HOLY FAMILY NURSING AND MIDWIFERY TRAINING COLLEGE

BEREKUM

A CLIENT/FAMILY CENTERED MATERNITY CARE STUDY ON

MADAM TAKYIWAA RITA

BY

MANSA KODUAH

4122210098

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

AUGUST, 2023

TABLE OF CONTENT

Contents

PREFACE

The family centered maternity care study also gives the student midwife an opportunity to use her knowledge and skills acquired both practically and theoretically during her period of training to care for a pregnant woman throughout pregnancy, labour and puerperium.

Moreover, the family centered care study helps the student midwife to use the new trend in midwifery like the patograph and nursing process in management of first stage of labour and to diagnose any complication during pregnancy. The nursing process provide framework for solving problems and making decisions in the management of the client and family in a systematic manner. The study also enables student midwife to educate the client and family and also promote cordial relationship between the student midwife, the mother and her family.

Furthermore, the study helps the student midwife to put into practice the concept of safe motherhood initiative which has being adapted to render quality maternity care through antenatal, labour and puerperium which will eventually reduce maternal and neonatal mortality.

The family centered maternity care study is an academic exercise required by the Nursing and Midwifery Council of Ghana so as to enable the student midwife to practice after completion of her training.

ACKNOWLEDGEMENT

My first and most grateful gratitude goes to God Almighty for giving me his strength, guidance, protection and knowledge to write this case study successfully.

I thank the Principal, Miss Monica Nkrumah for her motherly love, care, support and strict supervision in the upbringing of this piece.

I also thank my supervisor Madam Monica Boakye for her advice and strict supervision. I am also most grateful and appreciative to the stuff of Holy Family Nursing and Midwifery Training College, Berekum for their support and encouragement they gave me during the period of my training and writing of this case study, I wish you all well in everything for your hard work and sacrifice exhibited in writing this care study.

Again, I wish to express my gratitude and heartfelt appreciation to all the staffs of St Mathew Hospital Ampenkro; most especially midwife in-charge, Mrs. Akoto Irene and all the other staffs for their maximum support given to me throughout my care study.

Furthermore, my gratitude goes to my client, Madam Takyiwaa Rita and her entire family for providing me with all the necessary information, co-operation and hospitality during my time of visit to their home.

Moreso, my gratitude goes to the couples who gave birth to me Mr and Mrs. Koduah; I say may the good Lord bless them in his own way. for encouragement, also remembering me in prayers and given me the necessary support physically, emotionally and finically throughout my years of study I say God bless you abundantly.

Finally, my profound gratitude and sincerity goes to all the authors

INTRODUCTION

The family centered maternity care is a systematic approach used in the care of an expectant mother involving her family during which the care is extended to the community the client lives. It is based on consideration of the client as a unique individual with specific problems and needs to assist her in solving them.

This family centered maternity care was carried out on study was Madam Rita Takyiwaa , a 29year-old gravida two para one alive who was met on the 14th November, 2022 at the antenatal clinic of the St. Matthew's Hopital –Ampenkro during my clinical attachment. She was 36 weeks pregnant and that was her 9th visit to the antenatal clinic. The interaction when she came to the vital signs table. There are four (4) chapters outlined in this script. Chapter one talks about client particulars such as Social, Family, Medical, Surgical and Menstrual cycle, past and present obstetrical History.

Chapter two also talks about the first interaction with client, first home visit to client, continuous antenatal visit to the clinic, subsequent home visit and nursing care plan during antenatal.

Chapter three talks about admission and management of the various stages of labor, immediate care of the baby, subsequent care of the baby, summary of labour and nursing care plan during labour.

Chapter four is about the management of puerperium, first day post-delivery and discharge, postnatal home visits and tenth day postnatal visit to the hospital.

The problems both actual and potential disorders identified were managed using the nursing process and care plan was drawn at the end of each chapter except chapter one.

This report includes termination of care, summary and conclusion, bibliography, appendices and signatories. The source of information was from the client records, textbooks and her family.

WHY CLIENT WAS CHOSEN

Madam Rita Takyiwaa , 29 years old, gravida 2 para 1 alive visited the antenatal clinic at the St. Matthew's Hospital – Ampenkro on the 14th November, 2022. Client was 36 weeks pregnant at time of the visit. Client was selected during the health Education section on Birth Preparedness and Complication Readiness Plan. Client was quiet and upon observation she was worried. After the Education She was warmly welcomed and offered a seat. Upon glancing through her antenatal card during her turn for the vital sign to be checked, it was realized that she had complained of Waist Pains for 3(three) consecutive times of her previous antenatal visits and still complaining. She explained that it was making her worried since she has no knowledge of problem , She was reassured that she would be assisted with adequate management plan to get it under control.

Introduction was made as a student midwife from Holy Family Nursing and Midwifery Training College, Berekum on practical session. The concept of the family centered maternity care study was explained to her and the intension to use her as a client for the care study to enable me give individualized care to her and her family for the rest of the period of her pregnancy through labor to puerperium was made known to her. She accepted and promised to co-operate with me.

She was introduced to the midwife in-charge and approved. She gave direction to her house and phone numbers were exchanged and promised to visit her in the house but will call her before making the visit.

LITERATURE REVIEW

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

PREGNANCY

Perry (2014), states that pregnancy is a period of physical and psychological preparation for birth and parenthood. According to him prenatal visit ideally begins soon after the first missed menstrual period to ensure good health of the expectant mother and the fetus. Normal pregnancy lasts for about 40weeks or 280 days and health care providers refer to early, middle and late pregnancy as trimesters. The first trimester lasts from week 1 through to 13, the second from week 14 through to 26, and the third from week 27 through to 40. Pregnancy is considered to be at term if advances to 38 to 40weeks.

Marshall & Raynor (2014) further explains that during pregnancy there are profound but predominantly reversible changes occurring in maternal homodynamic and cardiac function. These complex adaptations are necessary to

1. Meet evolving maternal changes in physiological function.
2. Promote the growth and development of the utero placental fetal unit.
3. Compensate for blood losses at the end of labour.

The heart is enlarged by chamber dilatation and a degree of myocardial hypertrophy in early pregnancy leading to a 10 -15% increase in ventricular wall muscles. The enlarging uterus raises the diaphragm upward and to the left to produce a slight anterior rotation of the heart on its long axis. It also increases in blood volume known as haemodilution, further explains that to accommodate increase oxygen requirement and physical impact of enlarging uterus

intricate changes occurring in respiratory physiology. The driving force for change in the respiratory stimulation effect of progesterone initiating hyperventilation by increasing sensitivity to carbon dioxide. Through lowering threshold at which the respiratory counter is stimulated. The lower ribs flare outwards prior to any mechanical pressure from the growing uterus. Changes are mediated by progesterone and relaxant which increase rib cage and elasticity by relaxing ligaments in a similar mechanism to that occurring in the pelvis. Furthermore, adaptation of the central nervous system is probably the least well understood compared to other body system. The hormonal fluctuations occurring throughout pregnancy may remodel the female brain increasing the size of neurons in some regions and producing structural changes in others. Estrogen and progesterone readily enter the brain to act on nerve cells changing the balance between inhibition and stimulation. A pregnant woman's sleep pattern can be affected by both mechanical and hormonal influences.

The striking anatomical and physiological changes occurring in the urinary system are critical for optimal pregnancy outcome. In a healthy pregnancy the kidneys lengthen by up to 1.5cm and kidney volume increase by as much as 30%. The ureters become longer and are thrown in the single or double curves of various sizes. Dilated ureters with reduced peristalsis and mechanical obstruction by the enlarged uterus all contribute to urinary stasis leading to the increase risk of urinary tract infection in pregnancy. The trogon becomes deeper and wider as pregnancy progresses leading to reduced bladder capacity. To compensate for this the urethra lengthens by about o.5cm and the bladder tone increase to help maintain continence in spite of the urinary incontinence can be troublesome in pregnancy. As the uterus enlarges the bladder becomes distorted and it is drawn upwards interiorly becoming an abdominal organ by the third trimester.

Fraser Cooper (2013) 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 fetus. 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 fetal 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.

According to Perry (2013), 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 fetus. He also stated that normal pregnancy last for about fourth (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 fourth (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 - 27th week to 42nd of week gestation. Ideally this should be more flexible depending on the need, and the convenience of the patient.

LABOUR

Perry (2013) stated that five factors affect the process of labor 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 labor as follows; the first stage of labor 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 labor 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 are more rapid dilation of the cervix and increase rate of the descent of the presenting part. The second stage of labor; 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 labor as a series of events that takes place in the genital organs in effort to expel the viable products of conception out of the womb through the vagina into the outer world.

Labor 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 labor 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 labor are divided into four stages; first, second, third and fourth stage. First stage starts from the onset of true labor pain and ends with full dilatation of the cervix. Its average duration is 6 hours in multipara. 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 labor; that is the pelvis, passenger, powers and psyche. These are known as the four P’s.

Konar (2013) further stated that under bladder care; patient is encouraged to pass urine by herself as full bladder often inhibits uterine contraction and may lead to infection. If the woman cannot go to the toilet, she is given a bed pan. Privacy must be maintained and comfort must be ensured. If the patent fails to pass urine especially in late first stage, catheterisation is to be done with strict aseptic precautions.

Fraser & Cooper (2012) described labor as the process by which the fetus, placenta and membranes are expelled through the birth canal. It also explained that the first stage of labor can be divided into 3 stages namely: The latent phase which is prior to active phase of first stage of labor 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 labor 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. Henderson and Macdonald (2011) further stated that in order to provide woman-centered care during labor, the midwife should: asses the needs and expectations of each individual woman regarding labor and birth. Plan care with each woman in labor, tailored to meet her specific needs and expectations. Put the care plan into practice. Evaluate the care given to measure its effectiveness. She also stated that, labor is divided into four (4) stages, these are: first stage which deals with the onset of painful rhythmic uterine contractions and dilatation of the cervix. Second stage which deals with full dilation of the cervix and expulsion of the fetus. Third stage is the delivery of the placenta, membranes and the control of haemorrhage .The fourth stage is when the mother and baby are being monitored for the first six hours after delivery.

According to the above definitions, it means labor 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 (2013) 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 labor 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 color. 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 color and continues for 10-14 days.

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 puerperium 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.

CHAPTER ONE

1.0 ASSESSMENT OF CLIENT AND FAMILY

This chapter provides detailed information about client's personal , social, medical, surgical , family, past obstetric history and present obstetric history.

1.1 SOCIAL AND PERSONAL HISTORY

Madam Rita Takyiwaa a 29year old who is a native of Wenchi Sobinso in the Wenchi West District of the Bono Region of Ghana lives in Dormaa Ahenkro, house number and is currently residing in house number with her husband and child. She is fair in complexion and stands at a height of 161 centimeters. She speaks the Twi and English languages. She completed Senior High School and is currently a Trader.

She is happily married to Mr. Mutalah Mohammed, who also hails from Wenchi. Both are Muslims . They have a 3-year-old son, Ibrahim Haruna who schools at Methodist Kindergarten School. Her next of kin is her husband. According to her, they are financially sound and also have a support person to help them cater for their unborn baby.

1.2 FAMILY HISTORY

Madam Rita is the First born of Mr. Takyi Emmanuel and Madam Grace Donkor. Both are natives of Wenchi in the Bono Region and are alive. She has four (4) siblings. According to her, there is no history of any hereditary disease such as hypertension, heart disease, diabetes mellitus, asthma, mental illness, sickle cell disease, birth defects like spinal bifida, cleft palate. There is also no

history of twin pregnancy in their family. According to her, all deaths in their family are due to natural causes.

1.3 MEDICAL HISTORY

According to client, she has never suffered from any serious illness that needed hospitalization. She has no history of hypertension, heart disease, sickle cell disease, diabetes mellitus, jaundice, respiratory disease, (tuberculosis, asthma), epilepsy, and mental illness. She has never been transfused with blood before. However, she experienced slight abdominal pains, nausea, fever and headache and received treatment at Ampenkro Hospital at outpatient department basis. According to the client, she has no known allergy for any food or drug.

1.4 SURGICAL HISTORY

Madam Rita explained that she has had no surgical operation such as salpingectomy, myomectomy or caesarean section being done on her. She has not had any accident or injury to the hips or pelvis.

1.5 MENSTRUAL HISTORY

Madam Rita narrated that she had her menarche at the age of 15 years. She said she has a regular twenty-eight-day cycle (28 days). Her menses last for four (4) days. She does not experience dysmenorrhea. Her last menstrual period was on 9th March, 2022 and her calculated expected date of delivery was 16th December, 2022. The ultrasound scan was also 21st December, 2022.

1.6 HABITS OF DAILY LIVING / HOBBIES

Madam Rita Takyiwaa wakes up at dawn and have her morning prayers with the family. She uses tooth brush and closed -up to clean her teeth. She sweeps the bedroom and the compound of the

house every morning. According to her, the husband baths their son in the morning whiles she prepares their breakfast and serve her husband and her child. By 6:45am - 7:00am, she takes her son to school

She takes her bath twice a day and takes at least three-square meals a day, with fruits in between meals and sometimes fruit juice after lunch. She moves her bowl at least once daily usually in the morning and evening and passes urine depending on the fluid in-take. Madam Rita Takyiwaa said she enjoys watching movies. Her favorite food is Konkonte with Groundnut soup.

On Saturdays, she washes their clothes and scrubs their washroom. She irons her child uniform for Monday. She prepares supper at around, after which she feeds her child. She does not smoke cigarette or drink alcohol and usually watches the evening news on television before going to bed at around 9:50pm.

1.7 PAST OBSTETRIC HISTORY

PREGNANCY

Madam Rita Takyiwaa, G2P1 alive explained that she had her previous pregnancy in 2019 and was carried to term without complications such as pregnancy induced hypertension, antepartum haemorrhage, etc. According to her and the records she attended antenatal clinic regularly at the Ampenkro Hospital and received two (2) doses of tetanus immunizations and took four (4) doses of the intermittent preventive treatment (IPT) thus Sulphadoxine Pyrimethamine (SP) during each pregnancy. According to her she has no record of either spontaneous or induced abortion.

LABOUR

According to her, she reported to the maternity unit of St. Matthew's Hospital – Ampenkro in her first stage of labor. The baby cried immediately after birth. According to client the placenta and

membranes were delivered within some few minutes after delivery and there was no complication like postpartum hemorrhage and perineum was intact without tear.

PUERPERIUM

According to her, she breastfed her child exclusively for the first six months, and continued to breastfeed him till 2years old. She has also immunized her child against the preventable childhood diseases. The calendar method of family planning was used prior to pregnancy and was discontinued the month she planned to conceive. According to client, her husband and mother in-law were her support persons. Both mother and baby were in good health and had no record of ill health after delivery.

1.8 PRESENT OBSTETRIC HISTORY

According to the records, Madam Rita Takyiwaa reported for the first time at the antenatal clinic of St. Matthew's Hospital –Ampenkro for booking on 4th July, 2022 when she was about 11 weeks of pregnancy. Her last menstrual period was on 9th March, 2022 and her calculated expected date of delivery was 16th December, 2022. The ultrasound scan was also 21stDecember, 2022. During this visit the following were the findings on examination, laboratory investigations, vital signs and other observations;

Temperature	36.7 degrees Celsius
Pulse	86 beats per minute
Respiration	20circular per minute
Blood pressure	100/60 millimeters of mercury

Height	163 centimeters
Weight	84kilograms

LABORATORY INVESTIGATIONS:

Urine analysis

Protein	Negative
Glucose	Negative
Acetone	Negative
Hemoglobin level	11.1 grams per deciliter
Blood group	A
Rhesus factor	positive
Sickling	Negative
VDRL	Non-reactive
Hepatitis B test (HBsAg test)	Negative
HIV/AIDS	280 (Non- Reactive)
Stool routine examination	no abnormality detected

These findings were to serve as baseline data to be compared to future findings to detect any deviation from normal. Head to toe examination carried out revealed no abnormality. Client had no complain. According to the client she was given health education on nutritious diet, rest and sleep, personal hygiene and ultrasound scan during pregnancy.

She was given the following routine drugs:

Tablet Folic Acid	5mg daily times 30 days
Tablet Ferrous Sulphate	200mg once daily for 30 days
Tablet Multivitamin	200mg three times daily for 30 days.

According to client's maternal record book, she attended the clinic regularly and all routine examinations and laboratory investigations were carried out with no abnormalities detected. Client received the Sulphadoxine Pyrimethamine at the correct intervals and at the appropriate gestational ages and was asked to continue the rest after delivery.

The records also revealed that she received health education on danger signs in pregnancy, nutrition, anemia in pregnancy, etc. She was scheduled for monthly attendance but was encouraged to attend clinic any time she had any health problem. Everything went on normally with her except for client complaining of Waist Pain when she was 36 weeks pregnant.

CHAPTER TWO

2.0 INTRODUCTION

This chapter contains more information about first contact with the client, antenatal home visits, subsequent visit to the clinic by client, and nursing care plan on problem identified during the antenatal period.

2.1 FIRST CONTACT WITH CLIENT AT THE CLINIC

Client was met on 14th November, 2022 and was the first time Madam Rita Takyiwaa was met. This took place at the antenatal clinic at St. Matthew's Hospital Ampenkro this was her 9th visit and she was 36 weeks pregnant. When it was her turn for vital signs to be taken, She was warmly welcomed and offered a seat. Upon glancing through her antenatal card during her turn for the vital sign to be checked, it was realized that she had complained of backache for 3(three) consecutive times of her previous antenatal visits and still complaining. She explained that it was making her worried since she has no knowledge about it, She was assured that she would be assisted with adequate management plan to get it under control as well as care for her through the rest of her pregnancy, labour and puerperium. The physiology behind the backache during pregnancy was explained to her as being the weight of the gravid uterus on the sacral nerves and the change in posture during pregnancy and she was reassured. The concept of the family centered maternity care study was explained to her and the desire to involve her and her family was made known to her. She gladly accepted to participate to make it successful.

The client was introduced to the midwife in charge as the client to be used for the care study.

She was informed the care was a temporal one which she will be handed over to the public health for continuation of care.

All procedures to be carried out were explained to her. Her vital signs were checked and recorded as:

Temperature	36.0 degrees Celsius
Pulse	80 beat per minutes
Respiration	20 cycles per minutes
Blood pressure	100/74 millimeters of mercury
Weight	87 kilograms
Hemoglobin	12.0g/dL

PHYSICAL EXAMINATION

Madam Rita was then sent to the examination room and privacy was provided. She was asked to empty her bladder. Specimen bottle was offered to her to collect midstream urine sample for glucose and protein which both tested negative and the urine was amber in colour . She was helped to undress and put on the examination gown and assisted onto the examination couch. Hands were washed with soap under running water and hand was s dried.

HEAD

She was assisted into the dorsal position and the physical examination from the head was started. Her eyelids and face were not puffy, there was no jaundice on the sclera. There were no discharges from the eyes, nose and ears, her neck was examined and there were no lymph nodes. The mouth, teeth and tongue were cleaned with no dental carries, or offensive odour.

BREAST EXAMINATION

The breasts were first exposed and observe the colour, alignment, size and abnormality of the nipple. Then one breast was covered and Madam Rita was asked to put her hand under her head to examine her breast for presence of lumps and any abnormal discharge by palpation but no abnormality was detected. She was educated on how to examine her breast a week after menstruation, so as to detect any abnormality early enough for appropriate action to be taken. Cotton wool was put on the nipple and the areolar was squeezed to check for any abnormal discharge which was absent.

UPPER AND LOWER EXTREMETIES

Her hands were inspected for symmetry, swelling or oedema and there was no abnormality.

Her nails were pressed for capillary refill and it was normal. No abnormality was detected.

The lower limbs were of the same size, length and without oedema and her calf palpated for nerve damage and varicose veins.

BACK

The back was also examined for sacral oedema and also scars but no abnormality was detected.

Abdominal inspection, the shape and size of the abdomen was oval and medium. There was no scar except for some very few traces of strae gravidarum and linea nigra. Fetal movement was also observed.

During measurement of the symphysio-fundal height, the upper border of the symphysis pubis and the fundus were located and the zero mark of the tape measure was placed the border symphasis pubis and extended along the contour of the abdomen along the midline to the fundus. The symphysio-fundal height measured 36 centimeters and gestation was 36weeks**.**

fundal palpation, whilst standing at the client's right side and facing the head end of client, the palms were rubbed to become warm to prevent induced contractions. The fingers were curved around the top of the fundus to determine what was in the fundus. A soft mass was felt which indicated the buttocks.

During lateral palpation, each palm was placed on each side of the uterus at the level of the umbilicus. One hand was used to stabilize the uterus using a rotatory movement of the other hand to map out the back which was smooth at the mother's right side, the same movement was done to reveal the limbs which were rough on the left side of the mother.

Pelvic palpation, upon facing the woman's feet, she was asked to bend her knees slightly and also to breathe through her mouth slowly to help her relax the abdominal muscles. 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, a hard mass was felt indicating the head of the foetus.

Decent location of the anterior shoulder was done using two fingers 2cm below the umbilicus. The upper border of the symphysis pubis was also located and with the ulna border of the right hand placed on the upper boarder of the symphysis pubis. Five fingers were accommodated between the symphysis pubis and the anterior shoulder, indicating a descent of 5/5. Therefore, from the above, it was deduced that, lie was longitudinal, presentation was cephalic, descent was 5/5 and the position was right occiput anterior.

Auscultation, fetal stethoscope was rubbed in the palm to make it warm. It was placed at the area where fetal back was located. The ear was placed against the fetal stethoscope to listen for fetal heart beat for a minute as it was being compared with maternal pulse. The fetal heart rate was146 beats per minute.

VULVA EXAMINATION

On inspection the vulva was without any abnormality like warts, varicose vein, oedema, sore and no old episiotomy scar and no vaginal discharge

After the examination, she was helped out of the couch and assisted to dress up. She was thanked for her co-operation and findings were communicated to her and recorded in her antenatal record card.

A chair was provided to make her feel comfortable . Client was encouraged to wear cotton panties, change them frequently, also bath twice daily and use panty liners which are cotton. She was told to clean her perineum anterior posteriorly after using the toilet and always wash her panties and dry them in the sun. She was also encouraged to avoid strenuous work and ensure enough rest and sleep.

She was further encouraged to take her routine drugs, as prescribed, eat well nourishing diet and take in oranges and apples after meals to help in the absorption of iron. She was educated to use low heel shoes and support her back with pillows when sleeping or resting. She was encouraged again to take copious fluid and at regular intervals. She was served with the following drugs;

Tablet folic acid	5mg ones daily for 14 days
Tablet ferrous sulphate	200mg daily for 14 days
Tablet multivitamin	200milligrams daily for 14 days

Afterwards, she was informed of the intentions to visit her at home and a date was fixed. Telephone numbers were exchanged and she gave the directions to her house. She was also reminded of her next visit to the clinic which was 21st November, 2022.

2.2 FIRST ANTENATAL HOME VISIT

The first home visit to Madam Rita Takyiwaa and her family was on the 15th November, 2022, at about 4:00 pm. On arrival, a warm welcome was given and introduction was done to client. The purpose of the visit was to assess client's physical environment and interact with her family members and significant others. After exchange of greetings, their permission was sought to examine their environment.

Physical Environment

It was observed that she lived in a compound house with her husband and child. The house was built with cement block and roofed with iron sheet. The house contained one big hall and nine (9) rooms,3 toilets,3 bathroom and 2 kitchens. It was observed that client and her family slept under insecticide treated mosquito net. They were congratulated for that. It was also observed that client relates well with the other neighbors.

Her things were observed to be nicely arranged in her room and the kitchen as well with good ventilation. Their source of water was pipe borne. She stored water in a big plastic container with a fitting lid in the kitchen. Their source of lighting was electricity but they used a rechargeable lamp when the light goes off. There was a big dustbin with lid in which they put their rubbish and burn at least every two days. There was also a small dustbin nicely covered and placed in the kitchen and emptied into the big bin on daily basis. In order to inspect their toilet and bathrooms, their permission was sought for bladder emptying. It was observed that the toilet and bath house were well scrubbed and looking neat.

It was however observed that the back of the house was weedy. Client and family were congratulated for keeping their house neat, but were encouraged to maintain good environmental

hygiene by clearing the weeds at the back of their house, drain stagnant waters that might lead to breeding of mosquitoes

Client was asked about her eating habit and she said she had good appetite for food and could eat three (3) square meals with watermelon and oranges in between meals but she does not like taking much water as it causes frequent urination. She was encouraged to drink about eight glasses of water a day to prevent dehydration and aid in elimination of waste product in the body and drink less before bedtime.

She was educated on the importance of eating well nourishing diet because her unborn baby also needs nutrients for the baby's growth and development, good food aids in muscle growth and provides the nutrients and antioxidants that the woman needs to keep the immune system healthy. She was asked about food available at her area, which she informed me about them. She was encouraged to eat varieties of foods as this is more likely to let her get the required nutrients. For instances protein from animal and plant sources like meat, fish, eggs, beans, groundnut and agushie. A good source of folic acid can be found in dark green leafy vegetables examples kontonmire, cassava leaves, ayoyo etc. She was educated to take a lot of fiber diet like brown rice, whole grain cereals, fruits and vegetables to prevent constipation. She was congratulated for adding fruits to her diet.

She was also encouraged to take her routine drugs everyday as prescribed.

Client was educated on birth preparedness and complication readiness plan which included the need to arrange for blood in case of emergency, arranging for transport to clinic in advance in case labor sets in, and the need to save some money towards their needs during delivery. She was asked about national health insurance and she said she has registered with the National Health Insurance Scheme. Her card was collected and looked at and it was noticed that the expiry date was not

approaching. She was asked about her items for delivery and confinement and she disclosed that she had bought almost everything. Her items were inspected. She was encouraged to get everything before the next home visit.

True signs of labour were also explained to her such as regular, painful, rhythmic uterine contractions cervical dilation and the presence of show (that is, blood-stained mucus discharge).

She was also educated on the danger signs of pregnancy which includes vaginal bleeding, severe headache, swelling face and feet, severe vomiting and high fever.

She was reminded about the advantages of being prepared psychologically for labor and delivery by being confident and thinking positively that her delivery will be successful. She was encouraged to adhere to all the information given to her during the antenatal clinic.

They were thanked for their co-operation and reception. Client was reminded of her next visit to the clinic which was on the 21st November, 2022.

PSYCHOSOCIAL

According to Madam Rita, she lives with husband and child peacefully and has corrdial relationship with her neighbors. she is sociable and neither takings alcohol nor smokes. client attends mosque on Fridays and prays five times a day. Madam Rita likes to crack jokes and has respect for everyone. Which clearly show whenever she is been visited at home. client was education on True labour signs “show “and painful rhythmic regular contraction. Client was appreciated for the warm welcome and permission was sought to take a leave.

2.3 SUBSEQUENT VISITS TO THE CLINIC

On the 21st November, 2022, Madam Rita came the antenatal clinic at St. Matthew's hospital-Ampenkro. On arrival, she was warmly welcomed and a seat was offered to her. She was congratulated for the visit and vital signs were checked and recorded as follows;

Blood Pressure	112/80 millimeters of mercury
Pulse	84 beats per minutes
Respiration	23 cycles per minutes
Weight	90 kilograms

Urine was tested for glucose and protein which was negative and colour was amber. Routine head to toe examination was carried out. Procedure was explained to her, made to empty her bladder and privacy ensured. She was helped unto the couch, hands were washed and dried. A head to toe examination was done with no abnormality detected under the supervision of the midwife in charge.

On palpation gestational age were 37 with symphysio fundal height of 37 centimeters. On fundal palpation the buttocks occupied the fundus lie was longitudinal, on lateral palpation the position was left occipito anterior, on pelvic palpation the presentation was cephalic descent was 5/5th above the pelvic brim. On auscultation, fetal heart was 138 per minutes with good volume.

She was helped off the couch and also helped to dress up. Findings were recorded in the antenatal booklet and communicated to her. She was reminded of the signs of true labour which include painful rhythmic uterine contraction with blood stained mucus discharge (show) and cervical dilatation. She was asked to report immediately to the Clinic if she sees any of these signs.

On enquiry, she said the waist pain has been managed and expressed gratitude for the useful information and prudent management plan initiated. She however complained of heart burns on the 21st November, 2022. She was reassured that it will be reduced soon after delivery. The burning sensation was explained to client that it was due to slow backward flow of food from the stomach and it is felt in the chest region. The backward flow of food is caused by the hormone progesterone, which relaxes the cardiac sphincter causing reflux of gastric contents into the esophagus. She was educated it could be relieved by avoiding the intake of spicy foods and eating food rich in fat and oil. She was encouraged to prop up in bed when sleeping by using more pillows. She was also educated to have small frequent meal, avoid bending down whiles washing or doing household chores but rather sit to work. She also complained of insomnia on 21st November,2022, education was given to her about the insomnia which was due to excessive noise and was thought on how to prevent it from reoccurring. She was told to have enough rest and sleep, avoid tedious work, and rest in between chores. She was encouraged to continue to take in more fluid and fruits and to observe good personal hygiene by bathing twice a day, using cotton underwear, washing and drying them in the sun and possibly iron it if not well dried and also change her panty liner when wet. She was served with the following drugs;

Tablet folic acid	5mg daily for 7 days
Tablet ferrous sulphate	200mg three times daily for 7 days
Tablet multivitamin	200mg three times daily for 7 days

Client was served with the 6th dose of Sulphadoxine Pyrimethamine.

She left the clinic very happy and was promised another visit to them again in the house and was bid farewell.

2.4 SUBSEQUENT HOME VISIT

Client was visited again in the house on 26th November, 22. The presence of the entire family was met and they were happy. The purpose of the visit was to see how client and family were doing and also check if the education given was adhered to.

According to client the heartburns had been managed.

It was observed that the bushes around the house was cleared and all drains cleared as well. They were congratulated for a good work done.

On review of the birth preparedness and complication plan, client said the husband will donate blood for her if she will need one. She also said once her husband was a driver, he will bring her to the hospital when labour sets in.

Her items for conferment were brought for inspection and it was intact and well packed in a nice bag.

The signs of labor was revisited and encouraged her to report immediately to the labour ward.

Client was happy for the visit and we bid ourselves good bye.

2.5 SUBSEQUENT VISIT TO THE CLINIC

Madam Rita Takyiwaa visited the clinic again on the 28th November, 2022 as scheduled. She was welcomed and a seat was offered. After a little conversation, her vital were checked and recorded as follows;

Temperature	36.2 degree Celsius
Pulse	92 beats per minute
Respiration	20 cycles per minute

Blood pressure	110/70 millimeters of mercury
Weight	89kilogram

Madam Rita was asked to empty her bladder and a specimen bottle was given to her to take a midstream urine sample for testing. After which she was asked to wash her hands. Urine was tested and the result gave negative for both protein and glucose. After explanation of procedure to her, privacy was provided and physical examination was carried out from head to toe under the supervision of the midwife in-charge and no abnormality was detected.

On abdominal examination; her gestational age was 38 weeks with symphysio-fundal height of 38cm, presentation was cephalic with decent of $5/5^{th}$ fetal heart rate on auscultation was 140 bpm with good volume and regular rhythm.

Client was thanked and helped out of the couch after which she dressed up. All finding were communicated to her. She complained of lower abdominal pain which she was educated that, the lower abdominal pain was due to the descending of the foetal head into the pelvis hence should cope with it. She was told to have enough rest and sleep and reduce stress. The opportunity was taken to stress on the importance of clinic delivery. Permission was sought from the in-charge and client was taken around the labor ward for orientation.

She was served with the following drugs;

Tablet Folic Acid	5mg daily for 7 days
Tablet Ferrous Sulphate	200 mg three times daily for 7 days
Tablet Multivitamin	200 mg three times daily for 7 days
Tablet paracetamol	1 gram three times daily for 3 days

Client will be reminded about the next which is on 5^{th} December,2022 and then I asked permission to leave and we bid goodbye.

2.6 SUBSEQUENT VISIT TO THE CLINIC

Madam Rita Takyiwaa visited the clinic again on the 5th December, 2022 as scheduled. She was welcomed and a seat was offered. After a little conversation, her vital were checked and recorded as follows;

Temperature	36.4 degree Celsius
Pulse	84 beats per minute
Respiration	22 cycles per minute
Blood pressure	120/70 millimeters of mercury
Weight	91 kilograms

Madam Rita was asked to empty her bladder and a specimen bottle was given to her to take a midstream urine sample for testing. After which she was asked to wash her hands. Urine was tested and the result gave negative for both protein and glucose. After explanation of procedure to her, privacy was provided and physical examination was carried out from head to toe under the supervision of the midwife in-charge and no abnormality was detected.

On abdominal examination; her gestational age was 39 weeks with symphysio-fundal height of 39cm, presentation was cephalic with decent of 5/5th fetal heart rate on auscultation was 143 bpm with good volume and regular rhythm.

Client was thanked and helped out of the couch after which she dressed up. All finding were communicated to her. She complained of fatigue which she was educated that, the fatigue which was related to the time of labour being near hence, should cope with it. She was told to have enough rest and sleep and reduce stress. The opportunity was taken to stress on the importance of clinic

delivery. Permission was sought from the in-charge and client was taken around the labor ward for orientation.

She was served with the following drugs;

Tablet Folic Acid	5mg daily for 7 days
Tablet Ferrous Sulphate	200 mg three times daily for 7 days
Tablet Multivitamin	200 mg three times daily for 7 days
Tablet paracetamol	1 gram three times daily for 3 days

2.6 NURSING CARE PLAN FOR ANTENATAL

PROBLEMS IDENTIFIED

- 14th November 2022 –Backache
- 21st November 2022- Heart burns
- 21st November 2022-Insomnia
- 28th November 2022- Lower abdominal pains
- 5th December 2022- Fatigue

SHORT TERM OBJECTIVES

1. Client will cope with management of Backache within 8hours
2. Client's heart burns will be reduce within 24 hours and should be able to cope with throughout pregnancy.
3. Client will be able to sleep comfortably in bed within 48hours.
4. Client will cope with management of lower abdominal pains within 24hours.
5. Client's fatigue will resolve within 48hours.

2.10 LONG TERM OBJECTIVE

Client will go through pregnancy, labour, and puerperium successfully without any complication.

NURSING CARE PLAN DURING ANTENATAL

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVE	NURSING ORDERS	NURSING INTERVENTIONS	DATE/ TIME	EVALUATION	SIGN.
14/11/22 9:30am	Backache related to pressure of the descending head on the sacral nerves	Client will cope with reduced backache within 24 hours as evidenced by client verbalizing that she is able to cope	1. Assure client with words of encouragement. 2. Explain condition to client. 3. Educate client to assume a comfortable position when sleeping. 4. Encourage husband to perform sacral massage to reduced pain. 5. Encourage client to have enough rest and sleep. 6. Encourage client to assume correct posture when sitting or standing.	1.Client was reassured that pain will be relieved after delivery. 2. Physiology of backache was explained to her as pressure of the fetal head on sacral nerves. 3.Client was educated to support her back and side with pillow when sleeping. 4.Client's husband was encouraged to perform sacral massage. 5.Client was encouraged to have at least 2 hours rest during the day and 6 to 8 hours during night 6.Client was encouraged to sit on chairs with back support.	15/11/22 9:40am	Goal fully achieved as client visualized that she is able to cope with management of backache.	M.K

NURSING CARE PLAN DURING ANTENATAL

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVE	NURSING ORDERS	NURSING INTERVENTION	DATE\ TIME	EVELUATION	SIGN
21/11/22 4:20pm	Heart burns related to progesterone relaxing the cardiac sphincter causing reflux of gastric content into the esophagus	Client will be relieved of heart burns within 24 hours as evidenced by client verbalizing she has been relieved from heart burns.	1. Reassure client of competent care. 2. Explain the physiological reason of heart burns. 3. Educate client to reduce fatty and spicy foods. 4. Educate client to eat in bits but at frequent intervals 5. Educate client not to go to bed early after eating	1. Client was supported emotionally that she will be relieved of heart burns soon. 2. Physiology of heart burns was explained to client that is due to the reflux of gastric content into the esophagus. 3. Client was educated to reduce or stop fatty and spicy foods. 4. Client was educated to eat in bit as shorter intervals. 5. Client was educated to sit for about an hour after eating before going to bed.	22/11/22 5:20pm	Goal fully met as client verbalized been relieved of the heart burns.	M.K

NURSING CARE PLAN DURING ANTENATAL

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVE	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN.
21/11/22 9:30am	Insomnia related to frequency micturition	Client will be able to sleep at least 30minutes continuously during daytime as evidenced by client verbalizing that she was able to sleep for at least one hour continuously at night and 30minutes continuously during the day.	1. Reassure client that she will regain her normal sleeping pattern. 2. Explain the physiology of frequent micturition to client. 3. Encourage client to limit the intake of fluids containing natural diuretics such as coffee in the evening. 4.Encourage client to keep a bedpan at night. 5.Encourage client to lean forward when voiding.	1. Client was reassured that she will regain her normal sleeping pattern. 2. The physiology of frequency micturition was explained to her. 3. Client reduced the intake of fluids containing natural diuretics such as coffee in the evening. 4. Client keeps a bedpan closer to her bed at night. 5. Client leans forward whenever she is voiding.	21/11/22 10:30am	Goal fully met as client said that she is able to sleep 30 minutes in the day and one hour continuously at night.	M.K

NURSING CARE PLAN DURING ANTENATAL

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVE	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
28/11/22 9:30am	Altered body comfort (Lower abdominal pain) related to descent of the presenting part	Client will cope with lower abdominal pain within 24hours as evidenced by client verbalizing the ability to cope with management of lower abdominal pain.	1. Reassure client. 2. Explain the physiology of lower abdominal pain to the client. 3. Encourage client have adequate sleep 4. educate the client on divisional therapy such as watching interesting television show 5. Administer analgesics such as paracetamol as prescribed	1. Client was reassured 2. Physiology of lower abdominal pain was explained to client 3. Client was Encourages to have adequate rest and sleep 4. client was educated on divisional therapy such as watching interesting television show 5. Analgesics were served as prescribed	29/11/22 9:30am	Goal fully met as client informed me she is able to cope with the pain	M.K

NURSING CARE PLAN DURING ANTENATAL

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVE	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
5/12/22 9:30am	Activity intolerance (fatigue) related to weight of the product of conception and inadequate rest .	Client's fatigue will subside and body comfort will be restored within 48 hours as evidenced by client verbalizing reduction in fatigue and improvement in the body comfort.	1. Reassure client that fatigue will subside. 2. Encourage family members to help with house chores. 3. Encourage client to take up little work. 4. Teach client energy conservation techniques such as sitting rather than squatting or standing while washing. 5. Encourage client to have enough sleeping and rest	1. Client was reassured of adequate support to reduce fatigue. 2. Family members were encouraged to help with the household chores. 3. Client was encouraged to take up little work that she can tolerate. 4. Client was taught energy conservation techniques such as sitting rather than standing and squatting while washing. 5. Client was encouraged to have enough sleep and rest especially during the night.	7/12/22 10:00a m.	Goal fully met as client verbalized that fatigue was subside and improvement in body comfort .	M.K

CHAPTER THREE

LABOUR

3.0 INTRODUCTION

This chapter deals with admission and management of labor which includes management of first, second, third and fourth stage of labor, immediate care of baby at birth, examination of the placenta and membranes, summary of labor, condition of baby at birth and nursing care plan on problems and needs is identified during labor.

3.1 ADMISSION AND MANAGEMENT OF THE FIRST STAGE OF LABOUR

ADMISSION

Madam Rita Takyiwaa came to the facility on 8th December,2022 at 4:00am with gestational age of 39weeks +3day and was accompanied by her husband and mother-in-law. They were offered seat at the labor ward department after which greetings was exchanged and general condition was observed to be good. Madam Rita Takyiwaa was oriented to the ward environment where the washroom is and where she is going to keep her items. Her facial expression indicated that she was in pain. Her antenatal card was collected and glanced through quickly. On enquiry, she said she took her last meal which was Rice and stew around 6:30pm. She complained of lower abdominal ppain and was reassured that it will stop after delivery. The physiology was explained to her that it was due to contractions of the muscles of the uterus and pressure on the cervix.

Her bed was prepared and she was assisted into a warm comfortable bed. Procedures were explained to her and provided with privacy by closing the door. She was served a bed pan to empty

her bladder. Urine was taken (mid-stream) to be tested for glucose and protein which were all negative. The urine passed was 150mls. Vital signs checked and recorded as follows;

Temperature	36.3 degrees Celsius
Pulse	88 beats per minutes
Respiration	22 cycles per minutes
Blood pressure	110/80 millimeters of mercury

Procedure was explained and permission was sought to conduct physical examination on client, she was helped unto the couch, hands were washed with soap under running water, dried with clean towel and client was examined from head to toe. Hair line was examined for infection, eyes for pallor, discharges, and sclera for jaundice, ears and nose for discharges, neck for enlargement of lymph nodes. Breast was examined for masses and lumps, skin for rashes, legs for edema and varicose veins but none was detected. The abdomen was inspected for shape, scars, size, and skin for rashes but there was none.

Client's abdomen was globular in shape, presence of striae gravidarum and linear nigra but there was no previous surgical scar observed.

Client's abdomen was palpated and symphysio-fundal height measured at 36cm with gestational age of 39 weeks +3days, lie was longitudinal, presentation was cephalic, and descent was $4/5^{th}$ palpable abdominally and position was right occiput anterior.

Foetal heart rate was 130beat per minute, contractions were 3 in 10 lasting 25 seconds. Also, there was presence of fetal movement.

Client was helped to assume a lithotomy position. Hands were washed and dried and surgical gloves worn. Her vulva was inspected for vaginal warts, herpes, varicosities, offensive odor but she had none of those. In order to confirm if it was true labour signs she was experiencing; vaginal

examination was conducted. The swab was picked with the dominant hand and was dipped in a savlon solution in a gallipot. The swab was dropped from the dominant hand into the non-dominant hand per stroke. Labia majora was also wiped from anterior to posterior and the used swab was put into the receiver. Labia minora was also wiped from anterior to posterior and used swab was also disposed into the receiver. Her inner thigh was touched first to alert her and the labia minora was separated with two fingers of the non-dominant hand and the index finger of the dominant hand was inserted into the vagina and the middle finger was added to access the dilatation of the cervix.

The cervix and vagina were examined for warmth and softness. On examination, the cervix was well effaced, dilatation was four (4) centimeters at 4:10am and membranes were intact. The sacral promontory was not reached; ischial spines were blunt and had a wide pubic arch indicating that her pelvis was adequate. Hands were removed following the curve of carus and fist was made between the ischial tuberosity and all four (4) knuckles ischial were accommodated. After the procedure, she was cleaned and perineal pad was applied to the vulva. She was educated to change perineal pad when soiled and also wash and dry hands before touching the perineal pad. The gloves were removed by inverting them inside out and inspected before disposal in a plastic waste container. Hands were washed and dried with clean towel. She was encouraged to ambulate and lie laterally on her left side when she gets tired. She was made comfortable. Findings were explained to client and was encouraged urinate frequent and to ask questions.

All findings were recorded on a partograph.

She was admitted and her information recorded in the admission and discharge book and daily ward state and started my partograph at the same time. Client's husband was reassured and informed that Madam Rita Takyiwaa was in true labour. She was assisted to remove things for the

delivery that is sanitary sheet, cot sheet, mackintosh, toilet roll, comfit pad, baby dress, soap and dettol to wash her things. She was then given orientation to the bathroom, toilet, admission room and delivery room, she was also introduced to other staff to make her familiar with the ward environment.

PREPARATION BEFORE BIRTH

The skilled helper was the midwife in charge of the facility whose duty was to supervise the delivery help in case of resuscitation and the unskilled helper was client's relatives (husband and mother-in-law). The duty of client relative was to provide emotional support to the client and also to run errands in case client needs food or blood donation. The emergency plan was reviewed; thus, the ambulance team were informed as well as the physician assistant was also informed to be alert in case of emergency.

The delivery room was prepared for delivery; the room was made clean and warm by drawing the curtains closer, lights were switch on, and touch light was also made ready in an event of light off. Hands were washed with soap and water and dried with clean towel. The client was also assisted to wash her hands, chest and abdomen with clean water and soap and dried with clean towel to prepare for skin to skin contact. Delivery set was available waiting to be set at appropriate time. Oxytocin and other emergency drugs like magnesium sulphate and ergometrine were also made available.

Resuscitation area was made ready by switching on the light to keep the place warm if needed, all equipment such as ventilation bag and mask, stethoscope needed to help baby breath were assembled and tested for proper functioning.

The delivery trolley was set and the entire instrument needed for the delivery was assembled, a cot was prepared for the baby as well as a source of light was made available to assess the baby if needed.

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

Top Shelf Contained Sterile Items As Follows

- 2 Artery forceps
- 4 Drapes
- Cord scissors
- Gallipot with sterile cotton wool swabs
- Episiotomy set (artery forceps, dissecting forceps, episiotomy scissors, suturing forceps)
- Cord clamp (removed from cover)

3.5 Lower Shelf Contained

- Cheattle forceps and its container
- Identification band
- Cot sheets
- An oxytocin drug
- Injection tray containing oxytocin, vitamin k, syringe and needle
- Fetoscope
- Local anesthesia
- Antiseptic lotion
- Measuring jug for measuring blood loss

- Disposable gloves
- Catheter and drainage bag
- Mackintosh
- Sterile gloves
- Receiver for used swabs
- Perineal pad
- Bowl of water with bulb syringe
- Bedpan
- Clock
- Drum containing sterile gauze

MANAGEMENT OF FIRST STAGE OF LABOUR

Client was encouraged to lie on the left lateral position because it keeps baby's weight from applying pressure to the large vein (inferior vena cava) that carries blood back to the heart from the feet and legs, also because the liver is on the right of the abdomen, lying on the left side helps to keep the uterus off the large organs. She was also encouraged to ambulate to aid fetal head descent and also for contractions to be effective.

Subsequently, her pulse, contractions, and fetal heart rate were checked every 30 minutes, temperature, urine output, then blood pressure, vaginal examination, cervical dilatation and fetal head descent done four hourly were recorded on the partograph.

She was educated to change her perineal pad frequently and wash hands with soap and water before and after handling the perineal pad to prevent infections. She was educated not to bear down prematurely but do the deep breathing exercise that she was taught whenever she was in pain.

Client was encouraged to adhere to any instructions given during labour as it would help her deliver safely. She still complained of lower abdominal pain was continuously reassured that it would soon be over. Madam Rita Takyiwaa drank about 300mls chilled malt which she was sipping intermittently. Client was walking around the ward due to pains and was told to lie on bed when she is tired. She was then reassured that the labour would soon be over. Client was complaining of waist pain, and the sacral region was massaged to relieve the pain and she was encouraged that the pain will stop after delivery. She was educated to always wash her hands and not to insert fingers into the vagina. Client was noticed to be anxious and was reassured that labour will soon be over. At 8:10am, client was due for the next vaginal examination. On vaginal examination the cervical dilatation was 8 cm with membranes intact and no molding. Descent was $2/5^{th}$. Uterine contractions were 3 in 10 minutes lasting 41 seconds, maternal pulse 90 beats per minutes, fetal heart rate 140 beats per minutes with good volume, blood pressure 120/70 millimeters of mercury, temperature 37.0 degrees Celsius, urine output was 120mls. Urine was tested for protein and glucose and was all negative. At 10:10am, Madam Takyiwaa Rita complained of bearing down and the urge to pass stools. On vaginal examination, the membranes ruptured spontaneously and liquor was clear with no cord prolapse, molding was two plus (++), the cervical os was also fully dilated that is 10 cm and descent was $0/5^{th}$ with clear liquor and this was confirmed by the midwife in-charge. 100 mls of urine was emptied which read negative to both acetone and protein. Contractions were 4 in 10 minutes lasting above 43seconds. Fetal heart rate was 144 beat per minute.

3.2 MANAGEMENT OF THE SECOND STAGE OF LABOUR

Madam Rita Takyiwaa chose the lithotomy position for delivery. The procedure was explained to her, privacy was provided. Hands were washed and dried before putting on protective clothing including boots, face mask, eye goggle, and mackintosh apron. The vulva, lower abdomen and upper thigh were swabbed with savlon and she was draped with a sterile sheet on her abdomen and client was told that her baby will be delivered onto her abdomen. The set trolley was then drawn closer to the delivery bed. A clean perineal pad was applied to the perineum and anus to prevent delivery field from being contaminated with fecal matter. She was encouraged to push with each contraction and rest in between contractions after full dilatation confirmed.

The maternal pulse and fetal heart rate were checked by the in charge to determine whether both the mother and the fetus were in good health. Client complained of fatigue and could not push again. She was reassured that she would deliver soon, and was offered a cup of cold cocoa beverage and was encouraged to drink in order to get enough energy to push. As the head advanced with each contraction by maternal effort, my right fingers were placed against the baby's occiput to keep it flexed. Flexion was aided by pressing on the occiput slightly down allowing the smallest diameter to distend the perineum to prevent perineal tear. The head crowned and she was asked to breathe through her mouth, the sinciput, face and chin swept the perineum and it was delivered by a movement of extension. Cord around the neck was quickly felt and it was not present. The baby's face was cleaned and eyes were cleaned with sterile gauze from the inner cantus outwards.

Restitution was allowed to take place, followed by external rotation of the head. This brought the shoulders into anterior posterior diameter of the pelvic outlet. Hands were placed on each side of the head and a gentle downward traction was applied to deliver the anterior shoulder. The anterior

shoulder escaped under the symphysis pubis. Upward traction was then applied to deliver the posterior shoulder, which swept the perineum and the rest of the body was delivered by lateral flexion following the curve of carus onto the mother's abdomen.

The time of delivery was noted by the midwife in- charge as 10:20am to an alive female healthy baby, which was also confirmed by the mother. The baby was cleaned and body was dried of liquor to prevent hypothermia.

Madam Rita Takyiwaa was congratulated for her effort and co-operation.

3.3 IMMEDIATE CARE OF THE BABY

The immediate care of the baby begins as soon as the head was delivered. The eyes of the baby were cleaned with sterile gauze from the inner canthus outward. She was delivered by lateral flexion on the mother's abdomen to create bonding and was received into a warm cot sheet, liquor was wiped off from the body and airway suctioned further.

The cord was clamped 3 finger breadths away from the baby and 2 finger breadths from the first clamp and the cord was protected by gauze and separated baby from mother by cutting in between the cord to prevent splash of blood. The Apgar score was 8/10 for the first minute and all reflexes were present, the color was pink.

An identification band with the baby's sex, date and time of birth, mother's name was placed on the baby's wrist.

3.4 MANAGEMENT OF THE THIRD STAGE OF LABOUR

Procedure was explained to client and she was reassured that labour will soon end. She was still in the lithotomy position. The abdomen was palpated and after ensuring there was no second twin, injection oxytocin 10 units was given immediately to client by the midwife in charge. The artery

forceps was used to re-clamp the cord close to the vulva and a receiver was placed between her thighs to receive the artery forceps. The remaining cut end of the cord was placed into a sterile receiver near the vulva. Contraction of the uterus was waited for and it was confirmed abdominally which was firm and contracted. The dominant hand was placed on the uterus to feel for contraction. The non-dominant hand was placed above the level of the symphysis pubis with palm facing towards the umbilicus exerting pressure in an upwards direction, that was counter traction.

The placenta was delivered by controlled cord traction in a downward outward movement until the placenta was visible at the vulva. The placenta was received into cupped hands and membranes were delivered by gently twisting the membranes to free and prevent membranes from tearing.

The placenta and membranes were delivered at 10:25am and client was congratulated for her co-operation throughout the process of labour. Placenta and membranes were inspected for completeness before placing in a receiver. The fundus of the uterus was gently massaged for contraction. The uterus was well contracted to prevent bleeding. The estimated blood loss was 105mls. The vulva and perineal area were swabbed with savlon solution. Sterile gauze was rolled on both index fingers, the vagina, the vulva and perineum were parted and inspected for bruises and laceration. The cervix was also examined in clockwise manner to rule out any cervical tears. There were no tears and lacerations on examination. She was cleaned up and a clean perineal pad was applied to the vulva to prevent soiling herself. She was taught how to massage her uterus for it to contract to prevent any postpartum hemorrhage.

She was once again congratulated and asked her to call if she is bleeding profusely or if she needs anything. She was offered bedpan and asked her to urinate frequently to help the uterus contract. Client was then made comfortable in bed. Clients were informed that she has delivered a bouncing baby girl.

3.5 EXAMINATION OF PLACENTA AND MEMBRANES

This is done to rule out absence of lobes or fragment of membranes retained in utero so that prompt interventions can be taken. The placenta was held by the cord and the length measured was 49 centimeters long.

The placenta was examined under a good source of light and on a flat surface. The fetal surface was greyish blue with firm amniotic membranes and cord was inserted in the center of the placenta.

The maternal surface was dark red in color. It was covered with chorion which was opaque.

The membranes, lobes and cotyledons were inspected and they were intact. No infarct and edema were seen on the maternal surface, the cord was thick with Wharton's jelly.

The tip of the cord was wiped with a dry cotton for inspection. It had two arteries and one big vein.

The placenta was placed in a 0.5% chlorine solution in the sluice room for decontamination and discarded in the placenta pit. The delivery instruments were immersed in 0.5% chlorine solution for 10 minutes and washed in soapy water and rinsed in clean water and left on flat and airy surface for it to dry and it was later packed and sent for sterilization.

3.6 MANAGEMENT OF FOURTH STAGE OF LABOUR

The mother was taken to the lying – in ward. She was served a bed pan to empty her bladder. The estimated blood loss was 150mls. She was encouraged to empty her bladder regularly to prevent postpartum hemorrhage. She was covered with blanket to keep her warm. Her general condition was observed by monitoring the vital signs of mother and baby for every 15 minutes for 2 hours, 30 minutes for 1 hour and hourly for 3 hours were recorded. All findings were recorded on the fourth stage chart.

Vital signs were checked on the mother and recorded as:

Temperature	36.6 degrees Celsius
Pulse	82 beats per minutes
Respiration	20 cycles per minutes
Blood pressure	120/80 millimeters of mercury
Fundal height	16 centimeters

The following observations were made on the baby and recorded as follows:

Skin colour	pink
Breathing pattern	normal
Umbilical cord	not bleeding
Apex heart beat	140 beats per minutes
Temperature	36.5 degrees Celsius
Respiration	40 cycles per minutes

Bleeding per vagina was slight. She was encouraged to change her perineal every 4 hours and when soiled as well as urinating frequently to aid in involution of the uterus. She was advised to wash her hands before and after changing perineal pad and before breastfeeding. Baby was attached to breast so as to initiate lactation and informed to report any abnormality such as bleeding from the cord of baby and change in general condition of the baby. She was congratulated and thanked for her co-operation.

Prevention of Disease

Baby Takyiwaa was monitored during the first six (6) hours post-delivery. chloramphenicol drops was instilled on the baby's eyes as prophylaxes for eye infection. Vitamin K was given intramuscularly on the thigh to prevent bleeding. Hands were washed and cord was dressed with

chlorhexidine and cotton. These were done within the first 90minutes of birth to prevent infections such as ophthalmia neonatorum, a condition which is modifiable and hemorrhagic disease of the newborn.

Examination of the New Born

The procedure was explained vividly to the client, examination gloves were worn and the baby was examined head to toe to detect any deviation from normal. Baby was put on a flat surface, Baby was exposed and the general condition, respiration and skin color was noted and covered again to be examined from head to toe.

Head and Neck

On examination, the sutures and fontanelles were examined by running the index and middle fingers through the suture lines for bulging fontanelles and no abnormality was detected. There was no laceration on the scalp and no caput succedaneum as well. The head circumference was measured and it was 37 cm. The cartilage of the pinna was soft, the ears were well formed. The eyes were palpated for the presence of eye balls and its alignment with the ears. There was no redness of the conjunctiva or jaundice on the sclera. The nose was well formed with septum dividing it. Nose was patent. The mouth was examined for the presence of false teeth, cleft palate and cleft lip but there was none. Rooting, suckling and swallowing reflexes were present. There was no rigidity and congenital goiter.

Chest and Abdomen

The chest was inspected for movement and normal respiratory rate. During breast examination, the nipple was at the center of the areolar. There was no distention of the abdomen, enlarged spleen

or liver as well as bleeding of the cord. There were three blood vessels that run through the cord which indicated two arterial cord vessels and a cord vein.

Back

The spine was examined with the baby lying in prone position. The back was palpated for swellings, spinal bifida or a missing vertebra, meningomyelocele but there was none. The skin was examined for skin color, vernix caseosa, and lanugo, peeling of the skin, rashes and birth mark. There were no abnormalities with some amount of vernix caseosa.

EXTEMETIES

The upper extremities were equal with no extra digits. There were palmer creases and no webbed fingers. Grasping and Moro reflexes were present.

The lower extremities were also equal without an extra digit. Both legs were examined with no talipes and congenital dislocation of the hip. Knee flexes were normal.

Genitalia

The labia majora was prominent. Baby passed meconium and urinated soon after birth indicating the patency of the anus and urethra.

3.7 SUMMARY OF LABOUR NOTES

Madam Rita Takyiwaa had a spontaneous vaginal delivery to a healthy female infant of 8th December, 2022 at 10;20am, who cried immediately at birth. 10 units of oxytocin injections were given to the mother 10:21 am, uterus well contracted and placenta and membranes completely expelled at 10;25am.

The baby was a female, weight was 3.3 kilograms and the APGAR score in the first and fifth minute were 8/10 and 9/10 respectively. Perineum was intact and blood loss was approximately 150mls.

Duration of observable Labour

Stage	Duration
First Stage	6 hours
Second Stage	5 minutes
Third Stage	5 minutes
Total Stage	6 hours 10 minutes

3.8 CONDITION OF BABY AT BIRTH

Birth weight	3.3 kilograms
Apgar score	8/10, 9/10
Sex of baby	Female
Head circumference	37 centimeters
Chest circumference	32 centimeters
Waist circumference	22centimeterss
Full length	52 centimeters
Abnormality	None
General condition	Satisfactory

3.9 CONDITION OF THE MOTHER AFTER BIRTH

Temperature		36 degrees Celsius
Pulse		88 beats per minute
Respiration		22 cycles per minute
Blood Pressure		120/80 millimeters of mercury
Perineum		intact
Fundal height		18 centimeters
Blood loss		150mls
Condition		good

Condition of Baby After Birth

Vital Signs

Temperature	-	36.5 degrees Celsius
Apex beat	-	135 beats per minute
Respiration	-	40 cycles per minute
Weight	-	3.3 kilograms

Lobes and membranes of the placenta were complete, intact and healthy.

3.11 NURSING CARE PLAN DURING LABOUR

Problems Identified

0n the 8th December, 2022, client made the following complains;

1. Anxiety
2. Fatigue
3. Lower abdominal pain
4. Waist pain

Short Term Objectives

1. client will be relieved of anxiety by the end of labour
2. Client will be relieved of fatigue within 24 hours after delivery.
3. Client will cope with lower abdominal pains throughout labour
4. Client will be relieved of waist pain after labor.

Long Term Objective

Client will go through all the stages of labour successfully without any complications to mother and baby.

3.15 CARE PLAN DURING LABOUR

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVE	NURSING ORDERS	NURSING INTERVENTIONS	DATE/ TIME	EVALUATION	SIGN.
08/12/22 4:00am	Anxiety related to unknown outcome of labour	1. Client will be relieved of anxiety by the end of labour as evidence by client verbalizing that she is no more anxious. 2. Midwife observing client with relaxed looks	1.Reassure client 2. Explain every procedure to be carried to her to allay her anxiety 3. Educate her on the positive outcome of labour 4. Encourage client to perform deep breathing exercise 5. Encourage client to ask questions and answer them tactfully.	1. Client was reassured 2. Before timing contractions or listening to fetal heart rate, client was told 3. Client was told the finding of each examination 4. Client perform deep breathing exercise during uterine contractions. 5. Client asked questions on the outcome of contraction and answers was given tactfully	8/12/22 10:00am	Goal achieved as evidence by client verbalized she was no more anxious and midwife observe that client was relaxed in bed.	

3.15 CARE PLAN DURING LABOUR

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVE	NURSING ORDERS	NURSING INTERVENTIONS	DATE / TIME	EVALUATION	SIGN.
8/12/22 5:00am	Physical exhaustion (fatigue) related to strain and stress of labour	1. Client verbalizing that she feels strong after resting enough. 2. Midwife observing client looks active after enough rest	1. Reassure client. 2. Serve sips of water and nourishing fluids. 3. Encourage client that after enough rest and sleep she will be fine. 4. Improve ventilation and provide quiet environment to ensure enough rest and sleep.	1. Client was reassured that she will be relieved of fatigue. 2. Sips of water and nourishing fluids were served. 3. Client was encouraged that she will be fine after enough rest and sleep. 4. Client was provided with proper ventilation by switching funs on and quiet environment to ensure enough rest and sleep.	08/12/22 7::00am	Goal fully met as midwife observed client looked active after enough rest and client verbalized relieve of fatigue after resting Goal fully met as midwife observed client maintaining good personal hygiene throughout labour.	

3.15 CARE PLAN DURING LABOUR

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVE	NURSING ORDERS	NURSING INTERVENTIONS	DATE/ TIME	EVALUATION	SIGN.
08/12/22 8:00am	Lower abdominal pain related to physiology process involving first stage of labour	Client will cope with lower abdominal pains throughout labour as evidenced by client verbalizing that she is coping with pain and midwife witnessing client coping with pain	1. Reassure client 2. Educate client on physiology of lower abdominal pain 3. Massage the sacral region during contraction 4. Engage client in diversional therapy 5. Encourage client to assume left lateral position during first stage of labour	1. Client was reassured. 2. Client was told the lower abdominal pain was as result of descent of the presenting part 3. Sacral region was massaged during contraction to reduce pain 4. Client was engaged in conversation during labour 5. Client assumed left lateral position during the first stage to help reduce pain and to aid descent of the presenting part	08/12/22 10:15am	Goal fully achieved as client verbalized that she coped with the lower abdominal pain and midwife witnessing client cope with lower abdominal pain	

3.15 CARE PLAN DURING LABOUR

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVE	NURSING ORDERS	NURSING INTERVENTIONS	DATE/ TIME	EVALUATION	SIGN
8/12/22 10:00am	Altered body comfort (waist pain)related to descent of the foetal head exerting pressure on the sacral nerves.	Client's comfort will be restored within 4 hours as evidenced by; a) Client verbalizing ability to cope with waist pains.	1. Reassure client to cope with waist pains. 2.Support clients back with pillows 1when she lies down 3. Engage client in diversional therapy. 4.Massage client sacral region. 5.Encourage client to change adopt a favorable position.	1.client was reassured to cope with waist pains because it's a normal physiology which happens during labour. 2. Pillows were place at the back to make client relaxed and comfortable. 3. Conversation was ensured between the midwife and the client to take her mind off the pain 4.sacral massage was done by client support person to relieve the pain. 5.Madam Rita was encouraged to adopt the left lateral position to prevent supine hypotension	08/12/22 01:00pm Goal fully met as midwife observed client maintaining good personal hygiene throughout labour.	Goal fully met as client said she is able to cope well with the pain	

CHAPTER FOUR

4.0 POSTNATAL CARE

This chapter talks about the management of both mother and baby from delivery to six weeks' post-partum and care plans drawn for the management of problems identified during puerperium

4.1 DAY OF DELIVERY

Madam Rita Takyiwaa had a spontaneous vagina delivery to an a live female child at 10:20am on the 8th December 2022. Client and the baby were cleaned neatly and transferred to the lying-in ward after one-hour observation. Where her baby was wrapped nicely to prevent heat loss and put beside her mother after the third stage of labour. She was encouraged to empty her bladder whenever she feels the urge in order to prevent the occurrence of any postpartum hemorrhage; early ambulation was emphasized to promote effective circulation and drainage of lochia. She was encouraged to change perineal pad when soaked to prevent ascending infection. She was educated on the need for exclusive breastfeeding for six months and how to fix baby to the breast. Emphasis was also made on proper hand washing before breastfeeding or handling of the baby, after visiting the toilet, changing her perineal pad and changing of baby's soiled diapers. Madam Rita took fufu and palm nut soup for supper. The following were her vital signs:

and her baby were transferred to the lying in ward when the condition was satisfactory after one hour observation at the labour ward. Vital signs checked and recorded were as follows;

Temperature	37.1 degrees Celsius
Pulse	90 beats per minute
Respiration	21 cycles per minute

Blood pressure 110/70 millimeters of mercury

On abdominal examination, the uterus was well contracted and fundal height measured 18centimeters, lochia was moderate in amount of flow and the colour was rubra (red in colour with no clots).

Madam Rita was reminded to eat well balanced diet including fruits and vegetables. She was taught and assisted to fix the baby to breast to promote lactation. She was able to attach the baby well to the breast and was therefore recommended for it and encouraged to continue.

4.2 SUBSEQUENT CARE OF THE BABY

At 4:00pm, (7hours) after birth, Madam Rita Takyiwaa was informed about the need for baby bath, general examination of the baby and immunization and she responded positively. Head to toe examination was done and no abnormality detected and all findings were communicated to the mother.

4.3. EXAMINATION OF THE BABY

The baby was examined from head to toe in the presence of the mother to rule out any congenital abnormalities and birth injuries such as spinal bifida, syndactyly, cleft palate and polydactyly and etc. but there was none detected. The fontanelles were not bulging or sunken. The eyes, nose and the ears were normally situated and there was no abnormality detected. No cleft palate or lip observed when mouth was examined. There were also no false teeth present. Baby's skin was pink. On examination of the chest, the rise and fall of the chest was observed and baby had a normal breathing pattern. The nipples were normally situated with no swellings or discharges on palpation. The breasts were palpated for consistency and engorgement and none was felt. The abdomen was normal in shape and size with no rashes. There was no bleeding on the cord and it

was healthy. The umbilical cord had three vessels, two arteries and one vein. The abdomen was palpated for distension but it was not and there was no enlarged liver or spleen. The upper limbs were of equal length and size, presence of palmer creases, no extra digits (polydactyly) or webbed fingers (syndactyly). The legs were equal in length and the nail beds were pinkish in colour. There were no extra digits and talipes, no congenital dislocation of the hips by flexing the knees and twisting them and there was no crepitating sound heard denoting dislocation. The labia majora was inspected which covered the labia minora and the hymen appears large. Baby had passed urine and meconium which indicated patency of urethra and anus respectively. Baby was laid on one hand of mine with shoulders supported and the vertebral column was examined. There was no spinal or occult bifida or missing vertebra. The following measurement were taken and recorded on the baby as:

Baby's birth weight	3.3 kilogram
Respiration	53cpm
Head circumference	37 centimeters
Full length	52centimeters
Abnormalities	None
General condition	Satisfactory

Madam Rita was reminded to wind the baby after breastfeeding to bring out the air and excess milk to prevent distended abdomen and discomfort.

4.4. BABY'S FIRST BATH

Baby was given a warm bath the next day, 9th December, 2022 at about 12:00pm. Baby's items were collected from the mother and nearby windows were closed. A seat was provided for mother and she was encouraged to observe procedure. Hot and cold water was mixed and temperature of

the water was checked using the elbow, the temperature of the mixed water was also confirmed by the mother. Baby was wrapped in a cot sheet and placed on a flat surface;

Baby Bath and Cord Dressing

REQUIREMENTS

Top Shelf contained

- Chlorhexidine gel
- Sterile cotton wool swabs and gauze in a galipot
- Sterile water in a galipot

Bottom Shelf contained

- Baby's towel and baby's diapers
- Baby's dress
- Surgical gloves
- Cot sheet to wrap the baby
- Baby's sponge
- Soap in a soap dish
- Disposable gloves
- Jug of hot water
- Jug of cold water
- A bowl for mixing water
- Kidney dish for used gauze and swab
- A receptacle for used water
- Mackintosh apron

Baby's eyes were cleaned from inner canthus to outer canthus with clean cotton wool swabs soaked in sterile water, face was cleaned with wet towel and dried, supporting the nape of the neck with one hand and plugging baby's ears with the thumb and middle finger, the hair was washed with soapy sponge, it was then rinsed and wiped with clean towel. Baby was exposed and the arms, trunk, genital area and legs were washed paying attention to the skin folds. The back was turned with the left hand supporting the chest and washed. Baby was immersed in water and rinsed thoroughly, baby was put in a dry warm towel and dried with a small towel paying attention to skin folds. Baby was put in a warm cot sheet, oiled and dressed up exposing the cord to be dressed. Hands were washed and dried and sterile gloves worn to perform cord dressing. The cord was observed for looseness of ligature and relegated if necessary. The stem of the cord was held with one swab soaked in spirit, the skin was swabbed 5 centimeters from the base of the cord. The base of the cord was also swabbed. Again, the stem from the base upwards was swabbed, a swab was used for each stroke. The tip of the cord was swabbed, and the cord left exposed to dry.

Mother was thanked and encouraged to practice same at home, all items used were decontaminated in 0.5% chlorine solution for ten minutes, washed and dried to be processed for the next use. Hands were washed and dried, mother thanked and procedure document

The first day after delivery was 9th December, 2022, they looked good upon waking, up and according to client, she and her baby slept soundly during the night and their conditions remained satisfactory. She was informed of physical examination on her and the baby and permission was granted. Her vital signs checked recorded as follows:

Temperature	36.6 degrees Celsius
Pulse	80 beats per minutes
Respiration	22 cycles per minutes

Blood pressure 120/70 millimeters of mercury

Fundal height was 18cm, her vulva was inspected, lochia was red in colour (rubra) and flow was moderate and she was reminded to do pelvic floor and abdominal tightening exercise to aid in involution of the uterus and aid in good muscle tone. She was then given warm water to take her bath. She was also served with breakfast and she ate with delight.

The baby had no abnormalities like eye discharges, bleeding cord, and he could suckle. He also passed urine and stool normally according to the mother. The baby's weight was checked alternatively and vital signs were recorded as follows;

Temperature	-	36.6 degrees Celsius
Apex beat	-	138 beats per minute
Respiration	-	40 cycles per minute
Weight	-	3.2 kilograms

Baby was dressed, wrapped and given to the mother to breastfeed. Client was informed about their possible discharge that morning and was given health education on care of herself and the baby at home.

Mother was educated to continue with the rest of the immunization at the child welfare clinic to protect the baby against all preventable diseases. She was also educated that the baby will not be bathed but top and tail until cord comes off. She was also educated not to apply any cream or herbs on the umbilical cord to prevent infection. I emphasized the use of chlorhexidine only in dressing the cord and leaving it open to dry.

Her sister was encouraged to take good care of Madam Rita and her daughter when they go home so that she can have adequate rest and sleep. She was advised again not to apply any hot compressed or concoction on the cord and the fontanelle.

She was again informed that the cord can be a route or a source of entry of infection; therefore, cleanliness of the umbilical cord is essential. Client was educated on minimal handling with washed hands, dressing of the umbilical cord with chlorhexidine which she was taught and keeping the cord dry to heal by dry gangrene.

Madam Takyiwaa Rita was educated to inspect the cord daily for inflammation, offensive discharge, bleeding or odour.

She complained of lower abdominal pains. She was reassured that the pain will subside. Physiology of involution was explained to her and was encouraged to empty the bladder frequently and have enough rest. She was taught how to do postnatal exercise such as the Kegel's and abdominal exercise to aid in involution and drainage of lochia.

4.5 DISCHARGE (9TH DECEMBER, 2022) 1ST DAY POSTNATAL

She was discharged by the midwife in-charge at 10:30am in the morning with the following drugs:

Tablet folic acid	5mg daily for 14 days
Tablet ferrous sulphate	200mg three times daily for 14 days
Tablet multivitamin	200mg three times daily for 14 days
Tablet paracetamol	1000mg three times daily for 3 days
Capsule Amoxycillin	500mg three times daily for 7 days

Cotton and chlorhexidine for cord dressing were supplied by the clinic. She was advised to take her prescribed drugs appropriately and also dress the cord according to how she has been taught.

Madam Rita was then re-examined by the midwife in -charge to confirm that there were no abnormalities. She was discharged from the admission and discharged book and also on the daily ward state. The mother and the baby's records were recorded in the delivery records book. Her things were packed and client and her family expressed their gratitude to all staff in the ward. She was informed that they would be visited at home for continuity of care, that is twice daily for the first three days and once daily for the remaining four days, but since she spent part of the day at the hospital, she would be visited in the evening. She called the husband to pick them home and I promised to visit her home in the evening. The husband brought a taxi and picked them home.

4.6 FIRST POST-NATAL HOME VISIT (9TH DECEMBER, 2022)

Madam Rita and the family were visited in the evening on the 9th December,2022. Client was discharged home for continuity of care. From the second day, postnatal home visits were made twice daily, thus in the morning and evening around 6:30am and 5:00pm respectively. During the visit, a warm welcome and a seat were offered. The purpose of the visit was explained to them and history about the mother and the baby's feeding, sleeping pattern, bowel movement, micturition and baby's crying was taken, but according to the mother, everything was normal.And she complained of after pain and it was explain to her that the pain was due to the involution of the uterus and was asked to continue taking paracetamol.

Permission was sought to examine her and the baby from head to toe and it was granted. On examination from head to toe on client, no abnormality was detected. The uterus was well contracted, lactation had been established and the breasts were not engorged. The lochia was rubra and was draining well with no offensive odour.

Head to toe examination of the baby was done and, the fontanelles were not bulging. There were no discharges from the eyes, nose and ears, and there was no bleeding from the cord. The weight

was checked on alternative days. However, there were heat rashes on the baby, and mother was reassured that it would resolve soon. She was educated to dress the baby according to the weather and change diapers on baby to prevent the rashes. The baby was topped and tailed and the cord was dressed with cotton wool swab and chlorhexidine under aseptic technique.

Client and family were reminded on the danger signs that should be looked out for on the baby thus distended abdomen which could cause discomfort for the baby and that the baby's back should be wind after breast feeding for her to belch.

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

OBSERVATIONS OF BABY

OBSERVATIONS	**MORNING**	**EVENING**
Weight	**3.2kg**	**3.2kg**
Temperature	**36.4^{0c}**	**36.9**
Pulse	**140bpm**	**138bpm**
Respiration	**45cpm**	**41cpm**

4.7 SECOND POST-NATAL HOME VISIT

On 10th December, 2022 another visit was made as promised to Madam Rita at 7:30am and 6:00 pm respectively. Client's whole family was looking healthy on arrival. A warm reception and a seat were offered, . Client was asked of her previous complain and she verbalized that is relieve of it. The perineal pad was inspected before she took her bath and the flow of lochia was small and red in color which was not offensive. Head to toe examination was done and no abnormalities were detected. Madam Rita complained of backache. Client confirmed that baby had passed meconium and urine. Client was educated to support the back when sitting and ensure rest and when baby is asleep. Head to toe examination was performed on the new born and no abnormality was present. Documentation for both mother and baby for morning and evening are as follows;

MOTHER

OBSERVATION	**MORNING**	**EVENING**
Temperature	36.5^0C	$36.7\ ^0$C
Pulse	78 bpm	80 bpm

OBSERVATION	MORNING	EVENING
Temperature	$36.8\ ^0$C	36.4
Pulse	76 bpm	80
Respiration	21 cpm	22
Blood pressure	110/60 mmHg	110/80
Lochia	Rubra and not offensive	Rubra and not offensive
Condition of the uterus	17cm	17
Breast	Lactating	Lactating

Respiration	21cpm	22 cpm
Blood pressure	110/70 mmHg	110/60 mmHg
Symphysio-fundal height	16 cm	16 cm
Lochia	Rubra	Rubra
Condition of the uterus	Contracted	Contracted
Breast	Lactating	Lactating

BABY

OBSERVATION	**MORNING**	**EVENING**
Temperature	36.6 ^{0}C	36.5 ^{0}C
Apex beat	128 bpm	130 bpm
Respiratory	41 cpm	42 cpm
Weight	3.1kilograms	
Suckling	Good	Good
Stool colour	Yellow	Yellow
Condition of cord	Shrinked and almost off	Shrinked and almost off

Client was educated to continue with her personal hygiene, take in nutritious diet that includes more proteins to help repair worn out tissues and to continue practicing the exclusive breast feeding.

4.8 THIRD POST-NATAL HOME VISIT

Madam Rita was visited again on the 11th December, 2022 at 8:30am and 5:00pm. Greetings were exchanged and a seat offered. The environment was neatly kept, there were no complains, she verbalized that she is relieved of her backache. Head to toe exanimation was done on both mother and baby and no abnormalities were found. The baby passed urine and stool while it was top and tailed. The cord was examined and it was dry. The cord was dressed with chlorhexidine gel She was educated to change baby's napkin frequently.

Both mother and baby's assessment are as follows:

MOTHER

OBSERVATION	**MORNING**	**EVENING**
Temperature	36.1 ^{0}C	36.5 ^{0}C
Pulse	80 bpm	76 bpm
Respiration	18 cp m	20 cpm
Blood pressure	110/60 mmHg	110/70 mmHg
Symphysio-fundal height	15 cm	15cm
Lochia	Scanty Serosa and not offensive	Scanty Serosa and not offensive
Condition of the uterus	Contracted	Contracted
Breast	Lactating	Lactating

BABY

OBSERVATION	MORNING	EVENING
Temperature	36.5^0C	36.6^0C
Apex beat	128 bpm	132 bpm
Respiratory	42 cpm	40 cpm
Weight	3.0kilograms	
Suckling	Good	Good
Stool color	Brownish yellow	Brownish yellow
Cord condition	Shrinked	Shrinked

4.9 FOURTH DAY POST NATAL VISIT

On the 12th of December, 2022, around 8:00am, Madam Rita with the entire family were visited, their general health was good, head to toe examination was done and there was no abnormality detected .Madam Rita complains of fatigue. The mother was made to bath the baby under my supervision and kept warm in a cot sheet. The umbilical cord was inspected and the stump was clean and dry. The mother's assessment is as follows;

MOTHER

OBSERVATION	MORNING
Temperature	$36.4\ ^0$C
Pulse	80 bpm
Respiration	23 cpm
Blood pressure	110/70 mmHg
Symphysiofundal height	13 cm

BABY

OBSERVATION	**MORNING**
Temperature	36.4 ^{0}C
Apex beat	130 bpm
Respiratory	40 cpm
Weight	3.0 kilograms
Suckling	Good
Stool colour	Yellow
Stump	Clean and dry

4.10 FIFTH POST-NATAL VISIT

On the fifth day, 13th December 2022, they were informed that my last visit to them at home would be the seventh day, and that they would be handed over to the public health nurse for continuity of care. Client and family were educated on the need and importance of immunization and should make sure to send her baby to child welfare clinic to complete her immunization schedule.

The mother was asked to bath the baby under my supervision and kept warm in a cot sheet. The umbilical cord was inspected and the stump was clean and dry. The mother's assessment is as follows;

MOTHER

OBSERVATION	MORNING
Temperature	36.4 ^{0}C
Pulse	80 bpm
Respiration	20 cpm
Blood pressure	100/70 mmHg
Symphysiofundal height	13 cm

BABY

OBSERVATION	MORNING
Temperature	36.7 ^{0}C
Apex beat	132 bpm
Respiratory	40 cpm
Weight	3.0 kilograms
Suckling	Good
Stool colour	Yellow
Stump	Clean and dry

4.11 SIXTH POST-NATAL HOME VISIT

On the 14th December, 2022 around 9:00am, Madam Rita was visited, the baby was doing well as well as the family. Routine examination was carried out on both the mother and baby from head to toe and there was no abnormality detected on any of them. The perineal pad was inspected the

lochia was serosa with no odour. The baby was bathed with warm water and kept in a cot sheet. The umbilical cord stump was dressed well with chlorhexidine gel, urine and stool were also passed. Client complained of skin rashes on the baby's skin and was reassured and educated to dress baby according to weather and use talcum powder on the baby skin. Observations for both mother and baby were also recorded as follows:

MOTHER

OBSERVATION	**MORNING**
Temperature	36.5 ^{0}C
Pulse	80 bpm
Respiration	20 cpm
Blood pressure	120/80 mmHg
Symphysiofundal height	12 cm

BABY

OBSERVATION	**MORNING**
Temperature	36.5^{0}C
Apex beat	122 bpm
Respiratory	34 cpm
Weight	3.1 kg
Suckling	Good
Stool colour	Yellow
Stunp	Clean and dry stump and dressed with methylated spirit

She was congratulated for her effort during this day. She was then reminded of her last official home visit which is 17th of December,2022

4.12 SEVEN DAY POSTNATAL HOME VISIT/ SEVENTH POST-NATAL HOME VISIT

Madam Rita on the 15th of December, 2022 at 8:00 am as usual. Client's friend was present. After the usual chat, hands were washed and examination was done in client's room. Head to toe examination was carried out on both mother and baby and no abnormalities were found. Her lochia was serosa and without any offensive odour, client was educated on the care of the baby to prevent infection and also advised to continue with postnatal exercise The cord was off and the stump of the umbilicus was cleaned.

The vital signs of the baby are as follows;

BABY

OBSERVATION	**MORNING**
Temperature	36.6^0C
Apex	130bpm
Respiration	40cpm
Weight	3.2kg

MOTHER

OBSERVATION	**MORNING**
Temperature	36.4^0C
Pulse	80bpm
Respiration	18cpm
Blood pressure	100/70mmHg
Symphysiofundal height	11 cm

Client was also told about the end of the care rendered to her from pregnancy till delivery. It was explained to her earlier before the care that, the care study will end a week after she has delivered and that if after the one week she would need any support, it would be given to her. Client was encouraged to report any abnormality in her condition and that of the baby for management. Client was reminded of the first postnatal visits to the maternity home and permission was sought to leave. Client and her family were thanked for their support and co-operation throughout the visits, this they responded with friendly smiles and they said, "You rather need to be thanked".

4.13 FIRST POSTNATAL REVIEW VISIT (19th DECEMBER, 2022)

Madam Rita and her baby arrived at the clinic for postnatal care on the 19thDecember, 2022 at 8:55am in the morning and were accompanied by the mother. She was neatly dressed and looked very cheerful. The day was her eleven day after delivery. She was congratulated and seat was offered to them after exchanging pleasantries. She was given a specimen bottle to take midstream urine and asked to empty the bladder. The urine was tested for glucose and protein which were all negative. Client vital signs were checked and recorded as follows:

MOTHER

Temperature	36.9 degrees Celsius
Pulse	80 beats per minute
Respiration	20 cycles per minute
Blood Pressure	110/60 millimeters of mercury
Weight	60.0 kilograms

Privacy was ensured, washed and dried my hands and helped client to change her dress and gave her a cloth to cover herself and assisted her unto the couch. Head to toe examination was done on the mother without any abnormalities detected. Lactation had been established, abdominal muscles

were firm and elastic, the fundus was not palpable abdominally; lochia colour was alba, perineum intact, no oedema, no pallor and client's personal hygiene was good. After examination she was assisted to dress up. Findings were communicated to client and recorded into her antenatal record card and postnatal register.

Hands were washed and dried. Examination from head to toe was conducted on the baby with particular attention paid on the fontanelles, eyes, ears, nose, mouth, umbilicus, genitalia, anus, legs and back but was without any abnormalities. Both feeding and breathing pattern were normal and colour of the skin was pink. Both urine and stool passage were also normal.

Baby's vital signs and other observations were checked and recorded as follows:

Temperature	36.7 degrees Celsius
Pulse	136beats per minute
Respiration	32cycles per minute
Weight	3.0 kilograms

She was then reminded on family planning and she said she had decided on Depo Provera. She was further counselled to observe good personal hygiene at home to prevent infection by washing hands before and after changing perineal pad, avoid douching or inserting herbs in the vagina, wearing of cotton underwear, washing and drying them under the sun and possibly iron it if not well dry. She was educated to keep the fingers nails short always.

She was encouraged to bring the child to the child welfare clinic for immunization and monitoring of the baby's weight and growth. Mother was reminded to register the births and deaths registry. She was then handed over to the midwife in charge on duty and handed her over to the Public Health Nurse. She was told that, that was where she would come for her forty days postnatal clinic

and also for the continuity of care for the baby. She was finally asked if she had any complaints and said no. Client and mother were congratulated for complying with the advice given.

4.14 SECOND POST-NATAL VISIT TO THE CLINIC

According to the midwife in charge, on the 19th January, 2023. Madam Rita came to 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 and weight were checked and recorded as follows:

Temperature	36.0ºC
Pulse	80bpm
Respiration	20cpm
Blood Pressure	110/70mmHg
Weight	65kg

Madam Takyiwaa Rita was given a urine sample container to provide some urine to be sent to the laboratory for urine analysis to be performed. She was educated on the need and procedure to provide midstream urine for the examination. A sample of blood was also taken from Madam Bertha with her consent to be sent to the laboratory for her hemoglobin level to be tested. The results were explained to her as follows;

Hemoglobin	14.6g/dL
Urine protein	Negative
Glucose	Negative

Madam Takyiwaa Rita 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 examiningaka the abdomen, no abnormality such as subinvolution, 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 edema was looked out for. It was detected that she showed no abnormality.

Speculum examination revealed no bruises on the cervix but showed slit-like appearance. She had not resumed her menses when asked. She 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 fontanelle was 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	37.0ºC
Respiration	40cpm
Apex heart beat	122bpm
Weight	4.8kg

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

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

4.15 NURSING CARE PLAN FOR PUERPERIUM

PROBLEMS IDENTIFIED

9th December 2022	-	After pains
9th December 2022	-	Skin rashes
10th December 2022	-	Backache
12th December 2022	-	Fatigue

NURSING DIAGNOSIS

1. After pain related to uterine involution.
2. Altered skin integrity (skin rashes) related to excessive clothing on baby
3. Backache related to poor posture during breastfeeding
4. Fatigue related to stress from caring for the newborn baby

SHORT TERM OBJECTIVES

1. Client will be relieved of after pain within 72 hours

2. Baby will be free of skin rashes within 72 hours

3. Client will be relieved of backache within 48 hours

4. Client will have increased rest within 24 hours

LONG TERM OBJECTIVE

Client and baby will go through puerperium successful without any complications to both mother and baby and the entire family.

NURSING CARE PLAN DURING PUERPERIUM

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVE	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN.
9/12/22 7:30am	Altered body comfort (after pains) related to uterine involution	Client will be relieved of after pain within 72 hours as evidenced by client verbalizing that pain is relieved.	1. Reassure client. 2. Explain physiology of involution to client. 3. Encourage client to breastfeed frequently. 4. Assist client to empty her bladder 5. Encourage client to perform postnatal exercise. 6. Serve prescribed analgesic.	1. Client was reassured that the pain will be subside. 2. Physiology of involution was explained to client that the uterus contracts and goes back to its pre-pregnant state. 3. Client was encouraged to breastfed on demand. 4. Client was assisted to apply warm compress at the supra-pubic area to relieve pain. 5. Client was encouraged to perform kegel exercise 6. Prescribed analgesic paracetamol 1g start was served.	25/12/20 7:30am	Goal fully met as client verbalized being relieved of lower abdominal pain.	

DATE TIME	NURSING DIAGNOSIS	NURSING OBJECTIVE	NURSING ORDERS	NURSNG INTERVENTION	DATE/ TIME	EVALUATION	SIGN.
9/12/22 6:30am	Alteration in skin integrity (heat rashes) related to excessive clothing on baby.	Baby will be free from skin rashes throughout puerperium as evidenced by midwife observing baby's skin is free from rashes.	1. Reassure client 2. Educate mother to dress baby according to the weather. 3. Encourage client to wash with mild soap and rinse with water and dry baby's clothing under the sun and iron it if possible. 4. Advice mother to dress baby in cotton cloths. [[5. Educate client to remove soiled cloths and diapers on baby to prevent rashes.	1.Client was reassured that the rashes will subsided. 2. Mother was educated to dress baby according to the weather 3. Client was encouraged to wash with mild soap and dry baby's cloths under the sun and iron it if possible. 4. Mother was advised to dress baby with cotton cloths. 5. Client was educated to remove soiled cloths on baby to prevent rashes.	9/12/2022 8:30am	Goal fully met as client verbalized that baby's skin was free from rashes throughout puerperium.	M .K

NURSING CARE PLAN DURING PUERPERIUM

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVE	NURSING ORDERS	NURSING INTERVENTION	DATE TIME	EVALUATION	SIGN.
11/12/22 7:00am	Backache related to poor posture during breastfeeding.	Client will be relieved of backache within 48 hours as evidenced by client verbalizing absence of backache.	1. Reassure client. 2. Explain the cause of the backache to her. 3. Demonstrate how to adopt proper position during breastfeeding. 4. Encourage client's husband to perform back rub for client.	1. 1. Client was reassured and that pain will subside. 2. The cause of the condition was explained to her that it was due to the poor positioning. 3. Demonstration was done on how to adopt proper position and attachment during breastfeeding so that the baby's hips is in alignment. 4. Client's husband was encouraged to perform back rub for client.	27/12/20 6:30am	Goal fully met as client verbalized that she has been relieved of backache.	M .K

NURSING CARE PLAN DURING PUERPERIUM

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVE	NURSING ORDERS	NURSING INTERVENTION	DATE TIME	EVALUATION	SIGN.
12/12/20 6:30am	Fatigue related to stress of caring for the newborn baby	Client will have normal sleeping pattern within 24 hours as evidenced by client verbalizing being relieved of fatigue.	1. Reassure client. 2.Encourage her to feed baby frequently. 3. Encourage client to keep baby dry and comfortable 4. Advice client to sleep when baby sleeps. 5.Encourage client's relatives to support in the care of the baby. 6. Encourage client to feed the baby well before bed time.	1.Client was reassured that with effective care she will have enough rest. 2. Client was encouraged to feed baby on demand. 3. Client was advised to change baby's diapers or nappies when wet. 4. Client was advised to sleep when baby sleeps. 5. Client's relative was encouraged to support in the care of the baby. 6. Client was encouraged to feed the baby well before time.	29/12/20 6:30am	Goal fully met as client verbalized that she has been relieved.	

SUMMARY AND CONCLUSION

Madam Takyiwaa Rita 29-years gravida 2 para 1 alive and a native of Wenchi in the Bono East Region was met when she was 36 weeks pregnant on the 14th November, 2022 at the Ampenkro hospital during my practical experience. She was chosen as a client to help her go through pregnancy, labor and early puerperium successfully without any complications after she consented to.

During her prenatal period her antenatal card was collected and glanced through and noticed client complains of having waist pain. She was chosen for the care study so that she could be helped to manage her problem.

Her pregnancy was managed well and she cooperated throughout pregnancy. She went into labor and had spontaneous vaginal delivery to an alive female child on 8thDecember, 2022 with no complications like postpartum hemorrhage. She was visited at home during puerperium and cared for in their own environment. Client was managed throughout pregnancy, labour and puerperium until the tenth day puerperium when she was handed over to the public health nurse for continuity of care.

In undertaking this family centered maternity care study, my experience has enriched since I was able to put the things being taught both knowledge and skills into practice. Scientific approach was used in the nursing care to collect data from her, identified her needs which enabled me to render a comprehensive care. This has also made me recognize the importance of family support, participation and choice in rendering total care to the mother.

BIBLIOGRAPHY

Lowdermilk, D. L., Perry, S.E., & Cashion, K. (2014). *Maternity nursing*. (8th ed.). St. Louis: Mosby.

Fraser, D.M & Cooper, M.A (2013): *Myles Text book for Midwives* (16th Ed). London: Churchill Livingstone Elsevier Ltd.

Marie, E (2013) *Midwifery for Nurses (*2nd Ed.*) New* Delhi: CBS PUBLISHER & Distribution.

Perry, L *(*2013) *Maternity nursing* (7th Ed),Canada.

Weller, F.B (2014) *Midwifery for Nursing* (4th Ed), Australia.

Konar, H. (2013). D.C. Dutta`s Textbook of Obstetrics. Kolkata: New Central Book Agency(P) L

Marshall & Raynor (2014): Textbook for Midwives (16th edition). London; Churchill Livingestone Elesevier Ltd

APPENDIX 1

ANTENATAL RECORD

DATE	WEIGHT (KG)	BLOOD PRESSURE	URINE FOR PROTEIN/ SUGAR	GESTATIONAL AGE IN WEEKS	FUNDAL HEIGHT (CM)	PRESENT A-TION	DESCENT OF FETAL HEAD	FETAL HEART RATE (FH)	COMPLAIN	TREATMENT GIVEN	SIGN
19/05/22	76	100⁄70m mHg	negative⁄ negative	11weeks	-	-	-	-	Headache	Routine drugs	M.K
17/06/22	74	90/60mm Hg	negative⁄ negative	15weeks	14cm	-	-	-	No complaints	Routine drugs	M.K
15/07/22	75	100/60m mHg	negative⁄ negative	19 weeks	20cm	Varible	-	-	Feels well	Routine drugs.	M.K
12/08/22	75	113⁄60m mHg	negative⁄ negative	23weeks	22cm	Cephalic	-	130bpm	Complaints of waist pains.	Routine drugs.	M.K

MOTHER'S ANTENATAL

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)	COMPLAIN	TREAT-MENT GIVEN	SIGN
10/09/22	82	110/70m mHg	negative/ negative	27weeks	24cm	Cephalic	-	138bpm	No complaints	Routine drugs.	M.K
10/10/22	85	110/60m mHg	negative/ negative	31weeks	29cm	Cephalic	-	140bpm	No complaint	Routine drugs	M.K
24/10/22	87	100/74m mHg	negative/ negative	33weeks	32cm	Cephalic	5/5th	138bpm	No complaints	Routine drugs	M.K
07/11/22	80	110/60m mHg	negative/ negative	35weeks	33cm	Cephalic	5/5th	136bpm	No complaints	Routine drugs	M.K
14/11/22	82	100/74m mHg	negative/ negative	36weeks	36cm	Cephalic	5/5th	146bpm	Backache	Routine drugs	M.K
21/11/22	90	112/80	Neg/Neg	37 weeks	37cm	Cephalic	5/5th	138	Heart burns	Routine drugs	M.K
28/11/22	89	110/70	Neg/Neg	38weeks	38cm	Cephalic	5/5th	140	Lower abdominal pains	Routine drugs	M.K
05/12/22	91	120/70	Neg/Neg	39weeks	39cm	Cephalic	5/5th	143	Fatigue	Routine Drugs	M.K

APPENDIX II

COMPLETE DIAGNOSTIC INVESTIGATION

DATE	SPECIMEN	INVESTIGATION	NORMAL VALUES	FINDINGS	REMARKS
19/05/22	Blood	Haemoglobin	11-16g/dl	13.6g/dl	Normal
		Blood group	A, B, AB, O	O	Normal
		Rhesus factor	Positive/Negative	Positive	Normal
		Sickling	Negative	Negative	Normal
		G6PD	Reactive/Non-	Non-reactive	Normal
	Urine	Protein	reactive	Negative	Normal
		Glucose	Negative	Negative	Normal
			Negative		
17/6/22	Urine	Protein	Negative	Negative	Normal
		Glucose	Negative	Negative	Normal
12/8/22	Urine	Protein	Negative	Negative	Normal
		Glucose	Negative	Negative	Normal
09/09/22	Urine	Protein	Negative	Negative	Normal
		Glucose	Negative	Negative	Normal
10/10/22	Urine	Protein	Negative	Negative	Normal
		Glucose	Negative	Negative	Normal

COMPLETE DIAGNOSTIC INVESTIGATION CONTINUED

DATE	SPECIMEN	INVESTIGATION	NORMAL VALUES	FINDINGS	REMARKS
24/10/22	Urine	Protein	Negative	Negative	Normal
		Glucose	Negative	Negative	Normal
	Blood	Hemoglobin	11-16g/dl	11.6g/dl	Normal
07/11/22	Urine	Protein	Negative	Negative	Normal
		Glucose	Negative		Normal
14/11/22	Urine	Protein	Negative	Negative	Normal
		Glucose	Negative	Negative	Normal
	Blood	Haemoglobin	11-16g/dl	11.3g/dl	Normal
28/11/22	Urine	Protein	Negative	Negative	Normal
		Glucose	Negative	Negative	Normal

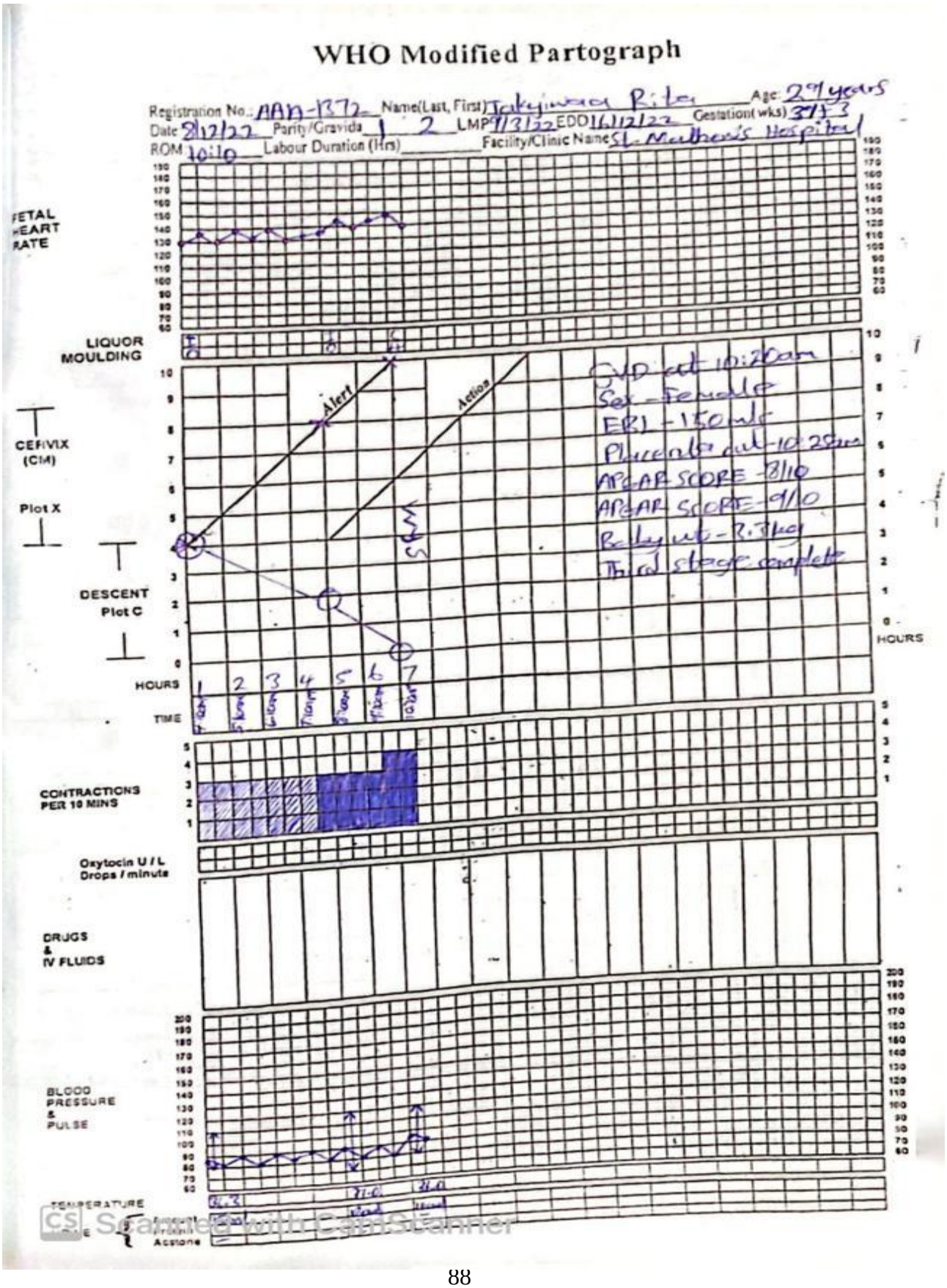
APPENDIX II1– PHARMACOLOGY OF DRUGS

NAME OF DRUG	CLASSIFICATION	DOSAGE	ROUTE OF ADMINISTRATION	ACTIONS AND USES	SIDE EFFECTS	SIDE EFFECTS OBSERVED ON CLIENTS
Tablet multivitamin	Vitamin preparation	200 mg 3 times daily.	Orally	1 Increase appetite. 2 Prevention and treatment of anaemia	Gastro-intestinal disturbance	None observed
Tablet ferrous sulphate	Iron preparation	200 mg 3 times daily.	Orally	1 Increase haemoglobin level. 2 Formation of red blood cells.	Gastro-intestinal disturbance	1. Dark stool observed.
Tablet folic acid	Vitamin preparation	5 mg daily.	Orally	Haemoglobin level increase Prevents neural tube defect	Gastro-intestinal disturbance	None observed
Tablet paracetamol	Antipyretic preparation. Analgesic.	1000 mg (l g) three times daily.	Orally	1. Relieve pain. 2. Reduce temperature of body.	Prolonged use caused liver damage	None observed
Tablet Sulphadoxine Pyrimethamine-ne (SP)	Anti-malaria	3 tablets every month for 3 months.	Orally	Prophylactic treatment of malaria.	Nausea, dizziness, headache, rashes, shortness of breath	None observed
Capsule amoxicillin	Antibiotic	500 mg three times daily	Orally	Treatment and prevention of infection.	Nausea and vomiting, anorexia, abdominal pain	None observed
Tablet metronidazole	Antibiotic	400 mg three times daily	Orally	Treatment and prevention of infection.	Gastro-intestinal upset	None observed

APPENDIX II1– PHARMACOLOGY OF DRUGS

NAME OF DRUG	CLASSIFICATION	DOSAGE	ROUTE OF ADMINISTRATION	ACTIONS AND USES	SIDE EFFECTS	SIDE EFFECTS OBSERVED ON CLIENTS
Injection syntocinon	Oxytocin drug	5 – 10 units	Intramuscularly or Intravenously	1. Control bleeding. 2. Stimulate uterine contraction.	Nausea and vomiting	None observed
Bacillus Calmette Guerin (BCG)	Vaccine	0.05mls- 0.1 ml	Intradermal	Stimulate the body to produce antibodies against tuberculosis.	Blister formation at the injection site	A blister was formed
Poliomyelitis 'O'	Antigen	2 drops	Orally	Prevention of poliomyelitis.	Diarrhoea, nausea	None observed
Injection tetanol toxoid	Antigen	0.5 mls	Intramuscular	1. Stimulate the body to produce antibodies against tetanus organism. 2. Prevention of mother to child transfer of tetanus.	Pain and tenderness at injection site	None observed

WHO Modified Partograph



LABOR NOTES

On 8/12/22 at 11:00am client G2P1 with 39+3 week gestation came to the ward with complains of lower abdominal and waist pains. On examination SFH - 39cm, FHR - 143bpm, Presentation - cephalic, descent 5/5, BP - 120/70mmHg, Pulse - 84bpm, Temp - 36.4°C, Resp - 22cpm, close monitoring [illegible]. At 10:20am she delivered an alive female child with A/S 8/10, 9/10, HC - 3?, FL - 52cm, Bwt - 3.3kg. Third stage completed, perineum intact, EBL - 150mls. Essential care provided for baby. Mother, baby are doing well and made comfortable in bed.

Please circle or write responses.

DELIVERY

DATE 8/12/22 TIME: 10:20am METHOD: (Spontaneous) / Vacuum Extraction / C/S / Other

PERINEUM: (Intact) / Episiotomy / Laceration

ANESTHESIA: (None) / Local / General

THIRD STAGE

Active Management: (Yes) / No ·Medication: Time 10:21am Type/Dose Oxytocin

PLACENTA: TIME: 10:25am (Complete) / Incomplete

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

BABY

Weight: 3.3kg
Sex: Male / (Female)
Baby Position: (Vertex) / Breech / Other

APGAR

Time	Color	Breath	Heart	Tone	Reflex	TOTAL
1min	2	1	2	2	1	8/10
5min	2	2	2	2	1	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	10:30am	126/70	92	18cm	150mls	100mls
		10:45am	120/80	88	contracted	No active bleeding	
		11:00am	110/72	86	contracted	No active bleeding	Nill
		11:15am	110/70	84	contracted	No active bleeding	
		11:30am	128/82	82	contracted	No active bleeding	Nill
		11:45am	110/60	80	contracted	No active bleeding	
		12:00pm	124/82	78	contracted	No active bleeding	Nill
		12:15pm	110/70	75	contracted	No active bleeding	
	Every 30 minutes For 1 hour	12:45pm	100/80	78	contracted	No active bleeding	Nill
		1:15pm	110/74	74	contracted	No active bleeding	

Birth Attendant Mansa Keduah assisted by Erica Benefo Date 8/12/2022

LSS 4th Edition external review draft · ©ACNM (to be published 2008)

MATERNITY CHART

NAME: Takyiwaa Rita

AGE: 29 years WARD: LYING-IN

NO AAA-1372 BED NO.: 4

Date	27/12/22	9/12/22	10/12/22	11/12/22	12/12/22	13/12/22	14/12/22	15/12/22
Days in Hospital	DO	D1	D2	D3	D4	D5	D6	D7
Days P. O.								
Hour AM	10:30am		7:30am		8:00am	7:00am	9:00am	8:00am
PM	-	5:00pm		5:00PM				

Temperature

C	F
41.1°	106°
40.5°	104°
40.0°	102°
39.0	102
38.5	101
38.0	98
37.5	99°
37.0	98
36.5	98°
36.0	97°
35.5°	96°
35°	95°

KEYS
- STANDING WEIGHT
- TEMPERATURE

Scale: 1cm : 1unit

Pulse

Resp.	22cpm	24cpm	24cpm	24cpm	20cpm	24cpm	20cpm	18cpm
B.M.	Passed	Passed	Passed	Passed	Passed	Passed	Passed	Passed
Urine	Passed	Passed	Passed	Passed	Passed	Passed	Passed	Passed
B. P. A/A	110	110	110	110	100	100	100	100
	70	60	70	70	70	70	70	70

NEW BORN EXAMINATION FORM

me: BABY YAA RITA Date of Assessment: 8/12/2022 Time: 11:20 Hrs
te of Birth: 8/12/2022 Time of Birth: _____ Sex: ☐ M ☑ F Age at time of Assessment (days/hrs) 1HR
ational Age ☐ 34 ☐ Mode of Delivery: ☑ Vaginal Assisted Vaginal C-Section
PGAR: 1min ☑ 5min ☑ Birth Weight: ☐ 3.3 kg ☐ Length: 52 cm Head Circumference: 37 cm
mperature at time of Assessment: 36.6 °C Urine passed: Yes ✓ No Meconium passed: Yes ✓ No
me of Assessor (Midwife/Doctor): MANSA KODUAH

Respiration
Rate < 30 b/m *
Rate < 60 b/m *
30-60 b/m
Retractions *
Grunting *
Stridor *

Activity/Movemnet
Spontaneous symmetric movements
Reduced/Absent Movement in ≥1 limb *
No Movement

Tone
Normal
Floppy *
Increased *

Colour
Pink all over
Pink body but blue hands/feet
Blue all over *
Pale *
Jaundiced *

Cord
Normal
Red. draining pus
Bleeding

Cry
Normal
Grill *
Absent *

7. Suck
☑ Good
☐ Weak
☐ Absent

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

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

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

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

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

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

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

16. Clavicle
☑ Normal
☐ Swelling/Fracture

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

18. Heart rate
Rate: 138
☑ 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
Doses (if known) _____

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

NEW BORN CHART

Name: BABY YAA RITA ..... No: ..... Birth Weight: 3.3 kg .....

Sex: FEMALE ..... Mother's No: AAA-1372 ..... Length: 52cm .....

Nature of Delivery: SPONTANEOUS ..... Diagnosis: TERM BABY .....

Date of Birth: 8TH DECEMBER, 2022 Time: 10:20AM ..... Date of Discharge: 9TH DECEMBER, 2022

Date	8/12/2022		9/12/2022		10/12/2022		11/12/2022		12/12/2022		13/12/2022		14/12/2022		15/12/2022							
No. of Days			D1		D2		D3		D4		D5		D6		D7							
Weight	3.3kg		3.2kg		3.1kg		3.0kg		3.0kg		3.1kg		3.2kg		3.3kg							
	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM
Temperature	36.6	36.5	36.4	36.7	36.6	36.5	36.5	36.6	36.4		36.7		36.5		36.6							
Stools	passed	passed	passed	passed	passed	passed	passed	passed	passed		passed		passed		passed							
Urine	passed	passed	passed	passed	passed	passed	passed	passed	passed		passed		passed		passed							
Remarks	Head Neck Trunk Limbs → No abnormalities detected																					

TEMPERATURE CHART

NAME: BABY YAA RITA

AGE: NEWBORN WARD: LYING-IN

NO.: BED NO.: 4

Date	8/12/22	9/12/22	10/12/22	11/12/22	12/12/22	13/12/22	14/12/22	15/12/22
Days in Hospital	D0	D1	D2	D3	D4	D5	D6	D7
Days P. O.								
Hour AM	10:30am	6:30am	7:30am	-	8:30am	7:30am	9:30am	8:30am
PM	-	-	-	5:45pm	-	-	-	-

Temperature

C	F	WT
41.1°	106	
40.5°	104	
40.0°	103	
39.4°	102	
39.5	101	
39.0	100	
37.5	99	
37.0	98	
36.5	97	
36.0	96	
35.5	95	
35.0	94	

KEY:
- BABY WEIGHT
- TEMPERATURE

Scale = 1cm : 1unit

Pulse

Resp.	82cpm	48cpm	44cpm	42cpm	44cpm	46cpm	52cpm	46cpm
B.M.	Passed	Passed	Passed	Passed	Passed	Passed	Passed	Passed
Urine	Passed	Passed	Passed	Passed	Passed	Passed	Passed	Passed

B. P. A.M.

NEW BORN EXAMINATION FORM

Name: BABY YAA RITA Date of Assessment: 8/12/2022 Time: 11:20A
Date of Birth: 8/12/2022 Time of Birth: 10:20AM Sex: ☐ M ☑ F Age at time of Assessment (days/hrs) 1HR
Astational Age ☐ 34+3d ☐ Mode of Delivery: ☑ Vaginal Assisted Vaginal C-Section
APGAR: 1min ☑ 5min ☑ Birth Weight: ☐ 3.3 kg ☐ Length: 52 cm Head Circumference: 37 cm
Temperature at time of Assessment: 36.6 °C Urine passed: Yes ✓ No Meconium passed: Yes ✓ N
Name of Assessor (Midwife/Doctor): MANSAH KODUAH

1. Respiration
Rate 53 b/m
☐ Rate < 30 b/m *
☐ Rate < 60 b/m *
☑ 30-60 b/m
☐ Retractions *
☐ Grunting *
☐ Stridor *

2. Activity/Movemnet
☑ Spontaneous symmetric movements
☐ Reduced/Absent Movement in ≥1 limb *
☐ No Movement

3. Tone
☑ Normal
☐ Floppy *
☐ Increased *

4. Colour
☑ Pink all over
☐ Pink body but blue hands/feet
☐ Blue all over *
☐ Pale *
☐ Jaundiced *

5. Cord
☑ Normal
☐ Red. draining pus
☐ Bleeding

6. Cry
☑ Normal
☐ Shrill *
☐ Absent *

7. Suck
☑ Good
☐ Weak
☐ Absent

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

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

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

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

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

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

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

16. Clavicle
☑ Normal
☐ Swelling/Fracture

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

18. Heart rate
Rate: 138
☑ 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 Immunizatio
☑ Antibiotics in mother
☐ Antenatal corticosteroids

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

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

SIGNATORIES

CANDIDATE NAME

NAME: MISS MANSA KODUAH

SIGNATURE: .....

DATE: 7/07/2023

THE MIDWIFE IN- CHARGE (ST. MATTHEW'S HOSPITAL- AMPENKRO)

NAME: MRS IRENE AKOTO

SIGNATURE: ..... (Ag.)

DATE: 14/07/2023

SUPERVISOR

NAME: MS. MONICA BOAKYE

SIGNATURE: .....

DATE: 7/07/2023

THE PRINCIPAL

MONICA NKRUMAH

SIGNATURE: ..... (A)

DATE: 14/07/2023