HOLY FAMILY NURSING AND MIDWIFERY TRAINING COLLEGE-BEREKUM

A CLIENT/FAMILY CENTERED MATERNITY CARE STUDY ON

JANET OWUSUWAA

BY

ANITA YEBOAH

4122190018

SUBMITTED TO THE NURSING AND MIDWIFERY COUNCIL OF GHANA IN PARTIAL FULFILMENT TOWARDS THE AWARD OF LICENSE TO PRACTICE AS A PROFESSIONAL REGISTERED MIDWIFE

AUGUST,2022

TABLE OF CONTENTS

LIST OF TABLES

PREFACE

The client and family centered maternity care study is a systematic approach, used in rendering holistic obstetric care to the expectant mother and family within her own community

throughout pregnancy, labour, delivery and puerperium based on a thoughtful understanding of client as a unique individual with specific problems and needs. These needs include the social, emotional, spiritual, psychological and educational aspect of her health. The care provided is individualized and recognizes the importance of family support, participation and choice.

This approach also helps the student midwife to identify the effects of pregnancy on the woman and the entire family and to use the knowledge acquired through training to meet the needs and problems of expectant mother and the entire family.

The family centered maternity care study is part of the Ghana Nursing and Midwifery Councils requirements for awarding license or certificate to students at the end of their training. The objective of this script is to introduce the reader to the principles of family centered maternity care in obstetrics and how the idea has been utilized to provide care. It helps the student midwife to put in practice the knowledge and skills acquired during training. It again, improves the interpersonal relationship between the student midwife and client as well as her family and community. It also improves the skills and builds her confidence. She uses scientific approach to collect data, analyze and identify problems or needs and evaluate the effectiveness of the care rendered.

The family centered maternity care goes a long way to decrease the incidence of infant and maternal mortality and morbidity rate when it is implemented effectively.

ACKNOWLEDGEMENT

My profound gratitude goes to the Almighty God for the direction, strength, ability and knowledge He gave me in conducting this study successfully.

My heartfelt appreciation goes to my client Madam Janet Owusuaa and her family, for their cooperation and consent during the time of care.

Furthermore, I also wish to express my profound gratitude to the midwife in charge of Tuobodom Health Centre Mrs. Felicia and her team most especially Madam Vida for their assistance and guidance as well as cooperation during the period of Study.

I would like to honour my supervisor Mrs. Celestine Ahiawornu and to my wonderful family, friends and loved ones for their care, love and support throughout my education. A special thanks goes to my sweet mum Madam Comfort Ankomah and my beloved father Mr. Kofi Boakye for their support and assistance. And not forgetting my friend Dramani Barikisu and Emmanuel Kyere for helping me during typing.

My final gratitude goes to the authors and publishers whose books were used to support my findings and other references, a big thank you to everyone.

INTRODUCTION

The Client/family centered maternity care study is a systematic approach used in caring for an expectant mother and her family with the aim of helping her throughout pregnancy, Labour and Puerperium. The concept also helps the student midwife to recognize each client as an individual with special needs and gives the student the opportunity to adopt a scientific approach to problem solving by collecting relevant data, identifying problems, plan and manage these problems and also evaluate the action put in place to solve the problem identified.

This care study is about Madam Janet Owusuaa Gravida 3 Para 2 all alive, a 27 years old woman. Whom I met when she was 37 weeks pregnant on 8th November, 20201 at Tuobodom Health Center. Madam Janet owusuwaa was very excited after a short interaction of about 15 minutes when she was told about my intention to use her for my study. Thorough assessment and physical examinations were carried out after procedures were explained to her. She had a normal pregnancy but complained of some minor disorders which was well-managed. My client was cared for from 37weeks onwards. She went through pregnancy successfully and admitted in labour on the 25th November, 2021 and delivered a healthy baby girl without any complication to both mother and baby and they were discharged on the 26th November, 2021.

This care study is in four (4) chapters;

Chapter one talks of client's particulars which include; social, family, medical, surgical, menstrual, environment, past and present obstetric histories as well as client's lifestyle and hobbies.

Chapter two describe the first contact with the client, the first antenatal home visit, her subsequent visit to the clinic, my subsequent home visits and nursing care plan ends this chapter.

The third chapter contains the admission and management of the first to fourth stages of labour including immediate and subsequent care of the baby with nursing care plan. The fourth chapter deals with management of puerperium with emphasis on care of mother and baby from the day of delivery to the first ten days after delivery. The various histories taken and care given to client is to establish rapport and mutual relationship between the client and family so that client can voice out her sentiments without restraint and go through her pregnancy, labour and puerperium safely without complication. A care plan was drawn to identify problems and management given with the use of nursing process at the end of each chapter. Summary and conclusion, bibliography, signatories as well as various appendices like antenatal records, laboratory records, postnatal and pharmacology of drugs are all included.

LITERATURE REVIEW

PREGNANCY

According to American College of Obstetricians and Gynecologists (ACOG) pregnancy is defined as carrying of one or more offspring known as embryo or foetus in the womb of a woman (American College of Obstetricians and Gynecologist, 2018). Pregnancy can occur any time after menstruating in conjunction with ovulation until she reaches menopause where ovulation ceases.

According to Ojo and Briggs (2006), when pregnancy occurs, menstruation ceases for some weeks or months after delivery. Most women experience some minor disorders such as morning sickness, nausea, frequency of micturition, heart burns among others. Ojo and Briggs went further to state that such conditions may not be life threatening but can be harmful: the women therefore need to be educated on these conditions so that they can understand and cope with their occurrence.

Pregnancy is a time of enormous physical and psychological change and adaptation as the woman and her family prepared or expected a new member of the family. This is an exciting and happy period of time for most women but may be over shadowed by anxiety and expectations (Marshall & Raynor, 2014).

Pregnancy is the condition of having a developing embryo or foetus within the body, the state from conception until the delivery of the baby. The normal duration is 280 days starting from last menstrual period or 266 days starting from day of conception or (40 weeks or 9 month and 7 days). Moreover, during pregnancy a lot of physiological and physical changes take place under the influence of hormones (Oestrogen and progesterone). Some of these hormonal change result in minor disorders such as morning sickness, frequency of micturition, varicose veins, chloasma, heartburns, and constipation among others (Verralls, 2011). During this

period almost all the organs of the woman's body are affected especially the uterus which has to grow and expand to accommodate the foetus. The uterus increases in weight from 57g to about 1kg at term. It also increases in size to accommodate the foetus. It grows from its normal size of 7.5cm to 30cm long, 5cm wide to 23cm, 2.5cm to 20cm thick at term. It is pear shaped but as pregnancy advances it becomes globular in shape. These signs and symptoms become obvious to the woman as her pregnancy advances (Verralls, 2011).

Marshall and Raynor (2014) defines antenatal care as the advice, supervision and attention a pregnant woman receives to ensure good health; a pleasant child-bearing experience and adequate preparation for labour and lactation; a live healthy baby at the end of pregnancy. It was also stated that antenatal care should commence from the time pregnancy is diagnosed and should continue until the safe delivery of the patient.

Marshall and Raynor (2014) also defines antenatal care as the care given to a pregnant woman from the time that conception is confirmed until the beginning of labour. Also, the midwife will provide a woman-centered approach to the care of the woman and her family by sharing information with the woman to facilitate her to make informed choices about the care. Some of the aims of antenatal care are;

1. To support and encourage a family's health and psychological adjustment to child bearing.
2. To monitor the progress of pregnancy.
3. To help and support mother in her choice of infant feeding.
4. To recognize deviation from normal.

Some cares rendered at antenatal care include, antenatal exercise, physical examination, urine testing, administration of some drugs such as Sulphadoxine Pyrimethamine, Tetanus toxoid injection and also, physical preparedness before birth.

In view of the above, the Ghana National Safe Motherhood Service Protocol (2016) states that, in order to promote quality care, antenatal care service must be organized in such a manner as to provide comprehensive and individualized care. As much as possible all care activities such as comprehensive history taking, physical examination and treatment, should be provided by the same care provider to the pregnant woman (Focus Antenatal Care).

Furthermore, pregnancy is divided into three trimesters. The first trimester is from conception until 12 weeks of gestation, and this phase is associated with changes such as breast tenderness and nausea etc. The second trimester starts from 13 to 27 weeks of gestation in which there is rapid growth development of the foetus. The third trimester is from 28 to 40 weeks gestation, as a period in which the foetus continues to grow and become mature.

AIMS OF FOCUS ANTENATAL CARE (FANC)

1. Early detection and management of complications.
2. Identification of pre-existing health condition.
3. Birth preparedness and complication readiness.
4. Health promotion and disease prevention.

The benefit of focus antenatal care are that; privacy and confidentiality is assured, national protocols are adhered to promotion of partner support and facilitate referral of client when the need arises, individualized care, education and counseling more tuned to client's needs, comprehensive care thus all care and services provided by the same provider.

LABOUR

Marshall and Raynor (2014) defines labour in the physical sense as the process by which the foetus, placenta and the membranes are expelled through the birth canal. Normal labour occurs between thirty seven to forty two weeks of gestation.

Tiran (2012) described labour by saying normal labour occurs spontaneously between 37 and 43weeks gestation with a vertex presentation of a single foetus and is completed within 24

hours without maternal or foetal trauma; physiology depends on interaction between the uterus, maternal pelvis and foetus.

During the first stage, cervical effacement and dilatation occur; contractions are fundal dominant; uterine POLARITY facilitates contraction and RETRACTION in the upper uterine segment and contraction and dilatation in the lower uterine segment. The second stage is from full dilatation of the cervix until complete delivery of the baby. The third stage involves separation and expulsion of placenta and membrane and control of haemorrhage. Normal labour according to World Health Organization (W.H.O) (2016) is defined as low risk throughout, spontaneous in onset with foetus, starting from the vertex, culminating in the mother and infant in good condition following birth. With the use of partograph, normal labour should not exceed 15 hours. Labour has four stages (Marshall & Raynor, 2014).

1. **The First stage of labour** begins with regular rhythmic uterine contractions to the full dilatation of the cervix and is managed by a partograph. The first stage lasts for about twelve to fourteen hours in primi Gravida and six to twelve hours in multigravida (Marshall & Raynor, 2014).
2. **Second stage of labour** start from the full dilatation of the cervix (10cm) to the complete expulsion of the foetus. This stage also varies with the parity of the woman. It also comprises of strong uterine contractions, descent of the head and expulsion of the baby (Marshall & Raynor, 2014). According to Magowan, Owen and Thomson, (2014) there are two distinct phases in the second stage of labour which are propulsive passive phase and expulsive active phase. The propulsive passive phase is from full dilatation until the head reaches the pelvic floor. During this time, the head is relatively high in the pelvis, the lower vagina is not stretched and the mother has no or little urge to push. The expulsive active phase begins when the fetal head reaches the pelvic floor and the mother usually has a strong involuntary desire to push, with this the head

crowns and it is delivered by extension, then the head restitutes. The anterior shoulder of the fetus is delivered with downward pressure on the head. The head is lifted upwards towards the mother's abdomen to deliver the posterior shoulder and the baby is delivered with lateral flexion onto the mother's abdomen.

3. **The third stage of labour** is the period from the birth of the baby to complete expulsion of the placenta and membranes, involving the separation, decent and expulsion of the placenta and membranes and control of haemorrhage from the placenta site. It usually last between 5 to 15 minutes but any period up to an hour may be considered normal. The third stage of labour should be actively managed to minimize the risk of postpartum haemorrhage. This involves the use of oxytocin, gentle control cord traction, counter pressure and massage of the uterus (Marshall & Raynor, 2014).
4. **The Fourth stage of labour** is advisable for mother and baby to remain in the midwife's care for at least 6 hours after birth, regardless of the birth setting. Much of this time is used for observation of mother and baby, clearing up and completion of records. During the fourth stage, uterine contraction, blood loss and vital signs are checked every 15 minutes for the first 2 hours, every 30 minutes for the next hour and hourly for the next 3 hours. Head to toe examination is done on the baby and the baby is bathed after six hours (Marshall & Raynor, 2014).

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

PUERPERIUM

Marshall and Raynor (2014) describes Puerperium as a period that starts immediately after delivery of the placenta and membranes and control of haemorrhage and continues for 6 weeks. It also states that the overall expectation is that by 6 weeks after the birth, all the systems in the woman's body will have recovered from the effects of pregnancy and returned to their non-pregnant state.

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

1. Immediate puerperium: this is the first 24 hours after delivery.
2. Early puerperium: is between the second and the seventh day after delivery.
3. Late puerperium: this is the period from the second week to the sixth week after childbirth.

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

The reproductive organs return to the non-pregnant state.

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

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

1. Manage minor disorders in both mother and baby.

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

Ojo and Briggs (1982) states that, at the end of labour, the uterus is still very large and mobile, the genital tract is greatly bruised, distended and perhaps lacerated. The abdominal muscles are flaccid. Within the period of six to eight weeks' puerperium, the bruises heal and genital organs and any other which underwent changes during pregnancy return to their pre-gravid states. This process of readjustment is called involution and lactation is established during this period. Involution is brought about by a shriveling up of the muscle fibres and the absorption of their substance, partly into the bloodstream and partly into the lochia. The lochia is made up of blood from the site where the placenta was attached and the crumbling of the uterus which had developed so greatly in pregnancy. In the first two days after childbirth, the lochia mostly consists of blood and is consequently red in colour and is called lochia rubra. The amount of blood decreases rapidly and lochia become pinkish in colour called lochia serosa. After the 9th day, it becomes paler known as alba. Ojo and Briggs (1982) also talks about some minor disorders that may occur after delivery as the body begins to change to it non-pregnant state.

1. After pains; after delivery, the uterus does not stop contracting. The contraction continues painlessly for the most part, but in some women, particularly multigravida, painful contractions persist in the few days of the puerperium and may require analgesics.
2. Backache; It mostly affects one out of five women in few weeks after delivery but occasionally occurs a month after childbirth. Backache appears to be more common if

the woman has had an epidural anaesthesia or a long second stage of labour. There is no specific treatment and backache gets better by itself.

3. Painful urination; in the first 24 hours after delivery, the mother sometimes finds it difficult to pass urine because of the stretching of the vaginal and bladder tissues during delivery. It is managed with early ambulation.

After delivery the uterus immediately begins its process of involution or reduction in size. It generally takes 6 weeks for complete physiologic involution and for the reproductive system to be restored to its non-pregnant state. Sub involution or failure of the uterus to return to its non-pregnant state occurs when the process of involution is prolonged or stopped as a result of haemorrhage, infection or retained placental parts. Uterine involution involves the return of the uterus to its non-pregnant state, diminishing in size, weight and anatomic location back into the pelvis. The placental site usually is completely healed without scarring by 6 weeks. Immediately after delivery, the uterus weighs about 1000g. At the end of 6 weeks postpartum, the uterus weighs 50 to 100g. Breastfeeding or breast stimulation assists in hastening the speed of uterine involution (Ojo & Briggs, 2006).

WHY I CHOSE MY CLIENT

I met Madam Janet Owusuwaa on 8th November, 2021at Tuobodom Health Center during her 8th antenatal clinic visits at 37 weeks of pregnancy. Exclusive Breastfeeding was the topic for education that morning. She participated and asks a lot of questions during the education. Client was approached and her response meant she needed further explanation on exclusive breastfeeding. I went to her after the general education to introduce myself to her as a student midwife of Nursing and Midwifery Training College Berekum. I educated her more on exclusive breastfeeding, it's important to the mother herself and the baby. I then sought her permission to take her as my client for the Family centered maternity care study in order to care for her and the family during the rest of her weeks in pregnancy, labour, and puerperium, of which she agreed. I introduced her to the midwife in-charge who also gave her consent.

CHAPTER ONE

CLIENT'S PARTICULARS

1.0 INTRODUCTION

This chapter is about assessment of the client and her family, which involves gathering of data from the client and her family. Information was acquired through observation, interview, medical records and antenatal records. It concerns the client's social, personal, family, menstrual environmental, past obstetric, present obstetric and lifestyle.

1.1 CLIENTS PROFILE/SOCIAL HISTORY

Madam Janet Gravida 3 para 2 all alive is a native of Tuobodom in Techiman South District Assembly in Bono East Region. She is Bono by tribe, 27 years old, fair in complexion, tall and weighs 58 kilograms and height of 156 centimeters during her first antenatal clinic.

She stays at Abromam in Tuobodom South opposite the information centre. But due to her pregnancy she has come back to stay with her parents at Diasempa beside the Godsword school at Tuobodom. She lives together with her family in a compound house at Diasempa. Madam Janet speaks Twi, and English but Twi is her native language, she completed junior high school at Tuobodom R/C. And her Senior high school at Kumasi Girls. She had her educational level up to Senior High School. She is a teacher at Godsword Preparatory School. Madam Janet and her husband are both Christian. They attend Christ Apostolic church international. Mr. Kingsford Osei is her husband. Mr. Kingsford Osei is also a native of Tuobodom in Techiman South Distric, he is 32 years old, and a Police Man.

According to Madam Janet, Madam Abena Nyanta is her next of kin who is her mother. Her source of support through the period of pregnancy is the husband and family members.

1.2 FAMILY HISTORY

Madam Janet is the third born of five children to Mr. Prince Owusu and Madam Abena Nyanta out of these children three are females and the rest are males. According to Madam Janet both parents are alive and there is no history of Hypertension, Diabetes Mellitus, Sickle cell disease, Asthma, Tuberculosis, Epilepsy, Leprosy, and mental illness in her family. Again, they do not have any history of congenital abnormalities such as cleft lip or palate, spinal bifida or heart disease in the family. She said there is no history of multiple pregnancy in her family. Deaths in her family are natural.

1.3 MEDICAL HISTORY

According to Madam Janet, she has never had any chronic illness, like hypertension, heart disease, sickle cell disease, diabetes mellitus, measles, liver cirrhosis, respiratory disorder, epilepsy, and anaemia or no allergies to food or drugs. She narrated that her usual illness is cold and fatigue from stress at work which she treats with over-the-counter drugs and some home remedies.

1.4 SURGICAL HISTORY

She said she has never undergone any surgical procedure. She also mentioned that she has never sustained any injury or road traffic accident that called for any abdominal or spine surgery or affected her pelvis or subsequent effect on pregnancy and labour. On examination, there was no scar indicating previous laparotomy such as caesarean section or appendectomy. She has neither received blood transfusion.

1.5 MENSTRUAL HISTORY

Madam Janet was 14 years when she attained menarche. Her regular menstrual cycle is 28 days, amount of blood loss is moderate each month and last for 5 days without any dysmenorrhea before the delivery of her first child. She uses sanitary pad during the flow and

changes it twice daily for the first three days. Client said she does not remember her last menstrual period.

1.6 LIFESTYLE AND HOBBIES

Madam Janet usually goes to bed at 8:00 pm and wakes up at 4: 30 am. Routinely, morning devotion is the first line of action she takes to give glory to Almighty God. She does few house chores like sweeping, dusting and prepares her children for school. Before she then starts to prepare breakfast. They eat breakfast together after which she sends her children to school. Since Madam Janet is a teacher, she also prepares for work. She close around 3pm, and picks her children from school at 4pm and comes back home at 4:30pm to prepare supper for the family. She normally prepares rice and stew with egg for supper. All these are done from Monday to Friday. Weekend is exempted; that is when she washes dirty cloths, scrubs the house and also goes to church on Sunday to pray. The game she prefers is Ludo and watching Nigerian movies. She uses pepsodent and brush every morning to clean her teeth. Fufu with palm nut soup and fish is her favorite meal. She eats three times daily with frequent hydration and empties her bowel twice daily. They watch movies together and have some fun until the day fades away. She neither smokes nor drinks alcohol**.**

1.7 PSYCHOSOCIAL HISTORY

According to Madam Janet there is a friendly relationship among herself, family and community members. She mentioned that there is no history of mental illness in either the maternal or paternal side of their family. Client mentioned that she has never suffered any form of abuse at home. According to Madam Janet, her husband provides all forms of support for her as well as the pregnancy been it financial or accompanying her to some antenatal care visits. She added that she is very satisfied with her marriage. Client indicated that she likes to pray and listen to gospel whenever she is stressed up. Client specified that there are no major situations in her environment that she perceives as negatively acting on her well-being.

Observation made on client's physical status, appearance and modes of behaviour clearly indicated that client was not in any form of emotional distress.

1.8 PAST OBSTETRIC HISTORY

Pregnancy

Madam Janet is Gravid 3 Para 2 all alive with no history of spontaneous or induced abortions. The interval between the second pregnancy and this current one was three years. According to the Antenatal records, she never had problem during her pregnancies such as pre-eclampsia, pregnancy induced hypertension, and ante partum haemorrhage, anaemia and gestational diabetes. She was regular attendant at Antenatal session and took her second Tetanus Diphtheria doses and supplement drugs served. She also took all health education very serious.

Labour

The mode of her first delivery was spontaneous vaginal delivery with some minor laceration at the perineum at the Toubodom health center. The outcome of labour was a life healthy male child (first child) with birth weight of 3.2kg and length of 50cm. The second child was a female and was also born through spontaneous vaginal delivery at Tuobodom Health Center. The outcome of labour was a live female child with weight 3.0kg and length of 52cm. All her children were delivered at Tuobodom in the Bono Region with three years spacing. They cried soon after birth. Postpartum complications such as postpartum haemorrhage, retained placenta, breast engorgement were not recorded.

Puerperium

She did not suffer any infection and puerperal psychosis during puerperium. Madam Janet breastfed all her children and practice exclusive breastfeeding. Both the first and second child were fully immunized against the childhood preventable diseases. Physical, social and emotional supports were abundant from her beloved husband and family members. She has never used any of the artificial family planning method except the natural method.

1.9 PRESENT OBSTETRIC HISTORY

Madam Janet first visited the antenatal clinic on 26\04\2021. Her gestational age was 9 weeks, her last normal menstrual period was 22nd February, 2021 and her expected date of delivery was calculated as 29th November, 2021. On scan, Madam Janet expected date of delivery was 4th December, 2021. Serving as baseline for the comparison with the subsequent antenatal recording, the following laboratory investigation and vital signs were recorded on her booking visit;

Temperature	35.9˚C
Pulse	78bpm
Respiration	20bpm
Blood pressure	128/75mmHg
Weight	58kg
Height	159cm
Symphysio fundal height	10cm.

The results of the various laboratory investigations done were as follows

Hemoglobin level	12.0g/dl
Sickling	Negative (-)
Blood group	O+
Rhesus factor	Positive (+)
Urine for pregnancy test	Positive (+)
HIV	Negative (–)
HEP-B	Negative (–)
VDRL	Non-reactive
Protein in urine	Negative (–)
Glucose in urine	Negative (-)
G6PD	No Defect

Stool for routine examination indicated no abnormality. On examination (head to toe), no abnormality was detected she was healthy and admitted that she had no complain. Pelvis was adequate and education on danger signs was given. She had no complaints so was educated on the need to attend antenatal clinic regularly. Her antenatal records also indicated that she was given her second dose of diphtheria injection on the 29th April, 2021 and first dose of sulphadoxine pyrimethamine on 16th June, 2021. She was put on the following drugs and was scheduled for the next visit.

Tab folic acid 5mg daily x 30 days

Tab ferrous sulfate 200mg daily for 30 days

CHAPTER TWO

ANTENATAL CARE

2.0 INTRODUCTION

This chapter elaborates the care that was rendered during pregnancy. This care started from the time of conception and continued throughout pregnancy. This includes first contact with client, subsequent visit by client to the clinic, home visits during antenatal period and care plan drawn to solve problems encountered by client.

2.1 FIRST CONTACT WITH THE CLIENT

Madam Janet is Gravid 3 Para 2 came to the antenatal clinic at Tuobodom Health Centre on 8th November, 2021 and that was the first time we met on her seventh [7th] visit to the clinic and she was also 37 weeks. She was warmly welcomed and a seat was offered to her and enquiry about her health and that of her family was made. She said they were all fine and that she was coming for antenatal care.

Exclusive breastfeeding was the topic for education that morning. She participated and asks a lot of questions during the education; client was approached and her response meant she needed further explanations. I went to her after the general education and her antenatal book was collected and glanced through then an introduction was made to her as a student midwife from Holy Family Nursing and Midwifery Training College Berekum, who came to have clinical experience and then wish to use her for my care study since she falls within the criteria for selection and help her gain more knowledge on exclusive breastfeeding, pregnancy and many more. All details of information and procedures involved in the study were explained to her and she gladly agreed and promised to give all the information needed and the maximum cooperation. In-charge was informed about it and confirmed that she falls within the criteria. She was asked to empty her bladder after a specimen bottle was given to her and it was explained to her the need to obtained midstream urine, to check for ketone, protein and glucose.

The urine reagent strip was used to check the urine and the test results were negative. Her history and vital signs were taken and the finding recorded in her antenatal book was as follows;

Haemoglobin level	12.3 g/dl
Weight	68kilograms
Temperature	36.5 degree Celsius
Pulse	76 beats per minute
Respiration	19 cycles per minute
Blood Pressure	90/60mmHg

PHYSICAL EXAMINATION

Head to toe examination was explained to her to gain cooperation and when consent was sought, the necessary equipment for the procedure were gathered and taken to the examination room. Madam Janet was asked to empty her bladder to make her comfortable during the procedure. Privacy was provided. She was asked to sit on the bed, lie lateral and then assume a supine position. Hands were washed and dried.

HEAD AND NECK

The examination was started on the client from the head and neck. The hair was inspected for cleanliness, lice, ringworm, dandruff, alopecia and infection.

Her face was inspected for edema and chloasma and rashes but no abnormality was detected. Her eyes were also inspected for pallor of the conjunctiva, yellowish or jaundice of the sclera but no abnormality was detected.

The ears were also inspected for discharges and the nose for any congestion and nothing abnormal was detected.

The mouth was examined for halitosis, the lips for pallor, and cracks, the tongue for pallor, the teeth for tooth decay and cleanliness. No abnormality was detected. As the procedure was on going, client was congratulated for having taken good care of herself.

The neck was examined for any distended neck veins, enlarged lymph nodes and thyroid gland. All these were absent.

BREAST EXAMINATION

Both breasts were exposed to check for size, shape, dimpling and nipple retraction and 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 systematically in a circular manner using the inner aspect of the fingers and client was taught self-examination.

Nipples were squeezed gently for fluid (colostrum) and were examined for blood and cleaned with cotton wool swab. The same was done for the other breast and no abnormality was noted. Breastfeeding history was asked and her desire to breastfeed was positive as her children were breastfed.

UPPER AND LOWER EXTREMITIES

She was asked for tingling and tightness of the finger on making a fist, the hands and fingers were inspected for edema, pallor of palms and nail bed and no abnormality was noted. The legs were inspected for size and equality and palpated for edema, tenderness in the calf muscles varicose veins, size and equality and no abnormality was noted.

BACK

The back was examined for deformity of the spine (scoliosis), edema of the sacral region, pain at the coast vertebra angle and no abnormality was detected. The condition of the skin was also noted to be normal.

ABDOMINAL EXAMINATION

Inspection; the abdomen was inspected for scars, size, shape, straie gravidarum, linear nigra and fetal movement. Linear nigra was present, the shape was ovoid with no scars, the size was average and there was fetal movement.

MEASUREMENT OF THE SYMPHYSIO-FUNDAL HEIGHT

The measuring tape was placed on the abdomen with zero end at the fundus and the tape extended to the symphysis pubis. The symphysio-fundal height measured 36cm and the gestational age was 37weeks.

Fundal palpation; the hands were rubbed together to make them warm in order not to Induce contractions. The palms were placed on either side of the fundus while facing the woman's head. Fingers were curved around the top of the fundus and a soft mass was felt, indicating that the buttocks were occupying the fundus.

Lateral palpation; One hand was used to stabilized the maternal uterus and the other hand used for the examination in circular way to determine the back and the limbs. It was noticed that the rough part was the foetal limbs, which was at the left side of the abdomen whiles the smooth part was foetal back which was at the right side of the abdomen. The lie was longitudinal and the position was right occipito anterior.

Pelvic palpation; facing the woman's feet**,** she was asked to flex her knees slightly and breath in and out slowly to aid in the relaxation of the abdominal muscle. The palms were placed on either side of the uterus below the level of the umbilicus and fingers directed toward the symphysis pubis, thumbs almost meeting. Presentation was determined to be cephalic as a hard mass was palpated, the lie longitudinal.

Decent; the anterior shoulder was located to determine descent of the head. Two fingers were kept over the anterior shoulder and the symphysis pubis was located. The right ulna border was

placed just above the symphysis pubis and the anterior shoulder. Five finger breadths were accommodated and the descent was recorded as 5/5th.

AUSCULTATION

Foetal stethoscope was warmed by rubbing it in the palm. The foetal heart was auscultated by placing fethoscope on where the back was located. The ear was placed against the fethoscope, making sure hands were not touching the fethoscope when the fetal heart beat was being counted. I compared the rate with the maternal pulse and counted the beats heard for one minute. It was 129bpm with regular rhythm.

VULVA EXAMINATION

Permission was sought from Madam Janet to examine her vulva, which was granted. Her vulva was well shaved with no edema or varicose vein on palpation.

Madam Janet was helped to dress up after the examination and all findings were explained to her. She was thanked for her understanding and cooperation. Hands were washed and dried and all findings were recorded in her antenatal book. She complained of backache and she was educated to support her back with pillow when sitting. Permission was sought from Madam Janet for home visit and it was granted and then directions to her house as well as her contact numbers were asked for. She was informed on the next antenatal visit which was on the 15th November, 2021. Routine drugs were served as follows;

Tablet Folic Acid	5 milligrams daily for 7days
Tablet Ferrous Sulphate	200 milligrams daily for 7days
Tablet Sulphadoxine Pyrimethamine	4th dose

She was again reminded on the home visit and said goodbye to her.

2.2 FIRST ANTENATAL HOME VISIT

The first home visit to Madam Janet house was on the 13th November, 2021 at exactly 3pm.The aim of the visit was to find out how her environment looked like. The second aim was to see whether she was prone to infection and also check on her items for labour (layette). Greetings were exchanged and seat offered. She was in the house with her family members who were back from work. Madam Janet lives in a family house which is a compound house with no toilet but there is a kitchen and bathroom is in the house. The house is built with blocks and roofed with aluminum sheet and its made up of eight rooms with a white ceiling. She lives with her family members and her last born and the other child was with her husband at Techiman and has cordial relationship with them. Inside her room was a neatly laid bed with a treated mosquito net hanged around it. Things were arranged nicely in her room and a curtain at her exit. The room was well ventilated. She has fan which she uses during the hot weather. Charcoal and firewood is her source of fuel for cooking. There is no tap water in the house so client fetches pipe borne water from a nearby house for domestic activities and stores it in a clean large covered plastic container with a lid. Electricity is the source of power used in the house. Since it is a family house, she shares the bath house with the family members. She gathers rubbish or waste in a container with a cover which she finally disposes it every day into a Zoom Lion container meant for public use. She was advised to always cover her dustbin to prevent flies from settling on uncovered food which could bring about infection. The compound was very clean and neat and the surrounding was neatly weeded. There was no stagnant water and no choked gutters. She also said that the whole family was ready to accept the new born into the family. She was encouraged to introduce her children to the pregnancy to prevent sibling rivalry. She also complained of loss of appetite and she was educated to eat in bit and remove all nauseating item around her environment. Madam Janet was educated on rest and sleep and the need to eat nutritious diet. I also educated her and the whole family on

corona virus and the safety protocols. During the education, I emphasized on frequent hand washing under running water, personal hygiene, diet, wearing of nose mask when going out and social distancing. She was asked to continue with her routine drugs as prescribed. She promised to do as educated. She was encouraged to maintain the neatness in her compound. Before leaving, her layette was checked, she had already packed her bag with items like; sanitary pads, toiletries etc. In this bag included purse with money, insurance card and antenatal book. Her permission to leave was sought and was reminded of her next visit to antenatal clinic on 15th November, 2021. I promised to pay her another visit.

2.3 SECOND ANTENATAL HOME VISIT

The second home visit was made on Monday 15th November, 2021, client came for antenatal care. She was given a seat to sit. The vital signs and weight were checked and recorded as:

Weight	68.5kg
Temperature	36.8 degrees Celsius
Pulse	90bpm
Respiration	20cpm
Blood pressure	100/60mmHg

Head to toe examination was conducted after she emptied her bladder and midstream specimen of urine taken and tested negative for protein and glucose. Hands were washed with soap and water and dried with clean towel. Fetal movement was observed, and the abdomen was of medium size and ovoid in shape. On palpation and measurement, the Symphysio-fundal height was 36cm and the gestational age was 38weeks. The descent was 5/5th, fetal heart beat was 148bpm. She was assisted to dress up after which hands were washed and dried. All findings were communicated to her and recorded in her antenatal booklet. She was asked about her food intake and bowel movement and she said she could now empty her bowels at least once daily as before, but has frequency in micturition and waist pains so she was told that it was due to

the fact that the fetal head was descending into her pelvis. She was advised to avoid prolonged standing and strenuous activities which could aggravate the problem. She was told to continue with routine drugs. Madam Janet was educated on the physiology of frequency in micturition and 22nd November, 2021 was given as her next visit. She was informed that labour may set in from now and she should report to the facility as soon as she sees any signs of labour. She was also informed to report to the facility if she encounters any challenges.

2.4 SUBSEQUENT VISIT TO THE CLINIC

On Monday, 22nd November, 2021 madam Janet visited the clinic. Client was warmly welcomed and was offered a seat to sit on and she told me that, she did not see the signs of labour so she is coming for her routine antenatal checkup. I took her through the normal antenatal care and the following were recorded;

Temperature	36.9 degrees Celsius
Pulse	80 beats per minutes
Respiration	20 cycles per minutes
Blood Pressure	110/70 millimeters of mercury
Weight	70 kilograms
Urine for Protein	Negative
Urine for Glucose	Negative

Client was helped to lie on the couch after she has emptied the bladder, she was undressed and wrapped with linen. Head to toe examination was conducted with no abnormalities detected. On abdominal examination, the abdomen was globular in shape and foetal movement was visible.

On palpation and measurement, the symphysio-fundal height was 37cm and the gestational age was 39weeks.

On auscultation, foetal heart rate was 138 beat per minutes with good volume. She was educated on true signs of labour such as present of show (blood-stained mucoid discharge), dilatation of cervix and painful regular rhythmic uterine contractions. Her expected date of delivery was confirmed to be approaching and was encourage to report to the clinic any time she noticed any of them. She was told to continue with the drugs she was given on the 15th November, 2021. Her next visit was on the 29th of November, 2021 and she was escorted to the gate.

2.5 NURSING CARE PLAN DURING ANTENATAL PERIOD

Madam Janet made the following complains during antenatal period;

1. 08/11/2021 Backache
2. 13/11/2021 Loss of appetite
3. 15/11/2021 Frequent micturition
4. 15/11/2021 Waist pain
5. 21/11/2021 Lower abdominal pain

SHORT TERM OBJECTIVES

1. Client backache will subside within 24 hours and cope throughout pregnancy.
2. Client will maintain a healthy nutritional state within 72hours.
3. Client will have knowledge on the physiology of frequency in micturition in late pregnancy within 24 and cope with frequency of micturition.
4. Client waist pain will lessen within a day and cope with it throughout pregnancy
5. Clients will be able to cope with lower abdominal pain till the end of pregnancy

LONG TERM OBJECTIVES

Madam Janet will maintain physical, social and emotional wellbeing throughout pregnancy, labour and puerperium without any complications to both mother and fetus.

TABLE 1: CARE PLAN DURING ANTENATAL PERIOD

Date /Time	**Nursing Diagnosis**	**Nursing Objectives/ Outcome Criteria**	**Nursing Orders**	**Nursing Intervention**	**Date /Time**	**Evaluation**	**Sign**
08/11/21 9:00am	Backache related to pressure on sacral nerves.	Client backache will subside within 24 hours and cope throughout pregnancy as evidenced by; 1. Client verbalizing backache has subside 2. Midwife observing client perform relieve measures.	1. Reassure client. 2. Explain the physiology of backache to client. 3. Educate client to maintain a good sitting posture. 4. Educate her on minimal work. 5. Educate client to avoid prolong standing.	1. Client was reassured. 2. Physiology of backache was explained to client. 3. Client was educated on supporting the back when sited. 4. Client was educated on minimal work. 5. Client was educated to avoid prolong standing.	08/11/21 9:00am	Goal fully met as client reported backache has subsided.	A.Y.

TABLE 1: NURSING CARE PLAN FOR MADAM JANET CONT'D…

Date /Time	Nursing Diagnosis	Nursing Objectives	Nursing Orders	Nursing Intervention	Date /Time	Evaluation	Sign
13/11/21 3:30pm	Nutritional imbalance related to loss of appetite	Client will maintain a healthy nutritional state within 72hours as evidenced by; 1. Client verbalizing she can eat well 2. Midwife observing that client is healthy.	1. Reassure client. 2. Educate client to take food in bits and at frequent interval. 3. Encourage client on mouth care. 4. Monitor clients' weight. 5. Encourage client to take vitamin supplement as prescribed.	1. Client was reassured she would regain her appetite. 2. Client was educated to take food in bits and at frequent interval. 3. Client was encouraged to brush her teeth twice daily and rinse mouth with water. 4. Client's weight will be monitored during her subsequent visit to the clinic 5. Client was encouraged to take in vitamin supplement as prescribed.	16/11/21 3:30pm	Goal fully met as client informed the midwife that she ate well as discussed.	A.Y.

TABLE 1: NURSING CARE PLAN FOR MADAM JANET CONT'D…

Date /Time	Nursing Diagnosis	Nursing Objectives/ Outcome Criteria	Nursing Orders	Nursing Intervention	Date /Time	Evaluation	Sign
15/11/21 10:00am	Impaired comfort related to frequency micturition.	Client will have knowledge on the physiology of frequency in micturition in late pregnancy within 24 and cope with frequency of micturition as evidenced by 1. Client verbalizing that she understands the physiology behind the frequency in micturition 2. Midwife observing that client is coping with it.	1. Reassure client. 2. Educate client on the physiology behind the micturition. 3. Encourage client to empty her bladder frequently. 4. Educate her proper vulva toileting and personal hygiene. 5. Educate client on urinating in the night before going to bed.	1. Client was reassured that she can cope with situation. 2. Client was educated that the frequency of micturition is due to the descent of the fetal head into the pelvis. 3. Client was encouraged to empty her bladder when she gets the urge to avoid further discomfort. 4. Client was educated on keeping her pants clean always and bathing at least twice a day. 5. Client was educated on the need to pass urine in the night before going to bed.	15/11/21 10:00am	Goal fully met as client understood the physiology behind frequency of micturition and made less complaint.	A.Y.

TABLE 1: NURSING CARE PLAN FOR MADAM JANET CONT'D…

Date /Time	**Nursing Diagnosis**	**Nursing Objectives/ Outcome Criteria**	**Nursing Orders**	**Nursing Intervention**	**Date /Time**	**Evaluation**	**Sign**
15/11/21 08:00am	Waist pains related to the hormonal changes during pregnancy.	Client waist pain will lessen within a day and cope with it throughout pregnancy as evidenced by 1. Client verbalizing pain has lessen. 2. Midwife observing client has understood condition	1. Reassure client. 2. Encourage client to wear low heel sandals. 3. Encourage client to have rest. 4. Teach client relaxation technique such as sacral massage. 5. Advice client to reduce house hold chores.	1. Client was reassured. 2. Client was encouraged to wear low heel sandals. 3. Client was encouraged to rest for every two hours. 4. Relaxation technique such as sacral massage was taught 5. Client was advised to get a support person.	16/11/21 08:00am	Goals fully met as client verbalized that she has coped with the waist pain.	A.Y.

TABLE 1: NURSING CARE PLAN FOR MADAM JANET CONT'D…

Date /Time	Nursing Diagnosis	Nursing Objectives/ Outcome Criteria	Nursing Orders	Nursing Intervention	Date /Time	Evaluation	Sign
21/11/21 09:00am	Lower abdominal pain related to descent of the fetal head.	Client's will be able to cope with lower abdominal pain till the end of pregnancy as evidence by; 1. Client verbalizing the ability to cope. 2. Midwife observing client employ relieve measures	1. Reassure client. 2. Assess level of pain using numerical pain rating scale (0-10) 3. Educate client on the physiology of descent of foetal head. 4. Engage client in diversional therapy. 5. Encourage client to always assume a position of comfort	1. Client was reassured. 2. Pain was assessed and she indicated her pain to be 3. 3. Client was educated on the physiology of decent of foetal head. 4. Client was engaged in diversional therapy. 5. Client was encouraged to always assume a comfortable position	26/11/21 09:00am	Goals fully met as client said she is able to cope with lower abdominal pain.	A.Y.

CHAPTER THREE

INTRAPARTAL CARE

3.0 INTRODUCTION

This chapter describes the management of all the four stages of labour of the client and the care plans drawn for problems identified in labour. Labour defined as the process by which the foetus, the placenta and its membranes are expelled through the birth canal.

3.1 ADMISSION AND MANAGEMENT OF THE FIRST STAGE OF LABOUR

ADMISSION

On Thursday 25th November, 2021, at 8:40pm I had a call from Madam Janet complaining of lower abdominal pain and I asked her to come to the clinic. I quickly went to the clinic waiting for them.

They arrived at 9:00pm and I warmly welcomed them and offered them seats, her antenatal card was collected and glanced through. History was taken. According to client she noticed blood mucoid discharge around 5:00pm. She also said she took rice and stew around 4:00pm. Client was reassured to allay any form of anxiety.

Client was sent to the first stage room, procedures involved were explained to her. Vital signs were taken and recorded as follows;

Temperature	36.6 Degrees Celsius
Pulse	92 beats per minute
Respiration	22 cycles per minute
Blood Pressure	137/90 millimeters of mercury.

Bed pan was served client for her to empty the bladder, the urine measured 150mls and was tested for protein and glucose and it revealed negative.

Intravenous line was set and blood sample was taken for grouping and cross matching in case of emergency.

Client was helped to undressed and gowned and positioned on bed. Hand hygiene was performed with soap and water. Privacy was provided and head to toe examination was started; anaemia, jaundice, edema, and other abnormalities were not detected. Permission was sought and the abdomen was exposed.

Inspection: The abdomen was ovoid and medium in shape, linea nigra and straie gravidarum seen. Fetal movement was visualized; there were no caesarean section scars and tribal marks on the abdomen.

Symphysio-fundal height, the measuring tape was placed on the abdomen with zero end at the fundus and the tape extended to the symphysis pubis. The symphysio-fundal height measured 38cm and the gestational age was 39weeks+4days.

Auscultation: fetal heart rate was 142bpm with good volume and rhythm. The uterine contractions were timed after sitting on a chair at the right side of the client and placing my palm on the fundus. After noting the frequency and the duration for ten minutes, I obtained two contractions in ten minutes [2:10] lasting for 28 seconds.

Permission was sought from client to perform vaginal examination after explaining to her the need for the vaginal examination and she agreed. Privacy was provided and was assisted unto the couch, plastic apron was worn, hand hygiene was performed after which sterile gloves were worn.

Before swabbing the vulva, it was inspected for scars, sores, vulva warts, vulva hematoma, vulva edema and clitoridectomy but none was present and the vulva was healthy. The vulva was swabbed with enough pieces of sterile cotton wool swabs soaked in savlon lotion. A swab was picked with the right gloved hand and put into the left hand to swab the vulva. The labia majora were swabbed from the symphysis pubis to the perineum on either side, the labia minora was swabbed in the same way. The vestibule was separated and swabbed as well. The

procedure was done under aseptic technique. After the vulva swabbing, the middle finger was inserted first followed by the index finger into the vagina following the curve of carus.

On vaginal examination, the vagina was warm and moist and also the cervix was soft and thin, membranes were intact and cervical dilatation was 4cm dilated at 9:14pm. The sacrum was well curved, ischial spine was blunt and pubic arch was wide and there was no moulding. There was no abnormality, client perineum was cleaned and a sterile pad was applied at the vulva. Client was covered with a cloth and made comfortable in bed.

Madam Janet was informed of findings and finally, recorded on the partograph sheet. This was done to detect any deviation from normal. Client was reassured of successful labour and was thanked for her cooperation. Client particulars were entered into the admission and discharge book and finding communicated to support person.

Client was encouraged to frequently empty her bladder to aid in the decent of fetal head and also to lie in left lateral position to prevent supine hypotension syndrome and also asked her to change her perineal pad when it gets soiled and applied new one.

Madam Janet complained of profuse sweating and was looking very anxious. When I asked why she was anxious, she said due to unknown outcome of labour. Client was and her mother were reassured of a successful outcome of labour to allay their fears and anxiety.

The fetal heart rate, uterine contraction and maternal pulse were checked every thirty minutes and recorded on the nurses note whiles the blood pressure, vaginal examination, and head decent were checked every four hours except temperature which was checked two hourly and recorded. Client was upgraded on all findings.

Her sacral region was massaged during contractions to soothen her and reduce pain. Client was engaged in a conversation to divert her attention from the pain and anxiety she claimed.

A bed was prepared for Madam Janet in the lying in room, on which she should be received after delivery.

Procedure was explained to Madam Janet and monitoring process was continued and that was in four hours' time. Vital signs was checked and recorded as followed

Blood pressure	135/ 80mmHg
Temperature	36.4^0C
Pulse	90bpm
Respiration	22cpm

On abdominal examination, at 2:50am the decent was $2/5^{th}$ above the pelvic brim; contractions were 4 in 10 minutes lasting for forty-five seconds. Fetal heart rate was 141bpm and volume was good. Urinalysis revealed protein, acetone negative and amount was 100mls, the vagina was warm and moist during vaginal examination, the cervix was soft and thin and cervical os was 8cm dilated with membranes intact and no moulding felt. No bleeding was observed when the fingers were removed and vagina mucus was odourless and colourless with little blood stain. The woman's genitalia were cleaned and dried and a sterile perineal pad was applied at the vulva. Client was thanked. The findings were plotted on the partograph sheet and communicated to client and support person.

Madam Janet was reassured that labour was progressing well, so she should feel at home, she was encouraged to pass urine frequently. She was also encouraged to ask questions concerning anything that bothered her.

She was given water to sip and later malt to drink. Client complained of feeling nauseated hence receiver was given to her for her to vomit in it.

3.2 PREPARATION FOR BIRTH

The midwife in-charge was chosen as the skilled personnel and informed to assist in case help was needed. Her sister and mother who were the unskilled personnel was told to stay around in case they will be needed to run errands during the delivery. Blood sample was taken for; hemoglobin levels and grouping and cross-matching for blood to make available in case of

emergency. The emergency plan was reviewed by making numbers of fellow midwives and obstetricians in the receiving hospital in referral cases available. The taxi driver was also available as his service may be needed as a means of transportation to help with advanced care if the need arises.

The area of delivery was prepared by drawing curtains for privacy and warmth. Since the baby would be delivered unto the mother's abdomen, it was washed and cleaned with sterile gauze and her hands were also washed. The resuscitation area was prepared by assembling items like bulb syringe, stethoscope, radiant heat bulb, cord clamp, ambubag, face mask, clean cot sheet, syringes etc. Opportunity was taken to re-emphasize on the breathing technique taught during the antenatal period.

SETTING OF TROLLEY

The trolley was set with the following instruments and items on top and button shelf;

The top shelf; which contain the sterile instrument contain the delivery pack and is made up of;

- Two sterile artery forceps
- One sterile cord scissors
- Sterile drape
- Membrane pierce
- Sterile receiver for placenta
- Injection tray containing 10 units of oxytocin
- Sterile Episiotomy Park containing scissors and suturing forceps

Button shelf also contains;

- Drum containing gauze and cotton wool
- Chettle forceps in its container
- Penguin

- Sterile gloves
- Perineal pads
- Cord clamps
- Savlon
- Measuring jug
- Identification band
- Examination gloves
- Cot sheet

Madam Janet complained of bearing down sensation at 3:10am whiles timing contraction there were five contractions each; one lasting for 45 seconds for 10 minutes. Client was transferred to the second stage room to observe for true signs of second stage of labour which includes bulging of the perineum, gapping of the anus and tickle of blood and fully dilatation of cervix. Madam Janet permission was sought to perform vaginal examination to confirm full dilatation of the cervix.

Hands were washed under running water with soap and dried with a clean dry towel. On vaginal examination the cervix was fully dilated and was 10cm, membranes ruptured spontaneously with clear liquor and the descent was $0/5^{th}$, moulding was one plus (1). This was confirmed by the midwife in charge at 3:14am.

3.3 MANAGEMENT OF THE SECOND STAGE OF LABOUR

Madam Janet had successfully passed through the first stage. Her cervix was fully dilated at 3:14am. The set trolley was pushed to the delivery bed. Protective clothing such as goggle, face mask, plastic apron and a well washed boots were worn. After hand washing, surgical gloves were put on to complete the sterility of the entire procedure. She was encouraged to assume dorsal position with the knee flexed as agreed earlier. The vulva was swabbed with the sterile cotton wool swabs soaked in savlon lotion. She was draped with 4 sterile towels; one on the

abdomen, under the buttocks as well as both thighs. A pad was applied to the perineum to prevent fecal content from entering the baby's face. She was reassured and encouraged to bear down with contractions and to rest in between contraction. As the pressure of the head thins out the perineum, the birth of the head was controlled with index and middle fingers placed on the fetal head to aid flexion to prevent perineal laceration. The pad placed on the perineum was equally supported and the head was allowed to crown slowly. With extension, the sinciput, the face, and chin swept the perineum for the head to be born. After the delivery of the head, clean gauze was used to wipe the eyes from the inner contours outwards. The face, mouth and nose were also wiped, inspection for cord around the neck was done but there was none. There was restitution followed by external rotation of the head (internal rotation of the shoulders occurred spontaneously). With both hands placed on each side of the baby's head, over the ears, a downward gentle pressure was applied towards the mother's perineum to deliver the anterior shoulder. The posterior shoulder was also delivered by upward movement towards the mother's abdomen. The trunk and the rest of the body were also delivered by lateral flexion onto the mother's abdomen at 3:19am. Baby was showed to the mother to confirm the sex. The baby was placed on the chest for skin to skin contact between the mother and baby and to provide warmth to the baby. The delivery time was noted as 3:19am by my in-charge and the sex confirmed as female.

3.4 IMMEDIATE CARE OF THE NEWBORN

Immediately the head was delivered, sterile gauze was used to clean the baby's face, eyes, mouth and nose. The baby was delivered onto the mother's abdomen. The baby was kept warm by wiping off the liquor thoroughly and was wrapped in a clean dry cot sheet. The baby was not suctioned, because the airway was clear and cried immediately. First minute Agar score was 8/10. The cord was clamped 3 centimeters away from the baby's abdomen and second clamp 2 centimeters from the first clamp. The cord and scissors were covered with gauze and

cut in- between the clamps to separate the baby from the mother. The fifth minute Apgar was 9/10. The baby was placed skin to skin on mother's abdomen and socks and cap put on, Baby was covered with a clean cot sheet and breastfeeding was initiated. Mother was instructed to hold the baby carefully. An identification band bearing mothers name, time of delivery and sex of baby was placed on baby's wrist.

3.5 MANAGEMENT OF THE THIRD STAGE OF LABOUR

The management of third stage of labour is complete expulsion of the placenta and its membranes from the birth canal until all sources of haemorrhage are arrested. This begins immediately after the expulsion of the baby. Procedure involve in this stage was explained to client's understanding. Permission was sought before continuing with the third stage management. During the active management of the third stage, Madam Janet uterus was palpated to exclude the presence of second twin. Oxytocin10 units were injected intramuscularly on the upper outer thigh of the client within the first minute by the midwife to stimulate uterine contraction. The cord was re-clamped to the perineum with an artery forceps. The left hand was put on the fundus to feel for contraction. As soon as contraction was felt, left hand was repositioned and placed on the suprapubic area with the palm facing the mother's abdomen. The uterus was pushed upward to prevent inversion of the uterus. The right hand held the forceps and the cord. Gentle downward traction was put on the cord and repeated until the placental tissues were visible at the vulva. The placenta was cupped in both hands and gently turned in a twisting motion to deliver the membranes. The act prevented the tearing off the membrane.

The placenta was delivered completely at 3:24am. Immediately, the fundus of the uterus was massaged through the abdomen until it was well contracted, blood clot was expelled from the uterus and measured 150mls. She was reassured and permission was asked to conduct vaginal examination to exclude any form of trauma to the cervix, vagina and the perineum. Fortunately,

there were no cervical, vaginal, or perineal tears. All soiled materials were removed and she was properly cleaned with Dettol solution and made comfortable in a well laid bed. She was encouraged to empty her bladder regularly to ensure good contraction. She glorified the name of the Most High God. Other family members and her husband were also allowed to see Madam Janet and her baby.

3.6 EXAMINATION OF PLACENTA AND MEMBRANES

After client was made comfortable in bed, the placenta was examined thoroughly in the sluice room. The maternal surface was examined in a cupped hand with no missing lobe, and membranes were intact. The cord was situated at the center of the placenta and there was one vein, two arteries in the cord and no abnormality was detected. The placenta was held by the cord allowing membranes to hang down. The membranes were spread out to aid in inspection. On examination; the chorion and amnion were intact. The fetal surface was smooth with shiny and bluish-grey in colour. The maternal surface of the placenta was red with complete lobes separated by grooves (sulci). The placenta was discarded after decontamination. The instruments and equipment used were soaked in 0.5% chlorine solution and were removed after 10 minutes, washed, rinsed and air dried and made ready for sterilization and storage. Hands were dipped in 0.5% chlorine solution before discarding the gloves. Amount of blood loss was 150mls. Hands were washed under running water with soap and cleaned with a dry towel. Client was congratulated for the effort made.

3.7 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 Janet and her baby were monitored for six hours before transferring them to the lying-in-ward. Client's vital signs were checked and recorded as follows: Temperature 36.8^{o}C, Pulse 84bpm, Respiration 22cpm, and Blood pressure 110/70mmHg. Madam Janet was asked to empty her bladder

frequently in order to help contractions of the uterus. Madam Janet was served with warm beverage and also encouraged to establish bonding and to initiate and maintain lactation. She was educated on how breastfeeding enhances the release of oxytocin which would improve uterine contractions, drainage of lochia, control of haemorrhage and also as a form of family planning. Madam Janet was examined from head to toe, her conjunctiva was pink and no abnormality detected. Uterus was well contracted and Symphysio-fundal height was 18cm, there was no active bleeding from the vagina. She was encouraged to report if she sees any profuse bleeding. She was asked to change her pad when soiled in order to prevent infection. Madam Janet's vital signs and uterus were checked every 15 minutes for 2 hours and 30 minutes for 1 hour and then hourly for three hours and findings recorded on the partograph. The findings were within the normal range. The baby was also monitored at the same interval to ensure that breathing was normal and the colour of its skin was pink.

3.8 CARE OF THE BABY

Prevention of Diseases

The following procedures were performed to prevent infection to the eye and cord and also prevent haemorrhagic disease of the newborn. Prevention of disease is done within the first 90 minutes. Two (2) drops of Chloramphenicol eye drop was instilled on each eye, the cord was dressed with sterile cotton and methylated spirit and vitamin K 1.0mg intramuscularly was given to the baby after head to toe examination was done. Baby skin was smeared with baby oil to provide warmth. Hands were washed with soap under running water and cleaned with dry towel.

3.9 EXAMINATION OF THE NEWBORN

A head to toe examination was performed on the new born under a good light in the presence of the mother. The procedure was explained to Madam Janet and she consented. Hands were

washed with soap under running water and cleaned with a clean dry towel. Sterile gloves were worn and the baby was wrapped and put on a warm, flat and safe surface. Baby was exposed systematically as it was examined from head to toe. On observation, the baby's colour was pink.

THE HEAD AND FACE: The head and scalp were normal with dark hair, sutures and fontanelles fully formed without any bulginess, sunkeness and caput succedaneum. The eyes were clear with no redness and the nose was patent with the nostrils separated by the nasal septum.

THE EARS: The cartilages of the two ears were well developed and were in alignment with the eyes. External auditory meatus was patent. The shape and size was also checked and no abnormality was detected.

THE MOUTH: The mouth examined by pressing the angle of the jaw which opened the mouth, upon inspection, there was no tongue tie, mouth and palate were all intact, there was no false tooth and the baby sucked when a finger was introduced into its mouth.

NECK: The neck was inspected and palpated with no enlarged lymph nodes or congenital goitre and could be turned and flexed.

CHEST AND ABDOMEN: The nipples on the chest were equally spaced and in alignment, there was no milk and engorgement. Respiration was observed as there was chest movement and it was regular and the respiratory rate was 40cpm. The abdomen was round. The umbilical cord was inspected for bleeding and it was in good condition, there was one vein and two arteries.

GENITALIA AND ANUS: The genitalia was examined and the labia majora covered the clitoris were a little prominent. The vaginal and anal opening were visible. The baby passed meconium and urine.

LIMBS AND DIGITS: The hands were in alignment and of the same size and length. The lower limbs were in alignment and of the same size and length. The digits were not webbed and had no extra digits. The axillae, elbow, groin and popliteal spaces were examined without with no abnormality detected.

SPINE: The baby was turned into the lateral position and the chest was supported with the non-dominant hand and her back was palpated.

There were no swellings, hairy patches and dimples indicating any spinal defect. Baby's ability to perform Moro and grasp reflex was also checked.

Measurements of the baby were done;

Head circumference	35 centimeters
Length of the baby	46 centimeters
Baby's weight	3.3 kilograms.

Gloves were removed and disposed aseptically before washing and drying hands. Findings were documented and communicated to her.

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

Temperature	36.2˚C,
Apex heart beat	130bpm,
Respiration	40cpm

3.10 MANAGEMENT OF THE MOTHER

Client was reassured and encouraged to have enough rest and sleep. The mother's initial vital signs were checked and recorded as follows; Temperature 36.5˚C**,** Pulse 88bpm, Respiration

20cpm, Blood pressure 120/70mmHg. The fundus was rubbed to facilitate contraction. Blood clots were expelled, and the Symphysiofundal height was 17 centimeters. Client was transferred to the lying-in-ward and baby put to breast. The estimated blood loss after the fourth stage was 150 milliliters. At the end of the fourth stage, the amount of urine passed was 100 milliliters. Lochia was red in colour (rubra), small in quantity and had no foul smell. Client was educated on frequent micturition and changing of perineal pads when soaked, how to fix baby to breast, the importance of exclusive breastfeeding for the first six months and feeding on demand was stressed on as well. Client's sister was allowed to see her and she was served with warm porridge and bread to restore energy. General condition of client was good and all labour notes were recorded on the partograph sheet.

3.11 SUMMARY OF LABOUR

Client was admitted to the ward with complaints of labour pains. Labour progressed spontaneously and client had spontaneous vaginal delivery of a live female child at 03:10am. Active Management of Third Stage of Labor was done. Perineum was intact and blood loss was small (150ml). Condition of baby was very good as well as mother. The placenta and its membranes were intact. Duration of labour lasted for six (6) hours 10 minutes.

3.12 CONDITION OF MOTHER

Client was made comfortable in bed and was helped to fix baby to breast. Vital signs were checked and the following examinations were done and recorded as follows; Blood pressure 120/70 mmHg, Temperature 36.5˚C, Pulse 88bpm, Respiration 20cpm, Fundus 18cm, Blood loss 150ml, Bladder 100ml. Condition of mother after delivery was good.

3.13 CONDITION OF BABY AT BIRTH

General examination of the baby was done and no abnormalities detected. The baby had a pink skin colour, umbilical cord was not bleeding. The baby was classified as normal and routine

care given. Baby passed urine and meconium within some few minutes after birth. The baby's vital signs and observations were as follows; Temperature 36.2˚C, Apex heart beat 138bpm, Respiration 40cpm, Apgar score for first minute 8/10, Apgar score for fifth minute 9/10 , Sex female, Weight 3.3 kg. No abnormality was detected, Baby was in good condition.

3.14 NURSING CARE PLAN ON LABOUR

Client complained of;

1. 25/11/2021 Lower abdominal pains.
2. 25/11/2021 Vomiting
3. 26/11/2021 Anxiety
4. 26/11/2021 Fatigue
5. 26/11/2021 Excessive sweating

SHORT TERM OBJECTIVES

1. Client lower abdominal pains will subside within 24hours.
2. Client vomiting will resolve within 24 hours.
3. Client anxiety will resolve within an hour.
4. Client will gain her strength within 4 hours.
5. Client will cope with sweating within 6 hours.

LONG TERM OBJECTIVES

Client will pass through all the stages of labour and puerperium without complications to mother and the baby.

TABLE 2: CARE PLAN ON LABOUR

Date/ Time	Nursing Diagnosis	Nursing Objectives	Nursing Orders	Nursing Interventions	Date/ Time	Evaluation	Sign
25/11/21 9:30pm	Lower abdominal pains related to uterine contractions	Client lower abdominal pains will subside within 24hours as evidenced by; 1. Client reporting her pain has subside 2. Midwife observing that client heeds to her advice	1. Reassure client. 2. Explain the physiology of labour pains to her. 3. Put client in a comfortable position. 4. Encourage client to perform deep breathing exercise. 5. Engage client in conversation as a form of divisional therapy.	1. Client was reassured. 2. The physiology of the pain was explained to the client. 3. Client was put in the left lateral position. 4. Client was encouraged to take deep breathing exercise, inside out. 5. The midwife stayed with the client and interacted with her.	26/11/21 9:30pm	Goal fully met as evidenced by client reported her pain has subsided	A.Y.

TABLE 2: NURSING CARE PLAN FOR MADAM JANET CONT'D…

Date/ Time	**Nursing Diagnosis**	**Nursing Objective/ Outcome Criteria**	**Nursing Orders**	**Nursing Intervention**	**Date/ Time**	**Evaluation**	**Sign**
25/11/21 9:42pm	Vomiting related to reduce digestion during labour.	Client vomiting will resolve within 24 hours as evidenced by; 1. Client reporting she no longer vomit. 2. Midwife observing that vomiting has ceased	1. Reassure client. 2. Explain the physiology associated with vomiting. 3. Hydrate client to prevent dehydration. 4. Provide client with emesis basin within easy reach. 5. Move away all nauseating objects from client.	1. Client was reassured. 2. The physiology of vomiting was explained to her understanding. 3. Client was given 500mls of iv fluids to replace fluid loss. 4. Client was provided with an emesis basin within easy reach. 5. Nauseating objects was moved away from client.	26/1121 09:42pm	Goal fully met as Madam Janet verbalized vomiting has stopped. .	A.Y.

TABLE 2: NURSING CARE PLAN FOR MADAM JANET CONT'D…

Date /Time	**Nursing Diagnosis**	**Nursing Objective / Outcome Criteria**	**Nursing Orders**	**Nursing Intervention**	**Date/ Time**	**Evaluation**	**Sign**
26/11/21 1:00am	Anxiety related to unknown outcome of labour.	Client anxiety will resolve within an hour as evidenced by; 1. Client's verbalizing she no longer feels anxious 2. Midwife observing client to have a relaxed facial expression	1. Reassure client. 2. Explain every procedure to be carried to her to allay fear. 3. Educate her on possible outcome of labour. 4. Encourage client to ask questions and answer them tactfully. 5. Introduce client to other staff.	1. Client was reassured. 2. Every procedure to be carried out was explained to client. 3. Client was educated on possible outcome of labour. 4. Client was encouraged to ask questions and answers were given tactfully. 5. Client was introduced to other staffs.	26/11/21 2:00am	Goal fully met as client felt relaxed.	A.Y.

TABLE 2: NURSING CARE PLAN FOR JANET CONT'D…

Date /Time	Nursing Diagnosis	Nursing Objectives	Nursing Orders	Nursing Intervention	Date /Time	Evaluation	Sign
26/11/21 3:00am	Fatigue related to the stress of labour.	Client will gain her strength within 4 hours as evidenced by, 1. Client reporting she has gained strength 2. Midwife observing client carry out activities of daily living on her own	1. Reassure client. 2. Explain the physiology of fatigue. 3. Encourage client to rest in between contractions. 4. Encourage deep breathing exercises along contractions. 5. Assist client with activities of daily living such as bathing, walking	1. Client was reassured of safe delivery. 2. Physiology of fatigue was explained to client's understanding. 3. Client rested in between contraction. 4. Deep breathing exercises was practiced by client 5. Client was assisted in performing activities of daily living such as bathing, walking	26/11/21 7:00am	Goals fully met as evidenced by client reported she has gained	A.Y.

TABLE 2: NURSING CARE PLAN FOR MADAM JANET CONT'D…

Date /Time	Nursing Diagnosis	Nursing Objectives/ Outcome Criteria	Nursing Orders	Nursing Intervention	Date/Time	Evaluation	Sign
26/11/21 3:10am	Excessive sweating related to labour process.	Client will cope with sweating within 6 hours. as evidenced by; 1. Client reporting sweating has reduced 2. Midwife observing that client is able to cope with sweating profusely	1. Mop client face when sweating. 2. Serve client with 300mls of fluids. 3. Serve fluid nourishing diet. 4. Educate client on the need of fluid intake during labour. 5. Check the vital signs regularly.	1. Client sweating was mopped. 2. Client was served with 300mls of orange juice every hour. 3. Client was served with 250mls of light soup. 4. Client was educated on fluid intake to aid in pushing during labour. 5. Client BP, pulse and respiration were monitored.	26/11/2021 at 3:20am	Goals fully met as Client verbalizing she is coping with sweating.	AY

CHAPTER FOUR

PEURPERIUM

4.0 INTRODUCTION

This chapter gives brief information about the subsequent care given to the mother and her baby after delivery as well as home visits.

4.1 DAY OF DELIVERY (26/11/2021)

Client delivered on 26th November, 2021 at 3:19am. Both mother and baby were monitored every 15 minutes for 2 hours, 30 minutes for 1 hour and hourly for 3 hours. Madam Janet and her baby were transferred to the lying-in ward for vigilant observation and they were made comfortable in bed with all observations recorded. Her health was enquired and the pains she complained during her labour had subsided. Madam Janet was examined from head to toe before she took her bath and no abnormality was found. The lochia was red in colour, moderate in quantity with no bad odour.

Findings from assessment of Madam Janet and her baby were recorded as follows;

Mother's assessment

Temperature	36.8 degrees celcius
Pulse	113 beats per minute
Respiration	23 cycles per minute
Blood pressure	136/89 millimeter of mercury
Symphysio fundal height	18 centimeters
Lochia	Rubra

Baby’s assessment

Temperature	36.7 degree celcius
Respiration	40 cycles per minute
Apex beat	132 beats per minute

Weight	2.9 kilograms
Skin colour	Pink
Cord	Clean
Cord bleeding	No
Suckling	Yes

Madam Janet was asked to change her perineal pad frequently when soiled to prevent ascending infection to the uterus and also empty her bladder to help involution of the uterus. She was advised to wash her hands before and after changing pad. She had her bath and kept warm with her baby in bed and encouraged on exclusive breastfeeding on demand and also she was advised to report any abnormal bleeding for prompt action to be taken. Madam Janet was also educated on simple hand washing before and after touching and feeding the baby and after visiting the toilet. She was encouraged to take enough rest and sleep especially after breast feeding and put the baby to sleep to restore her energy.

Madam Janet complained of after pains and painful micturation and was reassured and the physiology of after pains was also explained to her. She was also advised that whenever she has the urge to urinate, she should not hesitate in other to prevent stasis which would lead to infection. She was served with two tablets of Paracetamol to relieve the after pains and was encourage to rest.

4.2 SUBSEQUENT CARE OF THE BABY

Examination of the new born

After washing hands and drying them, the procedure was explained to Madam Janet Gloves were worn and the baby was examined in the presence of the mother in a clean, warm environment, with nearby windows closed and light switched on. Baby was placed on a covered flat surface with only the part being examined exposed systematically. Baby’s general

condition was stable. A detailed head to toe examination was carried out to determine any abnormality.

Head and Neck: The head was examined for skull formation, softness/tension of fontanelles, size and shape, lacerations, caput succedaneum as well as intracranial haemorrhage but no abnormality was detected. Head circumference was measured by encircling the head with a tape measure from the occipital protuberance to the supra-orbital ridge and it measured 32cm. The eyes opened spontaneously when the baby was held in an upright position and the conjunctiva was clear. Eyes were also examined for colour, redness, discharge, placement and conjunctiva for haemorrhage but no abnormality was found.

The nose was inspected for size and shape and examined for deviated septum but the septum was normal. The nostrils were inspected for patency and discharges and the mucosa for colour and polyps which were all normal.

The mouth was examined by pressing the angle of the jaw which opened the mouth and the tongue, gum and palate were inspected and there was no false tooth noticed. The palate was high arched, intact and the uvula centrally placed. There was no cleft palate or cleft lip, tight frenulum or tongue tie. Suckling, rooting and swallowing reflexes were checked and was present.

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

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

Chest and Abdomen: The chest was examined, the respiratory movement was regular and the respiratory rate was 40cpm. Breasts were palpated for consistency, masses, and the nipples for position and milk. The space between the nipples was noted and the nipples were in alignment.

The abdomen was round with no bleeding from the umbilical cord and no signs of infection. The cord was examined and there was one vein and two arteries. The liver, spleen and bladder were palpated for size, tenderness and masses but no abnormality was detected. Apex beat was present and was recorded as 130bpm.

Upper extremities: The length, movement and paralysis of the upper limbs were also noted. The digits were counted to be normal and separate to exclude webbing and the palm for the number of palmer creases. The shape and colour of the nail bed were inspected and reflexes (grasping, Moro) checked. Everything was normal.

Genitalia: The labia, clitoris, vagina, and urethra were inspected for patency, foreign bodies, adhesions and discharge. The anus was examined for patency and it was patent. The anus was also palpated for sphincter tone, masses, tenderness but it was normal. The baby passed meconium and urine.

Lower extremities: the leg and feet were inspected for symmetry, extra digits, webbing, movement, fare foot adduction, clubbed feet, knock-knees, bowed leg, tibia torsion and paralysis but no abnormality was found. The hip had no dislocation and the reflexes (knee jerk/ patella, plantar) were present. The feet were examined for any disability such as talips equinovarus. The axillae, elbow groin and popliteal spaces were examined without any abnormality detected.

Back: The spine was also examined with baby turned to one side. The back was palpated for swelling, dimpling, hairy patches to exclude spinal bifida and for missing vertebra, meningomyelocele but no abnormality detected

Baby's length was measured to be 46centimetres, weight was 3.3kg and temperature was 36.2◦C.

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

Six hours after the delivery of the baby, placenta and membranes, the baby was given a warm bath and she passed meconium and urine during her bath. After that the baby was wrapped nicely in a warm towel and her findings from assessment was recorded as follows;

Temperature	36.7ºC
Apex beat	132bpm
Respiration	40cpm
Weight	2.9kg

BABY BATHING

The baby was bathed after six hours observation with warm water and cord dressed.

REQUIREMENTS

- Soap
- Sponge
- Cream/ powder
- Sterile cotton in gallipots or wrapped
- Methylated spirit
- Basin
- Towels: 1 big towel and 3 small ones
- Cot sheets 2
- Apron
- Gloves
- A clean baby dress, cap and socks (if available)

- Mackintosh
- 2 jugs containing hot and cold water each
- Two receptacles for used water and dirty linen
- A receiver for used swab

PROCEDURE

The procedure was explained to mother and a tray was set. A plastic apron was worn and hands were washed with soap, water and dried with a clean towel. The water was mixed and the temperature was tested using the elbow. Sterile gloves were worn and baby was placed on a flat surface. She was undressed and wrapped in a big towel. The eyes were cleaned with cotton wool swabs soaked in clean water from inner canthus outwards. His face was cleaned with damp face towel and dried. The nape of baby's neck was supported with one hand. His ears were then plugged using two fingers of the hand and the head was washed with soapy sponge. With the body resting on the elbow and still supporting the nape, the baby was place at the edge of the bowl to rinse the soap off the head and dried. The baby was exposed; arms and front of trunk were washed paying attention to skin folds. The baby's back was turned with one hand supporting the chest and washed back down to feet paying attention to the skin folds. She was immersed in a bath of warm water with the head above the water and rinsed thoroughly. The baby was place on a flat surface covered with clean sheet. The baby was dried by using a clean small towel paying attention to the skin folds.

The cord was dressed by using sterile cotton wool swabs soaked in methylated spirit. The tip of the cord clamp was held with one sterile cotton wool swab and another was used to clean the base of the cord. The cord anteriorly and posteriorly was cleaned with each separate cotton wool swab from the base upwards. The tip of the cord was cleaned with another swab and the cord was left exposed and the swab which was used to hold the cord clamp was used to clean

it. The baby was dressed, wrapped and, given to mother to breastfeed. The waste materials were discarded according to infection prevention protocol.

Gloves were removed and disposed of. Hands were washed with soap and water before handling the baby.

Client took a warm bath in the morning after her perineal pad was inspected for the presence of lochia which was small, no odour and red in colour. The after pain and painful micturition were asked and she said both pains were better now. Her consent was sought for head to toe examination.

Everything was normal, breast was lactating well and uterus measured 18cm. Her vital signs were recorded as follows;

Temperature	36.8^0C
Respiration	20cpm
Pulse	100bpm
Blood Pressure	136/89mmHg
Symphysio fundal height	18cm
Lochia	Rubra

Madam Janet complained of inadequate sleep during the night as a result of feeding her baby at night. She was encouraged to continue breastfeeding at night since it is important for the growth of her child and also sleep when the baby was asleep especially during the day time. Baby was cleaned with warm water and cord was dressed with cotton wool swabs soaked in methylated spirit. Baby was examined from head to toe in the presence of the mother and no abnormality was detected. Baby was reassessed and dressed up neatly and the findings recorded as follows:

Temperature	36.9^0C
Respiration	40cpm

Apex beat	142bpm
Weight	2.9kg
Skin colour	Pink
Cord	Clean
Cord bleeding	No
Suckling	Yes.

All findings were communicated to Madam Janet. The baby was handed over to her to breast feed. Madam Janet took millet porridge with bread as breakfast. After that, she was given vitamin A supplement 200,000 international units. She was educated on healthy adequate nutritious diet to help in the production of more breast milk and improve her immunity, and help repair worn out tissues. Madam Janet was again educated on good personal hygiene, post natal exercise and on the various family planning methods. The essence of the exercise was to help the pelvic organs to return to their original position. She was informed of her discharge. Furthermore, Madam Janet was encouraged to feed her baby on demand. She was also advised to register the baby at the birth and death registry.

Baby was given BCG and polio “O” vaccine and mother was advised not to apply anything to the site in order to ensure effectiveness of the drugs and prevent baby from Tuberculosis and poliomyelitis respectively. She was then ask to come with the baby to take the rest of the immunization at the time scheduled in order to prevent the baby from any of the childhood preventable diseases like Measles, Tetanus and Diphtheria. Madam Janet took rice and stew with egg as lunch. She was helped to pack her items and also served her routine drugs. She was informed of a visit to her house for a period of one week starting from the next day and she agreed. After settling her bill with national insurance, she was discharged at 4:00pm.

4.3 DAY OF DISCHARGE (26/11/2021)

On 26st December, 2020 at 5pm client was discharged and that also happened to be the first day of delivery and Madam Janet and her baby were doing well. She woke up around 7:30am and brushed her teeth. The baby was being breastfed and she was suckling well. Permission was sought later to examine the baby. Hands were washed with soap under running water and dried with a clean dry towel.

On general examination, there was nothing abnormal detected. An opportunity was taken to demonstrate to the mother how to bath the baby. The baby was top and tailed, dressed and wrapped nicely in the presence of the mother and family. The cord was dressed with six sterile cotton wool swabs soaked in methylated spirit. The baby passed urine and meconium which was normal. The mother was educated not to apply hot compress on the fontanelles with the intention of closing it. It was explained to the family that the fontanelles would close by themselves. Client was encouraged to keep the cord clean and to not to use local herbs on it. She was also educated on the provision of warmth, maintaining temperature and prevention of infection. After the baby was top and tailed, her vital signs and weight were checked and recorded as follows:

Temperature	36.5 degree Celsius
Apex beats	140 beats per minute
Respiration	39 cycles per minute
Weight	2.9 kilograms

Mother's vital signs were checked and recorded as:

Temperature	36.5 degree Celsius

Pulse	80 beats per minute
Respiration	18 cycles per minute
Blood pressure	120/80 millimeter in mercury

Procedures to be done on her were explained to her and she consented. Head to toe examination was done and nothing abnormal was detected. Her breasts were lactating and nothing abnormal was observed. The vulva and perineal pad were inspected after permission was sought and lochia was red (rubra), flow was small and not offensive. She was reminded on changing of perineal pad frequently especially when soiled to prevent ascending infection to the uterus. Client then complained of perineal pain. She was reassured and educated that it was as a result of stretching of the vaginal and perineal tissues during delivery. She was then encouraged to practice good personal hygiene and do warm sitz bath to help reduce the pain. On palpation, the uterus was well contracted and symphysio fundal height was 18 centimeters.

Madam Janet took rice with tomato stew as her breakfast. She was educated to practice exclusive breastfeeding on demand especially in the night every two to four hours or at least 8 to 12 times per day and educated on the importance of breast milk to both mother and baby. Education on proper personal and environmental hygiene to prevent infections was reinforced. Client was also educated on the intake of healthy diets and its importance to her and her baby.

She was encouraged to take enough rest, perform postnatal exercises and ambulate to help her abdominal muscles and pelvic floor muscles gain their tone. She was also reminded on how to perform self-breast examination. The in-charge was informed about procedures and findings and client and baby were reassessed for confirmation. She was informed of her discharge and was helped to pack her things. Routine drugs were prescribed according to the protocol of the facility. She was told to come for one-week post-natal care on the 3rd December, 2021.

She was informed about the continuity of care and that she would be visited at home for seven days to check on her condition and that of the baby. Her sister was encouraged to take good care of her and also provide her with physical, emotional, psychological and financial support. She was again educated on the prescribed drugs, its route, dosage and effects and encouraged to register the baby at the births and deaths registry. Client was asked if she had any other complaints or questions and she said no. She was discharged at 5:00pm on the 26th November, 2021 with the following drugs:

Tablet Folic acid	5mg daily for 14 days.
Tablet Multivite	200mg daily for 14 days.
Tablet Ferrous Sulphate	200mg daily for 14 days.
Tablet paracetamol	1g tid for 3 days.

4.4 FIRST POST NATAL HOME VISIT (2ND DAY OF DELIVERY)

Madam Janet was visited in the house after delivery for the first time around 7:30am and 4pm on the 27th November, 2021.Greetings was exchanged and a seat was offered. The whole family was in good health and her previous complaints had improved, her painful micturition had resolved and after pains was better. Both mother and baby looked healthy on arrival to their house. Client was informed of the procedures to be carried out. Hands were washed and dried with a clean towel. The baby was cleaned and head to toe examination was done and no abnormality was detected. Baby passed meconium and urine. The cord was also dressed with cotton wool swabs and methylated spirit using aseptic technique; it was clean, dry and not offensive. The baby was dressed, wrapped and was given to client's sister. Madam Janet emptied her bladder and head to toe examination was done and there was no abnormalities detected. The conjunctiva was examined and there was no pallor. Uterus was well contracted

and measures 17cm. The perineum was clean dry and intact, lochia was small red (rubra) and not offensive. Her vital signs were checked and recorded as follows;

Observations	**Morning**	**Evening**
Temperature	36.8^0C	36.8^0C
Pulse	75bpm	77bpm
Respiration	22cpm	20cpm
Blood pressure	110/60mmHg	110/70mmHg
Lochia	Rubra	Rubra
Symphysio-fundal height	17cm	17cm

Baby was given to mother to breast feed. Baby was able to suck well.

The baby was assessed and findings were recorded as follows:

OBSERVATIONS	**MORNING**	**EVENING**
Temperature	36.9^0C	36.5^0C
Respiration	41cpm	40cpm
Apex heart beat	137bpm	134bpm
Skin colour	Pink	Pink
Cord bleeding	No	No
Suckling	Yes	Yes
Stool colour	Dark yellowish	Dark yellowish

During the physical examination of the mother, her breast was engorged and she was encouraged to continue breastfeeding the baby frequently and on demand to ensure that one breast was empty before the other one was given. Madam Janet was educated on family planning, danger signs in the newborn such as breathing difficulties, cyanosis, persistent vomiting and fever, the cord was clean, dry and not offensive. Client and family were

congratulated and permission was sought to leave and she was informed of the next home visit the next day during the evening visit.

4.5 SECOND POSTNATAL HOME VISIT (3RD DAY POST DELIVER)

Madam Janet was visited on the 28th November, 2021 around 7:34am and 4pm. She and her baby were in good health. All procedures to be carried out on them were explained to her.

The breast engorgement and after pains she complained had resolved and client could sleep well according to her. Her perineal pad was inspected and Lochia flow was small and red in colour without bad odour before she took her bath. Madam Janet was examined from head to toe and everything was normal, breast was lactating well. The symphysio fundal height was 16cm when measured and findings from assessment were recorded as follows;

Observations	**Morning**	**Evening**
Temperature	36.8degree Celsius	37.0degree Celsius
Pulse	75bpm	78bpm
Respiration	19cpm	21cpm
Blood pressure	110/60mmHg	120/70mmHg
Lochia	Rubra	Rubra
Symphysio-fundal height	16cm	16cm

Baby was then top and tailed, she passed urine and meconium stool and was also examined from head to toe and nothing was detected. Her cord was dressed and was quite dry, no signs of infection were found.

The baby was dressed up and findings were recorded as;

Observations	**MORNING**	**EVENING**
Temperature	37.0degree Celsius	36.8degree Celsius

Observations	MORNING	EVENING
Respiration	38cpm	38cpm
Apex heart beat	140bpm	142bpm
Skin colour	Pink	Pink
Cord bleeding	No	No
Cord	Shrinking	Shrinking
Suckling	Yes	Yes
Stool colour	Dark yellowish	Dark yellowish

The mother was advised not to apply anything on the cord and encouraged to continue with post-natal exercise and exclusive breast feeding. She was reminded of another visit the following day.

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

Madam Janet was visited in the house for the third time at 7:30am and 4pm on the 29th November, 2021 to her wellbeing and that of the baby and they were doing well and her breast engorgement had subsided and breast was lactating well. Perineal pad was inspected Lochia was small with red colour after that she took her bath. Nothing abnormal was detected during head to toe examination

Symphysio fundal height was 15cm and findings from assessment were recorded as;

Observations	Morning	Evening
Temperature	36.8degree Celsius	36.8degree Celsius
Pulse	76bpm	76bpm
Respiration	21cpm	19cpm
Blood pressure	110/60mmHg	100/70mmHg
Lochia	Rubra	Rubra

Observations	MORNING	EVENING
Symphysio-fundal height	15cm	15cm

Her baby was top and tailed in the presence of mother. No abnormality was found during head to toe examination. The cord was dressed with cotton wool with methylated spirit. She was dressed up and findings after assessment were;

OBSERVATIONS	MORNING	EVENING
Temperature	36.9degree Celsius	36.9degree Celsius
Apex beat	143bpm	144bpm
Respiration	40cpm	38cpm
Skin colour	Pink	Pink
Cord bleeding	No	No
Cord	Shrinking	Shrinking
Suckling	Yes	Yes
Stool colour	Dark yellowish	Dark yellowish

All findings were explained to her understanding. She was once again reminded of next visit and was thanked for her cooperation.

4.7 FOURTH POSTNATAL HOME VISIT (5TH DAY POST DELIVERY)

On the 30th Novemberr, 2021 around 8:00am, client and family were visited as usual, greetings were exchanged and seat was offered and all family members were in good condition according to the mother. Head to toe examination was carried out and no abnormality was detected. Baby's cord was dressed with six cotton wool swabs and methylated spirit, it was dry, not offensive and almost off. Head to toe examination was carried out on mother and no abnormality was detected. The Symphysio fundal height was 14 centimeters, perineum was clean and intact. Lochia was pink (serosa), small and not offensive. The breast was lactating well. She also complained of backache and she was reassured and educated on other positions

used in breastfeeding such as lying on her side to breastfeed and was also educated to support her back when sitting. Her vital signs were checked and recorded as follows:

Observations

Temperature	37.1degree Celsius
Pulse	77bpm
Respiration	22cpm
Blood pressure	113/60mmHg
Lochia	Serosa
Symphysio-fundal height	14cm

The baby's vital signs were checked and recorded as follows:

Temperature	36.8 degree Celsius
Apex beat	138 beats per minute
Respiration	40 cycles per minute
Skin colour	Pink
Cord	Dry, not offensive
Suckling	Yes
Stool colour	Yellowish

Mother was encouraged to ask questions. All findings were communicated to her and the necessary documentation was done. She was thanked and permission was sought to leave. She was reminded of another visit the next day.

4.8 FIFTH POSTNATAL HOME VISIT (6TH DAY POST DELIVERY)

The 5th day which was 1st December, 2021, Madam Janet and her family were visited at 8:30am. She looked strong and healthy. Everybody in the family was fine and the environment was very clean. Madam Janet perineal pad was inspected in the morning before she took her bath and

Lochia was pink, very small with no bad odour. Her permission was sought for head to toe examination after taken her bath, everything was normal and her findings were;

Temperature	36.5 degrees Celsius
Respiration	21cpm
Pulse	80bpm
Blood Pressure	100/60mmttg
Symphysio fundal height	13cm
Lochia	Serosa

On the fifth day, the symphysio fundal height was 13cm. The breast was lactating well baby's cord was clean and dry. The cord was dressed with cotton wool swabs soaked in methylated spirit after the baby has been topped and tailed. Examinations were done and everything was normal. Baby's vital signs were:

Temperature	36.6 degree Celsius
Respiration	42cpm
Apex beat	140bpm
Stool	Yellowish

Mother was encouraged to continue her good personal hygiene as well as that of the baby.

4.9 SIXTH POSTNATAL HOME VISIT (7TH DAY POST DELIVERY)

2nd December, 2021 was the sixth home visit to Madam Janet house at 10:00am. Client was doing well as baby and the entire family**.** Procedures to be done were explained to her. Head to toe examination was done on the baby and there was no abnormality detected. For the mother, Symphysio fundal height was 12cm. The perineal pad was inspected and the flow was scanty and pink in colour and not offensive. Her vital signs were also checked and recorded as follows;

Temperature	36.5^{o} C
Pulse	78bpm

Respiration	20cpm
Blood pressure	110/60mmHg
Symphysio fundal height	12cm
Lochia	Serosa

Baby was examined from head to toe and no abnormalities were found. Her cord was off with no bleeding from the site, and was educated not to apply anything to cord stump and relatives were asked to observe how baby bath is properly done since she will be doing it for me to see during my last visit. As she observed including her mother, she told me that the way the baby was bathed was quite different from the way her mother used to bath her grandchildren, but with closer observation, she can equally do same. Madam Janet was educated on the need to avoid exposure of the baby for a long period during bathing since baby will be prone to hypothermia. The baby looked healthy and active. The cord stump was clean, dry and not offensive. The baby too was looking active and fine. The baby was well wrapped after the bath. The baby's vital signs were checked and recorded as follows;

Temperature	37.0^{o} C
Apex heart beat	141bpm
Respiration	38cpm
Stool	Brownish

Client was encouraged to continue with the exclusive breast feeding, exercise and the intake of nutritious diet for strong immunity and promotion of lactation. Client and her family were thanked for their time and cooperation and were informed of the last home visit being the next day.

4.10 SEVENTH POSTNATAL HOME VISIT

This day was the last post-partum visit on the 3rd December, 2021 to Madam Janet and her family, I got to the house around 7:30am and after greeting, I was offered a seat. I observed

Madam Janet's mother bathing the baby. Their health was enquired and they were all doing well. Head to toe examination was carried out on both mother and baby after bathing and everything was normal. The fundus was not palpable. Her pad was inspected and the Lochia was pink in colour with no odour. Their vital signs were checked and baby was given to mother to breastfeed.

Baby's vital signs were as follows;

Temperature	36.9degree Celsius
Respiration	37cpm
Apex beat	141bpm
Stool	Brownish

Mother's vital signs were;

Temperature	36.8degree Celsius
Respiration	20cpm
Pulse	78bpm
Blood pressure	110/60mmttg

The mother was congratulated and reminded of the postnatal visit to the clinic. Since that was the last visit, she was informed to report to the clinic if she detects any problem. She was thanked for her cooperation and permission was sought to leave.

4.11 FIRST POST NATAL VISIT TO THE CLINIC

Madam Janet arrived at the clinic with her baby accompanied by her mother on the 3rd December, 2021 at 10:00am. They were offered a seat and then asked about their health and they were fine including the baby and all procedures to be carried out were explained to Madam Janet. Her vital signs were checked and recorded as follows:

Temperature	36.8^0C
Pulse	100bpm

Respiration	22cpm
Blood Pressure	100/60mmHg
Weight	50kg

Her midstream urine specimen was collected and tested for protein and sugar but all were negative. Her haemoglobin level measured 10.3g/dl. Madam Janet weight was 50kg. She was helped to lie on the couch for a head to toe examination having emptied her bladder. On inspection the hair was well kept, there were no discharges from eye, nose, the conjunctiva was not pale, the sclera had no yellow discoloration and the mouth was clean. The ears were not discharging, neck was palpated for swollen lymph nodes but no abnormality was detected. The breast was examined and no abnormality was found and was lactating well with no engorgement. On abdominal examination, the uterus was not palpable and no enlargement of any abdominal organ. The vulva was inspected and there were no varicose vein edema and bad odour. The Lochia was pale in colour with scanty flow and odourless. The extremities were free from any edema. All findings were communicated to her and she was commended for her cooperation.

The baby was also examined from head to toe and everything was normal and her vital signs and weight checked were as follows:

Temperature	37.2^0C
Respiration	40cpm
Apex beat	143bpm
Weight	3.2kg

All the information was recorded in the post-natal records. The mother was educated on good intake of well-balanced diet since this would improve her health status and also to produce more breast milk. She was also educated on family planning for her to have an informed choice so that during the six weeks post-natal visit she could make a right choice. She was also advised

to visit the child welfare clinic for the baby to complete all the immunization scheduled. She was thanked for her cooperation and also all the time spent together. She was very happy and was handed over to the midwife in-charge for the continuity of care who will intend hand her over to the community health nurse during the six weeks postnatal visit in my absence.

4.12 SECOND POSTNATAL VISIT TO THE CLINIC

Madam Janet visit to the clinic with the baby on 7th January, 2022; she was welcomed to the clinic by the midwife in charge. Both mother and baby were in healthy condition and had no complain. Her hemoglobin level was 14.1 gram per deciliter as checked and urine test for protein and sugar were negative. Her recordings were as follows, Temperature 36.7^{o}C, Pulse 80bpm, Respiration 20cpm, Blood pressure 120/70mmHg, Weight 63kg. Baby's Vital signs and weight were checked and recorded as fellows; Temperature 36.4^{o}C, Respiration 35cpm, Apex heart beat 134bpm, Weight 4.5 kg. Physical examination was done and no abnormality was detected, breast was lactating well uterus was well involuted and menstruation has not commenced. Baby's general condition was good head to toe examination was done and baby's posterior fontanelles were closed and the circumcision area had healed and clean. Client was handed over to the midwife in charge at the health center for baby immunization against polio, diphtheria, pertussis, tetanus, haemophilus influenza type B, hepatitis B given to children at six weeks. The extra vaccines namely pneumococcal and rotavirus for protection against pneumonia and diarrhea respectively was also reminded to be given, they were handed over to the child welfare clinic and family planning unit to ensure continuity of care and were educated to consult them in case of any problem .Client was congratulated. Madam Janet was encouraged to ask questions but she asked none and was made no complaints either. She was remaindered on exclusive breastfeeding, rest and sleep, exercise and nutrition. According to the midwife in charge, client was finally handed over to the community health nurse at

Tuobodom Health Centre for continuity of care but was asked to report to the facility any time she encountered any health related problem.

4.13 NURSING CARE PLAN ON PUERPERIUM

PROBLEM IDENTIFIED

Client complained of;

1. 26/11/2021 After pains
2. 26/11/2021 Painful micturation
3. 26/11/2021 Insomnia
4. 27/11/2021 Breast engorgement
5. 30/11/2021 Backache

SHORT TERM OBJECTIVES

1. Client will be able to cope with after pain within 48 hours
2. Client will be able to cope with frequency of micturition within 48 hours
3. Client will sleep 2 hours during the day and 3 hours during the night within 24 hours
4. Client will have a reduction of her engorged breast within 72 hours.
5. Client backache will be reduced within 24 hours

LONG TERM OBJECTIVE

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

TABLE 3: CARE PLAN DURING PUERPERIUM

Date/ Time	**Nursing Diagnosis**	**Nursing Objective**	**Nursing Orders**	**Nursing Intervention**	**Date/ Time**	**Evaluation**	**Sign**
26/11/21 9:00am	After pains related to involution of the uterus.	Client will be able to cope with after pain within 48 hours as evidenced by; 1. Client verbalizing her pain has reduced. 2. Midwife observing patient cope with frequent micturation	1. Reassure client. 2. Explain the physiology of after pain to client. 3. Encourage client to breastfeed frequently and on demand. 4. Encourage client to apply warm compress on the lower abdomen. 5. Serve prescribed analgesics.	1. Client was reassured. 2. The physiology of after pain was explained to client. 3. Client was encouraged to breastfeed frequently and on demand. 4. Client was encouraged to apply warm compress on the lower abdomen. 5. Client was served Paracetamol 1g daily before breastfeeding.	28/11/21 9:00am	Goal fully met as client verbalized she is no more in pains.	A.Y.

TABLE 3: CARE PLAN DURING PUERPERIUM CONT'D…

Date/ Time	Nursing Diagnosis	Nursing Objective	Nursing Orders	Nursing Intervention	Date/ Time	Evaluation	Sign
26/11/21 9:00am	Painful micturation related to bruising of urethral canal.	Client will be able to cope with frequency of micturition within 48 hours as evidenced by; 1. Client verbalizing that she can empty her bladder without pain. 2. Midwife observing patient cope with frequent micturation	1. Reassure the client that her pain is a sign of involution of the uterus and it will go with time. 2. Encourage client to empty her bladder frequently. 3. Educate client on relieve measures 4. Encourage client to continue breastfeeding the baby. 5. Serve prescribed analgesic.	1. Client was reassured that the pain was a sign of involution of the uterus and it would go with time. 2. Client was encouraged to empty her bladder frequently. 3. Client was educated on relieve measures. 4. Client was encouraged to continuously feed the baby on demand. 5. Prescribed analgesic was served {(tab paracetamol 1gram)	28/11/21 9:00am	Goal met as client verbalized that her pain was reduced.	A.Y.

TABLE 3: CARE PLAN DURING PUERPERIUM CONT'D…

Date/ Time	**Nursing Diagnosis**	**Nursing Objectives/ Outcome Criteria**	**Nursing Orders**	**Nursing Intervention**	**Date/ Time**	**Evaluation**	**Sign**
26/11/21 9:30am	Inadequate sleep related to night breastfeeding.	Client will sleep 2 hours during the day and 3 hours during the night within 24 hours as evidenced by; 1. Client verbalizing she is able to attain adequate sleep 2. Midwife observing that client sleeps 2 hours during the day and 3 hours during the night	1. Reassure client. 2. Encourage client to have periodic rest during the day when baby is asleep. 3. Educate client to breast feed baby to his satisfaction. 4. Encourage her relative to help her with the household chores. 5. Encourage client to limit the time she spend with visitors.	1. Client was reassured. 2. Client was encouraged to have a periodic rest when baby sleeps. 3. Client was educated to breast feed baby to his satisfaction. 4. Client's relatives were encouraged to help her with the household chores. 5. Client was encouraged to limit the time she spend with visitors.	28/11/21 8:00am	Goal fully met as client verbalizes that she has resumed her normal sleeping pattern.	A.Y.

TABLE 3: CARE PLAN DURING PUERPERIUM CONT'D…

Date/ Time	Nursing Diagnosis	Nursing Objective	Nursing Orders	Nursing Intervention	Date/ Time	Evaluation	Sign
27/11/21 8:00am	Breast engorgement related to inadequate emptying of breast.	Client will have a reduction of her engorged breast within 72 hours.as evidenced by 1. Client verbalizing that a reduction in engorged breast 2. Midwife observing client apply measures that has been taught	1. Reassure client. 2. Teach client on how to fix baby correctly to the breast. 3. Encourage client to apply cold and warm compress to the breast. 4. Encourage client to continue breastfeeding exclusively. 5. Encourage client to empty one breast before the other	1. Client was reassured. 2. Client was taught how to fix baby to breast. 3. Apply cold and warm compress alternatively. 4. Client was encouraged to continue breastfeeding baby exclusively. 5. Client was encouraged to empty one breast before the other	30/11/21 8:00am	Goal fully met as client verbalized that breast engorgement has reduced.	A.Y.

TABLE 3: CARE PLAN DURING PUERPERIUM CONT'D…

Date/ Time	Nursing Diagnosis	Nursing Objective	Nursing Orders	Nursing Intervention	Date/ Time	Evaluation	Sign
30/11/21 8:00am	Impaired comfort related to backache	Client backache will be reduced within 24 hours as evidence by; 1. Client verbalizing that there is no pain 2. Midwife observing client feels comfortable during breastfeeding.	1. Reassure client. 2. Teach client how to position herself when breastfeeding. 3. Give body massage. 4. Encourage client to sleep on a firm mattress. 5. Administer prescribe analgesics.	1. Client was reassured. 2. Client was taught how to position herself during breastfeeding. 3. Client body was massaged. 4. Client was encouraged to sleep on a firm mattress. 5. Prescribed analgesics Paracetamol 1g was served.	29/11/21 8:00am	Goal fully met as client verbalizes that she has been relieved of backache.	A.Y.

TERMINATION OF CARE

During the first postnatal visit, I took opportunity to express my sincere gratitude to my client for allowing me to use her for my care study. Madam Janet was handed over to the midwife in charge for continuity of care who will intend hand over to the community health nurse during the six weeks postnatal visit that is the second postnatal visit to the clinic in my absence. I thanked her once again and she also thanked me for my care and support for her and the baby. I escorted her to the entrance of the facility and we bid goodbye.

SUMMARY AND CONCLUSION

The study was carried out on Madam Janet, a 27year old woman who was Gravida 3 Para 2 all alive. She was met at Tuobodom Health Centre on the 8th November, 2021 during antenatal session and her pregnancy was 37weeks old. She was in good health when we met. She was given individualized care from the time she was met up to the end of puerperium.

The cordial relationship that existed among the client, family and staff of the clinic aided to educate them on personal, environmental health, maintenance as well as other health related issues. She gave the opportunity to be visited in the house and became familiar with the entire family. Various examination and laboratory investigations were carried out to aid in the progress of normal pregnancy.

She went through some minor disorders which we managed successfully. She had successful antenatal period and entered labour on the 25th November, 2021. She was monitored throughout the stages of labour to resolve all her problems by the use of nursing process and she delivered spontaneously of a healthy baby girl on the 26th November, 2021 at Tuobodom Health Centre, without any complications. Mother and baby were discharged a day after delivery in good condition on the 26th November, 2021.

Mother and baby were visited for seven continuous times at home where baby bath was done, vital signs were checked and recorded for both mother and baby and weight of baby and symphysio-fundal height of mother were also checked and recorded. Head to toe examination were conducted on both mother and baby during the postnatal home visits. Client was also educated on immunization and it was ensured that the baby received all the appropriate vaccines as at the time of care.

Madam Janet and her baby were very healthy and were in good condition when the interaction ended after which they were handed over to the midwife in –charge.

In conclusion, this family centered maternity care given to Madam Janet has enable me gain much experience about the importance of proper client management during pregnancy, labour and puerperium.

It has also improved my skills as a student midwife in planning, interviewing, setting objectives, implementing and evaluating them to solve client's problem identified. This would enable me give quality care to every woman who comes under my care.

BIBLIOGRAPHY

American College of Obstetricians and Gynecologist. (2018). Definition of term pregnancy. *Obstet Gynecol, 122,* 1139-1140.

Ghana National Safe Motherhood Service Protocol. (2016). *Improving the Ghanaian safe motherhood programme.* Accra: Ghana Health Service.

Magowan, B., Owen, P., & Thomson, A. J. (2014). *Clinical obstetrics & gynaecology* (3rd ed.). Endinburgh: Saunders.

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

Ojo, O. A., & Briggs, E. B. (2006). *A textbook for midwives in the tropics* (2nd ed.). London: Arnold.

Tiran, D. (2012`). *Bailliere's midwives' dictionary.* Edinburgh: Saunders.

Verralls, S. (2011). *Anatomy and physiology applied to obstetrics* (3rd ed.). Singapore: Elsevier.

World Health Organization. (2016). *Care in normal birth: a practical guide.* Geneva: WHO.

APPENDIX 1

COMPLETE DIAGNOSTIC INVESTIGATION ON MADAM JANET

DATE	SPECIMEN	INVESTIGATION	NORMAL RANGE	FINDINGS	REMARKS
26/4/2021	Urine	Protein	Negative	Negative	Normal
		Glucose	Negative	Negative	
	Blood	Haemoglobin level	11-16gms/dl	14.0 gms/dl	Normal
		PMTCT	Negative	Negative	
		Syphilis	Negative	Negative	
		Rhesus factor	Negative/Positive	Positive	
		Grouping	A, B, AB, O	O+	
		Sickling Test	Negative	Negative	
24/05/2021	Urine	Glucose	Negative	Negative	Normal
		Protein	Negative	Negative	

COMPLETE DIAGNOSTIC INVESTIGATION CONTINUED

DATE	SPECIMEN	INVESTIGATION	NORMAL RANGE	FINDINGS	REMARKS
21/6/2021	Urine	Protein Glucose	Negative Negative	Negative Negative	Normal
25/10/2021	Urine	Protein Glucose	Negative Negative	Negative Negative	Normal
15/11/2021	Urine Blood	Protein Glucose Haemoglobin level	Negative Negative 11-16gms/dl	Negative Negative 12.2gms/dl	Normal Normal

APPENDIX II

PHARMACOLOGY OF DRUGS FOR THE MOTHER

NAME OF DRUG	CLASSIFI-CATION	DOSAGE	ROUTE	ACTION AND USES	ACTUAL EFFECT	SIDE EFFECT	SIDE EFFECT EXPERIENCED
Caps iron (III) Polymaltose Complex	Haematinics	100 milligrams once daily	Orally	Aids in red blood cell formation	Increased haemoglobin level	Dark stools, diarrhoea and constipation	None observed
Folic acid	Vitamin preparation	5 milligram 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/quicke-ning repeated at 4-week interval till delivery.	Orally	Prevention of malaria	Prevention of malaria in pregnancy	Nausea, itching, headache, Dizziness	None observed

NAME OF DRUG	CLASSIFI-CATION	DOSAGE	ROUTE	ACTION AND USES	ACTUAL EFFECT	SIDE EFFECT	SIDE EFFECT EXPERI- ENCED
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
Capsule vitamin A	Group A vitamin supplement	200,000 units	Orally	Growth development and proper sight	Normal vision and healthy skin	Vomiting	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

PHAMARCOLOGY OF DRUGS FOR THE BABY

NAME OF DRUG	CLASSIFICATION	DOSAGE	ROUTE	ACTION/USES	ACTUAL EFFECT	SIDE EFFECT	SIDE EFFECT EXPERIENCED
Vitamin K	Coagulant	1milligram	Intramuscular	Production of prothrombin	No bleeding	None	None observed
Gentamycin eye drop	Prophylaxis antibiotic	2-3 drops	Instillation	Prevents eye infection	Infection was prevented	Nephroxi-city	None observed
Polio vaccine	Antigen	2 drops	Orally	Production of antibodies against poliomyelitis	On observation	None	None observed
Injection Bacillus Chalmette Guerin (BGC)	Antigen	0.05 Milligram	Intradermal	Vaccinates neonates against tuberculosis	On observation	Blister formation	None observed

PHAMARCOLOGY OF DRUGS FOR THE BABY CONT'D…

NAME OF DRUG	CLASSIFICATION	DOSAGE	ROUTE	ACTION/ USES	ACTUAL EFFECT	SIDE EFFECT	SIDE EFFECT EXPERIENCED
Pneumococcal	Antigen	0.5 milligram	Intramuscularly	Vaccinates neonates against pneumonia	Pneumonia prevention	Redness at the side of injection and fever	None observed
5 in 1 vaccine (Pentavalent)	Antigen	0.5 milligram	Intramuscularly	Vaccinates neonates against diphtheria, pertusis (whooping` cough), tetanus, hepatitis B, haemophilus influenza type B	Prevention of childhood preventable diseases	Low grade fever	None observed
Rota virus	Antigen	1.5 milligrams (2 drops)	Orally	Prevention of gastroenteritis	Gastroenteritis prevention	None	None observed

APPENDIX III

ANTENATAL RECORDS

DATE	WT	VITAL SIGNS (BP/TPR)	URINE/ PROTEIN/ SUGAR	HB (GDL)	GEST-ATION IN WEEKS	FUNDAL HEIGHT	PRESEN-TATION	DESCENT	FHR	COMPLAINS	TREATMENT	REMARKS
26/4/21	58kg	128/75 35.9^{o}c 78bpm 20cpm	Negative	12.0g ms/dl	9weeks	10cm	_	_	-	No complain	Routine drugs	Well
24/5/21	62kg	108/71 36.1^{o}c 80bpm 20cpm	Negative	_	13 Weeks	13cm	_	_	-	Healthy	Routine drugs.	Well

DATE	WT	VITAL SIGNS (BP/TPR)	URINE/ PROTEIN/ SUGAR	HB (GDL)	GEST-ATION IN WEEKS	FUNDAL HEIGHT	PRESEN-TATION	DESCENT	FHR	COMPLAINS	TREATMENT	REMARKS
21/6/21	64kg	113/71 36.4^{o}c 80bpm 20cpm	Trace\Negative	-	17 Weeks	16 cm	_	_	M+	No complains	Routine drugs and first SP	Well
19/7/21	68kg	112/72 36.7^{o}c 78bpm 20cpm	Negative	-	21 Weeks	22cm	Cephalic	-	M+	No complains	Routine drugs and second SP	Well
16/8/21	58.0 kg	115/68 36.5^{0}c 74bpm	Negative	-	25 Weeks	24cm	Cephalic	-	42bpm	No complains	Routine drugs and third SP	Well

DATE	WT	VITAL SIGNS (BP/TPR)	URINE/ PROTEIN/ SUGAR	HB (GDL)	GEST-ATION IN WEEKS	FUNDAL HEIGHT	PRESEN-TATION	DESCENT	FHR	COMPLAINS	TREATMENT	REMARKS
13/9/21	66kg	104/64 36.6^{O}c 20cpm 79bpm	Trace\Negative	11.5gms/dl	29 Weeks	30cm	Cephalic	-	140bpm	No complains	Routine drugs and fourth SP	Well
11/10/21	62.0 kg	123/69 36.5^{0}c 82bpm 22cpm	Trace\Negative	11.9	33 Weeks	35cm	Cephalic	5/5th	140bpm	Loss of appetite	Multivitamins	Well
25/10/21	67kg	100/60 36.5^{0}c 80bpm 22cpm	Negative	-	35 Weeks	36cm	Cephalic	5/5th	142bpm	Constipation and backache	Lactulose and Paracetamol	Well

DATE	WT	VITAL SIGNS (BP/TPR)	URINE/ PROTEIN/ SUGAR	HB (GDL)	GEST-ATION IN WEEKS	FUNDAL HEIGHT	PRESEN-TATION	DESCENT	FHR	COMPLAINS	TREATMENT	REMARKS
8/11/21	68kg	90/60	Negative/Negative	-	37 weeks	36cm	Cephalic	5/5th	145bpm	No complains	Routine drugs	Well
15/11/21	68.5 kg	100/60	Negative/Negative	-	38 weeks	36cm	Cephalic	5/5th	148bpm	No complains	Route drugs	Well
22/11/21	70kg	110/70	Negative/Negative	-	39 weeks	37cm	Cephalic	5/5th	145bpm	Loss of appetite	Multivitamin	Well

WHO Modified Partograph

Registration No.: 004980/21 Name(Last, First) Mackam Ouusana Janet Age 27years.
Date: 25/11/21 Parity/Gravida 2/3 LMP 26/4/21 EDD 27/11/21 Gestation(wks) 39weeks+4days.
ROM: 3:10am Labour Duration (Hrs) 6h/24mn Facility/Clinic Name Tuobodom Health Centre.

FETAL HEART RATE

LIQUOR MOULDING

CERVIX (CM)

Plot X

DESCENT Plot C

HOURS

TIME

Alert

Action

26/11/2021 SVD
@ 3:19am by LFC
Peri — Intact.
A/S — 2/10, 9/10
B/wt — 3.3kg
EBL — 150mls.
D/L — 6hours, 24minutes.
Delivered by — Anita Febeah.
Student Midwife.
Assisted by — Felicia Dombo
Midwife Incharge.

CONTRACTIONS PER 10 MINS

Oxytocin U / L
Drops / minute

DRUGS & IV FLUIDS

BLOOD PRESSURE

PULSE

TEMPERATURE

URINE
Amount
Protein
Acetone

BOR NOTES At 3:19am, client had an SVD to an alive female neonate with Apgars of 8/10, 9/10. Within 3 minutes, cord was clamped and cut. 1ml oxytocin 10units was given to mother on her thigh. Placenta and its membranes fully expelled at 3:24am by cord controlled traction with minimal blood loss of 150mls. Uterus well contracted and massage. Mother clean and made comfortable in bed. Essential care of the Newborn provided. Close monitoring of mother and baby.

Please circle or write responses.

DELIVERY

DATE: 26/11/2021 TIME: 3:19am METHOD: (Spontaneous) / Vacuum Extraction / C/S / Other

PERINEUM: (Intact) / Episiotomy / Laceration

ANESTHESIA: (None) / Local / General

THIRD STAGE

Active Management: (Yes) / No · Medication: Time 3:20am Type/Dose 10units of Oxytocin.

PLACENTA: TIME: 3:24am (Complete) / Incomplete

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

BABY

Weight: 3.3kg.

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	3:34am	110/70	84	17cm	150mls	100mls.
	3:49am	110/78	83	17cm		
	4:04am	100/80	90			
	4:19am	100/60	96			
	4:34am	110/70	88			
	4:49am	100/82	100			
	5:04am	100/80	98			
	5:19am	100/65	96			
Every 30 minutes For 1 hour	5:34am	100/80	89			
	5:49am	110/65	90			

Uterus well Contracted. Scanty. Emptied.

Birth Attendant Anita Jeboah Supervised by Felicia Dombo [Incharge]. Date 26/11/2021.

MATERNITY CHART

OKOUSUAA JANET

27 YEARS.

WARD: MATERNITY.

004980/21.

BED NO.: ONE.

	25/11/21	27/11/21	28/11/21	29/11/21	30/11/21	1/12/21	2/12/21	3/12/21
	DOA							
		1	2	3	4	5	6	7
Am	7:30	7:30	7:34	7:30	8:00	8:30	10:00	7:30
pm	5:00	4:00	4:00	4:00				
SFH	17cm	16cm	15cm	14cm	13cm	12cm	11cm	10cm	9cm
	37°	38°	39°	40°				
Pulse	84	85	74	84	83	86	80	83
	76	87	80	90				
	34	33	33	32	33	32	30	31
	28	28	30	34				
	Passed	Passed	Passed	Passed	Passed	Passed	Passed	Passed
	Passed	Passed	Passed	Passed	Passed	Passed	Passed	Passed
	100/60	110/80	100/60	110/60	117/60	110/74	110/80	107/69
	113/74	110/70	110/70	110/80				

KEY

TEMPERATURE

SYMPHYSIO-FUNDAL HEIGHT.

SCALE

1cm: 0.5 UNITS.

1cm: 1 UNIT.

NEW BORN EXAMINATION FORM

Name: BABY AMA OWUSUAA. Date of Assessment: 26/11/2021 Time: 3:50am

Date of Birth: 26/11/2021 Time of Birth: 3:19am Sex: ☐ M ☑ F Age at time of Assessment (days/hrs) _____

Astational Age: 39 Weeks + 4 Days Mode of Delivery: ☐ Vaginal Assisted Vaginal C-Section

APGAR: 1min ☑ 5min ☑ Birth Weight: ☐ 3.3 kg ☐ Length: 46 cm Head Circumference: 3.5 cm

Temperature at time of Assessment: 36.6 °C Urine passed: (Yes) No Meconium passed: (Yes) No

Name of Assessor (Midwife/Doctor): TEBOAH ANITA.

1. Respiration
Rate 39
☐ 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: 140
☐ 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
☑ None
☐ 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 AFIA OWUSUAA Date of Assessment: 26/11/2021 Time: 4pm

Date of Birth: 26/11/2021 Time of Birth: 3:19pm Sex: ☐ M ☑ F Age at time of Assessment (days/hrs) ____

Astational Age: 39 weeks 1 day Mode of Delivery: ☑ Vaginal Assisted Vaginal C-Section

APGAR: 1min 9 5min 9 Birth Weight: ☐ 3.3 kg ☐ Length: 46 cm Head Circumference: 35 cm

Temperature at time of Assessment: 36.6 °C Urine passed: Yes No Meconium passed: (Yes)

Name of Assessor (Midwife/Doctor): _____

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: 130
- ☑ 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
- ☑ None
- ☐ 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

TEMPERATURE CHART

NAME: BABY AFIA OWUSUAA.

AGE: NEWBORN. WARD: MATERNITY.

HOSP NO.: 004980/21. BED NO.: ONE.

Date	26/11/21	27/11/21	28/11/21	29/11/21	30/11/21	1/12/21	2/12/21	3/12/21
Days in Hospital	DOA							
Days P. O.		1	2	3	4	5	6	7
Hour AM	7:30	7:30	7:34	7:30	8:00	8:30	10:00	7:30
Hour PM	5:00	4:00	4:00	4:00				

Temperature

C	F	Weight
45.0°C		3.6kg
40.0°C		3.5kg
39.5°C		3.4kg
39.0°C		3.3kg
38.5°C		3.2kg
38.0°C		3.1kg
37.5°C		3.0kg
37.0°C		2.9kg
36.5°C		2.8kg
36.0°C		2.7kg
35.5°C		2.6kg
35°	95°	

KEY
TEMPERATURE
BIRTH WEIGHT
SCALE:
1cm : 1unit

Pulse	140	137	140	143	138	140	141	141
	130	134	142	144				
Resp.	39	41	38	40	40	42	38	37
	40	40	38	38				
B.M.	Passed	Passed	Passed	Passed	Passed	Passed	Passed	Passed
Urine	Passed	Passed	Passed	Passed	Passed	Passed	Passed	Passed
B. P. AM								
PM								

NEW BORN CHART

Name: BABY AFIA OWUSUAA ..... No: ..... Birth Weight: 3.3KG.

Sex: FEMALE. ..... Mother's No: ..... Length: 46cm

Nature of Delivery: SPONTANEOUS VAGINAL DELIVERY. Diagnostics: TERM DELIVERY.

Date of Birth: 26TH NOVEMBER, 2021 Time: 3:19AM Date of Discharge: 26TH NOVEMBER, 2021.

Date	26/11/21		27/11/21		28/11/21		29/11/21		30/11/21		1/11/21		2/11/21		3/11/21			
No. of Days	DOL		1		2		3		4		5		6		7			
Weight	3.3kg		3.2kg		3.1kg		3.0kg		3.0kg		3.1kg		3.2kg		3.3kg.			
	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM
Temperature	36.6°C	36.5°C	36.6°C	36.6°C	36.7°C	36.7°C	36.7°C	35.8°C	36.6°C		36.5°C		36.4°C		36.7°C			
Stool	Passed	Passed	Passed	Passed	Passed	Passed	Passed	Passed	Passed		Passed		Passed		Passed			
Urine	Passed	Passed	Passed	Passed	Passed	Passed	Passed	Passed	Passed		Passed		Passed		Passed			
Remarks	Head Neck Trunk Limbs Genitalia.		No Abnormality Detected.															

SIGNATORIES

THE STUDENT MIDWIFE

NAME: ANITA YEBOAH

SIGNATURE: .....

DATE: 4/10/2022.

THE MIDWIFE IN-CHARGE (TUOBODOM HEALH CENTRE)

NAME: FELICIA DOMBO

SIGNATURE: ..... /fm

DATE: 4/10/2022

THE SUPERVISOR, (HOLY FAMILY NURSING AND NURSING TRAINING COLLEGE, BEREKUM)

NAME: MRS CELESTINE AHIAWORNU

SIGNATURE: ..... (For)

DATE: 04/09/2022

THE PRINCIPAL (HOLY FAMILY NURSING AND MIDWIFERY TRAINING COLLEGE- BEREKUM)

NAME: MONICA NKRUMAH

SIGNATURE: ..... (fr)

DATE: 30th September, 2022.

ACADEMIC CO-ORDINATOR-NURSING
HOLY FAMILY NURSING & MIDWIFERY
TRAINING COLLEGE, BEREKUM

SIGNATORIES

THE STUDENT MIDWIFE

NAME: ANITA YEBOAH

SIGNATURE: ……

DATE: ……

THE SUPERVISOR THE MIDWIFE-INCHARGE (TUOBODOM HEALTH CENTRE)

NAME: MADAM FELICIA DOMBO

SIGNATURE: ……

DATE: …….

THE SUPERVISOR

NAME: MRS. CELESTINE AHIAWORNU

SIGNATURE: ……

DATE: …….

THE PRINCIPAL

NAME: MONICA NKRUMAH

SIGNATURE: ……

DATE: ……