A FAMILY CENTERED MATERNITY CARE STUDY

WRITTEN ON NKETIA HAGGER

FOUNTAIN CARE HOSPITAL -SAMPA

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TABLE OF CONTENTS

CONTENT **PAGE**

PREFACE

Birth is a dynamic and transforming experience, both on an individual and the societal level, and has the power to profoundly affect the lives of those involved. It is a physiological process characterized by non-intervention, a supportive environment and empowerment of the woman.

The client and family centered maternity care study is a study of the care rendered to a pregnant woman and her family. The study starts during pregnancy, continues through labour and ends after a successful puerperium. The study gives the student midwife the opportunity to ensure proper management of pregnancy, labour and puerperium.

The client and family centered maternity care study also forms part of the partial fulfilment for the award of a professional certificate in midwifery by the Nursing and Midwifery Council of Ghana by the end of the three-year training as a midwife.

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Very big thanks go to the almighty God for his grace and mercies upon my life. I am very thankful to him for giving me the wisdom, courage strength and understanding in carrying out this care study successfully.

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The client and family centered maternity care study also forms part of the partial fulfilment for the award of a professional certificate in midwifery by the Nursing and Midwifery Council of Ghana by the end of the three-year training as a midwife.

I would also like to make known my sincere gratitude to my client Mrs Nketiah Hagger and her family for their support and co-operation during my study on them. Without them, this would not have been a success. I say God richly bless them.

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INTRODUCTION

Family centered maternity care study which involves rendering holistic obstetric care to a particular client and her family from the first day we met during antenatal period through to labour and puerperium. The care study was conducted on Mrs. Nketiah Hagger, 29-year-old woman who is gravida 4 para 3 all alive at the time of the study. She comes from Sampa in the Bono Region. The interaction with her started on 1st November, 2021 during her 7th visit to the facility and she was 37 weeks pregnant then and was seen anxious. She was then reassured of competent care and was encouraged to share her fears. She had a spontaneous vaginal delivery to a baby boy on 17th November, 2021. Care was rendered to her during pregnancy, thus her antenatal visits through to labour and puerperium. Interactions with her ended eight days after delivery. The client was healthy throughout the beginning to the end of my interactions with her.

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

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

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

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

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

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

LITERATURE REVIEW

PREGNANCY

Fraser & Cooper (2009) Pregnancy is the period when the fertilized ovum embeds in the maternal uterus until it is born thus the state of conception till the delivery of the foetus. The normal duration is 280 days or 40weeks counting from the last day of the menstrual period, She further states that uterine blood flow in pregnancy supplies the myometrium endometrium and placenta, with the latter receiving nearly 90% of the total uterine blood flow near term. It further states that, the anatomical and physiological adaptations occurring throughout pregnancy affect virtually every body system. The timing and intensity of the changes vary between systems but all are designed to support foetal growth and development and prepare the mother for birth and motherhood. The uterus protects and supports the foetus, placenta and amniotic fluid. For most of the 40 weeks of pregnancy, the uterus expands to accommodate the growing foetus and remains relatively quiescent, yet at the time of labour it is able to contract regularly and forcibly to expel the foetus due to its unique properties of contractility and elasticity. She also says, the vagina also increases vascularity which results in the violet colour characteristic of Chadwick's sign. There is increased volume of vaginal secretions due to high level of oestrogen resulting in thick, white discharge known as leucorrhoea. Larger amount of glycogen is deposited in the vaginal epithelium due to high oestrogen availability. The glycogen is metabolized to lactic acid by the lactobacillus acidophilus, (Doderlein's bacillus), and this leads to increase vaginal acidity.

Weller (2014) defines pregnancy as being with child, the condition from conception to the expulsion of the fetus. During this period, a lot of physiological and psychological changes take place in the woman. This affects the entire system as a result of hormonal influence, some women suffer minor disorders like vomiting, heart burns, constipation, waist pains, nausea, ptyalism (excessive salivation), food craving and others which most of these changes go away after delivery. Also, if these are not treated early, they can lead to severe complications which could be life threatening, therefore, it is important for the pregnant woman to attend antenatal clinics as soon as she realizes she is pregnant, for supervision, observations, investigations, and examinations for early detection and treatment of any deviation from normal. During this period, the expectant mother needs special education, encouragement and care, in order to cope with these minor disorders. These educations are given at the antenatal clinics by the attending midwife. Antenatal care is a special care to promote a healthy mother and foetus. Focus antenatal is a special care given to a pregnant woman by the attending midwife and an obstetrician, during pregnancy to ensure that, maternal and foetal health are normal. The aim of focus antenatal is to detect early and treat any abnormalities, prevent complications, promote health and educate mothers on complication readiness.

Oduro-Kwarteng (2012) defines pregnancy as having a developing embryo of fetus in the uterus as a result of the union of an ovum and spermatozoa. The normal duration of pregnancy is 280days (40wks or 9months and 7 days) counted from the first day of the last menstrual period.

According to Perry (2006), pregnancy is the period of physical and physiological preparation for child birth and parenthood. According to him, the expectant mother ideally should begin prenatal visit soon after the first missed menstrual period for early detection of complications and to ensure good health of the expectant mother and foetus. He also stated that normal pregnancy last

for about forty (40) weeks or two hundred and eighty (280) days and healthcare providers refer to early, middle and late pregnancy as trimesters. The first trimester last from week one (1) to thirteen (13) weeks and the second from fourteen (14) to twenty six (26) weeks whereas the third trimester from twenty seven (27) weeks to forty (40) weeks. Any pregnancy that advances from thirty eight (38) to forty (40) weeks is considered to be at term.

Marie (2013**)** defines pregnancy as when the woman's egg and a man's sperm cell unit to form zygote. The duration of pregnancy has traditionally been calculated by the clinicians in terms of 10 lunar months or 9 months and 7 days or 280 days or 40 weeks, calculated from the first day of the last menstrual period. This is called menstrual or gestational age. It is divided into 3 trimesters. First trimester (first 12 weeks), second trimester (13 to 28 weeks) and last trimester (29 to 40 weeks), Third trimester - 27^{th} week to 42^{nd} of week gestation . Ideally this should be more flexible depending on the need, and the convenience of the patient.

LABOUR

Perry (2006) stated that five factors affect the process of labour and birth. These are the Passenger which is the fetus and placenta, Passageway which is the birth canal, Powers which is the contractions, Position of the mother and Psychological responds. He further identifies the stages of labour as follows; the first stage of labour begins with the onset of regular uterine contractions, effacement, dilatation of the cervix and progress in descent of the presenting part. The first stage of labour has been divided into three phases namely; the latent phase where there is more progress in effacement of the cervix and a little increase in descent. Active phase and transitional phase where there is more rapid dilation of the cervix and increase rate of the descent of the presenting part. The second stage of labour; this stage begins with full cervical dilation (10

centimeters) and complete effacement and ends with the baby's birth. He continued that, the second stage takes an average of 20 minutes for multiparous women and 50 minutes for nulliparous women. The third stage of labour which lasts from the birth of the fetus until the placenta is delivered. He stated that the placenta normally separates with the third or fourth strong contractions after the infant has been born. The duration of the third stage may be as short as 3-5minute although up to 1 hour is considered within the normal limits. Lastly, the fourth stage of labour last for 6 hours after delivery of the placenta. It is the period of immediate recovery when homeostasis is re-established. It is an important period of observation for complication such as bleeding.

Marie (2013) defines labour as a series of events that takes place in the genital organs in effort to expel the viable conception out of the womb through the vagina into the outer world. Labour is called normal if it fulfills the following criteria; Spontaneous in onset. With vertex presentation. Without undue prolongation. Natural termination with minimal aids. Without having any complication affecting the health of the mother and/ or the baby. The features of true labour signs are: Painful uterine contraction at regular intervals. ''Show''. Progressive effacement and dilatation of the cervix. Formation of the'' bag of waters''. The events of labour are divided into four stages; first, second, third and fourth stage. First stage starts from the onset of true labour pain and ends with full dilatation of the cervix. Its average duration is 6 hours in multiparae. Second stage starts from full dilatation of the cervix and ends with expulsion of the fetus from the birth canal. Third stage begins after the expulsion of foetus and ends with the expulsion of the placenta and membranes (afterbirth). Average duration is about 15 minutes in both multi and primigravidae. Fourth stage is the stage of observation after the expulsion of the afterbirth. Four

factors are significant in the process of labour; that is the pelvis, passenger, powers and psyche .These are known as the four P's.

Fraser & Cooper (2009) described labour as the process by which the fetus, placenta and membranes are expelled through the birth canal. It also explained that the first stage of labour can be divided into 3 stages namely: The latent phase which is prior to active phase of first stage of labour and may last for 6-8 hours in primigravida when the cervix dilates from 1cm to 3-4cm and the cervical canal shortens from 3cm long to less than 0.5 cm long. The active phase which is the time the cervix undergoes more rapid dilatation. This begins when the cervix is 3-4cm dilated and in the presence of rhythmic contractions, is completed when the cervix is fully dilated (10cm). The transitional phase which is the stage of labour when the cervix is from around 9cm dilated until it is fully dilated (or until the expulsive contractions of second stage are felt by the woman). There is often a brief lull in the intensity of uterine activity at this time.

Littleton (2005), normal labour is a sequence of events that occurs to expel the fetus, placenta and its membranes through the birth canal which starts with regular painful uterine contractions and dilation of the cervix. Also gives a full description of the four stages of labour. The first stage comprising of the latent phase where the cervix takes eight hours to dilate from 0-3 centimeter and the active phase, where the cervix dilates one centimeter every hour from 3- 10 centimeter. The second stage begins when the cervix becomes fully dilated to complete delivery of the baby. The third stage is the complete expulsion of the placenta, membranes and the control of hemorrhage. The fourth stage is the period of six hours observation of both mother and the baby after the third stage is completed. According to the above definitions, it means labour is the process in which the fetus, the placenta and its membranes are expelled through the birth canal after 28 weeks of pregnancy

PUERPERIUM

Perry (2006) defined postpartum period as the interval between the birth of the newborn and the return of the maternal reproductive organs to their normal non pregnant state. He said that the term puerperium refers to the six weeks period elapsing between the termination of labour and the return of the reproductive organs to their normal condition. This includes both the progressive changes in the breast for lactation and involution of the internal reproductive organ. He also enumerates that, there are 3 types of lochia namely: lochia rubra: it is seen in the first 3 days and consists of blood, decidua and trophoblastic debris and may contain some small clots. It is bright red in colour. Lochia serosa: it is seen during the next 4-9 days. It consists of old blood serum, leucocytes and tissue debris. It is pinkish in colour. Lochia alba: it is seen after 10 days and consists of leucocytes, decidua, epithelial cells and cervical mucus. It is white in colour and continues for 10-14 days.

Fraser & Cooper (2009) states that, puerperium begins immediately after delivery of the placenta and membranes and continues for six (6) weeks. The expectation is that by 6th week after birth, all the systems affected by the pregnancy in the woman's body would have recovered and returned to their non-pregnant state except the breast because of lactation. Myles also striked the difference between exercise and healthy activity verses rest, relaxation and sleep. Exploring each person's level of activity will encourage advice in relation to appropriate exercise and by association, nutritional intake and rest or relaxation and sleep. Undertaking regular pelvic floor exercise is of benefit to the woman's long term health.

According to Marie (2013) puerperium is the period following childbirth during which the body tissues, especially the pelvic organs revert back approximately to the pre-pregnant state both

anatomically and physiologically. The period is divided into; Immediate –within 24 hours. Early-up to 7 days, Remote –up to 6 weeks. Immediately following delivery, the uterus becomes firmer and retracted with alternating hardening and softening. At the end of 6 weeks, its measurement is almost similar to that of the non-pregnant state and it weighs 60 gram. The vaginal discharge for the first fortnight during puerprium is the lochia. The lochia originates from the uterine body, cervix and vagina. Depending upon the variation of the colour of the discharge it is named as: Lochia rubra (red) 1 -4 days. Lochia serosa (yellowish or pink or pale brownish) 5-9 days. Lochia alba (pale white) 10 -15 days. The average amount of discharge, for the first 5-6 days is estimated to be 250 ml.

According to Littleton, (2005) puerperium last from delivery of the placenta to approximately 6 weeks afterward. The immediate postpartum period consists of the first 24 hours after delivery. On palpation of the breast after delivery, breasts usually are enlarged, soft, warm and contain only a small amount of colostrum, the first milk. The nipples should be intact without redness, tenderness, cracks or blisters. Colostrum may be expressed. The breast may be engorged (enlargement and filling of the breast with milk), which may begin as a tingling sensation in her breast, 2 to 4 days after delivery. Also, with the uterus, immediately after delivery, it begins there 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 the failure of the uterus to return to a non-pregnant state, occurs when the process of involution is prolonged or stopped as a result of hemorrhage, infection or retained placental parts. Uterine involution involves the return of the uterus to a non-pregnant condition, diminishing in size and weight, and anatomic location back into the pelvis. The placental site

usually is completely healed without scarring by 6 weeks postpartum. Immediately after delivery, the uterus weighs about 1000g. At the end of 6 weeks postpartum, the uterus weighs 50 to 100g. Littleton (2005) furthermore says that, with the fundus, immediately after delivery, the fundus usually can be located midline at the level of or one to two finger breadths below the umbilicus. The position of the fundus also should be noted because the broad and round ligaments were greatly stretched during pregnancy and become very lax after the loss of the enlarged uterus after delivery, the uterus is easily displaced (usually above the umbilicus) by an overfilled bladder. The displacement interferes with the uterus ability to contract after delivery resulting in uterine atony and hemorrhage. However, with lochia, is the usual uterine discharge of blood, mucus and tissue after childbirth. Lochia contains the sloughing of deciduas tissues, including erythrocytes, epithelia cells and bacteria. Lochia is assessed according to color, amount and change with activity and time. Lochia rubra is the term given to the discharge on the first 3 days after delivery. Lochia rubra is small to moderate in amount and has a bright-red color. Lochia serosa, which occurs 4 to 10 days after delivery, is a watery, pink or brown tinged color, which is lighter in amount than is lochia rubra. Lochia serosa primarily contains serous fluid, leukocytes, erythrocytes and decidual tissues. Lochia Alba, a whitish yellow creamy discharge on days 10-17. Many women may have minimal discharge by day 14, however, it is not uncommon for lochia alba to last until 6 weeks postpartum. Lochia Alba consists of a mixture of leukocytes, decidual tissue and decreasing fluid content. Littleton (2005) again talked about the composition of breast milk which includes: Carbohydrate, protein, fat, sodium, potassium, calcium and iron. Breast milk is nutritionally superior to formula. Breast milk contains immunoglobulins, enzymes, and leukocytes to protect against infection. Breast milk is easily available at a perfect temperature and with no preparation. It also reduces the risk of bacterial

contamination, and reduces the risk of allergies. Breastfeeding enhances mother-infant attachment and promotes the development of facial and jaw muscles. It is therefore important for mothers to practice exclusive breastfeeding. Furthermore, once the infant is born and taken to the assessment room, a complete head to toe physical assessment is done to determine the infant's health status. A general inspection is done first to identify abnormalities. The body is inspected for color and texture. The newborn's heart is auscultated for rate and rhythm. Sometimes suctioning is required to remove residual fluid from the infant's mouth. The axillary body temperature is taken. The newborn is weighed and the infant's head circumference is measured (frontal occipito circumference). The face is inspected for symmetry, birth marks, milia, and nevi over the forehead and eyelids. The mouth is inspected for natal teeth and abnormalities of the hard and soft palate, the tongue should be at midline. The genitalia is also inspected by palpating scrotum to check for descent of the testes if a male. Suckling reflex is sometimes demonstrated spontaneously during the examination.

WHY CLIENT WAS CHOSEN

Madam Nketiah was seen at Fountain Care Hospital as a client on one of her usual antenatal visit to the hospital. On our first contact, her facial expression alerted that there might be something wrong with her so an approach was made to know what's eating her up and she said she was bothered about the outcome of labour and delivery. Assurance of competent care was given to her to allay fear and anxiety. Introduction of self was made as a student midwife from Holy Family Nursing and Midwifery Training College, Berekum, who is on clinical practice and the interest to select her for the study. She agreed and said she was glad. After going through her antenatal booklet, she was qualified to be used for the care study, thus a multiparous woman with no complication in her previous pregnancy, labour, and puerperium and also in her 37th gestational week.

CHAPTER ONE

CLIENT'S PARTICULARS

1.0 INTRODUCTION

This chapter gives you an overview information about the client, her family and community. It also includes her social, medical, surgical, past obstetrical, present obstetrical, family, menstrual and lifestyle histories.

1.1 SOCIAL HISTORY

Madam Nketiah is a 29-year-old woman gravida 4 para 3 all alive from Sampa in the Bono Region of Ghana. Madam Nketiah speaks Twi and English. She is fair in complexion with height of 162 centimetres tall and weighs 73 kilograms at booking. Madam Nketiah is a Christian who attends Roman Catholic Church, Sampa and had her former education and got to the Junior high school level and is currently working as a Hairdresser.

Madam Nketiah is the second born of her parents out of six children. The siblings are two females and four males and madam Nketiah is the first female born. Her husband, Mr. Adinkra Anthony from Sampa is a Driver. He is also a Christian who attends Roman Catholic Church, Sampa. Her next of kin is her husband. Madam Nketiah gravida 4 para 3 all alive lives with her husband in the same house at Sampa with all her children and in good relationship with her neighbours. They have a clean environment and they live in a house numbered NT-64.

1.2 FAMILY HISTORY

Madam Nketiah was born to Mr. Nketiah Paul and Mrs. Benewaa Comfort and is the second born. Both parents are from Sampa in the Bono Region. All her five siblings are living in

different places. According to Madam Nketiah, there is no history of twin pregnancy in their family and no known history of conditions like hypertension, diabetes, congenital abnormalities or mental illness. Both parents of Madam Nketiah are alive.

1.3 MEDICAL HISTORY

According to madam Nketiah, she does not have any chronic medical condition such as diabetes, hypertension, liver disease, respiratory disease, jaundice, anaemia, among others but rather she normally complains of mild headache and abdominal disturbance which she is relieved receiving treatment at the health centre and has not been hospitalized on account of any medical condition. She has no known allergy of food or drug.

1.4 SURGICAL HISTORY

Madam Nketiah said she had never undergone any surgical procedure like laparoscopy, caesarean section, salpingectomy nor hysterectomy since she was born, she has neither donated blood nor been transfused. She also said she has never been involved in any road accident or other accident which might have affected her pelvis or spine.

1.5 MENSTRUAL HISTORY

Madam Nketiah had her menarche when she was 13 years old. She has a regular menstrual cycle of 28 days which lasts for 6 days. She normally has mild dysmenorrhoea on the first and second day of her menstrual period but she does not take any medication since the pain subsides during the third day. She has a moderate blood flow and she uses sanitary pad during her menstruation. Her last menstrual period was on 12th February, 2021.

1.6 HABITS OF DAILY LIVING/HOBBIES

According to Madam Nketiah, She wakes up around 6:00am. She says her daily morning prayers and carries out any daily activity for daily living like brushing of teeth, emptying of bowel and bathing. She does her normal chores such as sweeping, cleaning and also prepares breakfast for her husband and children before her husband leaves for work when he is around. She said her breakfast is usually milo with skimmed milk and two fried eggs and toasted bread. She also said that she prepare lunch for the family around 12:30pm when she is at home. In the evening, she mostly prepares fufu with light soup for supper.

Madam Nketiah takes all kinds of foods but fufu with light soup is her favourite. She verbalised that she always enjoys cooking, washing and keeping the house clean. According to her, she likes watching television at her leisure time. She takes her bath twice daily as well as her whole family. She goes to bed around 8:30pm after she has finished reading her bible.

1.7 PAST OBSTETRICAL HISTORY

Pregnancy: Madam Nketiah gravida 4 para 3 female went through all her pregnancy successfully with no complications and said she has never had abortion or still birth and her pregnancies went to term. She has 2 females and a male. The interval between her first child and her second child is 2years, 2years between the second and the third child and 5 years between the third child and the current pregnancy. The birth weight of the first child was 2.8kg, the second child was 3.1kg and the third child weighed 3.0kg. According to her, she experienced some of the minor disorder of pregnancy such as nausea and vomiting, backache, leg cramps and

frequency of micturition which she reported to the hospital and they were explained to her as normal physiological changes in pregnancy which will resolve as the pregnancy advances.

She attended antenatal clinic ten times during her previous pregnancies and received all the doses of Sulphadoxine 500mg and Pyrimethamine 25mg on DOT (Direct Observation Therapy) for intermittent prevention of malaria. All investigation carried on her were normal.

Labour: Madam Nketiah indicated that, labour started spontaneously in her previous deliveries and added that she delivered them at Sampa Government Hospital. Client said her previous labour did not exceed 18 hours and shortly after the announcement of full dilatation she delivered, the placenta was also delivered and she added that she has no history of retained placenta, retained product of conception or PPH. Her children were healthy with no congenital abnormalities such as cleft palate or cleft lip, spinal bifida etc. There was no history of assisted delivery such as caesarean section, vacuum extraction and forceps delivery. There was no perineal tear or episiotomy.

Puerperium: Madam Nketiah went through her previous periods of puerperium successfully with no complication such as secondary postpartum haemorrhage. Client also stated that her children did not have any congenital birth defects like cleft palate or extra digits among others. She started breastfeeding her child within 60 minutes after birth and continued breastfeeding her for six months exclusively before she introduced her to other foods together with the breast milk. She also said that each of her child weaned off breast milk at the age of 1 year 6 months. Madam Nketiah also stated that her children were fully immunized against the nine childhood preventable disease which includes tetanus, poliomyelitis, yellow fever, hepatitis B, influenza,

tuberculosis among others. Her mother was always there to support her as well as her husband. In relation to family planning, she said she was using secure as her method for family planning.

1.8 PRESENT OBSTETRIC HISTORY

According to Madam Nketiah's antenatal card, her first antenatal visit was on 7th June, 2021 at 10:00am. Her last normal menstrual period was recorded as 12th February, 2021 and expected date of delivery was 19th November, 2021. Her gestational age was 17 weeks. Her vital signs and laboratory investigations on that day were as follows**:**

Vital Signs

Temperature	-	36.5^0c
Pulse	-	82bpm
Weight	-	73kgs
Blood Pressure	-	116/69mmHg
Height	-	162 centimetres

Laboratory Investigations

Haemoglobin	-	12.5g/dl
Urine protein	-	negative
Urine glucose	-	negative
HIV	-	Non-reactive
Hepatitis B	-	negative
G6PD	-	No defect

Head to toe examination was done on her and it was recorded in her antenatal book that her pelvis was adequate and also no abnormality was detected on her. Madam Nketiah was met on her 7th antenatal visit. She had taken 5 doses of sulphadoxine pyrimethamine and four dose of tetanus diphtheria (TD4) when she was met. She was given the following routine drugs;

Caps iron III daily for 30 days.

Tablet Folic Acid daily for 30 days

Client was still attending Antenatal clinic regularly before she was met and all her complains addressed, she was taking her routine drugs as prescribed. And all investigations and examination conducted on her were within normal range.

CHAPTER TWO

ANTENATAL CARE

2.0 INTRODUCTION

This chapter gives a brief insight of the care given to Madam Nketiah during pregnancy. It lays more emphasis on the first contact with client, various home visits and subsequent visits and also the nursing care plans drawn to solve her problems during pregnancy.

2.1 FIRST CONTACT WITH CLIENT

First contact with Madam Nketiah was on 1st November, 2021, when she was 37+3weeks pregnant at the Fountain Care Hospital-Sampa in the Bono Region. Her facial expression alerted that there might be something wrong with her so an approach to her was made to known what was eating her up and she said she was bordered because she was anxious about outcome of labour and delivery. Assurance was given to her to allay fears. After that, introduction was made as a student midwife from Holy Family Nursing and Midwifery Training College Berekum, who is on a clinical practice and the interest to select her for the care study was explained to her.

She agreed and said she was glad. All procedures to be carried out on her was explained to her understanding and she agreed for them to be done. She was encouraged to ask questions when necessary and was also thanked for her co-operation. Madam Nketiah's vital signs together with some investigations done on her were recorded below.

Temperature	36.5 degree Celsius
Pulse	82 beats per minute
Respiration	20 cycles per minute
Blood pressure	106/65 millimetres of mercury

Weight 83kilogram

Haemoglobin level 12.5 grams per decilitre

Urine testing: Client was given a specimen bottle and asked to provide midstream urine for protein and sugar. Hands were washed with soap under running water and dried with a clean towel. Protective clothing such as mackintosh apron and gloves were worn. The amount, odour, consistency and colour of the urine were checked. Urine had the normal straw colour. A chemically prepared strip was picked and dipped into the urine sample. The strip was immediately removed and the edge of the strip tap against side of reagent container. There was no change in colour of the strip indicating a negative result when compared closely with the corresponding colour chart on the container.

GENERAL HEAD TO TOE EXAMINATION

Permission was sought from her for head to toe examination to be performed on her which she consented. All the necessary requirements needed for the examination were gathered and sent to the examination room.

Privacy was provided and procedure explained to her after empting her bladder. Client was assisted to undress and covered with a cloth. She was assisted onto the examination bed and taught to lie on her side before lying on the back. Her permission was sought to perform head to toe examination. Hands were properly washed with soap under running water and dried with clean dry towel. Hands were rubbed together to warm them

Head and Neck: on inspection, her hair was neatly braided and the scalp was clean with no dandruff, no lice and no breakages found. Client was congratulated and encouraged to keep it up. The face looked cheerful and was examined for chloasma and edema but there was none.

Eyes: conjunctiva was checked for pallor and the sclera checked for jaundice but the conjunctiva was pink and sclera was clear. The eyes were without discharges. The nose was checked for discharge but there was none. The teeth**,** tongue and gum were clean with no cracked or dry lip, no dental caries or offensive odour. The ears were checked for discharges and dirt but there was none.

The neck was inspected and palpated for enlarged lymph nodes and thyroid gland and distended veins but none was detected.

Breast Examination: procedure was explained to client and consent sought to do breast examination and client accepted. Both breasts were exposed and inspected and was of normal size and shape, with prominent nipple and secondary areolar. No dimpling observed. Having her hand on the part to be examined under her head and the other hand on the side with the breast covered, the exposed breast was palpated for masses, enlarged axillary lymph nodes and areola was squeezed gently and was examined for any abnormal discharge as a swab was taken for observation but no abnormality was detected. The same process was repeated for the other breast. She was asked of breastfeeding history and her desire to breast feed was inquired, to which client responded that she practiced exclusive breast feeding in her previous pregnancy and she is willing to continue practicing exclusive breast feeding. She was encouraged to continue wearing maternity dresses, well-fitting braziers and educated on the need to perform breast care and self-breast examination for early detection of abnormality and treatment to prevent complication.

On the extremities: the arms were equal, hands and fingers were inspected for edema, pallor of palms and nail beds but no abnormality was detected. The lower extremities were inspected and

they were free from edema, tenderness in the calf muscle, varicose veins and they were of equal sizes.

On the back: no edema of the sacral region or deformity of the spine such as scoliosis was detected. There was no tenderness at the coastal vertebra angle.

Abdominal examination: On inspection, no scars or rashes were found, shape was ovoid and medium in size, striae-gravidanum, linea nigra and fetal movement were present.

Measurement of Symphysiofundal Height: The upper border of the fundus was located and the zero mark of the tape measure was placed on it. The tape was extended along the contour of the abdomen along the midline to the symphysis pubis. The Symphysiofundal height was 36 centimeters and gestational age was 36 weeks.

On fundal palpation: Upon facing the head of the woman by standing on her right hand side, the hands were rubbed together to prevent induced contraction, each hand was placed on either side of the fundus. The fingers were curved around the top of the fundus to determine what occupied the fundus. A soft mass was felt which indicated the buttocks.

On lateral Palpation: still facing the head of the woman, each palm was placed on each side of the uterus, midway between the symphysis pubis and the fundus. One hand was used to stabilize the uterus and the other performed the examination. A smooth part was felt at the right side indicating fetal back at the right hand side of the woman's abdomen and a rough part was felt at the left side indicating the fetal limbs. The position was right occipito-anterior.

On pelvic Palpation: Upon facing the woman's feet while standing at the right side of the client, she was asked to bend her knees slightly and also to breathe out slowly to help her relax. Each palm was placed on either side of the uterus just below the umbilicus, hands directing towards

the symphysis pubis as the thumbs were almost meeting, and a hard mass was felt indicating the head of the foetus.

Descent: Location of the anterior shoulder was done using two fingers. The symphysis pubis was located and the ulna border was placed just above the symphysis pubis and in between the anterior shoulder and the symphysis pubis; five fingers occupied the space indicating descent of $5/5^{th}$ meaning the foetal head was still above the pelvic brim. From the above, it was noted that the lie was longitudinal, presentation was cephalic, descent 5/5th and position was right occipito-anterior.

On auscultation; fetoscope was warmed by rubbing it in the palm. It was then placed at the right hand side of the mother where fetal back was located. The ear was placed against the fetoscope to listen to the fetal heartbeat for one full minute while comparing it with maternal pulse. Fetal heartbeat was 141 beats per minute.

Examination of The Vulva: Permission was soughted from Madam Nketiah to examine her perineum and genital area which she permitted. Client was assisted to relax on the examination bed. She was draped to ensure minimal exposure. Hands were washed with soap under running water and dried with clean dry towel and examination gloves worn. On inspection, the vulva was neatly shaved and had no scar, oedema, genital warts and no masses were palpated at the groins. Later all findings were communicated to her. She was then thanked for her cooperation. She was helped out of the examination bed. After that she was asked whether there was any complaint, had none. She was reminded of her next visit to the clinic which was 10^{th} November, 2021. She gave directions to her house and was thanked. The following routine drugs were given:

- Tablet Iron III 200mg daily for 7 days
- Tablet Folic Acid 5mg for 7 days.

A scheduled date for home visit on 1st November, 2021 was agreed upon

Client was encouraged to take the drugs as prescribed. She was then reminded again of danger signs of pregnancy such as severe frontal headache, bleeding, excessive vomiting and swellings (edema). She was informed to report to the facility before the date scheduled if she experiences any problem.

2.2 FIRST ANTENATAL HOME VISITS

Madam Nketiah was visited for the first time as scheduled on the first antenatal visit 1st November, 2021 was intended to assess the health condition of the client, observe her environment, source of water, light, ventilation, the number of people she shares her room with, where she empties her refuse and her interpersonal relationship with her family members and neighbours.

Her household was also inspected as well as her items for labour and delivery and then she was given the needed health education on problems that were encountered. A seat and warm welcome were offered by client and family. The reason for the visit was asked by client's mother as tradition demands. It was made known to them that the visit was made to enquire about their wellbeing. Client was asked if she had any complains but she said she had none.

PHYSICAL ENVIRONMENT

A quick assessment was made on Madam Nketiah's environment. The house in which they live is a boys' quarters. The house was built with cement blocks and was roofed with aluminium sheets. There were six rooms in the house with a detached kitchen directly opposite to the house. They had an attached place of convenience (toilet and bath). She sleeps with her husband in one

of the rooms and the others are used by the rest of the family. On entering her room, it was noticed she sleeps in a mosquito net and with two windows made with louver blades which enable ventilation and there was an adequate lighting system too. The kitchen was neat and all her things were well organized. They have a pipe just in front of the house from which they fetch water. She stores water in a barrel with a lid. Since their bathroom is only one, she shares it with her household. Their public toilet was inspected and it was neat as well. Her rubbish was also kept in a dustbin with a lid and empties it when full. The house was neat and client was in a good relationship with other relatives. She was asked about her preparation towards the delivery and she made it known that, she had all her things/layette for delivery ready. Permission was sought from Madam Nketiah to inspect the items. On assessment, It was realized that Madam Nketiah bought all the items with the exception of baby cap and socks. She was advised to buy them in order to prevent heat loss when the baby is delivered. Her things were neatly folded in a jute bag. She was asked to put her antenatal card always in the bag in order not to forget when labour sets in. she was then taught about the signs of true labour so that she will know when it starts. She was then encouraged to take her routine drugs as prescribed, and was reminded on her next visit to the clinic. Permission was then sought to leave and client and family were thanked for their warm reception.

PSYCHOSOCIAL

Client was visited and the members in the community testified client was a very friendly and loving woman. Madam Nketiah co-tenants said client was in good terms with her husband, relatives and the people around. After a short conversation with client, it was made known to student midwife that client

has about three intimate friends of which she tries to check on to know how they are fairing daily. Apart from being friends with people, client also has a heart of gold which makes her to assist people in times they need her in any form help. Client is a children loving type so upon calling her name on arrival, all the children around rushed to call her out. Client`s husband also testified that the wife is a

sociable type of person and has therefore joined many associations and has been attending a lot of social gatherings in the community and church as well. After a quick assessment by student midwife, it was indicated that client was truly in good terms with her members.

SECOND ANTENATAL HOME VISIST

Madam Nketiah was visited the second time on the 7th November, 2021 at 1:30pm. The aim of the visit was to ascertain if the identified helpers were still around to help, enquire about her health status and how she is coping with the physiological changes taking place and her preparation towards birth. Preparation toward delivery was still on progress. On arrival, greetings were exchanged and a warm welcome was given. After enquiring about their health, for which she responded positively.

The baby socks and cap had been bought and everything was set and arranged in a big hand bag which included antiseptic solution (Dettol), socks and cap, sanitary pad, 2 toilet roll, 2 toilet soap, 2 rubber (mackintosh), 4 old clothes, cot sheets, a night wear, baby sponge and towel and other items for birth as of the protocol of the facility. She had also taken the telephone number of a taxi driver in case her husband is not around. She was encouraged to add a purse with money and antenatal book.

She was educated to have enough rest and her family members were also encouraged to assist in household chores. She was also educated to maintain her personal hygiene to prevent infections. Madam Nketiah was again reminded on the true signs of labour such as appearance of 'show' painful regular rhythmic uterine contractions and spontaneous rupture of membranes. She was asked to report to the hospital any time she sees any of the signs mentioned. She was again reminded of her next visit to the hospital and was thanked for her cooperation and bid fare well.

2.4 SUBSEQUENT VISIT TO THE CLINIC

On the 10th November, 2021 at 8:00am Madam Nketiah came to the clinic, which was the second contact with her at the clinic but her 8th visit to the clinic. She was welcomed and offered a seat. She was asked about her general condition and she confirmed she was well. Every procedure that was going to be carried on her was explained to her. Her vital signs and weight were recorded as follows:

Temperature	36.4 degree Celsius
Pulse	80 beat per minute
Respiration	20 cycle per minute
Blood Pressure	113/65 millimetre of mercury
Weight	80 kilograms

Her haemoglobin level was checked and recorded as 12.9grams per decilitre. Urine test for protein and sugar were all negative. Privacy was provided. Hand washing with soap under running water was done and dried with clean dry towel, after which she was assisted to undress and helped unto the examination bed. Having emptied her bladder physical examination started, everything from head to toe was normal. On fundal palpation, the buttocks occupied the upper pole of the uterus. The lie was longitudinal, the back of the foetus felt on the mother's right side

and the abdomen and the limbs on the left side, the position was right occipitoanterior. The head occupied the lower pole with descent of 5/5th, Symphysio-fundal height was 39cm and gestational age was 38+3weeks. On auscultation, foetal heart was 139bpm with good volume and rhythm. All findings were communicated to her. She complained of waist pain, and also backache. She was reassured and educated on the causes and prevention of waist pains. She was also told that it was as a result of the growing uterus causing a change in the posture and the influence of the hormone (relaxing) which relaxes the ligament. She was encouraged to sleep on a firm surface to maintain a good posture when lying and support her back with pillow when sleeping and sitting and should wear low heeled shoes and sandals.Madam Nketiah was also encouraged to lift light objects and also rest after an activity.It was observed that lightening has taken place enough . Client's back was examined for oedema and also spine for any abnormality but no abnormality was detected. She was informed that, her next visit to the clinic will be on the 17th of November, 2021.

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2.8 NURSING CARE PLAN FOR ANTENATAL CARE

Problems Identified during Antenatal

Client complained of:

1.anxiety (1st November,2021)

2. constipation 8th November,2021)

3. heart burns (8th November 2021.)

4. backache on (8th November,2021)

5. waist pain on (15th November,2021)

Short Term Objectives

1. Client's anxiety will reduce within 1 hour .
2. Client will empty her bowl once daily within 24hours.
3. Client's heart burns will subside within 12hours.
4. Client's backache will subside within 24hours.
5. Client's waist pain will subside within 24 hours .

Long Term Objectives

Madam Nketiah will go through the pregnancy labour successfully without any complication to mother and foetus.

NURSING CARE PLAN FOR ANTENATAL CARE

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTIONS	EVALUATION	TIME/ DATE	SIGN.
01/11/21 At 8:40 am	Anxiety related to unknown outcome of delivery.	Madam Nketiah will be relieved from anxiety within an hour as evidence by: Midwife observing clients relieved from anxiety Client verbalizing that she is no more anxious.	1. Reassure client of competent care. 2. Encourage client to share fears and concerns. 3. Provide information regarding management of labour anxiety. 4.Allow client to ask questions. 5.Introduce the staff present to client.	1. Client was reassured of competent care. 2. Privacy was ensured to boost patient confidence as she shared her fears. 3. Information regarding management of anxiety in a supportive manner was given. 4.Client questions were answered. 5.Staff were introduced to client.	Goal fully met as evidence by: 1. Nurse observing client relieved from anxiety. 2. Client accurately verbalising measures to control anxiety and less anxious.	01/11/21 At 9:40 am	Y.S

NURSING CARE PLAN FOR ANTENATAL CARE CONTINUED

DATE/ TIME	NNURSING DIAGNOSIS	NURSING OBJECTIVES\	NURSING ORDERS	NURSING INTERVENTION	EVALUATION	DATE/ TIME	SIGN.

		OUTCOME CRIITERIA					
08/11/21 At 8:40am	Constipation related to activity of progesterone causing decreased peristalsis and relaxation of the large bowel during pregnancy.	Client will empty her bowel once daily as evidence by: 1.Client verbalizing that she is able to pass stool once daily without strains within 24hours. 2.Midwife observing normal bowel movement of at least once a day	1. Reassure client of possible measures to restore normal bowel movement. 2. Encourage client on the intake of more fluid. 3. Educate client on the intake of roughage like whole grain rice, fresh fruits and vegetables 4. Discuss the importance of fluid and dietary fibre in maintaining normal bowel activity. 5. Encourage client to do minimal exercise.	1. Client was reassured of possible measures to restore normal bowel movements. 2. Client was encouraged to take more fluid daily. 3. Client was educated to take in roughages contained foods like whole grain rice, fresh fruits and vegetables. 4. Importance of the intake of fluid and dietary fibre was discussed with client. 5. Client was sweeping with long broom and walking around.	Goal achieved as client said she had normal bowel movement.	09/11/21 At 8:40 am	Y.S

DATE/ TIME	**NNURSING DIAGNOSIS**	**NURSING OBJECTIVES\ OUTCOME CRITERIA**	**NURSING ORDERS**	**NURSING INTERVENTION**	**EVALUATION**	**DATE/ TIME**	**SIGN.**

08/11/21 At 8:40am	Heart burns related to reflux of gastric content into the oesophagus secondary to relaxed cardiac sphincters by progesterone.	Client heart burns will reduce within 24 hours as evidence by: 1. Client verbalizing that her heart burns has reduced. 2.Client mother testifying that client heart burns has reduced	1. Reassure client of possible measure to get rid of heart burns. 2. Encourage client to suck ice cubes. 3. Encourage client to sit for a while after meals before going to bed. 4. Encourage client to use more pillows when sleeping. 5. Encourage client to reduce spicy and oil food consumption.	1. Client was reassured of the possible measures to get rid of heart burns. 2. Client sucked ice cubes. 3. Client sat for a while before going to bed. 4. Client used more pillows to elevate her head when sleeping. 5. Madam Nketiah reduced intake of spicy and oil food.	Goal fully met as Client verbalized that she was relieve of heartburns.	09/11/21 At 8:40am	Y.S

NURSING CARE PLAN FOR ANTENATAL CARE

NURSING CARE PLAN FOR ANTENATAL CARE

DATE/	NNURSING	NURSING	NURSING ORDERS	NURSING	EVALUATION	DATE/	SIGN

TIME	DIAGNOSIS	OBJECTIVES\ OUTCOME CRIITERIA		INTERVENTION		TIME	.
08/11/21 At 8:45am	Backache related to weight of pregnant uterus, relaxation of muscles and ligaments by progesterone and relaxin.	Madam Nketiah's backache will subside within 24 hours as evidence by; 1.Client verbalizing that the pain has reduced. 2. Client scoring zero on pain assessment scale.	1. Reassure client possible care to relieve backache. 2. Encourage client to have rest. 3. Encourage client to apply warm compress to the back. 4. Encourage client to support her back with pillows while lying down. 5. Encourage client to wear low heel shoe and lift light objects.	1. Client was reassured on the possible care to relieve backache. 2. Client had enough rest. 3. Client was applying warm compress to the lower back. 4. Client was supporting her back with pillows while lying down. 5. Client was wearing low heel shoe and lifting light objects.	Goal fully met as evidence by: 1. Client verbalizing that pain has reduced. 2. Client scoring zero on comparative pain assessment scale. 3. Client looking more cheerful on assessment.	09/11/21 At 8:45pm	Y.S

NURSING CARE PLAN FOR ANTENATAL CARE

DATE/ TIME	NNURSING DIAGNOSIS	NURSING OBJECTIVES\ OUTCOME CRIITERIA	NURSING ORDERS	NURSING INTERVENTION	EVALUATION	DATE/ TIME	SIGN .
15/11/21 At	Waist pain related to effect of	Client's waist pain will be reduced within 12hours as	1. Reassure client that her condition can be	1. Client was reassured that the condition could be managed.	Goal fully met as evidenced by :	16/11/21 At	Y.S

8:45am	pregnancy hormone (relaxin)acting on the pelvic joints	evidenced by Client verbalising that waist pain has reduced. 2.Client husband reported that client is no more feeling waist pain.	managed. 2. Educate client on physiology behind waist pain. 3. Teach client to assume good posture during sitting and standing. 4. Encourage support person to give sacral massage. 5.Encourage client to rest when tired	 2. Client was educated on the physiology of waist pain and she understood. 3. Client was taught to assume good posture during sitting and standing and she applied them. 4. Support person to and gave sacral massage when it was necessary. 5. Client was educated to have enough rest and she rested 3hours during the day.	Client verbalising that her waist pain has reduce	8:45am	

CHAPTER THREE

LABOUR

3.0 INTRODUCTION

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

3.1 ADMISSION AND MANAGEMENT OF FIRST STAGE OF LABOUR

On Tuesday 16th November, 2021 Madam Nketiah came to the Hospital with complains of abdominal pains she was assessed and just after the assessment, she complained that she has seen "Show" around 10:40pm when she went to the washroom . She was admitted at the maternity ward around 11:25pm. On observation, her general appearance was good and her facial expression indicated that she was in pain. She was made comfortable in bed, her antenatal card was collected and glanced through to check her expected date of delivery which was calculated to be 19th November 2021. She was introduced to the other staff present in order to make her comfortable. Procedure to be done was explained to her and consent was gained. Bedpan was served to empty her bladder and urine measured was 120mls and midstream urine collected also tested negative for both protein and glucose, her haemoglobin level checked was 13.1 gram per decilitre. Her vital signs were checked and recorded as follows:

Temperature	36.4 degrees Celsius
Pulse	82 beats per minute

Blood pressure 100/60mmHg

Hands were washed with soap under running water and dried with a clean towel. Client was assisted to undress and examined from head to toe and no abnormalities were detected. The abdomen was ovoid in shape, medium in size and fetal movements were visible on inspection. The palms were rubbed together to provide warmth and palpation was done. The lie was longitudinal, presentation was cephalic, gestational age was 39 weeks and symphysio fundal height was 41 cm, descent was $3/5^{th}$ above the symphysis pubis. On auscultation the fetal heart rate was heard and when counted for a full minute, it read 130 beats per minute. The contractions were timed after sitting comfortably at the right side of the client and placing the palm on the fundus. After noting the frequency and duration for 10 minutes, contractions were obtained 2 in ten minutes and it lasted for 22 seconds. After the above examinations, permission was again sought for vaginal examination to be performed, permission was granted. She was assisted to lie in the lithotomy position with the legs parted. Hands were washed with soap under running water and dried with a clean towel. A sterile glove was then worn. On inspection of the vulva, there were no scars, rashes, warts, varicose veins and sores. Cotton swabs were soaked in savlon solution and it was used to clean the vulva. The vagina was entered with the middle finger and then followed by the index finger. On vaginal examination, the vagina felt warm, moist and slippery. The sacral promontory was not reached and the sacrum was well curved. The ischial spines were also blunt. The cervix was 4cm dilated around 11:30cm, effaced, soft and thin and well applied to the presenting part with membranes intact moulding was zero and position was right occipito- anterior. Station was -4. The pubic arch was wide and the intertuberous diameter admitted all four knuckles. She was cleaned afterwards and a new perineal pad was applied. Gloves were removed and hands were washed and dried. All findings were explained to Madam

Nketiah and the dilatation board was shown to her explaining the progress of labour. She was asked to ambulate if she can, in order to speed up the dilatation and lie on her side when she feels tired. She was again encouraged to empty her bladder when she has the urge as this will help with the effective contractions and dilatation of the cervix. She was also asked to change her perineal pad and apply a new one when it gets soiled. She was cautioned not to push as this will make the cervix oedematous and prolong the labour process. She was educated on how to perform deep breathing exercise whenever she felt pains as this will help relieve her of its intensity. She was asked if she felt hungry and wanted to take in something and she said no and the information was recorded on a partograph.

PREPARATION FOR BIRTH

The midwife in-charge who was supervising labour was chosen as a skilled helper. She was informed that she may be called to help in case of emergency for the baby and mother during and after delivery. The mother of the client who was the unskilled helper was informed to be available in order to run errands when needed and also make his taxi ready as its service may be needed when there is an emergency. The number for St. Mary's Hospital was checked in case an emergency arises.

The area for delivery was prepared ensuring that it's clean, closing nearby windows and doors, drawing curtains down, testing of light and making provision for artificial lighting and switching off fans. It was ensured that the equipment needed for resuscitation is clean and prepared for resuscitation when necessary. The resuscitation equipment was assembled and tested for functioning and they were in good condition. The equipment included suction device, ambu bag and mask, head cover, stethoscope, source of light, scissors, oxygen cylinder with oxygen etc. Client was reminded that the baby would be delivered onto her abdomen and she agreed.

MANAGEMENT OF FIRST STAGE OF LABOUR

Madam Nketiah was monitored continuously. The blood pressure, temperature, descent, moulding and liquor were monitored 4 hourly and recorded whiles the fetal heart rate, maternal pulse and contractions were monitored every 30 minutes and was recorded on the partograph. Madam Nketiah complained of severe lower abdominal pains and was really anxious looking. So it was explained to her that the pains was as a result of descent of the presenting part of the fetus and uterine contractions so she was reassured to relieve her of the anxiety. It was observed that client was putting her hands at the perineal area in order to place her perineal pad correctly whenever it tried to fall. Labour progressed normally and at the next 4 hours at 03:30am the next vaginal examination was due, contractions were 4 in 10 lasting 45 seconds and descent was $2/5^{th}$. Fetal heart rate was 136 beats per minute, temperature was 36.5 degrees Celsius, pulse was 98 beats per minute and BP was 110/80mmHg and the cervix was 7cm dilated.

Membranes ruptured spontaneously at 7:30am exactly. The above information was recorded on a partograph sheet. Madam Nketiah was continuously monitored on the partograph. The delivery trolley containing all the items needed was set with the following;

Top shelf containing: Cord scissors, Cord clamp, 2 artery forceps, Episiotomy scissor, two cot sheets, 10 units of oxytocin injection, 4 sterile drapes, Pair of sterile gloves, 2 gallipots (one containing cotton swabs soaked in savlon solution and the other containing gauze).

Bottom shelf containing: Placenta bowl, Measuring jug, Sucker in a bowl of water, Rubber apron, Bedpan, Rubber mackintosh, Extra sterile gloves, Receiver for used swabs, Perineal pad, Foetoscope, Urethral catheter, Identification band.

At 7:36pm, client complained of the urge to bear down, vaginal examination was done which revealed full dilatation of the cervix (10 cm). Fetal skull was overlapped but can be separated and liquor was clear which is normal indicating foetus is not in distress. Descent was $0/5^{th}$ and contractions were 4 in 10 lasting above 45 seconds. On Auscultation, fetal heart rate was 140 beats per minutes. The perineum budged and the anus gaped. The first stage lasted for 8hours 10minutes.

3.2 MANAGEMENT OF THE SECOND STAGE OF LABOUR

After performing vaginal examination, client was informed that she was due to deliver her baby and every procedure going to be performed was communicated to her and her consent was gained. She was asked about the position she wanted and she chose the lithotomy position. Windows were closed in order to provide privacy as well as fans turned off in order to ensure warmth in the delivery room for the baby to be delivered. Protective clothing which are plastic apron, boots, face masks and sterile gloves were worn. Delivery pack was opened by the midwife in charge. Her legs were flexed and parted since lithotomy was the chosen position. The second stage was explained to Madam Nketiah again that she should push with each contraction and breathe through her mouth when the contraction wears off. Client's vulva was swabbed with five cotton swabs soaked in savlon antiseptic lotion as well as the upper thighs. Sterile towel was used to drape her abdomen, under her buttocks as well as both thighs and she was reminded that the baby will be delivered unto her abdomen. This was done in order to provide a sterile field for the baby. Madam Nketiah did as she was told and pushed with each contraction. After some few minutes with effective uterine contractions and good maternal effort, the fetal head advanced. The anal area was covered with a sterile perineal pad to prevent stool from contaminating the delivery field and getting into contact with the baby's face. The index and middle fingers were

used to aid flexion to prevent crack or tear of the perineum. The outlet was roomy so episiotomy was not needed. Client was reminded of the deep breathing exercises and to push whenever she gets the urge to and also rest when the contractions subsides. With the contractions, the head crowned. Client was asked to stop pushing but rather breathe through her mouth to prevent rapid expulsion and with extension the sinciput, the face and the chin swept the perineum for the head to be born. Client was sweating profusely after the head was born, so she ordered for malt which was already in her bag to drink to prevent hypoglycaemia. The baby's face was cleaned with sterile gauze as well as the eyes from the inner canthus to the outer canthus. Immediately the head was delivered, feeling for cord around baby's neck was done but it was not felt. Restitution occurred and internal rotation of the shoulder which is simultaneous with external rotation of the head occurred. The fetal head was held in both palms, each palm on the parietal bones and with little downward traction, the anterior shoulder was delivered. The posterior shoulder was also delivered with upward traction. The rest of the body was delivered by lateral flexion onto the mother's abdomen. The baby cried immediately it came out. The time of delivery was noted to be 7:40am and the sex which was male as confirmed by the client. Madam Nketiah was congratulated for her effort and for the arrival of her baby. The second stage lasted for 8minutes.

IMMEDIATE CARE OF THE NEWBORN

Immediately the head was delivered, sterile gauze was used to clean the baby's face and eyes from the inner canthus outwards. The baby was dried thoroughly and wrapped in a dry warm sheet in order to prevent heat loss. The first minute Apgar score was assessed and it was 8/10. Within the first 3 minutes, the cord was measured 3 finger breaths from the baby's abdomen and clamped with the cord clamp and clamped again measuring 2 finger breaths from the first clamp, the cord was covered with gauze and cut in-between the clamps to separate the baby from the

mother. The windows and doors were closed as well. An identification band was placed on the baby's wrist bearing the mother's name, date, baby's sex and time of delivery. Fifth minute Apgar was assessed and it was also 9/10. The baby was made warm by maintaining skin to skin with mother for an hour, during which breastfeeding was initiated.

3.3 MANAGEMENT OF THE THIRD STAGE OF LABOUR

After delivery of the baby, the procedure was explained to the client. After palpating the abdomen to rule out the presence of an undiagnosed twin, 10 units of oxytocin was given at 3:35am intramuscularly at the thigh with the purpose of augmenting uterine contraction to aid separation and detachment of the placenta and controlled cord traction was applied. This is done in order to prevent retained placenta or retained products of conception. The cord was reclamped closer to the perineum, a receiver was placed in between client's thighs to receive the placenta and membranes. Her bladder was checked to rule out full bladder and it was palpable so client was encouraged to pass urine in order to empty the bladder to prevent bleeding. The left palm was placed on the uterus to feel for contractions, when the uterus was well contracted, the cord was held together with a forceps and with the palm facing the fundus of the uterus at the suprapubic region. Control cord traction was applied on the cord in a downward manner to deliver the placenta. Steady traction was maintained until the placenta was visible at the vulva. The placenta was cupped in both hands and was twisted gently to deliver it and its membranes. It was completely delivered at 7:41am. A quick examination of the placenta was made to detect any possible retained products of conception and was then placed into the receiver afterwards. The uterus was then massaged to expel clots and to stimulate it to contract in order to prevent postpartum bleeding. The perineum,vagina and cervix were examined for possible tear and bleeding under a good source of light but there were no abnormalities. The client was taught how

to perform uterine massage and was made known to her how the uterus will feel like when it contracts. A clean pad was used to clean the liquor and the blood from her body and a fresh perineal pad was applied to the vulva. She was then asked to lie on her back and cross her legs so that any bleeding could be noticed. She was also asked to empty her bladder whenever she felt the urge in order to prevent bleeding after she was sent to the lying-in ward. She was then thanked for her co-operation. Her husband was informed about the safe delivery of a baby boy as they were expecting and he was very happy. The placenta and membranes were sent to the sluice room to be examined and discarded afterwards per the protocol of the facility. The placenta and membranes were immersed in 0.5% bleach solution for ten minutes to minimize the risk of infection during its examination.

EXAMINATION OF THE PLACENTA

The placenta was placed in 0.5% chlorine solution and it was examined. The placenta was held by the cord with the membranes hanging. The membranes were checked for completeness and it was intact. The placenta was laid on a flat surface; the amnion was peeled from the chorion up to the umbilical cord to permit full visualization of the chorion. The lobes fitted together without any gab and edges also forming a uniform circle at the maternal surface and this showed that there were no lobes missing. There were no blood vessels radiating into the membranes and there were also no white patches on the maternal surface. The cord was situated at the centre of the placenta with one vein and two arteries seen. There was no indication of abnormalities. The instruments and equipment used were immersed in 0.5% chlorine solution for 10 minutes. They were then washed, rinsed, dried and then sent for sterilization. Gloves were removed and hands were washed under running water with soap and dried with a clean towel.

3.4 MANAGEMENT OF THE FOURTH STAGE OF LABOUR

Mother

Mother spent 1hour after delivery at the delivery room before being transferred to the lying-in ward for further observations to be carried out. During the first six hours post-delivery, permission was sought from client to check lochia, the amount and colour and to have her vital signs checked from time to time and permission was granted. Client's vulva was gently cleaned with gauze and a clean perineal pad was applied and she was covered with warm cloth. She was advised to rest during this period. Evidence of bleeding was checked every 15 minutes, lochia was red (rubra) in colour with moderate flow. The uterus was well contracted when felt. The Symphysio-fundal height was 17 centimetres. Vital signs were checked and recorded as follows:

Temperature	36.6 degrees Celsius
Pulse	80 beats per minute
Respiration	21 cycles per minute
Blood pressure	105/63mmHg

The vital signs were checked for every 15 minutes for 2 hours, 30 minutes for 1 hour and hourly for 3 hours. Client was asked to change perineal pad anytime it was soaked and to show the pad for inspection of colour and amount of lochia before disposal and also perform hand washing after changing the pad and after urinating as well. Mother and baby's condition were satisfactory.

PREVENTION OF DISEASE

Baby was also monitored during this first six hours post-delivery. Tetracycline eye ointment was applied on the baby's eyes (conjuctiva) as prophylaxis for neonatal eyes infection. Vitamin k 1mg was given intramuscularly on the thigh to prevent bleeding. Hands were washed with soap under running water and cord was dressed with methylated spirit and cotton. These were done within the first 90 minute to prevent infections such as ophthalmia neonatorum a condition which is notifiable, neonatal tetanus and haemorrhagic disease of the new born. Baby was then covered to provide warmth and to prevent heat loss. The baby was then put to breast by mother after teaching her the proper way of positioning the baby to breast. Client was further asked to report when she observes any bleeding, discharges and redness of the cord. After these examinations hands were washed with soap under running water and dried with a clean towel

EXAMINATION OF THE NEWBORN

At 8:41am, procedure was explained to the mother after one-hour skin to skin and consent was given. Measurements of the baby's head circumference were 36 centimetres, length of the baby was 48 centimetres and his weight was 2.9kg. Baby's vital signs were checked and recorded as:

Temperature	36.4 degrees Celsius
Apex heart beat	134 beats per minute
Respiration	42 cycles per minute

Examination gloves were worn and baby was examined in front of the mother. Baby was put on a covered flat surface undressed and uncovered to visualize the general condition of the skin then

covered and only the part to be examined was exposed. A detailed head to toe examination was carried out and recorded as follows:

On the head and neck: head was examined for widen sutures and bulging or depressed fontanelles and to rule out abnormalities such as microcephaly, anencephaly and hydrocephalus.

The eyes were examined for jaundice, discharges, placement and redness but no abnormalities were found. The nostrils were also inspected for discharges and patency of the nose, nasal septum, the mucosa for colour and polyps which were all normal, the tongue was inspected for tongue tie, false teeth in the mouth and lips for symmetry, cleft lip and palate but none was detected. The ears were at the same level with the canthus of the eye. External auditory meatus was patent and the cartilage in the pinnae was checked for softness and no abnormalities were detected. On the neck was inspected and palpated for swelling, congenital goitre, enlarged lymph nodes and none were detected.

On the chest and Abdomen: respiratory movements were normal, nipples were in alignment and the abdomen was round with no bleeding from the umbilical site. The umbilical arteries were two and one vein. The liver, spleen and bladder were palpated for size, tenderness and masses but no abnormality was detected

On the extremities: hands and arms were inspected for symmetry, movement and paralysis, and the palm for the number of palmer creases. Fingers were examined for clubbed finger, extra digits or loss of a finger but no abnormality was detected. The length and movement of the lower

limbs were noted. The digits were counted to be normal with no extra digits. The lower limbs were also examined for congenital dislocation of the hip but none was detected.

On the spine: the baby's back was turned and palpated for swelling, dimpling, hairy patches to exclude spinal bifida, kyphosis, lordosis or any deformity of the spine but none was present.

Genitalia and anus: the genitalia were examined, the location and patency of the urethral meatus were checked and they were all in their rightful position. Testicles were palpated if it has descended, number and position but there was no abnormality found. 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 in the process of examination.

No abnormality was detected in all the examinations conducted. Gloves were removed and disposed, hand washing was done with soap under running water and dried with a clean towel. Findings were communicated to mother and reported to the midwife in charge. The procedure was then documented.

SUMMARY OF LABOUR

Date and time of delivery	-	17th November, 2021 at 7:40am
Type of delivery	-	spontaneous vaginal delivery
Time of expulsion of placenta and membranes	-	7:41am
Drugs given	-	injection oxytocin 10 units

DURATION OF LABOUR

1st stage	-	7hours 36minutes

2nd stage	-	8minutes
3rd stage	-	6 minutes
Total time	-	7 hours,50 minutes

CONDITION OF MOTHER AND BABY

MOTHER

Temperature	36.6 degrees Celsius
Pulse	80 beats per minute
Respiration	21 cycles per minute
Blood pressure	105/63millimeters of mercury
Symphysio fundal height	17centimeters
Lochia	red in colour
Uterus	well contracted

Mother's condition was satisfactory

BABY

Temperature	36.4 degrees Celsius
Apex heart beat	134 beats per minute
Sex	Male
Birth weight	2.9kilograms

Length of baby	48 centimetres
Meconium	Passed
Urine	Passed
First minute APGAR score	8/10
Fifth minute APGAR score	9/10

Baby’s condition was good.

3.5 CARE PLAN DURING LABOUR

Problems identified during labour

1. Lower abdominal pains (17/11/21)

2. Anxiety (17/11/21)

3. Fatigue (17/11/21)

4. Risk of dehydration (17/11/21)

5. Risk of infection (17/11/21)

SHORT TERM OBJECTIVES

1. Client will cope with the lower abdominal pains within 4 hours and throughout labour

2. Client's anxiety will resolve within 30 minutes

3. Client will be relieved of fatigue within 2 hours.

4. Client's fluid volume will be maintained within 2 hours and throughout labour

5. Client will show no sign of perineal infection after 72 hours.

LONG TERM OBJECTIVES

Madam Nketiah will go through labour successfully without any complications to mother and baby.

CARE PLAN DURING LABOUR

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES/ OUTCOME CRITERIA	NURSING ODERS	NURSING INTERVENTION	EVALUATION	DATE/ TIME	SIGN
17/11/21 At 11:40pm	Lower abdominal pains related to physiological processes in the first stage of labour	1.Client will be able to cope with the lower abdominal pains within 4 hours and throughout labour as evidence by: Client showing a relaxed facial expression in between contraction. 2.Midwife observing that client is coping with labour pain.	1. Reassure client that measures will be put in place to relieve her of the pain. 2. Perform sacral massage. 3. Encourage client to do deep breathing exercise with each contraction. 4. Encourage client to empty her bladder frequently. 5. Educate client on ambulation and position.	1. Client was reassured about measures to relieve her of pain. 2. Sacral massage was done. 3. Client did deep breathing exercise with contractions. 4. Clients bladder was emptied frequently. 5. Client was educated on ambulation and position.	Goal met as midwife observed that client rested in between contractions	17/11/21 At 3:30am	Y.S

CARE PLAN DURING LABOUR CONTINUED

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES/ OUTCOME CRITERIA	NURk2SING ODERS	NURSING INTERVENTION	EVALUATION	DATE/ TIME	SIGN
17/11/21 At 12:00am	Anxiety related to unknown outcome of labour.	Client's anxiety will resolve within 30 minutes as evidence by: 1. Client verbalizing that she is no more anxious. 2. Midwife observing that the client is relaxed.	1. Reassure client of the competent care that will ensured to alleviate her anxiety. 2 Introduce successful client to the client 3. Explain the stages of labour to the client. 4. Explain every procedure to be carried on client and allow her to ask questions. 5. Update client with progress of labour.	1. Client was reassured that she could trust the midwives and rely on them for the care of her child. 2. client was enlightened on sex determination 3. The stages of labour were explained to the client. 4. Every procedure carried on client was explained to her and questions were answered. 5. Client was updated with progress of labour.	Goal met as 1. Client said she was no more anxious and delivered successful. 1. Midwife observing that the client is relaxed.	17/11/2 At 12:30am	Y.S

CARE PLAN DURING LABOUR CONTINUED

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES/ OUTCOME CRITERIA	NURSING ODERS	NURSING INTERVENTION	EVALUATION	DATE/TIME	SIGN
17/11/21 At 1:00am	Fatigue related to Physical stress of labour	1.Client will be relieve of fatigue within 2hours and throughout labour as evidenced by: client been active during labour midwife visualising active client. 2.Client verbalising she has been relieved of fatigue	1.Reassure client that she will regain her normal strength. 2.Encourage Client to continue with relaxation techniques during contractions. 3.Teach client to do deep breathing exercise during contractions. 4. Encourage client to take sips of milo and drink. 5. Encourage client to assume a comfortable position.	1.Client was regained of her normal strength. 2. Client was comfortable with relaxation techniques. 3. Client performed deep breathing exercise during contractions. 4. Client took sips of milo and milk throughout labour. 5. Client assumed left lateral position.	Goal fully met as client was involved actively in labour	17/11/21 At 3:00am	Y.S

CARE PLAN DURING LABOUR CONTINUED

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES/ OUTCOME CRITERIA	NURSING ODERS	NURSING INTERVENTION	EVALUATION	DATE/ TIME	SIGN
17/11/21 At 1:00am	Risk for dehydration related to loss of bodily fluid (sweating, vomiting and excessive micturation).	1.Client's fluid volume will be maintained within 2 hours and throughout labour as evidence by: Client verbalizing that the sweating has reduced. Midwife observing that, client show no sign of dehydration	1. Reassure client. 2. Encourage client to take liquid foods to replace fluid loss. 3. Assess the hydration level of the client. 4. Measure urine output. 5.Mop client face when sweating	1. Client was reassured. 2. Client took sips of water. 3. Client's hydration level was assessed 2 hourly. 4. 200mls of urine was measured. 5. Client's face was mopped with clean towel when sweating.	Goal met as midwife reported that Client verbalise that the sweating has reduced. Midwife observed client showed no sign of dehydration	17/11/21 At 3:00am	Y.S

CARE PLAN DURING LABOUR CONTINUED

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES/ OUTCOME CRITERIA	NURSING ODERS	NURSING INTERVENTION	EVALUATION	DATE/TIME	SIGN
17/11/21 At 2:00am	Risk of perineal infection. related to improper handling of perineal pad.	1.Client remains healthy throughout labour and puerperium as evidenced by: The midwife observing that client showed no sign of perineal infection. 2.Client verbalising she has no signs of infections like pyrexia.	1.Reassure client that she will show no signs of infection. 2. Encourage client to wash hands with soap under running water before and after changing her pad. 3. Educate client not to use pad when it falls. 4. All procedures should be performed aseptically. 5. Educate client to change pad when soiled.	1.No sign of infection was detected on client. 1. Client was washing her hands with soap and clean water before and after changing her pad. 2. Client applied fresh pads when the old one falls. 3. All procedures were performed aseptically. 4. Client was changing her pad when soiled.	Goal met as the midwife observed that; Client shows no sign of infection.	20/11/21 At 2:00am	Y.S

CHAPTER FOUR

PUERPERIUM

4.0 INTRODUCTION

This chapter gives information about the care and management that was given to client and her baby from the period placenta and its membranes were fully expelled. It entails the day of delivery, subsequent care of the baby, postnatal home visits, first and second visits to the clinic as well as care plans drawn for problems identified.

4.1 FIRST DAY OF DELIVERY

On Wednesday 17th November 2021, client and her baby were transferred to the lying in ward at 8:2am after the one-hour continuous skin to skin. She was encouraged to empty her bladder as soon as she feels the urge to do so as to prevent postpartum haemorrhage and to change her pad when soaked.

Procedure to be carried on both mother and baby was explained to her and consent was given. Privacy was also ensured. Head to toe examination was carried out on mother no abnormalities were detected.

During abdominal examination, her uterus was well contracted and on palpation symphysio-fundal height was 17 centimetres. Client`s lochia was inspected and it was red (rubra) without odour and moderate in flow.

Client was educated on how to massage the uterus by rubbing the palm on the fundus to help it contract effectively. They were closely observed for 6 hours postpartum. She was made comfortable in bed. Vital signs were checked and recorded as follows:

Temperature	36.6^{o}c
Pulse	82 bpm
Respiration	21cpm
Blood pressure	105/63mmhg

Her vital signs were checked every 15 minutes for 2 hours 30 minutes for 1 hour and hourly for the last 3 hours. She took a bottle of malt with bread and egg. She was asked to put the baby to breast and her mother was allowed to visit her.

SUBSEQUENT CARE OF THE BABY

The vital signs were taken and recorded as follows:

Weight	2.9kg
Temperature	36.2^{o}c
Apex beat	134bpm
Respiration	42cpm

All findings were communicated to the mother and recorded.

The baby was bathed after six hours observation with warm water. Head to toe examination was done but no abnormality was detected and the cord was dressed with sterile cotton wool swab soaked in spirit. The baby was given first immunization, which was Bacillus Calmette Guerine(

CG) vaccine 0.05ml intradermal at the right upper arm to prevent tuberculosis and oral polio vaccine (OPVD) 2 drops orally to prevent poliomyelitis.

The baby was wrapped in a warm dry sheet to maintain body temperature and he was placed beside her mother to breastfeed him. The mother was advised not to apply anything at the injection site. She was told that there can be tissue reaction over the area, a scar formation later indicated that the child had been immunized against tuberculosis effectively.

BABY BATHING AND CORD DRESSING

Requirement

Sterile cotton in a clean gallipot, gloves, apron, mackintosh, methylated spirit, receiver for used swaps, basin, towels (2),soap, sponge, cream, cot sheets (2) baby powder, baby dress, cap, socks, 2 jugs containing hot and cold water each and two receptacles for used water and dirty linen

The procedure was explained to mother and a tray was set. A plastic apron was worn and hands were washed with soap under running water and dried with a clean towel. Cold and hot water were mixed and temperature was tested using the elbow. Disposable gloves were worn and baby was placed on a flat surface. The baby was undressed and wrapped in a big cot sheet. The eyes were cleaned with cotton wool swabs soaked in clean water from inner cantus to outer cantus. His face was cleaned with a moderately wet face towel and dried. The baby's neck was supported with one hand using two fingers of the hand to protect the ears and the head was

washed with soapy sponge. With the body resting on the inner part of the elbow and still supporting the nape of the neck, the baby was place at the edge of the bowl to rinse the soap off the head and dried. With the baby 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. The baby was rinsed off soap thoroughly and was placed in a basin 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 waste materials were discarded according to infection prevention protocol. Gloves were removed and disposed of. Hands were washed with soap and water, and dried with a clean towel.

Hands were thoroughly washed with soap under running water and dried with a clean towel. Sterile gloves were worn. After which cord was inspected for bleeding but no abnormality was detected. The tip of the cord was held with a swab in the non-dominant hand. The base of the cord was cleaned with another cotton wool swab and was discarded. The whole cord was cleaned using four of the cotton wool swabs from the base upwards. One cotton wool swab was used to clean the anterior part, two (one each) for the lateral sides and another one was also used to clean the posterior part of the cord. The tip of the cord was dried with the swab that was used to hold it. The cord was left exposed to allow it to dry and 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 off. Hands were washed with soap under running water and dried with a clean towel. Client was advised not to apply any other concoctions on it. Findings were reported and documented.

4.2 FIRST DAY POST DELIVERY (AT CLINIC)

Thursday 18th of November 2021 at 9:ooam was the first day post-delivery. Madam Nketiah and her baby looked healthy. Procedure to be carried out was explained to her and consent was given. She was assisted to undress and privacy was provided by closing windows and drawing curtains. Head to toe examination was carried out on both mother and baby and no abnormalities were detected.

During abdominal examination, her uterus was well contracted on palpation and symphysio-fundal height measured 16 centimetres. Client`s lochia was inspected and it was red (rubra) without odour and moderate in flow. She was encouraged to change her perineal pad frequently to prevent ascending infections to the uterus. An enquiry about her eating and sleeping pattern was made for which she said it was resuming to normal. Client complained of after pains and told it was told the pain was a sign of inovulation of the uterus and it would go with time. Her vital signs were checked and recorded as follows:

Temperature	$36.1^{o}c$
Pulse	72bpm
Blood pressure	110/70mmHg
Respiration	18cpm

She took a warm bath and applied a new perineal pad. She was served breakfast which was milo with bread and egg which she was able to eat all. The baby`s vital signs, weight and other investigations were checked and recorded as follows:

Temperature	36.4^{o}c
Apex Heart Beat	140 beats per minutes
Respiration	45 cycles per minutes
Weight	3.3 kilograms
Stool	Blackish Green
Suckling	Good
Urine	Passed
Cord condition	Clean and fresh

She was educated on exclusive breastfeeding on demand and the importance of breast milk to the mother and baby. She was also encouraged to feed the baby especially during the night which will serve as family planning as well as aiding in involution of the uterus. She was also educated on proper positioning and fixing baby to breast. Education on breast examination, importance of good nutrition like taking fruits, vegetables, drinking a lot of water and taking diet rich in fibre.

Education on postnatal exercises, personal hygiene and family planning was done. She was reminded of immunization continuation at child welfare clinic and how to maintain the child's temperature by wrapping him and also manage common breast problems such as engorged breast, cracked nipples and mastitis. Permission was sought to also examine the baby. Hands were washed with soap under running water and dried with clean dry towel. On general examination, nothing abnormal was detected.

The baby was topped and tailed, the cord was checked for bleeding and discharge but there was none. The baby was dressed and wrapped nicely in the presence of mother and she was educated on top and tail. The cord was dressed with cotton soaked in spirit. Client was educated on the effect of hot compress application on baby`s head in other to close the fontanelles and was discouraged from doing so. Mother was educated to keep the cord clean and apply only cotton soaked in spirit to prevent infection instead of using local herbs and also, recognizing danger signs of the baby like fever, difficulty in feeding and to the mother, offensive vaginal discharge and report.

Madam Nketiah was informed about her discharge and routine drugs were prescribed as per the protocol of the facility, the dosage and time drugs are to be taken was explained to her. She was assisted to pack her things and encouraged to register at birth and death registry.

Client was informed about home visit for 7 days for continuity of care. She was also informed about her first postnatal visit on the 23rd of November, 2021. She was discharged home at 4:00pm on the same day on the following drugs

Syrup Iron lll polymaltose three times daily for 7 days

Table amoxicillin 300 milligrams three times daily 5 days

Table metronidazole 300 milligrams three times daily 5 days

Tablet paracetamol 1gram three times daily for 3 days

She was assisted to pack her things and escorted with her items to sit in her husband’s car.

4.3 SECOND DAY POST DELIVERY (FIRST POSTNATAL HOME VISIT)

On 19th November 2021 at 9:ooam in the morning, the first post delivery home visit was done. Madam Nketiah was visited in her house. Greetings were exchanged and seat was offered. She was asked about her health and that of the entire family and a positive response was given.

Client was informed of the procedures to be carried out and permission was granted. After washing hands with soap under running water, Madam Nketiah was examined from head to toe with the symphysio-fundal height of 15 centimetres. The perineal pad was checked and the colour of the lochia was bright red with no foul smell and scanty in amount. The breast was lactating well. The conjunctiva was examined and there was no pallor. Her elimination pattern was returning to normal as well as her eating pattern. She was asked any complaint and she had none. Her vital signs were as follows:

Temperature	36.2degree Celsius
Blood pressure	110/70 millimetre of mercury
Pulse	72 cycles per minutes
Respiration	18 beats per minutes

The baby was also examined from head to toe with no abnormalities detected. The baby was pink in colour, there was no sign of jaundice noted on the sclera or palm, there was no bleeding from the cord and it was clean, suckling was good, the stool colour was dark green, baby was

active and sleeping pattern was good. The baby's weight was 2.9 kg. Baby`s vital signs are as follows:

Temperature	36.2degree Celsius
Heart beat	I40 beats per minute
Respiration	42 cycles per minute

Madam Nketiah was educated on family planning, danger signs of the new born such as breathing difficulties, chest in-drawing cyanosis and weak cry. Baby was topped and tailed. Client and her mother were congratulated and permission was sought to leave. She was informed of the next home visit which is in the evening.

On the 19th November,2021 at 5:00pm in the evening, Madam Nketiah was visited once again. We exchange greetings and a seat was offered. She was asked about their health and positive respond was given. Permission was sought from Madam Nketiah to examine her and the baby which she agreed. There were no observed abnormalities for both mother and baby. Baby was topped and tailed and cord dressing was done.The breast was lactating well.

Vital signs ware checked and recorded as follows:

Mother's vital signs

Temperature	36.3 degree Celsius
Blood pressure	104/68 mm/Hg
Pulse	74 beats per minutes
Respiration	20 cycles per minutes

Lochia	bright red

Baby's vital signs

Temperature	36.7degree Celsius
Heart beat	138 beats per minutes
Apex heart rate	42 cycles per minutes

Madam Nketiah was promised another visit the following day on 20th November,2021 and permission was sought to leave.

4.4 THIRD DAY POST DELIVERY (SECOND POSTNATAL HOME VISIT)

On 20th November, 2021 at 9:00am in the morning, Madam Nketiah was visited to assess both mother and baby. On observation, the general condition of the family was good. Procedure was explained to the client and head to toe examination was conducted and no abnormalities were detected. The mother`s lochia was checked and it was bright red in colour (rubra) the flow was scanty with no offensive smell. She was congratulated on maintaining vulva hygiene. Symphysio fundal height was 14 centimetres

Mother was asked of any complaint and she had none. Mother`s vitals are as follows:

Temperature	37.2 degree Celsius
Blood pressure	110/64 mm/Hg

Pulse	68 beats per minute
Respiration	22 cycles per minute

The baby was also examined from head to toe and there were no abnormalities detected. The baby passed brownish yellow stool and urine. Baby was topped and tailed. The cord was clean and mother was reminded not to put anything on the cord such as chalk or herbs. The baby weighed 2.8 kg. Baby was well wrapped and given to mother to breastfeed and suckling was good. Baby`s vital signs are as follows:

Temperature	36.5degree Celsius
Apex heart beat	148beats per minute
Respiration	42cycles per minute
Weight	2.8kg

The baby was topped and tailed and dressed nicely after which permission was sought to leave and visit them the next day.

In the evening of 13th November, 2021, Madam Nketiah was offered a visit again. Greetings were exchanged and seat was offered. She was asked about her health and that of the baby and positive response was given. Permission was sought to examined mother and baby and it was granted. Head to toe examination was conducted on both 20ther and baby. No abnormalities detected. Baby was topped and tailed, cord dressing done and given to mother to breastfeed.

Mother’s vital signs

Temperature	36.5 degree celsuis
Blood pressure	104/68mmHg
Pulse	74 beats per minutes
Respiration	20 cycles per minutes
Baby's vital signs	
Temperature	37.0 degree Celsius
Apex heart rate	138 beats per minutes
Respiration	40 cycles per minute.
Suckling	Good

4.5 FOURTH DAY POST DELIVERY (THIRD POSTNSTAL HOME VISIT)

The third home visit was on the 21th November 2021 at 9:ooam. Client and family were doing well. Procedure was explained to her. Hand washing was done and head to toe examination was done. Perineal pad was inspected and the flow of lochia was small, brownish red in colour (serosa) and not offensive. Client complained of headache. She was educated to have enough rest to relieve the headache. The symphysio-fundal height was 13 centimetres. Her vital signs were checked and recorded as follows:

Temperature	37.0degree Celsius

Pulse	82beats per minute
Blood pressure	105/66mellimeters of mercury
Respiration	21cycles per minute

Baby`s vital signs were as follows:

Temperature	36.9 degree Celsius
Apex heart beat	138beats per minute
Respiration	38cycles per minute
Weight	2.7kg

Baby was also examined and topped and tailed. Baby`s cord was clean and dry, active and with good suckling. Baby's weight was 3.1 kg and client was thanked for her cooperation and support. She was asked to take her routine drugs. Permission was sought to leave.

On the 21st November, 2021 at 5:00pm, Madam Nketiah was visited as the second visit for the day. On arrival, Madam Nketiah was washing her baby clothes. Greetings were exchanged and a seat was offered. Mother was asked of the headache and she verbalised it has subsided. Permission was sought for examination of mother and baby and was granted. Examination was done and no abnormality was detected. Baby was topped and tailed as well as cord dressing done. The breast was lactating well and baby's suckling was good.

Mother's vital signs

Temperature	36.2 degree Celsius
Blood Pressure	110/72 mmHg
Pulse	78 beats per minutes
Respiration	19 cycle per minutes

Baby's vital signs

Temperature	37.1 degree Celsius
Apex heart beat	136 beats per minutes
Respiration	36 beats per minutes

Madam Nketiah was thanked for her cooperation and support. She was told the next home visit as the next morning. Permission was sought to leave.

4.6 FIFTH DAY POST DELIVERY (FOURTH POSTNATAL HOME VISIT).

On 22nd November 2021 at 8:30am, client was visited. Both mother and baby were found in good health. Enquiry was made about her headache and she said was ok. Head to toe examination was done after seeking permission from client and everything was normal. Lochia was pink (serosa) on inspection. Symphysio fundal height measured 12 centimetres and her vital signs were as follows:

Temperature	36.8^{o}c degree Celsius
Pulse	70beats per minute

Respiration	20cycles per minute
Blood pressure	120/80mellimeters of mercury

The baby was also examined with no abnormalities detected. The cord was well dressed, it was dry and dark in colour and almost falling without odour. The baby passed yellowish brown stool and urine. The baby was well dressed and wrapped in a clean cot sheet and was given to the mother to breastfeed. Baby`s weight was 3.2kg. Baby`s vital signs were as follows:

Temperature	36.3 degree Celsius
Apex Heart Beat	140beats per minute
Respiration	40cycles per minutes

Baby was topped and tailed and client was advised to take nutritious meals like beans, meat and green leafy vegetables to keep her healthy and also to continue to breastfeed the baby on demand. She was asked of any complain and she replied that she had no complain. Permission was sought to leave and Client was reminded of the next visit.

4.7 FIRST POSTNATAL VISIT TO THE CLINIC

On the 23rd day of November 2021 at 9:30am, Madam Nketiah came to the postnatal clinic with her baby and mother. They were welcomed and a seat was offered to them. Client and baby were looking healthy and well dressed.

The purpose of the visit was to assess the physical and psychological well-being of the mother and child. Client was asked of how she and her family were coping with the new born, workload, rest and sleep.

General observation was made on her behaviour towards baby and mothers were good. All procedures to be carried out on her and the baby was explained to her and concern was soughted. She was asked to empty her bladder and midstream urine was collected from her for protein and glucose and all tested negative. Her haemoglobin level was checked and it was 12.8q/dl. Vital signs were checked and recorded as follows:

Temperature	36.1 degree Celsius
Respiration	18cycles per minute
Pulse	74 beats per minutes
Blood pressure	120/80mellimmeters of mercury

Privacy was provided and client was helped to lie on the examination bed. Hands were washed with soap under running water and dried with a clean dry towel. Head to toe examination was performed on her. On the head, her hair looked tidy. The conjunctiva was pink with no pallor or jaundice, no discharges were seen from the eyes, nose and ears. There was no abnormality detected in the mouth, and there was absence of enlarged nodes on the neck. Breast was lactating well, no engorgement, sore or cracked nipples were present neither were there abnormal masses in the breast. On abdominal examination, the abdomen was firm, there was no tenderness, no scars, enlarged liver or spleen on examination. The symphysio fundal height was 12 centimeters.

The vulva was examined for infection, the perineum was intact and there was no offensive vaginal discharge and the lochia was small and was alba. No abnormality was found in all examinations. She was thanked for the cooperation and was helped out of the bed. All findings were communicated to client afterwards. Her baby was also examined from head to toe. Her hair

looked neat and nicely combed, sutures were present and touching each other. The conjunctiva was pink, no jaundice of the sclera and no discharges from the eyes. The ears and nose were inspected and the lip as well but no abnormality was detected. After the head to toe examination, no abnormality was detected. On examination, the cord was seen clean and dry.

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

Temperature	36.8 degrees Celsius
Apex heart beat	134 beats per minute
Respiration	36 cycles per minute
Weigh	3.4kilograms

Madam Nketiah was informed that the circumcision is about to be done and if she would like to observe but her response was negative . The baby was prepared and circumcised by the midwife in-charge. The area was applied with gel and wrapped with sterile gauze after which baby was clothed and given to mother to breastfeed . Education was given to mother to always wash hands with soap under running water before handling the baby and to also keep the wound clean and dry to prevent infections and report any signs of bleeding, swelling or discharges. Madam Nketiah was thanked for been coorperative throughout the procedure. She was also advised to report to the hospital in case of any abnormalities detect like cord infection. Client was accompanied to pick a taxi home

SIXTH DAY POST DELIVERY (FIFTH POSTNATAL HOME DELIVERY)

On 23rd November,2021 at 9:00am in the evening, client was visited. Greetings were exchanged after which a seat was offered. Mother and baby were both in a healthy condition. Head to toe examination was performed on the mother and there was no abnormality detected. Lochia was inspected and the colour was serosa and amount drained was scanty with no foul odour. Symphysio-fundal height measured 11 centimetres and vital signs was checked and recorded as follows:

Temperature	36.6degree Celsius
Pulse	80 beats per minute
Blood pressure	110/70mmHg
Respiration	22 cycles per minute

Head to toe examination was done with no abnormality noted. According to client, the baby passed yellowish soft stool and urine early in the morning. The cord was dressed and it was dry and almost falling. The baby's weight was 2.8kg Vital signs were checked and recorded as follows:

Temperature	36.6 degree Celsius
Apex Heart Beat	138beats per minute
Respiration	36cycles per minute

The baby was topped and tailed paying attention to the skin folds, he was then dressed and wrapped nicely and given to the mother. Madam Nketiah complained of sleeplessness and was encouraged to sleep as soon as baby sleeps. Permission was sought to leave. Madam Waja and family were encouraged to help in taking care of the baby.

4.9 SEVENTH DAY POST DELIVERY (SIXTH DAY POSTNATAL HOME VISIT)

The sixth postnatal home visit was made on 24th November, 2021 at 9:00am, greetings were exchanged with client and her family and a seat was offered. They were all in good health. Permission was sought and routine examination was carried out on both mother and baby from head to toe and there was no abnormality detected. Mother was lactating well. Her perineal pad was inspected and the lochia was serosa and it was scanty with no odour. Enquiry was made about her sleeplessness and she said she had at least an hour sleep after feeding her baby and her husband also confirmed. She complained of loss of appetite and constipation .She was educated on the need to take enough, highly nutritious diet and eat regularly but in bits. She was also

encouraged to always take in fruits and fibre diets to prevent constipation. Symphysio fundal height was 10 centimetres. Vital signs were checked and recorded as follows:

Temperature	36.7 degree Celsius
Pulse	76beats per minute
Respiration	19cycles per minute
Blood pressure	104/62mellimeters of mercury

Permission was again sought to perform head to toe examination on the baby of which there was no abnormality detected. On examination, the cord was seen to have fallen The mother was encouraged to still keep the stump clean. Vital signs were checked and recorded as follows:

Temperature	36.7 degree Celsius
Apex Heart Beat	124beats per minute
Respiration	40 cycles per minute

The baby was bathed and dressed nicely and the weight was 2.9kg. The mother was asked if she had any complains that day but she had nothing to report. She was thanked and reminded of the last visit which will be the next day.

4.10 EIGTH DAY POST DELIVERY (SEVENTH DAY POSTNATAL HOME VISIT)

On the 25th December, Madam Nketiah and family were visited in the morning at 8:30am which was the last visit for the week. The whole family was in good health. Enquiries about constipation and loss of appetite were made and she said she took enough diet and was able to

pass stool twice. She was asked of any complaint and she had none. Procedures to be done were explained to her. Head to toe examination was done on the mother and there was no abnormality detected. The perineal pad was inspected and lochia was brownish red in colour and not offensive. Vital signs were checked and recorded as;

Temperature	36.2 degree Celsius
Pulse	84beats per minute
Respiration	21cycles per minute
Blood pressure	111/68 millimetres of mercury
S.F.H	9cm

Head to toe examination was conducted and there was no abnormality noted. Vital signs were checked and recorded as follows:

Temperature	36.2^{o}c
Heart beat	140bpm
Respiration	44cpm
Weight	2.9 kilograms

The baby was bathed by his grandmother under supervision and the cord stump was dressed. She was educated on the importance of visiting the clinic. She was reminded of her second

postnatal visit on the 28th 0f December, 2021. Madam Nketiah and her family were congratulated and thanked for their cooperation and they in turn showed their appreciation.

Explanation was given to Madam Nketiah on the need to be handed over to the midwife in charge for continuity of care on the 25th November, 2021. Explanation was again given to her that our programme was ending that day but client was reassured of midwife in charges' competency. She was also encouraged to register her child with the birth and death registry. Client was accompanied to her house and a seat was offered. Client and her family was thanked for their cooperation, information provided and permission was sought to leave.

TERMINATION OF CARE

On the 25th of November, 2021, Madam Nketiah was handed over to the midwife in charge and the Community Health Nurses at the Child welfare clinic for the continuity of care during her second postnatal visit on 28th December, 2021. It was made known to her that, updates of her will be received from the midwife in charge and she will be called if needs arises for any information and she gladly said, she will be available anytime needed.

She and her entire family were thanked for availing themselves and helping achieve the study. Madam Nketiah expressed her gratitude for the care given to her. She was told to register the baby with Birth and Death Register. She and her family were bid farewell.

4.11 SECOND POSTNATAL VISIT TO CLINIC

On the 28th of December 2021 according to the midwife in-charge, Madam Nketiah visited the clinic for six weeks visit. They were warmly welcome and they all looked very healthy. General examination was conducted on the client from head to toe as well as vital signs after her permission was sought. Her vital signs were checked and recorded by the midwife in-charge as follows:

Temperature	36.4ºC
Pulse	78bpm
Respiration	20cpm
Blood Pressure	110/70mmHg

Madam Nketiah was given a urine sample container to provide some urine to be sent to the laboratory for urine analysis to be performed. A sample of blood was also taken from Madam Nketiah with her consent to be sent to the laboratory for her haemoglobin level to be tested. The results were explained to her as follows;

Haemoglobin	12.2 g/dL
Urine protein	Negative
Glucose	Negative

Madam Nketiah was sent to the palpation room where privacy was provided by drawing the curtains and closing doors and windows. She was helped to lie on the examination bed. Hands were washed with soap under running water and dried with a clean dry towel.

Head to toe examination was done on her. On the head, hair was neat and well styled. The conjunctiva was pink and there were no discharges from the eyes, nose and ear. No abnormality was found on the mouth and neck. On the breast, no abnormalities such as sore nipple, engorgement, cracked nipple and mastitis were detected and the breasts were lactating well. On examining the abdomen, no abnormality such as sub involution, tenderness, enlargement of liver and spleen was detected. No scars were found and uterus was not palpable. With the lower extremities, certain condition such as oedema was looked out for. It was detected that she showed no abnormality.

Client was educated on the need to start a family planning method to prevent unwanted pregnancy.

Her baby was also examined from head to toe to look out for abnormalities. On the head, the anterior fontanelles were palpated for pulsation and it was normal. The posterior fontanelle had closed. There were no discharges from the eyes and nose. The skin was nice with no rashes. The chest, upper and lower extremities were normal. The umbilical stump was inspected and it had healed. The lower extremities were normal. The findings on the baby were as follows:

Temperature	36.2ºC
Respiration	34cpm
Apex heart beat	134bpm
Weight	5.3kg

Madam Nketiah and her baby were handed over to the child welfare clinic and family planning unit for the six weeks' immunization against diphtheria, pertussis, tetanus, haemophilus influenza and hepatitis B.

She was encouraged to ask questions but she had none and had no complaints. She was reminded on exclusive breastfeeding, rest and sleep, exercise and nutritious diet, which would help in lactation. She was finally handed over to the public health nurse for continuity of care but report to the facility anytime she encountered any health related problem. She was thanked for her co-operation and understanding.

4.12 CARE PLAN DURING PUERPERIUM

PROBLEMS IDENTIFIED

Madam Nketiah complained of:

1. After pain (18th November,2021)
2. Headache(21st November, 2021)
3. sleeplessness (23rd November,2021)

4 Backache (24th November, 2021)

5 Skin rashes (25th November,2021)

SHORT TERM OBJECTIVES

1. Client's after pain will subside within 12hours.

2. Client's headache will be relieved after 8 hours.

3. Client would be sleep well within 24 hours

4. Client would be relieved of backache within 48 hours

5. Baby would be relieved of skin rashes within 72 hours

LONG TERM OBJECTIVES

Madam Nketiah will go through puerperium successfully without any complication to both mother

PUEPERIUM CARE PLAN

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	EVALUATION	DATE/ TIME	SIGN
18/11/21 At 8:15am	After pains related to uterine involution	Client's after pain pains will reduce within 12 hours as .evidenced by; 1.Client verbalizing that the pain has subsided. 2.Midwife verbalising that client is relieved of afterpain	1. Reassure the client that it would dissolve with time. 2. Explain the physiological changes that take place in the uterus during puerperium. 3. Encourage client to void frequently. 4. Encourage client to do pelvic exercises. 5.Continue to breastfeed baby	1. Client was reassured that the pain was a sign of involution of the uterus and it would go with time. 2.Physiological changes that takes place in the uterus were explained to client, that is the uterus returning to its non-pregnant state 3. Client voided frequently. 4. Client did pelvic exercises e.g. Kegel's exercise 5.Client continued to breastfeed baby	Goal met as client said that pain has subsided.	18/11/21 At 8:15pm	Y.S

PUERPERIUM CARE PLAN CONTINUED

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	EVALUATION	DATE/ TIME	SIGN
21/11/21 At 10:10am	Headache related to stress of labour.	Client's headache will resolve within 8 hours as evidenced by; 1. Client verbalizing she has no headache. 2. The midwife observing a relaxed facial expression.	1. Reassure client of possible care to relieve the headache. 2. Encourage client to have rest during the day 3. Encourage client relatives to give assistance to client. 4. Encourage support person to restrict visitors. 5. Administer analgesics.	1. Client was reassured of possible care to relieve. 2. Client was resting for at least 2 hours' in the day and 8 hours sleep at night. 3. Client's relatives were assisting with the household chores. 4. Client's support person limited visitors so that she can rest and sleep 5. Tablet paracetamol 1gram was administered to client	Goal met as verbalized by client that the headache has resolved and having a relaxed facial expression.	21/11/21 At 6:00pm	Y.S

PUERPERIUM CARE PLAN CONTINUED

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	EVALUATION	DATE/ TIME	SIGN
23/11/21 At 8:40am	Sleeplessness related to breastfeeding and crying of baby during the night.	Client will sleep for 1 hour continuously at night after each feed as evidenced by; Client verbalizing that she is able to sleep for at least 1 hour continuously. 2. Husband confirming that client have continuous sleep at least hour at night after each feed.	1. Reassure client. 2. Encourage client to sleep in the afternoon when baby falls asleep. 3. Educate client to use kangaroo method in feeding baby. 4. Encourage client relatives to change baby's napkins when soiled. 5. Encourage client to breastfeed baby on demand.	1. Client was reassured. 2. Client was sleeping in the afternoon when the baby is sleep. 3. Client used kangaroo method in feeding baby. 4. Client relatives were changing baby's napkins when soiled. 5. Client breastfed baby on demand.	Goal fully met as client verbalizing that she can sleep well 2. Husband confirming that client sleeps at least an hour continuously at night after each feed.	23/11/21 At 8:40am	Y.S

PUERPERIUM CARE PLAN CONTINUED

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	EVALUATION	DATE/ TIME	SIGN
24/11/21 At 8 :40am	Impaired comfort related to backache	Client will be relieved of backache within 48hours as evidenced by: Client verbalising she has been relieved of backache. 2.Midwife visualising that client scoring mark on comparative pain assessment scale	1. Reassure client that she will be relieved of the pain 2 .Teach client how to position herself when breastfeeding. 3.Encourage client to wear well-fitting or supportive brassier. 4. Encourage client to eat food in frequent interval but in bit. 5. Encourage client to attach baby properly during breastfeeding.	1. Client was reassured that she will be relieved of the pain. 2. Client was encouraged to support back with pillows when breastfeeding baby. 3. Client used proper types of position used in breastfeeding. 4. Client was encouraged to wear well-fitting brassier 5. Client was encouraged to fix baby properly to the breast.	Goal was met as Client reporting she has been relieved of the pain.	26/11/21 At 8:40am	Y.S

PUERPERIUM CARE PLAN CONTINUED

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	EVALUATION	DATE/ TIME	SIGN
25/11/21 At 8:40am	Skin rash related to warm environment	Baby will be relieved of skin rashes within 72 hours as evidenced by: 1.Mother verbalising that rashes are no more. 2Midwife observing that rashes has disappear.	1. Reassure mother that rashes will disappear. 2. Explain the physiology of rash to mother. 3. encourage mother to use Johnson baby soap when bathing baby. 4.Educate mother to dress baby with cotton clothes. 5.Encourage mother to apply Baby powder on the baby's skin	1. Client was reassured that the rashes will disappear.. 2. Physiology of rash was explained to mother. 3.Mother used Johnson baby soap when bathing baby. 4. Mother dressed baby with cotton clothes. 5. Mother applied baby powder to baby's skin.	Goal fully met as midwife observed skin rashes disappear	28/121201 At 8:40am	Y.S

SUMMARY AND CONCLUSION

Madam Nketiah Hagger,a 21 years of age, Gravida 4 Para 3 alive ($G4P3^{A}$) was the client used for the Client and Family centred Maternity Care Study at Sampa Government Hospital. Her first antenatal visit to the facility was on 7th June, 2021 when she was 17th weeks pregnant. The first contact with client was on 1st November, 2021 for her usual antenatal visit to the clinic with gestation of 37weeks. After a careful history taking, her main problems identified were anxiety of which it was able to be managed accordingly. All necessary laboratory investigations were carried out during and after pregnancy. On 17th November, 2021 at 11:25pm, client was admitted to the labour ward and she had a spontaneous vaginal delivery of a live male child at 3:30am.

She was discharged home 0n the same day at 4:00pm and the necessary education on rest and sleep, nutrition, personal hygiene, care of the baby, breast care and breastfeeding were given accordingly. Her puerperium period was successful and all the care was given to ensure good health of both mother and baby.

On 25th November, 2021, client was handed over to the community Health Nurses at the Child Welfare Clinic for continuity of care during her second visit on 28th December, 2021.

Client and Family centred maternity care study is an effective approach to health care of expectant mothers. It is very interesting but need a lot of hard work, commitment, encouragement, supervision and advice before one can achieve her goal. The midwife needs to be smart, bold, humble, sociable and intelligent to achieve her objectives.

This approach of nursing Madam Nursing Nketiah and her family has paved way to care for a pregnant woman and be able to find solutions to problem which are encountered during pregnancy, labour and puerperium. It has given the opportunity to put what has been taught in the classroom into practice. Moreover, it has also broadened the knowledge on issues concerning pregnancy, labour and puerperium. With this experience gained, the best standard of care will be rendered to all clients that will come my way irrespective of their social status and the environment in order to reduce maternal and infant morbidity and mortality.

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APPENDIX 1

ANTENATAL RECORDS

DATE	WEIGHT (KG)	BLOOD PRESSURE	URINE FOR PROTEIN/ SUGAR	GESTATIONAL AGE IN WEEKS	FUNDAL HEIGHT (CM)	PRESENTA-TION	DESCENT OF FETAL HEAD	FETAL HEART RATE (FH)	TREATMENT GIVEN	COMPLAIN
7/06/21	73.4kg	116/69mm Hg	Trace／ Negative	17 weeks	20	-	-	-	Headache	Routine drugs

DATE	WEIGHT (KG)	BLOOD PRESSURE	URINE FOR PROTEIN/ SUGAR	GESTATIONAL AGE IN WEEKS	FUNDAL HEIGHT (CM)	PRESENTA-TION	DESCENT OF FETAL HEAD	FETAL HEART RATE (FH)	TREATMENT GIVEN	COMPLAIN
19/07/21	75kg	103/60mm Hg	negative/ negative	23 weeks	24cm	Breech	5/5th	143	No complain	Routine drugs
16/08/21	77kg	111/57mm Hg	negetive/ negative	26+3weeks	25cm	Breech	5/5th	141	No complains	Routine drugs.
13/9/21	78.5kg	102/62mm Hg	Negative/ Negative	30+3weeks	27cm	Breech	5/5	150bpm	Routine drugs	No complain

DATE	WEIGHT (KG)	BLOOD PRESSURE	URINE FOR PROTEIN/ SUGAR	GESTATIONAL AGE IN WEEKS	FUNDAL HEIGHT (CM)	PRESENTA-TION	DESCENT OF FETAL HEAD	FETAL HEART RATE (FH)	TREATMENT GIVEN	COMPLAIN
11/10/21 /	79	91/63	Negative/ Negative	34+3weeks	36cm	Cephalic	5/5	153	Routine drugs	No complains
25/10/21	73	98/69	Negative/ Negative	36+3weeks	37cm	Cephalic	5/5	I44	Routine drugs	No complains

DATE	WEIGHT (KG)	BLOOD PRESSURE	URINE FOR PROTEIN/ SUGAR	GESTATIONAL AGE IN WEEKS	FUNDAL HEIGHT (CM)	PRESENTA-TION	DESCENT OF FETAL HEAD	FETAL HEART RATE (FH)	TREATMENT GIVEN	COMPLAIN
01/11/20	73	100/80	Negative / Negative	37+3weeks	38cm	Cephalic	5/5	141	Routine drugs	Anxiety

DATE	WEIGHT (KG)	BLOOD PRESSURE	URINE FOR PROTEIN/ SUGAR	GESTATIONAL AGE IN WEEKS	FUNDAL HEIGHT (CM)	PRESENTA-TION	DESCENT OF FETAL HEAD	FETAL HEART RATE (FH)	TREATMENT GIVEN	COMPLAIN
08/11/20	83	106/65	Negative/ Negative	37+3weeks	38cm	Cephalic	5/5	141	Routine drugs	Constipation Heartburns Backache
15/11/21	80	113/65	Negative/ Negative	38+3weeks	39cm	Cephalic	5/5th	142	Routine drugs	Waist pain

ITN Given – 7/06/2021

TETANUS IMMUNIZATION	PREVIOUS TT 3		TD 1 Yes TD 2 and TD 3 TD 4		NO	
	CURRENT TT 4th dose		Date		Batch Number	
			19/07/21		222600620A	
INTERMITTENT PREVENTIVE TREATMENT (IPT)FOR Malaria	1ST dose SP* 3 tabs (Directly Observed Therapy) 19/07/2021	Gestation age In weeks 23weeks	2nd dose (1 month after 1st dose (Directly Observed Therapy) 16/08/2021	Gestation age In weeks 26+3weeks	3rd dose (1 month after 2nd dose (Directly Observed Therapy)13/09/21	Gestational age in weeks 30+3weeks
	4th dose 3 tabs (Direct observed therapy)11/10/21	Gestation age in weeks 34+3weeks	5th dose 3 tabs (Direct Observed Therapy) 01/11/21	Gestation age in weeks 37+3 weeks		

*NB:- Sulfadoxine _Pyrimethamine – (SP) should be given to pregnant women after 16 weeks or when mother feels baby's movement(after quickening) till delivery and should be given at least 1month after last dose

APPENDIX II

COMPLETE DIAGNOSTIC INVESTIGATIONS ON MADAM NKETIAH HAGGER

DATE	SPECIMEN	IVESTIGATION	NORMAL VALUES	FINDINGS	REMARKS
7/06/21	1. Blood	Haemoglobin level	12g/dl-16g/dl	12.5g/dl	Normal
		Sickling status	Negative	Negative	Normal
		Grouping and Rhesus factor	A, B, AB, and O	O Positive	Normal
			Positive and negative		Normal
		HIV status	None reactive	Negative	Normal
	2. Urine	VDRL	None reactive	Non-defect	Normal
		Hepatitis status	Negative	Negative	Normal
		G6PD status	None reactive	Non-defect	Normal
		Sugar	Negative	Negative	Normal
		Protein	Negative	Negative	Normal
19/07/21	1. Urine	Sugar	Negative	Negative	Normal
		Protein	Negative	Negative	Normal

DATE	**SPECIMEN**	**IVESTIGATION**	**NORMAL VALUES**	**FINDINGS**	**REMARKS**
16/08/21	2. Urine	Sugar Protein	Negative Negative	Negative Negative	Normal Normal
13/09/21	Urine	Sugar Protein	Negative Negative	Negative Negative	Normal Normal
11/10/21	1. Blood 2. Urine	Haemoglobin level Sugar Protein	12g/dl-16g/dl Trace Negative	11.6g⁄dl Negative Negative	Normal Normal Normal
01/11/21	1. Blood 2. Urine	Haemoglobin level Sugar Protein	12g/dl-16g/dl Negative Negative	13.9g⁄dl Negative Negative	Normal Normal Normal

01/11/21	1.Urine	Sugar Protein	Negative Negative	Negative Negative	Normal Normal
10/11/21	1.Urine	Sugar Protein	Negative Negative	Negative Negative	Normal Normal
10/12/21	1.Urine	Sugar Protein	Negative Negative	Negative Negative	Normal Normal

APPENDIX III

PHARMACOLOGY OF DRUGS FOR THE MOTHER

NAME OF DRUG	CLASSIFI-CATION	DOSAGE	ROUTE	ACTION AND USES	ACTUAL EFFECT	SIDE EFFECT	SIDE EFFECT EXPERI-ENCED
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 (4^{th} dose)	Subcutaneously	Protection against tetanus	Tetanus was prevented	Fever and urticaria rash	None observed
Tablet sulphadoxine pyrimethamine	Anti-malaria and prophylaxis	3 tablets given at 16 weeks/quickening's repeated at 4-week interval till delivery.	Orally	Prevention of malaria	Prevention of malaria in pregnancy	Nausea, itching, headache, Dizziness	None observed
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
NAME OF DRUG	**CLASSIFI-CATION**	**DOSAGE**	**ROUTE**	**ACTION AND USES**	**ACTUAL EFFECT**	**SIDE EFFECT**	**SIDE EFFECT EXPERI-ENCED**
Injection Pitocin	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	CLASSIFI-CATION	DOSAGE	ROUTE	ACTION/ USES	ACTUAL EFFECT	SIDE EFFECT	SIDE EFFECT EXPERIENCED
Vitamin K	Coagulant	1milligram	Intramuscular	Production of prothrombin	No bleeding	None	None observed
Tetracycline eye ointment	Prophylaxis antibiotic	0.5g	Applied	Prevents eye infection	No infection observed	Nephroxicity	None observed
Polio vaccine	Antigen	2 drops	Orally	Production of antibodies against poliomyelitis	Under observation.	None	None observed
Injection Bacillus Calmette Guerin (BGC)	Antigen	0.05 Milligram	Intradermal	Vaccinates neonates against tuberculosis	Under observation	Blister formation	None observed
Pnuemo coccal	Antigen	0.5 milligram	Intramuscularly	Vaccinates neonates against pneumonia	Under observation	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

NAME OF DRUG	CLASSIFI-CATION	DOSAGE	ROUTE	ACTION/ USES	ACTUAL EFFECT	SIDE EFFECT	SIDE EFFECT EXPERIENCED
Rota virus	Antigen	1.5 milligrams (2 drops)	Orally	Prevention of gastroenteritis	Under observation	None	None observed

NEW BORN EXAMINATION FORM

Baby Hicelah
Date: 7/11/21 Time of Birth: 7:40am Date of Assessment: 7/11/21 Time: 8:41am
Age: 39+2 Mode of Delivery: ☐ Vaginal ☐ Assisted Vaginal ☐ C-Section Age at time of Assessment (days/hrs) 1 day
Apgar: 1min 9 5min 9 Birth Weight: ☐ 2.9 kg ☐ Length: 51 cm Head Circumference: 34 cm
Temperature at time of Assessment: 36.2 °C Urine passed: (Yes) No Meconium passed: (Yes) No
Assessor: (Midwife/Doctor): Eli Susana

7. Suck
- ☑ Good
- ☐ Weak
- ☐ Absent

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

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

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

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

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

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

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

16. Clavicle
- ☑ Normal
- ☐ Swelling/Fracture

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

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

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

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

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

22. Limbs
- ☑ Normal
- ☐ Abnormal _____

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

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

24. Anus
- ☑ Patent
- ☐ Imperforate*

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

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

Indicate severe disease that requires urgent referral Spontaneous Vaginal Delivery
Diagnosis (if known) _____

Plan: (Overall assessment) [ ] Normal [ ] Baby with a Problem [ ] Danger Sign/ <1500g/ severe Jaundice
[ ] Special Care [ ] Problem. Continue supportive in-patient care [ ] Urgent Referral / Advanced Care [ ] Discharge

NEW BORN EXAMINATION FORM

Baby Hicetah

Date: 7/11/21 Time of Birth: 7:40am Sex: ☑ M ☐ F Time: 8:41am

Age: ☐ 39+2 ☐ Mode of Delivery: ☐ Vaginal Assisted Vaginal C-Section Age at time of Assessment (days/hrs) 1 day

Apgar: ☑ 5min 9 Birth Weight: ☐ 2.9 kg ☐ Length: 51 cm Head Circumference: 34 cm

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

Assessor (Midwife/Doctor): Heli Susana

7. Suck
- ☑ Good
- ☐ Weak
- ☐ Absent

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

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

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

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

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

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

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

16. Clavicle
- ☑ Normal
- ☐ Swelling/Fracture

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

18. Heart rate

Rate: _____
- ☑ Normal (100-160)
- ☐ <100 *
- ☐ >160*

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

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

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

22. Limbs
- ☑ Normal
- ☐ Abnormal _____

23. Genitalia

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

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

24. Anus
- ☑ Patent
- ☐ Imperforate*

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

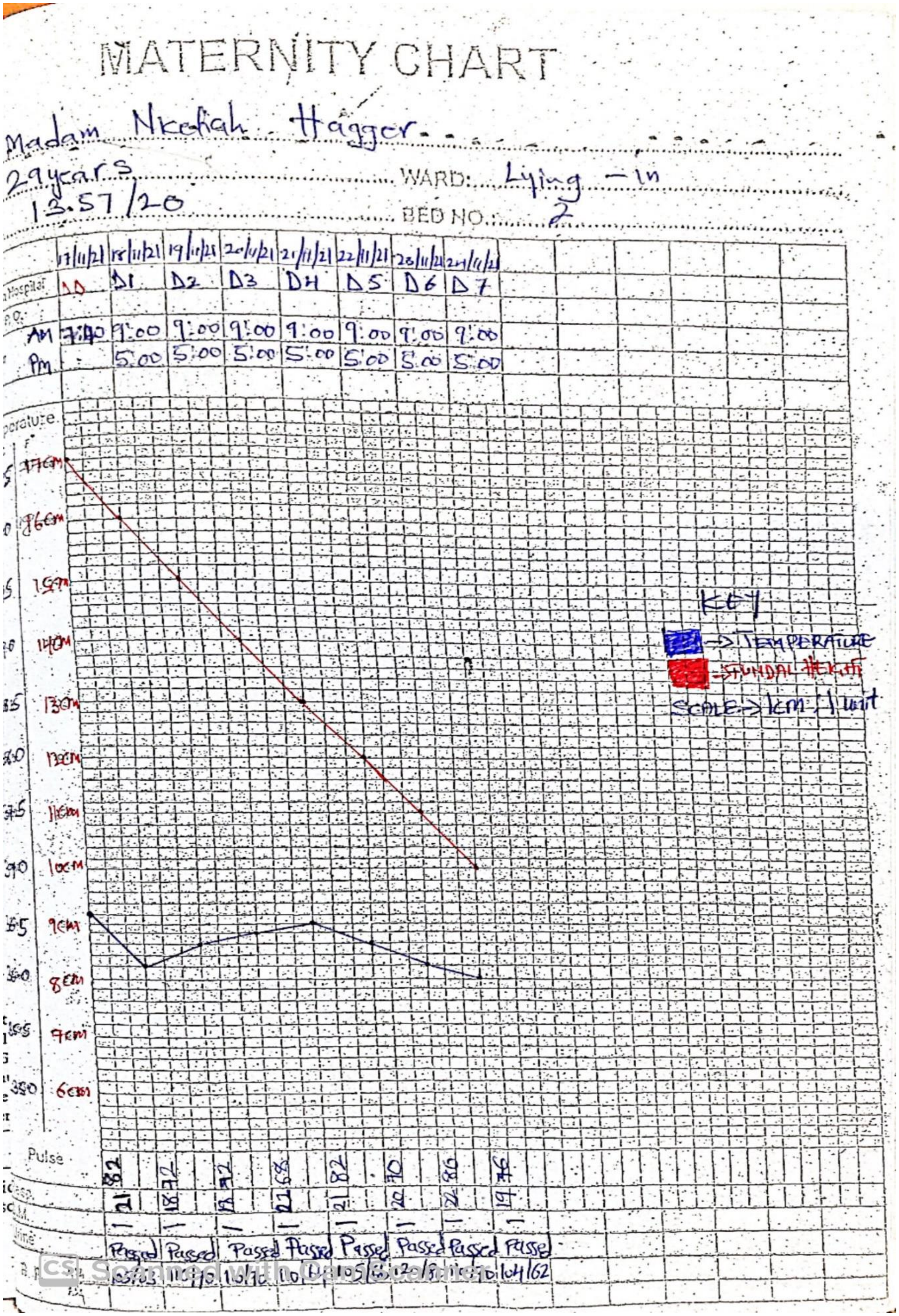
26. Services provided
- ☑ Vitamin K1 given
- ☑ Eye care provided
- ☑ Cord care provided
- ☑ Breastfeeding initiated
- ☑ Breastfeeding established
- ☑ Immunization (BCG/Polio)
- ☑ BCG ☑ Polio Immunization
- ☑ Antibiotics in mother
- ☑ Antenatal corticosteroids

Indicate severe disease that requires urgent referral

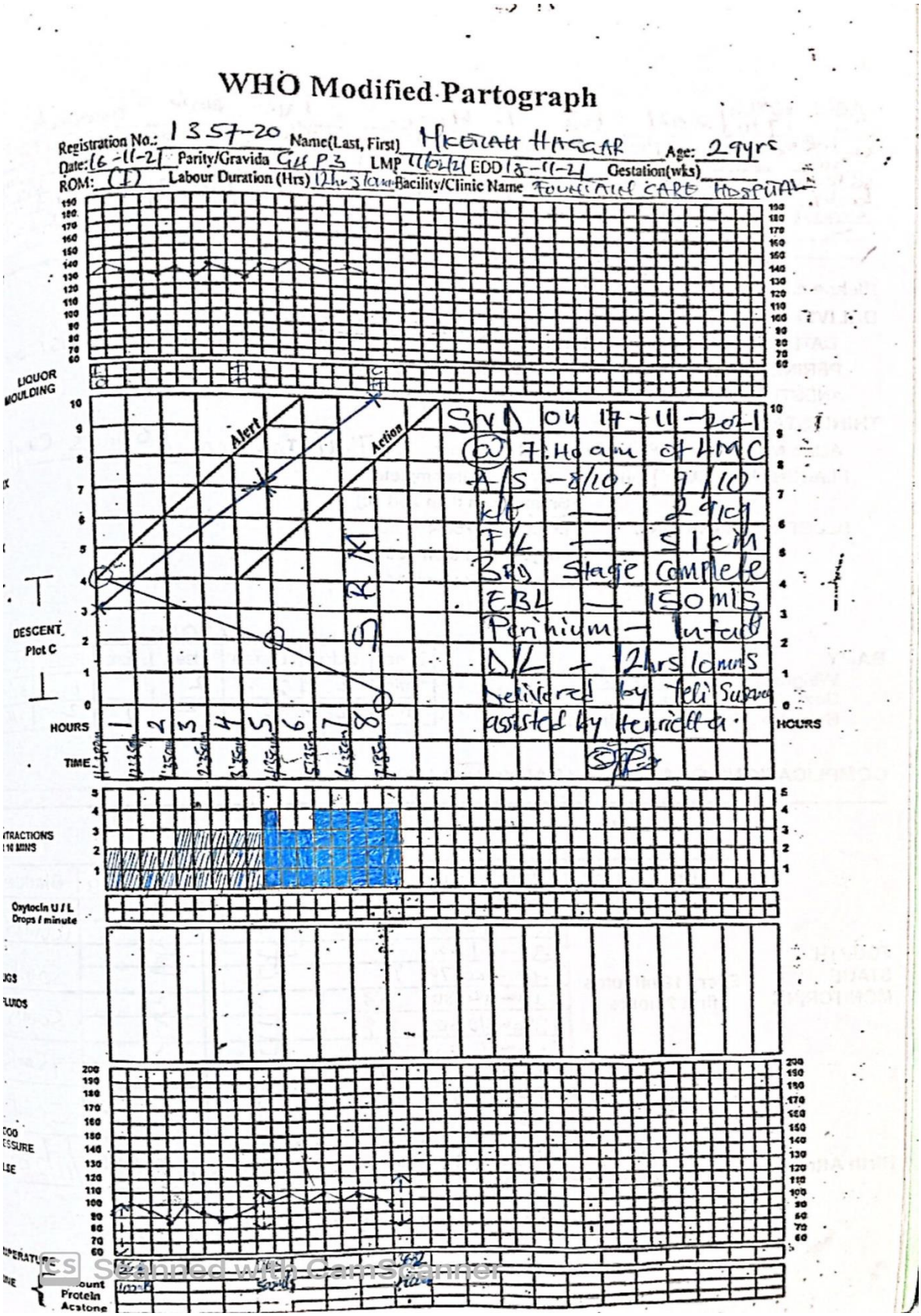
Mode of Delivery (if known) Spontaneous Vaginal Delivery

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

[ ] Normal Care [ ] Problem, Continue supportive in-patient care [ ] Urgent Referral / Advanced Care [ ] Discharge


MATERNITY CHART
Madam Nkefiah Hagger
29years
13.57/20
WARD: Lying - in
BED NO.: 2
17/11/21 18/11/21 19/11/21 20/11/21 21/11/21 22/11/21 23/11/21 24/11/21
DD D1 D2 D3 D4 D5 D6 D7
AM 7:40 9:00 9:00 9:00 9:00 9:00 9:00 9:00
PM 5:00 5:00 5:00 5:00 5:00 5:00 5:00
Temperature
17cm 16cm 15cm 14cm 13cm 12cm 11cm 10cm 9cm 8cm 7cm 6cm
KEY
TEMPERATURE
FUNDAL HEIGHT
SCALE → 1cm / 1 unit
Pulse 82 72 72 68 82 70 86 76
Resp. 21 18 18 21 21 20 22 19
Urine Passed Passed Passed Passed Passed Passed Passed Passed
104/62
Scanned with CamScanner

WHO Modified Partograph



LABOR NOTES On 17/11/2021 @ 7:40am a live male neonate was delivered through SVD with APS 8/10, 9/10. Oxytocin 10 units was given and active management of 3rd stage conducted, Perineum intact, Head circumference 34cm, estimated blood loss 150mls, baby was examined from head to toe [illegible] and other essential care done for baby, 4th stage of labour [illegible]

Please circle or write responses.

DELIVERY

DATE: 17/11/21 TIME: 7:40am METHOD: (Spontaneous) / Vacuum Extraction / C/S / Other

PERINEUM: (Intact) / Episiotomy / Laceration

ANESTHESIA: None / Local / General

THIRD STAGE

Active Management: (Yes) / No ·Medication: Time 7:41 Type/Dose 10units Oxytocin

PLACENTA: TIME: 7:41am (Complete) / Incomplete

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

BABY

Weight: 2.9kg

Sex: (Male) / Female

Baby Position: (Vertex) / Breech / Other

APGAR

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

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

	Frequency	Time	B/P.	Pulse	Fundus	Bleeding	Bladder
FOURTH STAGE MONITORING	Every 15 minutes first 2 hours	8:00am	110/60	98	Contracted	No active bleeding	100mls
		8:15am	110/70	96			
		8:30am	100/70	86			50mls
		8:45am	120/70	97			
		9:00am	120/80	83			50mls
		9:15am	110/80	79			
		9:30am	110/70	86			75mls
		9:45am	100/60	91			
	Every 30 minutes For 1 hour	10:15am	110/70	70			50mls
		10:45am	110/70	94			

Birth Attendant YEH SUSANA Date 17/11/2021

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TEMPERATURE CHART

Baby Hicketah.

Newborn

1357/20.

WARD: Lying-in

BED NO.: 2

	17/11/21	18/11/21	19/11/21	20/11/21	21/11/21	22/11/21	23/11/21	24/11/21
	D0	D1	D2	D3	D4	D5	D6	D7
AM	7:40	9:00	9:00	9:00	9:00	9:00	9:00	9:00
PM	5:00	5:00	5:00	5:00	5:00	5:00	5:00	5:00

Temperature

Pulse

KEY

→ TEMPERATURE

→ BABY'S WEIGHT

SCALE: 1cm : 1unit

TEMPERATURE CHART

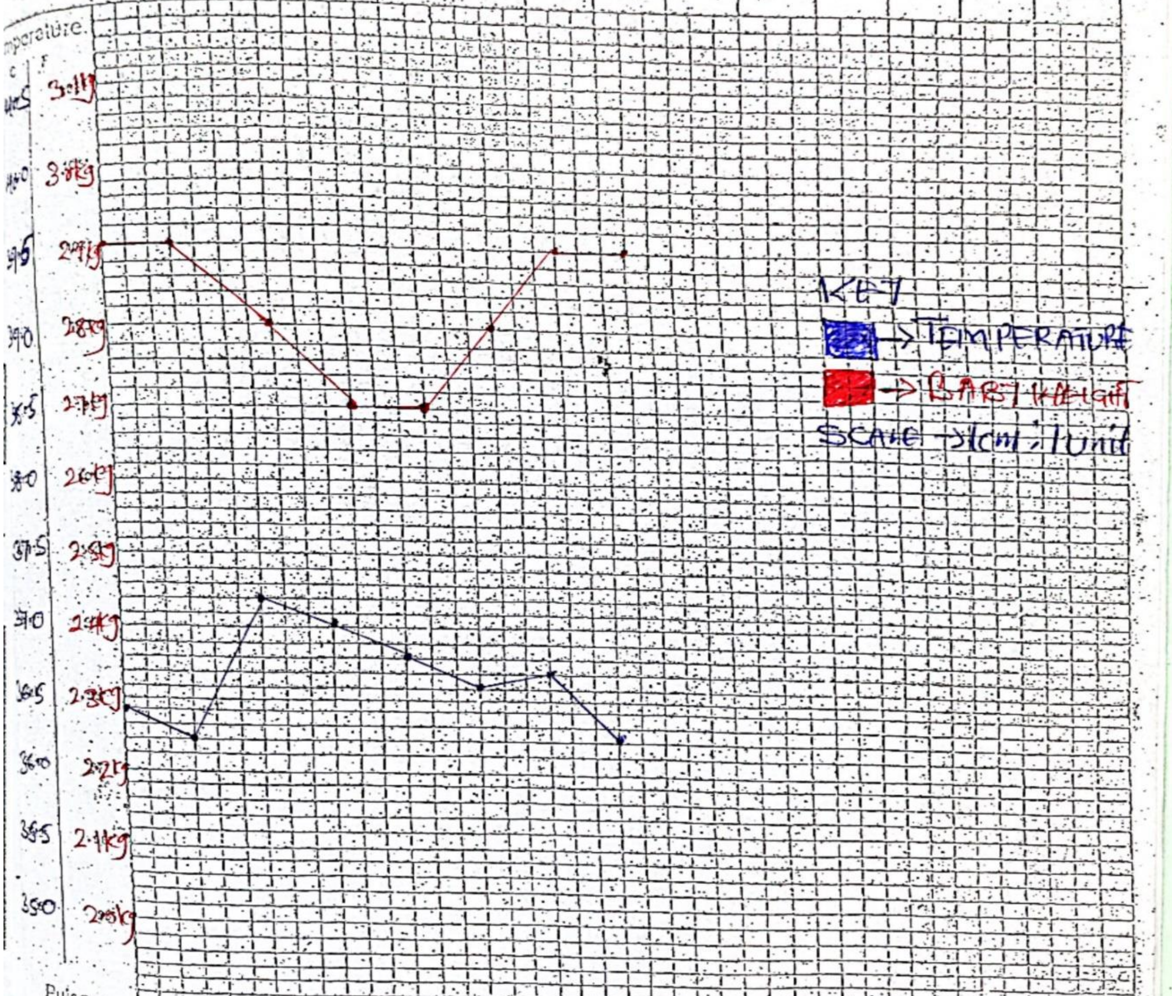
Baby Mise Kah

Newborn .... WARD: Lying – in

1357/20. .... BED NO.: 2

Date	17/11/21	18/11/21	19/11/21	20/11/21	21/11/21	22/11/21	23/11/21	24/11/21
Day in Hospital	AD	D1	D2	D3	D4	D5	D6	D7
AM	7:40	9:00	9:00	9:00	9:00	9:00	9:00	9:00
PM	5:00	5:00	5:00	5:00	5:00	5:00	5:00	5:00

Temperature.



Pulse

Resp.

B.M.

Urine. Passed Passed Passed Passed Passed Passed

SIGNATORIES

THE STUDENT MIDWIFE

NAME: MISS YELI SUSANA

SIGNATURE: .....

DATE: 03/10/2022

THE SUPERVISOR THE MIDWIFE-INCHARGE (FOUNTAIN CARE HOSPITAL - SAMPA)

NAME: MRS. OPPONG-BASSI EUNICE

SIGNATURE: ..... (for)

DATE: 04/10/2022

THE SUPERVISOR

NAME: MRS. AHIAWORNU CELESTINE

SIGNATURE: ..... (for)

DATE: 04/09/2022

THE PRINCIPAL

NAME: MONICA NKRUMAH

SIGNATURE: ..... (fr)

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

DATE: 30th September, 2022.