoglobin estimation, there infuse normal saline or ringer's lactate, running it fast if the woman is in shock, (1 litre in

15minutes(until the woman stabilized (you may need to infuse up to 3littres to commit the shock).

5. Empty bladder and keep it empty. Insert a catheter if the woman is unable to pass urine.
6. Check that placenta and membranes and complete
7. examine the cervix, vagina and perineum for tears if bleeding persist;
8. In order to keep the uterus well contracted, add 20units of oxytocin to 1litre of IV fluids; and infuriate 60 drops per minutes. A second infusion line may be required if the first is running quickly to treat shock. Try putting the baby to the breast or use nipple stimulation if the baby will not suckle.
9. Perform bimanual compression of the uterus, or aortic compression to try and control the bleeding.
10. Assess clothing status. Failure of a clot to form after 7 minutes, or a soft clot that breaks down easily, suggests coagulopathy. Transfusion with blood or blood products will be necessary.
11. If blood transfusion is not available locally and bleeding cannot be controlled, arrange for urgent referral to a higher level health facility.
12. Keep accurate records
13. Accompany the woman to a higher level facility, arrange for her relatives/potential blood donor to also accompany her.
If bleeding persist
14. Uterine and utero-ovarian ligation maybe necessary.
15. If this fails to control the bleeding, a sub-total hysterectomy will be necessary.

Monitor woman's condition carefully over the 24 – 48hours. This include

- Checking that the uterus is firm and well contracted

- Blood loss (in order to estimate accurately, put a sanitary napkin or other clean material under the woman's buttocks and ask her to extend her legs and cross them out the ankles of about 20-30minutes. The blood will then collect in the area of the public triangle)
- Temperature
- Pulse
- Respiration
- Blood pressure
- General condition (e.g. color, level of consciousness)
- Fluid intake (after the woman has stabilized, IV fluids should be given in a rate of 1 liter in 4 – 6hours)
- Blood transfusion should be monitored and the volume transfused recorded as part of fluid intake
- Urinary out
- Keeping accurate records

Before the woman goes home, her haemoglobin should be checked and iron supplementation should be given if indicated (because blood loss leads to depletion of iron stores in the body.)

Where hookworm is endemic, give one of the following.

- Albendazole 400mg by mouth once or
- Mebendazole 500mg by mouth once, or 100mg twice a day for 3 days

Never leave the woman alone until

- Bleeding is controlled and
- Her general condition is good

In atonic Postpartum Haemorrhage, never insert a vaginal pack

16. Find the bleeding point, if visible, and clamp it. Then suture the tear if accessible. If not, prepare the woman for referral to a higher level health facility.

2.7 COMPLICATIONS

- Shock
- Death
- Septicaemia
- Orthostatic hypotension
- Anaemia
- Fatigue, which may make maternal care of the new-born more difficult.
- Postpartum anaemia increases the risk of postpartum depression.
- Blood transfusion maybe necessary
- In the most severe cases, haemorrhagic shock may lead to anterior pituitary ischemia with delay or failure of lactation (i.e. postpartum pituitary necrosis)
- Occult myocardial ischemia, coagulopathy, and death also may occur.
- Sheehan's syndrome classically presents as a failure to lactate. It is caused by pituitary infarction following postpartum haemorrhage. Subsequent features include a failure to resume menstruation, loss of secondary sexual characteristics, hypothyroidism (where the thyroid stimulating hormone (TSH) is inappropriately low despite reduced free low T4 level) (Mabelle Baissari; Sahar Siddik; World Health Organization).

2.9 Prevention (Wikipedia)

Oxytocin is typically used right after the delivery of the baby to prevent PPH. The use of uterotonics (oxytocin alone as the first choice plays a central role in the treatment of PPH. Uterine massage is recommended for the treatment of

PPH as soon as it is diagnosed, and initial fluid resuscitation with isotonic crystalloids is recommended.

RISK FACTORS FOR PPH

- Previous PPH or manual removal
- Placental abruption especially if concealed
- Intrauterine fetal demise
- Placental previa
- Gestational hypertension with proteinuria
- Overdistended uterus(e.g. twins, polyhydramnios)
- Pre-existing maternal bleeding disorder
- Operative delivery-cesarean or assisted vaginal
- Prolonged labour
- Rapid labour
- Induction or augmentation
- Shoulder dystocia
- Acquired coagulopathy

2.10 Definition of nursing care plan

This is a deliberate and systematic face of the nursing process involving decision making and problem solving (from lectures).

Nurses make use of collected data and diagnostic statements to formulate goals and design intervention of action to prevent, reduce or eliminate the patient's problem.

2.11 NURSE'S RESPONSIBILITY IN THE ADMINISTRATION OF MEDICATIONS TO PATIENT

When administering drugs to patients, the nurse should check for the following.

The right patient

The right drug

The right dose

The right time

The right route

The right documentation

After checking all the above, nurse should discuss with patient before administering the drug to the patient.

CHAPTER THREE – PRESENTATION OF CASE

3.1 DEMOGRAPHIC IDENTIFICATION OF THE CASE ON ADMISSION

Name	Mrs X
Age	36years
Sex	Female
Nationality	Cameroonian
Occupation	Farming
Religion	Presbyterian
Marital Status	Married
Telephone	675-268-221
Address	Mbatu
Weight	68kg
Bed Number	Private 4
Ward	Post Natal Ward
Date of Admission	12/10/2016

3.2 CLERKING/ASSESSMENT BY NURSE (HISTORY TAKING AND EXAMINATION) ASSESS PATIENT FROM HEAD TO TOE

History Taking

GRAVIDA 5 PARA 202-1

We received patient from doctor's consultation with elective C/S indicated for placental praevia on the 12/10/16.

LMP 08/02/2015; EDD 15/11/2016

Head to toe Assessment

Hair long and clean

Head No lesions, no palpable nodules

Eye sunken eyes
Buccal cavity Offensive odour
Skin pale and dry skin
Breast soft, no nodule
Abdomen lesion and scars
V/E lochia discharge
Legs not swollen

3.3 PAST MEDICAL HISTORY

- Minor ailments:

- Fever
- Headache

3.4 PAST SURGICAL HISTORY

- Surgical operation – <15 (2010) for placenta praevia

3.5 FAMILY HISTORY

- No genetical disease common
- Twins not common

3.6 SOCIAL HISTORY

Mrs X of 36 years old is a farmer and her husband a businessman. She does not smoke but drink alcohol on occasions

3.7 PHYSICAL ASSESSMENT

On admission, the following measures were used to assess the patient.

Temperature	–	36oC
Pulse	–	77b/m

Respiration – 19c/m
Blood pressure – 153mmHg
100

3.8 Client prepared for CS and wheeled to the theatre: She was catheterized. where operation started at 3:00pm, extraction of a life female baby at 3:2pm Apgar 10baby's weight 2.5kg, Head circumference 33.3. The 3rd stage was completed by the doctor and theatre teams. It was an elective C/S indicated for placenta praevia.

The procedure was transverse lower uterine segment hysterectomy, manual delivery of the placenta. There was Massive haemorrhage of the lower segments.

Gestive historiography + reperitonisation then closure of the abdominal wall layer. The blood loss was = 1000cc (report of MD) Diuresis = 300cc.

She was wheeled into the post natal ward after the operation in a semi-conscious state. Sanitary pads were placed under her buttock, her vital signs where monitored/

- Blood pressure – 122/82 mmHg
- Pulse – 123b/m
- Respiratory rate – 22c/m
- Temperature – 36°C

3.9 NURSE'S OBSERVATION (while taking the patient to post natal ward)

As we wheeled the patient on a stretcher to the post natal ward we noticed that the patient was bleeding profusely with the blood dripping on the floor. We took a roll of toilet paper to clean the blood on the stretcher. The patient was restless. As soon as we arrived the post natal ward we called for the MD. He arrived and immediately examined the patient and declared that it was a case of severe immediate postpartum haemorrhage. He ordered for the

immediate injection of 30 iu of oxytocin im. directly, and he also massaged the uterus.

He ordered for the transfusion of same group and cross matched blood - 2pints of blood. The patient was transfused with the 2 pints of blood as ordered by the MD.

3.10 DIAGNOSIS BY DOCTOR

Diagnosis: Severe Postpartum haemorrhage

The doctor order for the transfusion of 2 pints of blood

3.11 PRELIMINARY LAB RESULTS

- Haemoglobin estimated to be low (9.9g/dl)
- (Blood group “O”) Rhesus positive

3.12 FOLLOW UP MEDICAL PRESCRIPTION

Plan 1 12/10/2016

1. Transfuse 2 paunch of blood
2. Liquid 2500cc / 24 hours
 - Normal saline
 - Dextrose 5% 1000cc/24hours
3. Steritax 75g
2 ampule start
4. Ampicillin inj 1g/8hourly
1 ampule
5. Novalgin inj / 6hourly
1 ampule
6. Oxytocin 30Iu
7. Monitor Temperature, consciousness, bleeding blood pressure, pulse.

Plan 2 15/10/2016

Remove catheter

Oral treatment

1. Rapiclav 1g
1 table x 2 days
2. Paracetamol 300mg
2 tablets x 3 days
3. Ranferon gel
1 tablet x 2 days

Management of the patient in the ward

- We monitored her vital signs (BP, pulse, RR, temperature), within 15 to 30minutes until she regained consciousness.
- We placed sanitary pads and monitored it for excessive bleeding.
- We asked the patient's carers not to give anything to the patient to eat until the return of bowel sounds – after passing out flatus. We equally asked them to start with liquid (simple tea) and easily digestible foods (Irish potatoes).
- We monitored urine output for quantity and colour.
- We used and teach hygienic measures to reduce the number of microorganisms that can cause infection (e.g. hands washing, Perineal care).
- We promote adequate rest and nutrition for healing.
- We observe for signs of infection.
- We teach the woman how to apply perineal pads (front to back).
- Teach the woman to take all her antibiotics prescribed rather than stopping them after her symptoms go away.

- We encouraged her about foods that are high in proteins (meat, cheese, milk, legumes) and vitamin C(citrus fruits and juices), because these nutrients are especially important for healing. Food rich in iron to correct anaemia include meat, enriched cereals and bread, and dark green, leafy vegetables.
- We taught the nursing mother proper breastfeeding techniques to reduce the risk of mastitis (an infection of the breast).
- We monitored the op site for bleeding.
- We did wound dressing.
- We administered drugs prescribed with the consent of the patient
- We removed the urinary catheter that was placed for 3 days before the operation as ordered by the doctor who carried out the operation.

3.12 Table 1: DAILY DRUG CHART

Date	Time	Drug	Dose	Route	Frequency	Remarks
12/10/16	6pm	- Steritax	2g	IVD	Stat	Served
		- Novalgin	1A	IVD	Stat	Served
		- Oxytocin	30IU	IVD	Stat	Served
13/10/16	12am	Novalgin	1A	IVD	6hourly	Served
		Ampicillin	1g	IVD	8hourly	Served
	6am	Novalgin	1A	IVD	6hourly	Served
	8am	Ampicillin	1g	IVD	8hourly	Served
	13pm	Novalgin	1A	IVD	6hourly	Served
	2pm	Ampicillin	1g	IVD	8hourly	Served
	6pm	Novalgin	1A	IVD	6hourly	Served
	8pm	Ampicillin	1g	IVD	8hourly	Served
14/10/16	12am	Novalgin	1A	IVD	6hourly	Served

Date	Time	Drug	Dose	Route	Frequency	Remarks
	2am	Ampicillin	1g	IVD	8hourly	Served
	6am	Novalgine	1A	IVD	6hourly	Served
	8am	Ampicillin	1g	IVD	8hourly	Served
	12pm	Novalgine	1A	IVD	6hourly	Served
	2pm	Ampicillin	1g	IVD	8hourly	Served
	6pm	Novalgine	1A	IVD	6hourly	Served
	8pm	Ampicillin	1g	IVD	8hourly	Served
15/10/16	12am	Novalgine	1A	IVD	6hourly	Served
	2am	Ampicillin	1g	IVD	8hourly	Served
	6am	Novalgine	1A	IVD	6hourly	Served
	8am	Ampicillin	1g	IVD	8hourly	Served
16/10/16	9am	Rapiclav			12hourly	Served
		Ranferon			Daily	Served
		Paracetamol			8hourly	Served
17/10/16		Rapiclav			12hourly	Served
		Ranferon			Daily	Served
		Paracetamol			8hourly	Served

Table 2: date 13-10-2016 Nursing care plan 1 Need: the need to avoid danger in the environment and injury

Nursing diagnosis: Risk for ineffective tissue perfusion related to excessive blood loss secondary to uterine atony and a birth injury.

Objective	Nursing intervention	Rational	Evaluation
The woman will not have signs or symptoms of hypovolemic shock within 40minutes to 1hour of care.	<ul style="list-style-type: none"> - Administer fluids prescribed - Administer blood prescribed - Administer oxytocin - Monitor blood pressure - Monitor signs of bleeding 	<ul style="list-style-type: none"> - Increase blood volume t - replace blood loss - enhance uterine contraction assess the BP - to detect bleeding 	The woman will not have signs and symptoms of hypovolemic shock within 40minutes to 1hour of care.

Table 3: Nursing care plan2; Date 13/10/2016 - Need: the need to maintain body temperature and other vital signs within normal rang

Nursing diagnosis: High temperature related to infections of the delivery tract.

Objective	Nursing intervention	Rational	Evaluation
To bring down the temperature to normal within 30 minutes of care norm range	<ul style="list-style-type: none"> - Reduce clothing and improved ventilation - Tepid sponge the patient with warm water - Change patients 	<ul style="list-style-type: none"> - To improve heat loss - To reduce temperature by evaporation - Prevent infection and bed sores 	Patient's temperature is normal with in 30minutes of

Objective	Nursing intervention	Rational	Evaluation
(36.5°C–37.5°C)	beddings if soil with sweat - Administer antipyretic as prescribed (paracetamol) - Monitor temperature regularly	- Reduce temperature - To assess severity of the condition	care

Table 4: Nursing care plan 3 Date 14/10/2016 Need: need to learn, discover or satisfy the anxiety that leads to normal development and health

Nursing diagnosis: anxiety related to knowledge deficit.

Objective	Nursing intervention	Rational	Evaluation
Woman will be able to cope with the unexpected complication. Anxiety will be at a manageable level after 10 minute of care	- Identify woman's reactions to unexpected complications and correct. Misconceptions and exaggerations of facts or myth - Be calm and reassuring when in contact with the woman. - Encourage verbalization of woman concerning her fears and perceptions - Stay with the woman and her partner	- Supplying factual information reduces fear, identifying reactions establishes basis for intervention. - Anxiety can be transferred by voice or body language - This helps establish a basis for patient teaching and identification of fears - Having professional present promotes a feeling of security.	Within 10 minutes of care, the woman was able to cope with the unexpected complication

Table 5: Date 15-10-2016 Nursing care plan 4 - Need: need to avoid danger in their environment and injury

Nursing diagnosis: Risk for infection related to loss of skin integrity (caesarean Incision) and increase risk factors (blood loss, invasive procedures).

Objective	Nursing intervention	Rational	Evaluation
<p>The woman will not have signs of infection as evidenced by an oral temperature below 38°C (100.4°F) and normal progression of lochia that does not have a foul odour. The woman will not be self-contaminated</p>	<ul style="list-style-type: none"> - Use hand washing when providing care. - Teach woman personal hygiene measures, such as hand washing perineal care, and regular changes of perineal pads - Determine vital signs every 4 hours or more frequently if signs of infection are present - Observe lochia for amount, colour and odour with vital signs - Observe the wound each shift for redness, oedema, ecchymosis, discharge and - Maintain medical and surgical aspects when in contact with woman 	<ul style="list-style-type: none"> - Limits the transfer of infection between patients and from one area of the body to another. Regular pad changes also reduce the amount of time organisms have to multiply in this warm, dark and moist environment - An elevated temperature and rising pulse are signs of infection. If they occur, woman should be assessed for other signs and symptoms of infection. - Infections are evidenced by foul smelling lochia that may be increased or decreased. It is sometimes brown. 	<p>The woman will not be contaminated after nursing care</p>

Objective	Nursing intervention	Rational	Evaluation
	<ul style="list-style-type: none"> - Teach woman wound care protocol and general hygiene - Promote fluid and fluid and nutritional intake. Record intake and output 	<ul style="list-style-type: none"> -A wound infection is characterized by signs of inflammation. The future line may separate if the infect in the area. - Reduces the potential for infection for the woman at risk because of complication of postpartum -reduces the spread of infection by self-contamination. - Adequate nutrition is essential for healing. - Decreased output can indicate kidney shutdown 	

3.14 Table 6: Daily Evaluation of patient

Date	Time	Observation
12/10/16	Evening/7pm	Body weakness, pain at the operation site, headache
13/10/16	Morning/8am	Back ache, dry lips, slight body weakness
	Evening/8:30pm	Back ache reduce, lip not dry anymore, no body weakness and pain at the op site
14/10/16	Morning/7am	Slight head ache, pain at the operation site
15/10/16	Morning/8am	No complain
	Evening/5pm	No complain
16/10/16	Morning/8am	No complain
	Evening/5pm	No complain
17/10/16	Morning/8am	She is feeling fine
18/10/16	Morning/8:30pm	she is strong

3.15 Table 7: Vital Sign chart

Date	Period	T°C	BPmmHG	Body weight	Pulse	RR	Bowel	Urine	Vomiting
12/10/16	Evening	36 °C	122/82	68kg	123b/m	22c/m	-	4	-
13/10/16	Morning	37 °C	120/70	68kg	100b/m	20c/m	-	3	-
	Evening	37.5 °C	11/75	68kg	82b/m	18c/m	-	3	-
14/10/16	Morning	36.5 °C	115/80	68kg	80b/m	19c/m	-	2	-
	Evening	38.5 °C	110/70	68kg	84b/m	19c/m	-	2	-
15/10/16	Morning	38 °C	115/75	67kg	83b/m	18c/m	-	3	-

Date	Period	T°C	BPmmHG	Body weight	Pulse	RR	Bowel	Urine	Vomiting
	Evening	37°C	105/70	67kg	84b/m	20c/m	-	2	-
16/10/16	Morning	35.5°C	112/60	67kg	78b/m	18c/m	2	2	-
	Evening	37°C	112/75	67kg	68b/m	22c/m	1	2	-
17/10/16	Morning	37°C	110/75	67kg	80b/m	21c/m	1	2	-
	Evening	37°C	110/70	67kg	82b/m	20c/m	1	2	-
18/10/16	Morning	37.5°C	112/65	67kg	75b/m	19c/m	-	2	-

EVOLUTION OF THE STATUS OF PATIENT AND NEW BORN BABY

The patient was discharged in a good condition and the baby was also well.

The baby was sucking well and her temperature on discharge was within the normal range (37⁰c). The woman's temperature was 37.5⁰c and the operation site was clean and dry.

CHAPTER FOUR - REVIEW OF MEDICATION

4.1 GLUCOSE 500mls

Indication: Dehydration, hypoglycaemia, energy source, fluid replacement, for IV administration of drugs

Contraindication: Hyperglycaemia

Precaution: If hypertonic, low PH may cause venous initiation

4.2 SODIUM CHLORIDE

Indication: Electrolyte imbalance, management of extracellular volume depletion, dehydration. For IV administration of drugs.

Precaution: Restrict intake if impaired liver renal function, cardiac failure, peripheral and pedal edema.

Contraindication: Intracellular sodium deficit, cardiac failure hypertension, premature labour

4.3 STERITAX (ceftriaxone)

Group: It is a cephalosporin

Mode of Action: It inhibits the action of bacteria cell wall, mitosis and growth of bacterial

Indication: Septicaemia, pneumonia meningitis

Dose: 1g daily, 2.4g daily in severe infection or 50mg 1g twice daily

Route: IM, IV

Site effect: Diarrhoea, abdominal pains, mouth soreness, body rashes, hypersensitivity reaction

Contraindication: History of hypersensitivity to penicillin

4.4 AMPICILLIN

Dosage: Adult 250-500mg 6hourly for 5-10day

Contraindication: Hypersensitivity Ampicillin

Side effects: Allergic reactions, anaphylactic reactions, nausea and vomiting, diarrhoea

4.5 NOVALGIN:

Group: It is an analgesic, antispasmodics, anti-rheumatic, antipyretic drug

Mode of Action: It alters the response of heat regulating centre and raise pains threshold and helps to relax smooth muscles

Indication: Neurological problems, labour pains, myocardial infection, spastic dysmenorrhea, post operation.

Dosage: Adult 1-2 tablets daily

Route: IV, orally

Site effect: Vertigo, hypersensitivity reaction, anaphylactic reactions

Contraindication: Allergy, pregnancy

4.6 RANFERON CAPSULE

Indication: Iron deficiency anaemia, poor diet, poor absorption of food, and increased requirement of foliate in the body, foliate deficiency, for eye and ear wash.

Mode of Action: Ranferon capsule works by producing blood cells and platelets in the body; producing and maturing the red blood cells, inhabiting the herpes simplex virus growth; catalysing the vitamin conjunction rejection in the body.

Composition and active ingredients:

Fe fumigate (350mg)

Folic Acid (0.7mg)

Vitamin C7 (5mg)

Zinc sulphate (5mg)

Cyanocobalamin (5mg)

Side effects:

Gastrointestinal problems

Stomach pains

Black stool

Nausea

Allergic rejection

Bitter taste in the mouth

Precautions: Do not take this drug if you are allergic to it. If you are pregnant for planning to become pregnant

4.7 RAPICLAV

Indication: Used for bacterial infection of the respiratory tract, urinary tract, bacterial infection of the skins. Heart, gums, ear and other conditions.

Composition and active ingredient

It contains Amoxicillin and clavulanic acid as active ingredients.

Action: Killing bacteria by inhibitory the production of bacterial cell wall.

Blocking the activity of beta lactamase chemical

Side effects

- Nausea – pain
- Skin rash - irritation at the site of injection
- Severe skin allergies – vomiting

4.8 PARACETAMOL

Paracetamol tablets belong to a group of medications called analgesics.

INDICATION

They are used for the relief of mild to moderate pains and feverish condition such as headache, toothache, colds, influenza, joint pain and period pains.

DOSES

Adults including elderly and children over 12years; 1to 2 tablets every 4 to 6hours are required to, to a maximum of 8 tablets in a day.

Children 6-12years; half to 1 tablet every 4-6hours as required, to maximum of 4 tablets n a day.

Children under 6years; not recommended.

SIDE EFFECTS

Allergic reactions- skin rash.

Blood- changes in numbness and types of blood cells.

4.9 SIDE EFFECTS OBSERVED ON CASE AND MANAGEMENT OF THEM

The patient did not manifest any signs of side effects

CHAPTER FIVE - DISCHARGE SUMMARY

5.1 Date of admission: 12/10/2016

5.2 Date of Discharge: 18/10/2016

5.3 Diagnosis on admission - Elective CS for placenta praevia

5.4 Diagnosis on discharge - Severe Postpartum Haemorrhage post CS-Treated

5.5 TREATMENT RECEIVED - Oxytocin 30 IU; Ampicillin injection 1g 8hourly ; Novalgin injection 1 ampule 6 hourly; Rapiclav 1 tablet 2 times daily for 3 days; Paracetamol 300mg 2tablets 3 times a day; Ranferon capsule 1 tablet daily for 3 days

5.6 RESPONSE TO TREATMENT - Very good

5.7 CONDITION ON DISCHARGE

Favourable, patient is strong and healthy, good skin colour, patient eats well and the pain at the operation side has subsided and the body temperature was normal. Baby was in good health.

5.8 Home Treatment

Ferrous sulphate to be taken for 1month 2weeks

5.9 ADVICE ON DISCHARGE

- Take medication and respect the duration (for 1month 2weeks)
- Take a balance diet and enough fruits
- Drink a lot of water at least 2 litres a day
- Practice good hygiene (change pad at least 3times a day, clean the breast well before breast feeding the baby, avoid many people from carrying the baby in order to prevent infection)
- Avoid stress and have a good bed rest
- Rest peck next appointment

5.10 APPOINTMENT DATE

The next appoint is in 6weeks time for baby's vaccination and family planning.

CHAPTER SIX - CONCLUSION

6.1 POSITIVE FINDINGS

The staff and doctors of the Regional Hospital Bamenda are very polite and willing to teach students who are willing to learn.

Even though the patient nurse ratio is very high the nurses still try as much as possible to attend to all the patients.

6.2 DIFFICULTIES ENCOUNTERED

Nothing can be done smoothing without some barriers or obstacles on the way. Despite all that was learned, there were some barriers and problems that were encountered.

The patient was not cooperative sometimes and this made it difficult for the required nursing procedure to be carried out.

The patient did not want to stay in the hospital so she was rejecting her medication saying that she was not sick again and fit to go home.

6.3 PROPOSED SOLUTIONS

The patient was encouraged to cooperate with the nurse so as to hasten her recovery and not to worry too much about her situation.

The patient was educated that if she goes home without fully recovered, her situation may become worse at home.

6.4 RECOMMENDATIONS

The government should organize seminar to educate people and the nurses more on the causes, risk factors and how to prevent postpartum from occurring after the third stage of labour.

The government or hospital should employ more health personnel so as to reduce the work load on the few nurses and improve on the nursing care.

6.5 CONCLUSION

In the maternity after delivery and in the theatre after CS we should send the mother to the post natal ward only after ensuring that the uterus is well contracted and all possible causes of post-partum haemorrhage have been explored and repaired.

We should educate the carers to monitor the beddings of the mother every 15 minutes and report any bleeding to the nurses

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