

HOLY FAMILY NURSING AND MIDWIFERY TRAINING COLLEGE

BEREKUM

A CLIENT /FAMILY CENTERED MATERNITY CARE STUDY ON

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BY

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PREFACE

Family centered maternity care study is a systematic approach of rendering holistic midwifery care to gravid woman and her family throughout pregnancy, labor and puerperium base on a thoughtful understanding of the client as a unique individual with special problems and needs.

The family centered maternity care is mainly based on total nursing care in which the physical, psychological, spiritual, social, and rehabilitative aspect of the client is considered. It includes the expectant mother, her family and the community in preparing towards the impending arrival of a new family member.

The client and family centered maternity care study also helps students midwives to make good use of the new trends in midwifery like the use of partograph to monitor client in the first stage of labor and the continuity of care to the client after delivery. With this it also enables the student to practice the aspect of midwifery that deals with the client needs, the right of the clients in rendering quality and proper care to her satisfaction. It also helps the student to gain knowledge in the changes and management, ideals and practices in the clinics and maternity homes.

The care study offers the student midwife the opportunity to put the knowledge and skills acquired during training into practice. It also enables her to detect problems and needs of the mother and her family.

Also, the family centered maternity care study helps to reduce maternal and neonatal morbidity and mortality. The client and family centered maternity care study is compiled into a document in partial fulfillment for the award of registered midwifery certificate by the Nursing and Midwifery Council of Ghana.

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INTRODUCTION

The family centered maternity care is an academic work which gives the student midwife the opportunity to nurse a client throughout pregnancy, labor and puerperium using the knowledge and skill acquired during the 3-year training programme.

The study is based on the use of nursing process as guidelines to identify and help the pregnant woman in solving every problem identified during the period of care.

The study was conducted on Madam Grace Ameyaa, a 25year old gravida2 Para1 alive. She hails from Kintampo in the Bono-East of Ghana but stays at Sawaaba. We had an encounter on Tuesday 24th November, 2021 at Glory Prince of Peace Maternity Home and Clinic 36 weeks' gestation and had come for her sixth antenatal care visit.

Introduction was made as a student midwife who wishes to take care of her throughout the rest of her pregnancy, through delivery and puerperium. She had no health issues when we had the encounter.

The interaction ended after client had delivered spontaneously to a live female child without any complication. Mother and baby had a successful puerperal period and they were handed over to the public health nurse for continuity of care in a healthy state after six weeks of care.

There are four chapters outlined in this script.

Chapter One: Is the collection of the client's social, medical, menstrual, lifestyle and hobbies, past and present obstetrical histories.

Chapter Two: Involves antenatal care which begins from the time of conception till the ninth month when the woman was due for delivery.

Chapter Three: Is about the care given to the client during labor and delivery.

Chapter Four: Talks about the puerperium.

At the end of each chapter is a care plan drawn to solve problems encountered by client, summary, conclusion, bibliography and appendix. The client will be called Madam Ameyaa throughout this project

LITERATURE REVIEW

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. A pregnancy is considered to be at term if advances to 38 to 40weeks.

Ojo and Briggs (2011), states that when pregnancy occurs, menstruation ceases for some weeks or months after delivery. Most women experience some minor disorders such as morning sickness, nausea, frequency of micturition, heart burns among others. Such conditions may not be life threatening but can be harmful: the women therefore need to be educated on these conditions so that they can understand and cope with their occurrence. Antenatal care is the advice, supervision and attention a pregnant woman receives to ensure good health as well as early detection and treatment of complications which may affect the woman or her baby.

Myles (2009) states that as soon as pregnancy is confirmed, many physiological changes take place in the body and return to its pre-pregnant state during puerperium due to the effect of hormones namely estrogen and progesterone. These hormones are responsible for the major changes that take place during pregnancy. Even though these hormones have their own effects by causing the minor disorders that occur during pregnancy, they are one way or the other an advantage for the mother and the growing fetus since the fetus depends solely on the mother for survival in utero. variety of care that are rendered to the expectant mothers and their entire families which includes history taking, physical examination (head to toe examination and

abdominal examination. inspection, palpation and auscultation), laboratory investigation (urine, blood and stool), administration of routine drugs (folic acid, fersolate and multivitamin), and tetanus toxoid, education on minor disorders, danger signs of pregnancy, diet, travelling, rest and sleep, exercise, personal and environment hygiene, birth preparedness and complication readiness.

Fraser & Cooper (2009), states that, all changes in the mother's body during pregnancy are due to the effects of specific hormones. These changes enable her to nurture the fetus, prepare her body for labor and develop her breast and lay down stores of fats to provide calories for production of breast milk during puerperium. Psychological state is also affected by hormonal changes. The gestational period is divided into three Trimesters. The first trimester is from the time of conception to the 12th week. The second trimester is from the 13th week to the 24th week whilst the third trimester is from the 25th week to the 38th week of pregnancy antenatal care is given to the woman throughout the period and should commence from the time pregnancy is diagnosed and continue until the safe delivery of the baby.

Weller (2009) stated that, pregnancy is a condition from conception to the expulsion of the fetus. The normal period is 280 days or 40 weeks counted from the first day of the last menstruation period. It is divided into three trimesters. The first trimester is from the day of conception to the 12th week. The second start from the 12th week to the 28th week and the third trimester is from the 29th week to delivery. Physiological changes occur in the body under the influence of hormones which affect all the systems and organs with the greatest change taking place in the uterus as it has to accommodate and nourish the developing fetus, prepare the woman body for labor, develop her breast and lay down stores of fats to provide calories for production of breast milk during puerperium. Any disorder due to the physiological changes is

managed to prevent further complications such as anemia which can endanger the life of both the mother and growing fetus.

LABOUR

Myles (2009) defines labor in the physical sense as the process by which the fetus, placenta and the membranes are expelled through the birth canal. Normal labor occurs between thirty seven to forty two weeks of gestation. Labor has four stages. Stage one comprises of latent phase and may last 6 to 8 hours in primigravidae when the cervix dilates from 1cm to 4cm. The active phase within the first stage is when the cervix usually undergoes more rapid dilatation. This begins when the cervix is 4cm dilated and the woman has the presence of rhythmic contractions, progressively dilates to 10cm or full dilatation. Second stage of labor is the expulsion of the fetus. It begins when the cervix is fully dilated and the woman has the urge to expel the baby. There is stretching of the clitoris, gaping of the anus and bulging of the perineum. Labor completes when baby is born. In multigravida women, it lasts 15 -30 minutes. Third stage of labor begins after the expulsion of the fetus and ends with the expulsion of placenta and membranes. The fourth stage is a period of careful observation of the mother made to assess excessive bleeding and the firmness of the contracting uterus immediately after the third stage of labor and it lasts six hours after delivery of the placenta.

The National Safe Motherhood Service Protocol (2008) labor begins with a regular painful uterine contractions lasting at least twenty (20) seconds (timed by a trained observer) occurring at a frequency of at least two contractions in every ten minutes and with cervical dilatation of at least 4 centimeters. Signs that women may experience prior to labor includes show (pink mucous discharge from the vagina), engagement of the baby's head. The hormone oxytocin is responsible for the strong regular contractions of labor which when released cause

the uterus to contract. Labor contractions feel very different from Braxton Hicks contractions that women experience during pregnancy but the most important difference is that labor contractions come regularly. Each one starts gradually, builds up to a peak and then fades away. Typically when labor begins, contractions are short in length around 20 – 30 seconds long. As labor progresses contractions become gradually longer and stronger which dilates the cervix.

Ojo (2011) defines labor as the process by which the uterus empties its contents after 38 weeks of pregnancy. It entails the contraction and retraction of uterine muscle fibers, the dilatation of the cervical os and complete expulsion of the fetus, liquor amnii, placenta and membranes. Normal labor starts spontaneously at term with the fetus presenting vertex and the process is accomplished within 24hours by an unaided maternal effort without any serious injury to the mother or the baby. Labor is divided into 4 stages. The first stage of labor is the period from the onset of regular uterine contraction to full dilatation of the cervical os. The second stage of labor starts with full dilatation of the cervical os to expulsion of the baby. The third stage of labor entails complete expulsion of placenta and membranes and also involves the control of bleeding. The fourth stage is a period of six hours following delivery of placenta.

Marshall& Raynor (2014) states that, labor, purely in the physical sense, maybe described as the process by which the fetus, placenta and membranes are expelled through the birth canal; however, labor is much more than a purely physical event. Diagnosing the onset of labor is extremely important, since it is on basis of finding that decisions are made that will affect the intrapartum care and support subsequently.

Konar (2011) states that, labor is a series of event that takes place in the genital organ in an effort to expel the viable products of conception out of the womb through the vagina into the outer world. Onset of labor is very much unpredictable to foretell precisely the exact date of

onset of labor. It not only varies from case but even in different pregnancies of the same individual. Conventionally events of labor are divided into four stages: First stage starts from the onset of true labor pains and ends with full dilatation of the cervix. It is in other words, the 'cervical stage' of labor. Its average duration is twelve hours (12) in primigravida and six hours (6) in multipara. Second stage starts from the full dilatation of the cervix (not from the rupture of the membranes) and ends with expulsion of the fetus from the birth canal. It has got two (2) phases thus the propulsive phase starts from full dilatation up to the descent of the presenting part to the pelvic floor and the expulsion phase is distinguished by maternal bearing down efforts and ends with delivery of the baby. Its average duration is two hours (2) in primigravida and thirty minutes (30) in multipara. Third stage begins after expulsion of the fetus and ends with expulsion of the placenta and membranes (after-births) and control of hemorrhage. Its average duration is about fifteen minute (15) in both primigravida and multipara. The duration is, however, reduced to five minutes (5) in active management. Fourth stage is the stage of observation for at least one hour (1) after expulsion of the after-births. General condition of the patient and the behavior of the uterus are to be carefully monitored. 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 patient fails to pass urine especially in late first stage, catheterization is to be done with strict aseptic precautions. Rest and ambulation; if the membranes are intact, the patient is allowed to walk about. This attitude prevents venacava compression and encourages descent of the head. Ambulation can reduce the duration of labor, need of analgesia and improves maternal comfort. Labor is monitored electronically or analgesic drug (epidural analgesia) is given. The transition from the first stage to the second stage is

evidenced by the following features: Increasing intensity of uterine contractions, Urge to defecate with descent of the presenting part, complete dilatation of the cervix on vaginal examination.

Tiran (2008) is defined as the process by which product of conception are expelled from the uterus through the birth canal. Labor normally occurs spontaneously at term, which is between 38 and 42 weeks of pregnancy. The fetus should present with vertex and once started, the contractions should increase in strength and frequency without interruption and artificial stimulation until fetus, placenta and membranes are expelled by the maternal effort through the vagina. Partograph is the graphical recording of labor progress obtained by assessment of visual patterns of cervical dilatation and descent of the presenting part in conjunction with records of maternal and fetal wellbeing.

PUERPERIUM

Konar (2011) Puerperium is the period following childbirth during which the body tissues, specifically the pelvic organs reverts back approximately to the pre-pregnant state both anatomically and physiologically. This begins as soon as the placenta is expelled and last for approximately six weeks when the uterus becomes regressed to the non-pregnant size called involution, the period is arbitrarily divided into(a) immediate-within 24 hours;(b) early-up to 7 days and remote-up to 6 weeks. In its anatomical consideration, the uterus immediately following delivery becomes firm and retract with alternate hardening and softening. At the end of six weeks, its measurement is almost similar to that of the non-pregnant state and weighs about sixty (60) grams. The physiological consideration of involution is most marked in the body of the uterus where the changes occur in the muscles, blood vessels and endometrium.

National Safe Motherhood Service Protocol (2008) states that the postnatal period is the period that starts from the end of delivery of the placenta and membranes and control of hemorrhage to six weeks after delivery. The purpose of postnatal care is to maintain the physical and psychological wellbeing of the mother and child. Postnatal care includes education of the mother on the care of her baby, detection and treatment or referral of any abnormalities for further management. The essential components of postnatal care are therefore: Comprehensive screening to detect complications in mother and baby, Treatment of complications in mother and baby, Assessment and support for infant feeding, Malaria and anemia prevention. Some common discomforts of postpartum period in mothers listed are after pains, perineal pain, bowel and urinary changes, stretch marks, fatigue, sleeplessness, backache, headache, hemorrhoids and mood changes in the first week. Those associated with the newborn are caput succedaneum, tongue tie, rashes and vomiting after feeds. The major causes of death in this period are infections, hypertensive complications, hemorrhage and thrombo embolism of which predisposing factors includes: Conditions or complications during the antenatal period, Complications of labor, related to duration of labor and mode of delivery.

Myles (2008) states that, Puerperium starts immediately after the delivery of the placenta and membranes and continues for six weeks. The overall expectation is that by six weeks after the birth of the baby, all the body systems will have recovered from the effects of pregnancy and return to their non-pregnant state. Between exercise and healthy activity verses rest, relaxation and sleep. Exploring each person's level of activity will encourage advice in relation to appropriate exercise and by association, nutritional intake and rest or relaxation and sleep. Following the birth of the baby and expulsion of the placenta, the mother enters a period

of physical and psychological recuperation. Undertaking regular pelvic floor exercise is of benefit to the woman's long term health.

Marie Elizabeth (2013) describes puerperium as 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 grams. The lower uterine segment becomes thin, flabby and collapsed structure. The cervix contracts slowly; the external os admits to finger for the few days but by the end of the first week, narrows down to admit the tip of a finger only. The external os never revert back to the nulliparous state. During puerperium the number of muscle fibers is not decreased but there is substantial reduction in the myometrial cell size. 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 color 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. With all definitions and changes it can be deduced that puerperium is the period from birth to 6 weeks of delivery.

Ojo and Briggs (2011) states that puerperium is a period that starts immediately after the delivery of the placenta and arrest of hemorrhage and ends at about 6 weeks when the uterus returns to its pre pregnant state. The first ten day of puerperium is term as the lying-in period where close observation of both mother and baby are considered. During this period, bonding is fostered through the establishment of breastfeeding. The abdominal muscle are flaccid and

within a period of six weeks postpartum is called puerperium, and where the bruises heal, the genital organs and any other organ which underwent changes during pregnancy return to their pregravid state. This process of readjustment is called involution. Lactation is also established during the said period. Lochia is the term used to describe the discharge from the uterus during the puerperium. The woman is

educated on what goes on throughout the puerperal period and how to cope with these changes.

The puerperal woman needs a lot of rest and sleep, regular exercise, intake of adequate fluids and nutritious diet rich in protein, carbohydrate and vitamins. The mother is educated on how to care for the baby to prevent infections. Among this education include cord dressing, changing of napkins frequently and exclusive breastfeeding. Emphases are also laid on family planning within six weeks after childbirth.

WHY CLIENT WAS CHOSEN

Madam Grace Ameyaa was chosen as a client on 4th December, 2021 at Glory Prince Of Peace Maternity Home and Clinic during one of her usual antenatal visit. During interaction, she was worried about constipation which was not present in her previous pregnancies. Physiology and education on the topic was provided. Introduction was made as a student from Holy Family Nursing and Midwifery Training College Berekum, and was at the clinic for practical experience and wishes to use her for my care study. Permission was sought from her to be taken as a client for the care study which she accepted. All details of information and procedures involved in the study were explained to her and she gladly agreed and promised to give all the maximum cooperation. All the necessary particulars were collected. Appointment for home visit was booked, direction to her house was given and phone numbers were exchanged.

CHAPTER ONE

CLIENT PARTICULARS

1.0 INTRODUCTION

This chapter gives a preview on the various histories and information about the client, her family and the community in which she lives.

1.1 SOCIAL AND PERSONAL HISTORY

Madam Ameyaa, is a 25 year old gravida 2 para 1 all alive comes from Kintampo in the Bone-East Region of Ghana, but stays at Sawaaba a suburb of Kintampo in the Bone-East Region. She is dark in complexion and weighs 47kg and 158cm in height. Her native language is Bono. She is a Christian who worships at Roman Catholic. She does petty trading at home but sometimes assists the husband at the farm. Madam Ameyaa is married to Mr. Peter Adinkrah. They have been married for almost 10 years. According to Madam Ameyaa, she is a Junior High School graduate. Her source of support through the period of pregnancy is the husband and the family.

1.2 FAMILY HISTORY

Mr. Kofi Kyeremah and Mrs. Vida Keremah are Madam Ameyaa's parents. She is the third born of her parent's children among three siblings. Both parents come from Kintampo in the Bone-East Region of Ghana and they speak Bono. According to Madam Ameyaa, there is no history of Hypertension, Diabetes Mellitus, Sickle cell disease, Asthma and mental illness in her family. They do not have any history of congenital abnormalities such as cleft lip or palate or heart disease in the family. She admitted that multiple pregnancies run through her family. Deaths in her family occur naturally.

1.3 MEDICAL HISTORY

According to Madam Ameyaa, she has no history of medical condition such as hypertension, diabetes, hepatic disorders, kidney problems, pulmonary disorders among others. She has never been admitted to the hospital. Even though she sometimes suffers from certain illnesses, she is treated as an outpatient client whenever she reports to the hospital for treatment. Throughout her life, she has never reacted to any drug or a type of food. She is not on any lifelong medication. She has neither donated blood nor been transfused.

1.4 SURGICAL HISTORY

According to Madam Ameyaa, she has never received or donated blood. She has not been involved in any road traffic accident which could affect the adequacy of her pelvis. She has never undergone any surgical operation since infancy. None of her family members has ever undergone any surgical procedure.

1.5 MENSTRUAL HISTORY

Madam Ameyaa was 17 years when she had her menarche. Her regular menstrual cycle is 28 days; amount of blood loss is moderate each month and last for 5 days. She uses sanitary pad during the flow and changes it two times daily. Her last menstrual cycle was on 15th March, 2021. She has no history of dysmenorrhea. Her expected date of delivery was calculated to be 22nd January, 2022.

1.6 CLIENT'S HOBBIES AND LIFESTYLE

Madam Ameyaa usually goes to bed around 10:00 pm and wakes up around 5: 30 am. Routinely, morning devotion is the action she takes to give glory to Almighty God for his kind gesture and benevolence towards her life and her family. She does few household chores like sweeping, dusting and baths her children. She then starts to prepare breakfast. She serves her children their meal after which she prepares them for school. Since Madam Ameyaa is a trader,

she also prepares for work after taking her bath and making sure everything is in order in the house. She goes to the market and come home at 3:30pm to prepare supper for the family. All these are done from Monday to Friday. On weekends, she does certain chores such as washing dirty cloths, scrubbing the house and goes to church on Sundays to pray. She sometimes assists her husband at the farm. She prefers watching local movies and chatting with family. Banku with okra soup and fish is her favorite meal. She eats three times daily and takes in enough water and empties her bowel twice a day. Together with her family, they watch movies and have some fun until the day fades away. She neither smokes nor drinks alcohol.

1.7 PAST OBSTETRICAL HISTORY

Madam Ameyaa is Gravida 2 Para 1 all alive with no history of spontaneous or induced abortions. The interval between the first pregnancy and the current one was four years. According to the Antenatal records, she never had problem during her pregnancies such as pre-eclampsia, pregnancy induced hypertension, ante partum hemorrhage, anemia and gestational diabetes. She experienced some minor disorders like leucorrhoea, ptyalism, of which she was managed. She was a regular attendant at Antenatal session and took her fourth Tetanus dose. She took five doses of Sulphadoxine Pyremethamine

The mode of her first delivery was spontaneous vaginal delivery with no laceration at the perineum at Glory Prince Of Peace Maternity Home/Clinic, Kintampo on 5th of July, 2017. The outcome of labor was a live healthy male child (first child) with birth weight of 3.0kg and length of 50. The babies cried soon after birth. Postpartum complications such as postpartum hemorrhage, retained placenta, breast engorgement were not recorded and client confirmed not experiencing any complications. She stated that she did not suffer any complications after delivery. Madam Ameyaa exclusively breastfed her children for the first six (6) months and

continued with supplementary feeds. The first, second and third child were fully immunized against the childhood preventable diseases. Much attention was given to her from her beloved husband and family during this period. She has never used any artificial family planning method but uses the natural family planning (calendar method). She attended the postnatal clinic as scheduled.

1.8 PRESENT OBSTETRICAL HISTORY

Madam Ameyaa reported to the antenatal clinic on 20th of June, 2021 with the last menstrual period on 15th of April, 2021. Upon this the expected date of delivery was calculated to be 22nd of January, 2022. Serving as baseline for the comparison with the subsequent antenatal recording, the following laboratory investigation and vital signs were recorded on her booking visit;

| | |
|----------------|------------------------------|
| Temperature | 36.4 degree Celsius |
| Pulse | 82 beats per minute |
| Respiration | 21 cycles per minutes |
| Blood Pressure | 90/60 millimeters of mercury |
| Weight | 47 kilograms |
| Height | 158 centimeters |

The results of the various laboratory investigations done were as follows

| | |
|-----------------------------|--------------------------|
| Haemoglobin | 9.9 grams per deciliters |
| Sickling test | Negative |
| Blood group | O |
| Rhesus | Positive |
| Hepatitis B | Non-Reactive |
| VDRL | Negative |
| G6PD | Normal |
| HIV status | Non-Reactive |
| Urine for protein and sugar | Negative |
| Gestational weeks | 4 weeks |

Symphysio fundal height Not palpable

No abnormality was detected on Madam Ameyaa after carefully conducting head to toe examination. She complained of lower abdominal pains. Madam Ameyaa was regular at antenatal clinic, and her complaints were addressed and scheduled for the next visit. Madam Ameyaa attended subsequent visit at the antenatal clinic and the routine care and drugs were given to her. She was served with the following routine drugs.

Tablet ferrous one daily x 30 days

Tablet Folic Acid one daily x 30 days

Tablet Multivitamin one daily x 30 days

Paracetamol one gram tid x 3 day

CHAPTER TWO
ANTENATAL CARE

2.0 INTRODUCTION

This chapter describes the care given to the client during antenatal period. It also gives information about first contact with client, home visits made and nursing care plan on problems identified.

2.1 FIRST CONTACT WITH THE CLIENT

Madam Ameyaa was a regular attendant to the antenatal clinic and it was through one of these visits that she was met on the 24th of November, 2021 at 36weeks gestation and her 6th visit to the clinic. She was warmly welcomed and a seat was offered to her and enquiry about her health and that of her family was made. She said they were all fine and that she was coming for antenatal care and she also complained of constipation which was not present in her previous pregnancies, physiology of constipation was explained to her. Her antenatal book was collected and glanced through and then introduction was made to her as a student midwife from Holy Family Nursing and Midwifery Training College, Berekum who came to have clinical experience and then wish to use her for my care study. All details of information and procedures involved in the study were explained to her and she gladly agreed and promised to give all the information needed and the maximum cooperation. She was asked to empty her bladder after a specimen bottle was given to her and it was explained to her the need to obtain midstream urine, to check for ketone, protein and sugar. Vital signs were taken and the finding recorded in her antenatal book was as follows;

Haemoglobin level 11.5g/dl

Weight 55kg

| | |
|----------------|--------------------|
| Temperature | 36.5 ^{0C} |
| Pulse | 95bpm |
| Respiration | 20cpm |
| Blood Pressure | 110/60mmhg |

Head to toe examination was explained to her. The necessary equipment for the procedure were gathered and taken to the examination room. She was asked to sit on the bed, lie lateral and then assume a supine position. Hands were washed and dried. Under the supervision of the midwife-in-charge, the following examinations were carried out on Madam Ameyaa.

Physical examination; The examination was started on the client from the head and was supervised by the midwife-in-charge. On inspection, the hair was observed to be neatly braided and appeared clean. Her face was also clean and no abnormality was detected. Her eyes were normal in color and in good condition. The ears were also in proper alignment with the eyes, the nose had patent nares. The mouth was very clean with teeth very clean and in good condition, the lips were nicely kept with a lip balm applied to it, the tongue was kept clean. No abnormality was detected. As the procedure was on going, client was congratulated for having taken good care of herself. The neck was free from lymph nodes and goitre.

The breast was exposed to check for size, shape, signs of pregnancy, dimpling and nipple retraction and condition of the skin. One breast was covered and she was asked to put the hand of the part to be examined under her head. The breast was palpated systematically in a circular manner using the inner aspect of the fingers and client was taught self-examination. Nipples were squeezed gently for fluid (colostrum) and were examined for odor, blood and cleaned with

cotton wool swab. The same was done for the other breast and no abnormality was noted.

Breastfeeding history was asked and her desire to breastfeed was positive as her children were breastfed.

She was asked for tingling and tightness of the finger on making a fist, the hands and fingers were inspected for edema, pallor of palms and nail bed and no abnormality was noted. The legs were inspected for size and equality and palpated for edema, tenderness in the calf muscles varicose veins, size and equality and no abnormality was noted. The back was examined for deformity of the spine (scoliosis), edema of the sacral region, and no abnormality was detected. The condition of the skin was also noted to be normal.

Abdominal examination.

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

Measurement of the Symphysio-fundal height; the upper border of the symphysis pubis was located. For measuring the symphysio-fundal height, the zero mark of the measuring tape was placed on the upper border of the symphysis pubis and extended along the contour of the abdomen to the fundus. The symphysio-fundal height measured 35cm and the gestational age was 36 weeks.

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

Lateral palpation; the palms were placed on both sides of the uterus, midway between the symphysis pubis and the fundus. The uterus was stabilized with one hand and examined by the other hand. The palpation was started from the abdominal midline to the lateral side of the abdomen and from the symphysis pubis to the fundus in a rotatory manner. The fetal back (the smooth part) was located at the right side of the woman's abdomen, and the limbs (the rough part) were at the left side.

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

Decent; the anterior shoulder was located to determine descent of the head. Two fingers were kept over the anterior shoulder and the symphysis pubis was located. The right ulna border was placed just above the symphysis pubis and the anterior shoulder. Four finger breadths were accommodated and the descent was recorded.

Auscultation; Fetal stethoscope was warmed by rubbing it in the palm. The fetal heart was auscultated by placing fetal stethoscope on the area where the back was located. The ear was placed against the stethoscope, making sure hands were not touching the stethoscope when the fetal heart beat was being counted. Comparing the rate with the maternal pulse and counting how many beats were heard for one minute, it was 142bpm with regular rhythm.

Vulva examination; Permission was sought from Madam Ameyaa to examine her vulva, which was granted. Hands were washed using aseptic techniques before the procedure. The woman was

helped to relax onto the examination bed. She was made to bend her knees and was told to separate her legs gently. With the aid of a direct light, her inner thighs were touched gently before touching any of her genitals in order not to startle her. The labia, clitoris and perineum were inspected. The skin was very smooth and clean and the pubic hair was free of nits and lice. The labia tissue felt soft and consistent on palpation. There was no swelling, redness, marks, rashes, pimples or sores. There were no abnormal discharges. No signs of fistulae were also observed. She was asked to bear down while holding the labia open to watch for any bulging of the anterior or posterior vaginal walls.

Madam Ameyaa was helped to dress up after the examination and all findings were explained to her. She was thanked for her understanding and cooperation. Hands were washed and dried and all findings were recorded in her antenatal book. She complained of backache and she was educated to support her back with pillow when sitting. Permission was sought from Madam Ameyaa for home visit and it was granted and then directions to her house as well as her contact numbers were asked for. She was informed on the next antenatal visit which was on the 11th December, 2021. Routine drugs were served as follows;

| | |
|-----------------------------------|--------------------------------|
| Tablet Folic Acid | 5 milligrams daily for 7days |
| Tablet Ferrous Sulphate | 200 milligrams daily for 7days |
| Tablet Multivitamins | 200milligrams daily for 7days |
| Tablet sulphadoxine pyrimethamine | fourth dose |

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

2.2 FIRST ANTENATAL HOME VISIT

The first home visit to Madam Ameyaa's house was on the 7th December, 2021 at exactly 2:40pm. The aim of the visit was to assess her home environment and to know how she is prepared toward birth. Greetings were exchanged and seat offered on arrival. She was in the house with her children who were home due to the pandemic. The husband was not yet back from work, thus the farm. Madam Ameyaa lives in a single room house. The house is built with mud and plastered a bit with cement, roofed with aluminum sheet. She lives with her husband and child. There is a borehole in her neighborhood, where she fetches water for domestic activities and stores it in a clean large blue barrel with a lid. Electricity is the source of power used in the house. She has a kitchen which is built with wood which was very clean and in a good condition. She gathers rubbish or waste in a container with a cover which she finally disposes every day into the public refuse dump. She was advised to always cover her dustbin to prevent flies from settling on uncovered food which could bring about diseases. The compound was very nice because it looked very neat and the surrounding was neatly weeded. There was no stagnant water and no gutters. She also said that the whole family was ready to accept the new born into the family. She was encouraged to introduce her children to the unborn child to prevent sibling rivalry. She also complained of loss of appetite and she was educated to eat in bit but frequently and ensure oral hygiene. She was asked to continue with her routine drugs as prescribed. She promised to do as educated. She was encouraged to maintain the neatness in her compound. Before leaving, her layette was checked, she had already packed her bag with items like; sanitary pads, toiletries etc. In this bag included purse with money, insurance card and antenatal book. She was also educated on birth preparedness and complication readiness plan by asking her the person who would accompany her to the hospital to deliver as well as take care of

the house during that same period and she replied saying her husband would take that responsibility. The permission to leave was sought and she was promised of another visit

Psychosocial environment, Madam Ameyaa, the husband, the child and family-in laws have a cordial relationship with each other, she has a warm and friendly relationship with the tenants, other family members staying around the house and neighbours. Her friends most of the times visit her and also visits them at her leisure time. She is very free and likes to crack a jokes. She has respect for humans and likes to make new friends.

After all interaction, Madam Ameyaa and her family were then appreciated for their warm reception and permission was sought to leave. The next visit scheduled and was then seen off by client.

2.3 SECOND ANTENATAL HOME VISIT

The second home visit was made on 14th December, 2021 at 2:00pm. The visit was made purposely to check on the health status and educate Madam Ameyaa on birth preparedness and complication readiness plan. Client was doing well except that she complained of backache and waist pain. She was therefore encouraged not to stand and sit for too long, she was also advised to let a family member assist in household chores, and also was reassured by explaining the physiology of backache in late pregnancy. She was educated on the true signs of labor such as rhythmic regular uterine contractions and show, and was told to give a call and report immediately to the clinic as soon as she sees any danger signs of pregnancy such as severe frontal headache, severe lower abdominal pains, bleeding per vaginum and excessive vomiting. She was thanked for her cooperation and reminded of her next visit to antenatal clinic on 18th December, 2021. Permission was sought to leave.

2.4 CARE PLAN DURING ANTENATAL PERIOD PROBLEMS IDENTIFIED DURING ANTENATAL

Madam Ameyaa complained of the following;

1. Loss of appetite
2. Constipation
3. Backache
4. Waist pain

SHORT TERM OBJECTIVES

1. Client will regain her appetite and take 1/2 of meal served within 48hours
2. Client will be able to pass stools once every 48 hours.
3. Client will cope with backache throughout pregnancy.
4. Client will cope with waist pain throughout pregnancy.

LONG TERM OBJECTIVES

Madam Ameyaa will go through pregnancy, labor and puerperium successfully without any complication to herself and her fetus.

2.1 ANTENATAL CARE PLAN

| DATE/ TIME | NURSING DIAGNOSIS | NURSING OBJECTIVES /OUTCOME CRITERIA | NURSING ORDERS | NURSING INTERVENTION | DATE/ TIME | EVALUATION | SIGN |
|--------------------|--|--|--|--|--------------------|--|------|
| 04/12/21 3:00pm | Loss of appetite related to hormonal changes during late pregnancy | <p>1. Client will regain her appetite and take 1/2 of meal served within 48hours as evidenced by midwife observing it.</p> | <p>1. Reassure Madam Ameyaa.</p> <p>2. Encourage Madam Ameyaa to take food in bits and at frequent interval</p> <p>3. Encourage Madam Ameyaa to practice mouth care.</p> <p>4. Encourage Madam Ameyaa to take vitamins supplement as prescribed.</p> | <p>1. Madam Ameyaa was reassured she would regain her appetite.</p> <p>2. Madam Ameyaa was educated to take food in bits and at frequent interval.</p> <p>3. Client was encouraged to brush her teeth twice daily and rinse mouth with water before and after each meal.</p> <p>4. Client was encouraged to take in lots of fruits and vegetables.</p> | 23/12/21 7:00am | Goal fully met as midwife observed client taking 1/3 of meal served. | |

ANTENATAL CARE PLAN CONT'D

| DATE/TIME | NURSING DIAGNOSIS | NURSING OBJECTIVE / OUTCOME CRITERIA | NURSING ORDERS | NURSING INTERVENTION | DATE/TIOME | EVALUATION | SIGN |
|--------------------|--|--|--|--|--------------------|---|-------------|
| 07/12/21 4:00pm | Constipation related to physiological changes during late pregnancy. | 1. Client will be able to pass stools once every 48 hours. as evidenced by client verbalizing it. | 1. Reassure client. 2. Educate her to take in foods rich in fiber. 3. Encourage her to take at least 500mls of fluids every day. 4. Encourage client to engage in tolerable exercise such as walking. | 1. Client was reassured. 2. Client was educated to take in food rich in fiber like fruits and vegetables. 3. She was encouraged to take 500mls of fluids per day, at least. 4. She was advised to engage in tolerable exercise such as walking. | 10/12/21 4:00pm | Goal fully met as client reported she had resumed normal bowel movement (once daily). | |

ANTENATAL CARE PLAN CONT'D

| DATE/TIME | NURSING DIAGNOSIS | NURSING OBJECTIVES /OUTCOME CRITERIA | NURSING ORDERS | NURSING INTERVENTION | DATE /TIME | EVALUATION | SIGN |
|--------------------|---|---|--|--|--------------------|--|-------------|
| 14/12/21 4:00pm | Backache related to pressure on sacral nerve. | Client will cope with backache throughout pregnancy as evidenced by client behavior and making less complaints. | <ol style="list-style-type: none"> 1. Reassure client 2. Encourage client to avoid prolong sitting and standing. 3. Administer prescribed medication 4. Encourage client`s family to assist with household chores. 5. Encourage client to sleep on firm mattress. | <ol style="list-style-type: none"> 1. Client was reassured. 2. Client was encouraged to avoid prolong standing and sitting. 3. Client was served prescribed medications 4. Client`s family were encouraged to help her with household chores. 5. Client was encouraged to sleep on a firm mattress. | 16/12/21 4:00pm | Goal fully met as evidenced that client is coping with backache. | |

ANTENATAL CARE PLAN CONT'D

| DATE/TIME | NURSING DIAGNOSIS | NURSING OBJECTIVE | NURSING ORDERS | NURSING INTERVENTIONS | DATE /TIME | EVALUATION | SIGN |
|--------------------|--|---|--|--|--------------------|--|-------------|
| 18/12/21 4:00pm | Waist pain related to descent of fetal head putting pressure on sacral nerve | Client will cope with waist pain throughout pregnancy as evidenced by client`s actions. | 1. Reassure Madam Ameyaa. 2. Encourage Madam Ameyaa to have rest and sleep. 3. Teach Madam Ameyaa on good body mechanics. 4. Educate Madam Ameyaa on minimal work and exercise. 5. Give prescribed analgesics. | 1. Madam Ameyaa was reassured. 2. Madam Ameyaa was encouraged to have rest and sleep. 3. Madam Ameyaa was advised to avoid prolong standing. 4. Madam Ameyaa was educated on minimal work and exercise. 5. Prescribed analgesics were served (tab paracetamol 1g tid). | 23/12/21 7:00am | Goal fully met as evidenced by client`s actions. | |

CHAPTER THREE

LABOUR

3.0 INTRODUCTION

This chapter describes the management of all the four stages of labor of the client and the care plan drawn for problems identified in labor.

3.1 ADMISSION AND MANAGEMENT OF THE FIRST STAGE OF LABOUR ADMISSION

Madam Ameyaa reported to the facility on the 23rd December, 2021 at 12:40am with the gestational age of 39weeks and was accompanied by her sister-in- law. They were offered seat at the labor ward department after which greetings were exchanged between us. Her items were collected and general condition was also observed to be good. Madam Ameyaa was oriented to the ward environment, where the washroom is and where she was going to keep her items. She complained of lower abdominal pain and waist pains. Madam Ameyaa was in an anxious state and was educated on the various stages of labour and was reassured. Her vital signs were checked and recorded as follows;

| | |
|----------------|--------------------|
| Temperature | 36.5 ^{0C} |
| Pulse | 90bpm |
| Respiration | 22cpm |
| Blood pressure | 110/70mmHg |

A general examination was conducted under the supervision of a senior midwife. According to Madam Ameyaa she had seen blood stained mucoid (show) prior to her coming. She was accompanied to the labor room and helped onto the delivery bed after emptying her bladder. The

volume of her urine was 100mls with protein negative and glucose negative. Privacy was provided and her consent was sought. Hand washing was performed with soap under running water. Head to toe examination was carried out. There was no pallor observed. On the conjunctiva, sclera, palms, tongue, and soles of the feet, no signs of anemia were present. The feet were also not edematous and were in a good condition. No enlarged veins at the neck. An abdominal examination was done to check for the position and presentation of the fetus which was right occipito-posterior and cephalic respectively. The fetus was in a good condition and the descent of the fetal head was 3/5th. The size, shape and presence of any scars were also checked. There were no scars present. Symphysis-fundal height was 37 centimeters. On auscultation, fetal heart rate was 140 beat per minutes. The contractions were 3 in 10 lasting 25 seconds. There was no abdominal tenderness excluding enlargement of the liver and spleen.

Vaginal examination

The procedure was explained to the client and privacy was provided. The woman was encouraged to empty her bladder. The client was helped to be in the lithotomy position. She was draped. Proper hand washing was done with soap under running water and hands were dried with a hand towel. Examination gloves were worn. Her soiled pad was removed and discarded using the left hand. The woman was asked to flex her knees and separate her legs. The vulva was inspected and there were no scars from previous births. On examination, a swab was picked using the right hand and was dipped in a different gallipot containing salvon. The swab was dropped from right into left hand and the labia majora, minora and then the vestibule were swabbed using one swab per stroke; and wiping from anterior to posterior. The swabs were disposed of. With the labia minora still separated, the right middle finger was gently inserted into the vagina and was firmly pressed downwards causing the relaxation of the vaginal wall and

muscles. The index finger was gently inserted. The vagina was warm and moist, the cervix was soft. There was a cervical effacement. There was neither cord presentation nor prolapse as the membranes were still intact. The cervical dilatation was 4cm at 1:00am when vaginal examination was performed. The woman was dried and a clean pad was applied. Sterile gloves were removed and hands were washed using soap and water. Hands were dried using a hand towel. The woman was helped to turn over to her left side. She was made comfortable in bed. Findings were reported to the woman and she was encouraged to ask questions and express her concerns. She was informed about the progress of labor. All findings were documented using a partograph.

Preparation for birth

In preparing for birth, two skilled helpers were identified. The first skilled helper was the Midwife-in-charge who was consulted in case of anything and the second skilled helper was a staff nurse who always helps the Midwife-in-charge whenever there was a labor case. The unskilled helper was the client's sister-in-law. The physician Assistant was informed that, there was a client in labour so in case of any emergency, he will be consulted. Client's sister-in-law was also asked to contact the taxi driver to be alert in case there is the need for referral, he would be called. The clinic was made ready in case there is the need for a referral. The area for delivery was prepared by assisting client to wash her hands and abdomen to prepare for skin-to-skin care prior to the second stage of labor. Windows and doors were closed, and curtains were drawn when labor was imminent to provide privacy and also to provide warmth. A portable lamp was made available to assess the baby in case of light off. Hands were washed thoroughly with soap under running water to prevent the spread of infection. The area for ventilation was also prepared and the equipment was checked. A dry, flat and safe space was prepared to receive ventilation if

needed. The equipment to help babies breathe was assembled at the area for ventilation. The functions of the equipment were tested especially the ventilation bag and mask. Equipment assembled to prepare for birth included the following; sterile gloves, cot sheets, head covering, scissors, cord clamp, suction device, ventilation bag and mask, stethoscope and clock. Delivery set and emergency drugs were made ready for use.

3.1 MANAGEMENT OF THE FIRST STAGE LABOR

Having finished with birth preparation, Madam Ameyaa was seen anxious since she did not know the outcome of the labor and was seen pushing each time there was contractions. Client was reassured of normal labor with a healthy baby without any complications after delivery. Client was encouraged to breathe through her mouth when there was contraction and also avoid pushing during contractions since the cervix was not fully dilated. Client was also encouraged to empty her bladder frequently to enhance effective contraction and descent of the fetal head since full bladder could slow down progress of labor. Client was educated not to use her perineal pad when it falls and the importance of changing the pad when soiled and not to be touching the perineal area. The fetal heart rate, contractions and maternal pulse were monitored every thirty minutes but temperature, blood pressure, dilation of the cervix and descent of the fetal heart rate were checked every four hours.

Setting of trolley

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

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

- Two sterile artery forceps
- One sterile cord scissors
- Sterile drape

- Membrane pierce
- Sterile receiver for placenta
- Sterile Episiotomy Pack containing scissors and suturing forceps

Bottom shelf also contains;

- Drum containing gauze and cotton wool
- Chisel forceps in its container
- Bulb syringe in a bowl of water
- Sterile gloves
- Perineal pads
- Cord clamps
- Savlon
- Measuring jug
- An injection tray containing 10unit of oxytocin.
- Identification band
- Examination gloves
- Cot sheet

At 5:00 am, Madam Ameyaa complained of urge to bear down. Vagina examination was down again and cervical dilatation was 8cm, contractions were present, decent was 1/5th, membranes were intact with moulding (+) which indicated that the parietal bones were in apposition.

Contractions were 4 in 10minute lasting for 45seconds, Fetal Heart Rate (FHR) was 139beats per minute, maternal pulse was 86bpm, blood pressure130/70mmHg and temperature 36.3degree

whilst urine measured 100mls and protein and acetone were tested negative. She was hence made comfortable in bed. Madam Ameyaa complained of severe bearing down sensations with the uterine contraction becoming more expulsive and frequent, at 7:00am vaginal examination was performed again due to her complaints and cervical os was fully dilated at 10cm, membranes ruptured spontaneously with clear liquor. Descent was 0/5th, moulding was two plus(++) which indicated that the bones were overlapping each other but could not slip off, contractions were 4 in 10 minutes lasting 45 seconds. Fetal heart rate was 146 beats per minute, and maternal pulse was 96 beats per minute and liquor was clear. The abdomen was also cleaned with savlon to prepare skin to skin care. The midwife in charge confirmed full dilatation. Findings were recorded on partograph sheet and client was informed of full cervix dilation. During this time, she complained of exhaustion and was reassured and encouraged to rest in between contractions and 300mls of milo drink was also served. The delivery trolley was set. The already set delivery trolley was pushed to the delivery bed.

3.2 MANAGEMENT OF THE SECOND STAGE OF LABOUR

Madam Ameyaa had successfully passed through the first stage. Her cervix was fully dilated at 7:00am. The set trolley was pushed to the delivery bed. Protective clothing such as head gear, goggles, face mask, plastic apron and boots were worn. After hand washing, surgical gloves were put on to complete the sterility of the entire procedure. She was encouraged to assume dorsal position with the knee flexed as agreed earlier. The vulva was swabbed with sterile cotton and savlon lotion. She was draped with 4 sterile towels; abdomen shouldn't be covered because you will deliver baby on it for skin to skin, under the buttocks as well as both thighs. Full dilation of the cervix was confirmed by the midwife on duty. A pad was applied to the perineum to prevent fecal content from entering the baby's face. She was reassured and encouraged to bear down with contractions and to rest in between contractions. After crowning,

the birth of the head was controlled with the index and middle fingers placed on the fetal head to aid flexion to prevent perineal laceration. With extension, the sinciput, the face, and chin swept the perineum for the head to be born. After the delivery of the head, sterile gauze was used to wipe the eyes from the inner canthus outwards. The face, mouth and nose were also wiped. There was restitution followed by external rotation of the head indicating internal rotation of the shoulders occurred spontaneously. With both palms on each side of the baby's head, over the ears, a downward gentle pressure was applied towards the mother's perineum to deliver the anterior shoulder. The posterior shoulder was also delivered by upward movement towards the mother's abdomen. The trunk and the rest of the body were also delivered by lateral flexion onto the mother's abdomen at 7:00am.

3.3 IMMEDIATE CARE OF THE BABY

The immediate care of the baby starts from the delivery of the baby's head. The baby's eyes were cleaned from inside out with sterile gauze. The liquor was cleaned from the baby's body and the baby was covered with a warm dry cloth. The baby cried immediately. The first minute Apgar score was assessed to be 8/10; baby was shown to the mother to identify the sex of the baby. The cord was re-clamped tightly with a cord clamp 3 centimeters away from the baby's abdomen to prevent bleeding. An identification tag was put on the baby's hand. This tag bears the mother's name, sex, date and time of delivery. The fifth minute Apgar score was assessed to be 10/10. The baby was put skin to skin with mother, respiration monitored and breastfeeding initiated.

3.4 MANAGEMENT OF THE THIRD STAGE OF LABOUR

The management of third stage of labor is complete expulsion of the placenta and its membranes from the birth canal until all sources of hemorrhage are arrested. This begins immediately after the expulsion of the baby. Procedure involve in this stage was explained to

client's understanding. Permission was sought before continuing with the third stage management. During the active management of the third stage, Madam Ameyaa's uterus was palpated through the abdomen to exclude the presence of second twin. Oxytocin 10 unit was injected intramuscularly on the upper outer thigh of the client. The cord was re-clamped with an artery forceps closer to the perineum. The left hand was put on the fundus to feel for contraction. As soon as contraction was felt, left hand was repositioned and placed on the suprapubic area with the palm facing the mother's abdomen. The uterus was pushed upward (counter pressure) to prevent inversion of the uterus. The right hand held the forceps and the cord. Gentle downward traction was put on the cord and repeated until the placental tissues were visible at the vulva. The placenta was cupped in both hands and gently turned in a twisting motion to deliver the membranes. The act prevented the tearing of the membrane.

The placenta was delivered completely at 7:05am and lobes were intact and it was placed in the receiver. Immediately, the fundus of the uterus was massaged through the abdomen until it was well contracted. Client was taught to be massaging her uterus from time to time. Blood clot was expelled from the uterus and the blood expelled measured 150mls. She was reassured and permission was asked to conduct examination to exclude any form of trauma to the cervix, vagina and the perineum. There were no cervical, vaginal, or perineal tears. All soiled materials were removed and she was properly cleaned with savlon solution and made comfortable in a well laid bed. She was encouraged to empty her bladder regularly to ensure good contraction and to report any sever bleedings. The instruments were placed in a 0.5% chlorine solution for decontamination. She gave thanks to the glorification of the name of the Most High God. Other family members and her husband were also allowed to see Madam Ameyaa and her baby.

3.5 EXAMINATION OF PLACENTA

The placenta was held by the cord with the membranes hanging and the membranes were examined for completeness and it was intact. The placenta was then laid on a flat surface for further examination. The amnion was peeled from the chorion up to the umbilical cord and was fully viewed, the lobes fit together without any gap and edges also forming uniform circle at the maternal surface and this meant that there was no missing lobe, there was no white patches on the maternal surface, there was also no blood vessels radiating into the membranes which meant no succenturiate lobe. The cord was situated at the centre of the placenta with one vein and two arteries seen in the cord. There was no abnormality detected. The placenta was discarded after decontaminating it according to the protocol of the facility. The instruments and equipment used were soaked in 0.5% chlorine solution for ten minutes and washed, rinsed, dried and repacked for sterilization. Hands were dipped in chlorine solution before discarding the gloves.

3.6 MANAGEMENT OF THE FOURTH STAGE OF LABOUR

The fourth stage of labor begins right after delivery of the placenta, membranes as well as the arrest of bleeding until six hours after the delivery. During the fourth stage, the client and the baby were under close observation for early detection of postpartum complication that arose.

Mother

Madam Ameyaa and baby were transferred to the lying-in ward after an hour observation. She was encouraged to continue breast feeding. Mother's vital signs were closely monitored every 15 minutes for 2 hours, every 30 minutes for an hour and every hour for three hours. The uterus was felt for contraction every 15 minutes to make sure it was well contracted. Her vital signs were recorded as follows;

| | |
|----------------|--------------------|
| Temperature | 37.2 ^{0C} |
| Pulse | 80bpm |
| Respiration | 20cpm |
| Blood pressure | 120/60mmHg |

Madam Ameyaa was also educated on how to feel for contraction and also massage her uterus. The symphysio fundal height was measured and recorded as 16cm. Mother was advised to report any severe bleeding observed. The lochia was red in color (rubra) , moderate flow and had no odor. She took Porridge. Family members were also encouraged to visit Madam Ameyaa and the new born baby. The baby was observed for color, breathing, bleeding from the cord and warmth but no abnormality was found. The baby was able to suckle the mother's breast.

Prevention of disease (prophylaxis for the baby)

The baby's eyes were cleaned with sterile cotton wool swab with normal saline from the inner to outer canthus and chloramphenicol eye drop was instilled. The umbilical cord was dressed with six cotton wool swabs and methylated spirit. Vitamin k₁ was given after the examination. Hand washing was performed before and after handling of baby. This was done within the first 90 minute after birth to prevent infections such as ophthalmia neonatorum and hemorrhagic disease of the new born therefore the following treatments were given.

Examination of the new born

This is done within the first 90 minutes after birth. After washing hands and drying them, the procedure was explained to Madam Ameyaa. Disposable gloves were worn and the baby was examined in the presence of the mother in a clean, warm environment, with nearby windows

closed and light switched on. Baby was placed on a covered flat surface with only the part being examined exposed systematically. Baby's general condition was stable. A detailed head to toe examination was carried out to determine any abnormality.

The hand and face: The head was examined for softness/tension of fontanelles, size and shape, lacerations, caput succedaneum as well as intracranial hemorrhage but no abnormality was detected. Head circumference was measured by encircling the head with a tape measure from the occipital protuberance to the supra-orbital ridges and it measured 35cm. The eyes opened spontaneously when the baby was held in an upright position and the conjunctiva was clear. Eyes were also examined for color, redness, discharge, placement and conjunctiva for hemorrhage but no abnormality was found. The nose was inspected for size and shape and examined for deviated septum but the septum was normal. The nostrils were inspected for patency and discharges and the mucosa for color and polyps which were all normal. The mouth was examined by pressing the angle of the jaw which opened the mouth and the tongue, gum and palate were inspected and there was no false tooth noticed. The palate was high arched, intact and the uvula centrally placed. There was no cleft palate or cleft lip, tight frenulum or tongue tie. Suckling, rooting and swallowing reflexes were checked and was present. The ears were inspected; the upper notch of the pinnae was at the same level with the canthus of the eye. External auditory meatus was patent and the cartilage in the pinnae was checked for its softness. The shape and size was also noted and no abnormality was detected.

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

Chest and abdomen: The chest was examined, the respiratory movement was regular and the respiratory rate was 40cpm. Breasts were palpated for consistency, masses, and the nipples for

position and milk. The space between the nipples was noted and the nipples were in alignment. The abdomen was round with no bleeding from the umbilical cord and no signs of infection. The cord was examined and there was one vein and two arteries. The liver, spleen and bladder were palpated for size, tenderness and masses but no abnormality was detected. Apex beat was present and was recorded as 132bpm.

Limbs and digits: The length, movement and paralysis of the upper limbs were also noted. The digits were counted to be normal and separate to exclude webbing and the palm for the number of palmer creases. The shape and color of the nail bed were inspected and reflexes (grasping, Moro) checked. Everything was normal. With the lower limbs, the leg and feet were inspected for symmetry, extra digits, webbing, movement, fare foot adduction, clubbed feet, knock-knees, bowed leg, tibia torsion and paralysis but no abnormality was found. The hip had no dislocation and the reflexes (knee jerk/ patella, plantar) were present. The feet were examined for any disability such as talips equinovarus. The axillae, elbow groin and popliteal spaces were examined without any abnormality detected.

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

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

Baby's length was measured to be 49centimetres, weight was 3.3kg and temperature was 36.5°C.

In all, there was no abnormality detected. The baby was classified as normal and routine care of

the baby continued. Gloves were removed and disposed aseptically before washing hands with soap under running water and dried with clean dry towel. The baby's was neatly wrapped. All findings were recorded.

CONDITION OF BABY AT BIRTH

| | |
|---|---------------------|
| Temperature | 36.5 ^o C |
| Apex beat | 132 bpm |
| Respiration | 40cpm |
| Other assessments were recorded as follows; | |
| Sex | Female |
| Head circumference | 33cm |
| Length | 49cm |
| Weight | 3.3kg |
| Chest Circumference | 32cm |
| Abnormality | None detected |

Within few minutes after birth, baby passed urine and meconium.

| TIME | 1 st min | 2 nd min |
|-------------|---------------------|---------------------|
| APPERENCE | 2 | 2 |
| PULSE | 2 | 2 |
| GRIMACE | 1 | 2 |
| ACTIVITY | 2 | 2 |
| RESPIRATION | 1 | 2 |
| TOTAL | 8/10 | 10/10 |

The general condition of the baby was satisfactory.

Condition of mother

| | |
|----------------|--------------|
| Blood pressure | 120/70mmHg |
| Pulse | 73bpm |
| Respiration | 20cpm |
| Temperature | 36.0 |
| Uterus | contracted |
| SFH | 16cm |
| Lochia | Rubra |
| Condition | Satisfactory |

Condition of placenta

| | |
|---------------------|----------------------|
| Maternal surface | Normal (Dark red) |
| Fetal surface | Normal (Bluish grey) |
| Lobes and membranes | Complete and healthy |
| Blood Vessel | 2 Arteries, 1 vein |
| Cord situation | Central |

3.7 SUMMARY OF LABOUR

| | |
|--|------------------------------|
| Time of delivery | 7:00am |
| Time of placenta expulsion and membranes | 7:05am |
| Type of delivery | spontaneous vaginal delivery |
| Estimated blood loss | 150mls |

Duration of labour

| | |
|------------------------|----------|
| First stage of labour | 7 hours |
| Second stage of labour | 30minute |

| | |
|--------------------------|------------------|
| Third stage of labour | 10minute |
| Total duration of labour | 7hours 40minutes |

3.8 CARE PLAN DURING LABOUR

Problems identified during labor

1. Lower abdominal pain
2. Fatigue
3. Frequency of micturition
4. Anxiety

SHORT TERM OBJECTIVES

1. Client will cope and be relieved of lower abdominal pains within 24 hours by the end of labor.
2. Client will be relieved of fatigue within 24 hours after labor.
3. Client will be relieved of frequency of micturition within 24 hours by the end of labor.
4. Client anxiety will resolve of within 24 hours by the end of labor.

LONG TERM OBJECTIVES

Madan Ameyaa will go through pregnancy, labor and puerperium successfully without any complication to her and the baby.

| DATE/ TIME | NURSING DIAGNOSIS | NURSING OBJECTIVES /OUTCOME CRITERIA | NURSING ORDERS | NURSING INTERVENTION | DATE/ TIME | EVALUATION | SIGN |
|-----------------------|--|---|--|--|-----------------------|--|-------------|
| 23/12/21 12:43am | Lower abdominal pain related to descent of fetal head. | Client will cope and be relieved with lower abdominal pains within 24 hours by the end of labor as evidenced by client`s actions. | <ol style="list-style-type: none"> 1. Reassure client. 2. Explain the physiology of the pain to her. 3. Encourage client to practice deep breathing exercise. 4. Provide diversional therapy. 5. Encourage ambulation | <ol style="list-style-type: none"> 1. Client was reassured. 2. The physiology of the pain was explained to the client. 3. Client was encouraged to practice deep breathing exercise. 4. Client was engaged in a conversation 5. Client was encouraged to walk around the bed. | 24/12/21 7:20am | Goal fully met as client verbalized that she was able to cope with the pain. | |

| DATE/TIME | NURSING DIAGNOSIS | NURSING OBJECTIVE | NURSING ORDERS | NURSING INTERVENTION | DATE/TIME | EVALUATION | SIGN |
|---------------------|------------------------------------|--|--|--|--------------------|---|-------------|
| 23/12/21 12:43am | Fatigue related to stress of labor | Client`s fatigue will be relieved within 24 hours after labor as evidenced by client`s actions | 1. Reassure client 2. Encourage client to do deep breathing exercise 3. Monitor labor progression to avoid prolong labor 4. Encourage her to have rest. | 1. Client was reassured. 2. Client was encouraged to do deep breathing exercise 3. Partograph was used to monitor labor progression. 4. Client was encouraged to have rest. | 24/12/21 7:20am | Goal fully met as evidence by client`s actions. | |

| DATE/ TIME | NURSING DIAGNOSIS | NURSING OBJECTI- VE | NURSING ORDERS | NURSING INTERVENTION | DATE/ TIME | EVALUATIO N | SIGN |
|-------------------------|--|---|---|---|------------------------|--|-------------|
| 23/12/2 1 12:43am | Anxiety related to unknown outcome of labor. | Client anxiety will resolve within 24 hours by the end labor as evidenced by client`s behavior | 1. Reassure client. 2. Give feedback on every progress of labor. 3. Educate her on possible outcome of labor. 4. Encourage client to ask questions. 5. Update client on the progress of labor. | 1. Client was reassured. 2. Client was given feedback on the progress of labor. 3. Client was educated on possible outcome of labor. 4. Client was encouraged to ask questions and answers were given tactfully. 5. Client was updated on the progress of labor. | 24/12/21 7:20am | Goal fully met as client was seen relaxed in her bed. | |

| DATE TIME | NURSING DIAGNOSIS | OBJECTIVE S | NURSING ORDERS | NURSING INTERVENTION | DATE TIME | EVALUATION | SIGN |
|----------------------|---|--|--|---|----------------------|---|-------------|
| 23/12/21 9:00am | Frequency of micturition related to pressure on bladder by the foetal head. | Client will cope and be relieved of frequent micturition within 24 hours after delivery evidenced by client verbalizing it | <ol style="list-style-type: none"> 1. Reassure client 2. Bed pan should be at her reach when she wants to urinate. 3. Explain the physiology of frequent micturition. | <ol style="list-style-type: none"> 1. Client was reassured 2. Bed was served when client wanted to urinate. 3. Physiology of frequent micturition was explained to the client. | 23/12/21 7:20am | Goal successfully met evidenced by client`s actions | |

CHAPTER FOUR

PUERPERIUM

4.0 INTRODUCTION

This chapter provides information about the subsequent care given to the mother and her baby after delivery till six weeks.

DAY OF DELIVERY

On Thursday, 23rd December, 2021. Madam Ameyaa had a spontaneous vaginal delivery with an alive female infant.

Both mother and baby were monitored every 15 minutes for 2 hours, 30 minutes for 1 hour and hourly for 3 hours. Madam Ameyaa and her baby were transferred to the lying-in ward for vigilant observation and they were made comfortable in bed with all observations recorded. Her health was enquired and the pains she complained during her labor had subsided. Madam Ameyaa was examined from head to toe before she took her bath and no abnormality was found. The lochia was red in color, moderate in quantity with no bad odor.

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

Mother's assessment

| | |
|-------------------------|--------------------|
| Temperature/ | 37.0 ^{0C} |
| Pulse | 80bpm |
| Respiration | 20cpm |
| Blood pressure | 120/60mmHg |
| Symphysio fundal height | 16cm |
| Lochia | Rubra |

Madam Ameyaa was asked to change her perineal pad when soiled to prevent ascending infection to the uterus and also empty her bladder to help involution of the uterus. She was

advised to wash her hands before and after changing pad. She had her bath and kept warm with her baby in bed and encouraged on exclusive breastfeeding on demand. She was also advised to report any abnormal bleeding for prompt action to be taken. Madam Ameyaa was also educated on simple hand washing before and after touching and feeding the baby and after visiting the toilet. She was encouraged to take enough rest and sleep especially after breast feeding and put the baby to sleep to restore her energy. Madam Ameyaa complained of loss of appetite and was reassured it was temporal will subside with management. She was served with two tablets of paracetamol to relieve the after pains and was encourage to rest.

Vital signs for baby were checked and recorded as follows;

| | |
|-----------------|--------------------|
| Temperature | 36.7 ^{0C} |
| Apex heart beat | 132bpm |
| Respiration | 39cpm |
| Weight | 3.3kg |

4.2 SUBSEQUENT CARE OF THE BABY

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

| | |
|-----------------|--------------------|
| Temperature | 36.7 ^{0C} |
| Apex heart beat | 132bpm |
| Respiration | 38cpm |

Weight 3.3kg

BABY BATHING

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

REQUIREMENTS

Soap

Sponge

Cream/ powder

Sterile cotton in a gallipot or wrapped

Methylated spirit

Basin

Towels: 1 big towel and 3 small ones

Cot sheets 2

Apron

Gloves

A clean baby dress, cap and socks

Mackintosh

2 jugs containing hot and cold water each

Two receptacles for used water and dirty linen

A receiver for used swab

The procedure was explained to mother and a tray was set. The mother and the support person were made to observe the procedure. A plastic apron was worn and hands were washed

with soap, water and dried with a clean towel. The water was mixed and the temperature was tested using the elbow. Sterile gloves were worn and baby was placed on a flat surface. she was undressed and wrapped in a big towel. The eyes were cleaned with cotton wool swabs soaked in clean water from inner canthus outwards. Her face was cleaned with damp face towel and dried. The nape of baby's neck was supported with one hand. Her ears were then plugged using two fingers of the hand and the head was washed with soapy sponge. With the body resting on the elbow and still supporting the nape, the baby was place at the edge of the bowl to rinse the soap off the head and dried. The baby was exposed; arms and front of trunk were washed paying attention to skin folds. The baby's back was turned with one hand supporting the chest and washed back down to feet paying attention to the skin folds. she was immersed in a bath of warm water with the head above the water and rinsed thoroughly. The baby was placed on a flat surface covered with clean sheet. The baby was dried by using a clean small towel paying attention to the skin folds. The cord was dressed by using sterile cotton wool swabs soaked in methylated spirit. The tip of the cord clamp was held with one sterile cotton wool swab and another was used to clean the base of the cord, the whole cord anteriorly and posteriorly each with a separate swab from the base upwards. The tip of the cord was cleaned with another swab and the cord was left exposed and the swab which was used to hold the cord clamp was used to clean it. The baby was dressed, wrapped and, given to mother to breastfeed. The waste materials were discarded according to infection prevention protocol. Mother was told that the baby will be topped and tailed till cord falls off. Gloves were removed and disposed of. Hands were washed with soap and water before handling the baby. Client was in a good condition after the procedure was carried out.

4.3 FIRST DAY POST DELIVERY AND DISCHARGE

The first day post-partum for Madam Ameyaa was 24th December, 2021. She took a warm bath in the morning after her perineal pad was inspected for the presence of lochia which was small, no odor and red in color. She complains of after pain and she said, the pains were better now. Her consent was sought for head to toe examination. Everything was normal, breast was lactating well and uterus measured 15cm.

Her vital signs were recorded as follows;

| | |
|----------------|--------------------|
| Temperature | 36.4 ^{0C} |
| Pulse | 74bpm |
| Respiration | 20cpm |
| Blood pressure | 110/60mmHg |

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

| | |
|-----------------|--------------------|
| Temperature | 36.5 ^{0C} |
| Apex heart beat | 138bpm |
| Respiration | 40cpm |

Weight

3.2kg

All findings were communicated to Madam Ameyaa. The baby was handed over to her to breast feed. This proved that what was taught during antenatal period was well understood. She was educated on healthy adequate nutritious diet to help in the production of more breast milk and improve her immunity, and help repair worn out tissues. Madam Ameyaa was again educated on good personal hygiene, post natal exercise and the various family planning methods. The essence of the exercise was to help the pelvic organs to return to their original position. She was informed of her discharge. Furthermore Madam Ameyaa was encouraged to feed her baby on demand. She was also advised to register the baby at the birth and death registry.

Baby was given Bacillus Calmette Guerine (BCG) and polio “O” vaccine and mother was advised not to apply anything to the site in order to ensure effectiveness of the drugs. She was then asked to come with the baby to take the rest of the immunization at the time scheduled in order to prevent the baby from any of the childhood preventable diseases. Madam Ameyaa took fufu and chicken soup after birth.

Client was served with the following drugs to send home:

Tab Ferrous Sulphate(tablet) - 200mg 1 daily for 30days

Tab Multivitamins (tablet) - 200mg 1 for daily for 30days

Tab Folic acid (tablet) - 5mg 1 daily by 30days

Tab Metronidazol - 400mg tid for 7days

Caps Amoxicilin - 500mg tid for 7days

Tab paracetamol - 1g tid for 7days

She was informed of a visit to her house for a period of one week starting from the next day and she agreed. After settling her bill with national insurance, she was discharged.

4.4 FIRST POST NATAL HOME VISIT

Madam Ameyaa was visited in the house after delivery for the first time around 7:00am and 4pm on 24th December, 2021. Greetings were exchanged and a seat was offered. The whole family was in good health and her previous complaints had gotten better, her loss of appetite had resolved and after pains was better. Client was informed of the procedures to be carried out. Hands were washed and dried with a clean towel. Baby passed meconium and urine. Baby was examined from head to toe. No abnormality detected. Vital signs checked and recorded. The baby was cleaned. The cord was also dressed with cotton wool swabs and methylated spirit using aseptic technique; it was clean, dry and not offensive. The baby was then dressed properly and handed over to the client's mother-in-law who had come to assist the client after childbirth. Madam Ameyaa emptied her bladder and head to toe examination was done. The conjunctiva was examined and there was no pallor. The breasts were soft and lactating well. The uterus was well contracted with symphysio fundal height of 15cm. The perineum was clean, dry and intact, lochia was small red (rubra) and not offensive. Her vital signs checked and recorded during the morning and evening visits.

| Observation | Morning | Evening |
|-------------|--------------------|--------------------|
| Temperature | 36.0 ^{0C} | 36.1 ^{0C} |
| Pulse | 74bpm | 76bpm |
| Respiration | 20cpm | 21cpm |

| | | |
|----------------|------------|------------|
| Blood Pressure | 100/60mmHg | 110/70mmHg |
|----------------|------------|------------|

Baby was given to mother to breast feed. Baby was able to suck well. On assessment the baby's skin color was pink and there was no cord bleeding. Findings were recorded as follows;

| Observation | Morning | Evening |
|-----------------|--------------------|--------------------|
| Temperature | 36.2 ^{0C} | 36.3 ^{0C} |
| Apex heart beat | 130bpm | 134bpm |
| Respiration | 40cpm | 42cpm |
| Weight | 3.2kg | 3.2kg |
| Urine | Passed | Passed |

Madam Ameyaa was educated on family planning, danger signs in the newborn such as breathing difficulties, cyanosis, persistent vomiting and fever. Client and family were congratulated and permission was sought to leave and she was informed of the next home visit the next day during the evening visit.

4.5 SECOND POSTNATAL HOME VISIT

Madam Ameyaa was visited on the 25th December, 2021 around 7:00am and 4:00pm. Client and her baby were in good health. All procedures to be carried out on them were explained to her. Her perineal pad was inspected and lochia flow was small and red in color without bad odor before she took her bath. Madam Ameyaa was examined from head to toe and everything was normal, breast was lactating well. The symphysio fundal height was 14cm when measured. Her vital signs were taken and recorded as;

| Observation | Morning | Evening |
|----------------|--------------------|--------------------|
| Temperature | 36.2 ^{0C} | 37.2 ^{0C} |
| Pulse | 76bpm | 78bpm |
| Respiration | 21cpm | 20cpm |
| Blood Pressure | 110/60mmHg | 110/70mmHg |

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

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

| Observation | Morning | Evening |
|-----------------|--------------------|--------------------|
| Temperature | 36.8 ^{0C} | 36.8 ^{0C} |
| Apex heart beat | 135bpm | 135bpm |
| Respiration | 40cpm | 41cpm |
| Weight | 3.1kg | 3.1kg |
| Urine | Passed | Passed |

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

4.6THIRD POSTNATAL HOME VISIT

Madam Ameyaa was visited in the house for the third time at 7:00am and 4pm on the 26th December, 2021 to check up on how they were faring. They were doing well. Perineal

pad was inspected. Lochia was small with red color. She took her bath after everything in the evening. Nothing abnormal was detected during head to toe examination. Symphysis fundal height was 13cm and findings from assessment were recorded as; Her vital signs were recorded as;

| Observation | Morning | Evening |
|----------------|--------------------|--------------------|
| Temperature | 36.0 ^{0C} | 36.0 ^{0C} |
| Pulse | 70bpm | 75bpm |
| Respiration | 20cpm | 20cpm |
| Blood Pressure | 110/60mmHg | 110/70mmHg |

No abnormality was found during head to toe examination. The cord was shrinking with no bleeding and was dressed with cotton wool with methylated spirit. She was dressed up and findings after assessment were checked and recorded.

All findings were explained to her understanding. She was once again reminded of next visit and was thanked for her cooperation. Baby's vital were checked and recorded as;

| Observation | Morning | Evening |
|-----------------|--------------------|--------------------|
| Temperature | 36.4 ^{0C} | 36.6 ^{0C} |
| Apex heart beat | 138bpm | 140bpm |
| Respiration | 41cpm | 42cpm |
| Weight | 3.0kg | 3.0kg |
| Urine | Passed | Passed |

4.7 FOURTH POSTNATAL HOME VISIT

On 27th December, 2021 around 7:00am, client and family were visited as usual, greetings were exchanged and seat was offered and all family members were in good condition according to the mother. Head to toe examination was carried out and no abnormality was detected. Baby's cord was dressed with cotton wool swabs and methylated spirit, it was dry, not offensive and almost off. Head to toe examination was carried out on mother and no abnormality was detected. The Symphysio fundal height was 12 centimeters, perineum was clean and intact. Lochia was serosa, leucocytes and not offensive. The breast was lactating well. She also complained of backache and she was reassured and educated on other positions used in breastfeeding such as lying on her side to breastfeed and was also educated to support her back when sitting. Her vital signs were checked and recorded as;

| | |
|----------------|--------------------|
| Temperature | 36.4 ^{0C} |
| Pulse | 79bpm |
| Respiration | 20cpm |
| Blood pressure | 110/70mmHg |

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

| | |
|-----------------|--------------------|
| Temperature | 36.8 ^{0C} |
| Apex heart beat | 130bpm |
| Respiration | 41cpm |
| Weight | 3.0kg |

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

4.8 FIFTH POST NATAL HOME VISIT

The 5th day postnatal visit was on 28th December, 2021 around 7:00am. Everybody in the family was fine and the environment was very clean. Madam Ameyaa's permission was sought for head to toe examination after taken her bath, inspection of lochia was done and the colour was pink (serosa) without any bad odour and the flow was moderate. Her vital signs were checked and recorded as;

| | |
|----------------|--------------------|
| Temperature | 36.7 ^{0C} |
| Pulse | 80bpm |
| Respiration | 21cpm |
| Blood pressure | 120/70mmHg |

On the fifth day, the symphysio fundal height was 11cm. The breast was lactating well. Examinations were done and everything was normal. The baby's cord was off and healing well. Baby's vital signs were checked and recorded as;

| | |
|-----------------|--------------------|
| Temperature | 36.6 ^{0C} |
| Apex heart beat | 136bpm |
| Respiration | 40cpm |
| Weight | 3.1kg |

Urine

Passed

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

4.9 SIXTH POST NATAL HOME VISIT

29th December, 2021 was the sixth home visit to Madam Ameyaa's house at 7:00am.

Client was doing well as well as baby and the entire family. Procedures to be done were explained to her. Head to toe examination was done on the baby and there was no abnormality detected. For the mother, Symphysis fundal height was 10cm. The perineal pad was inspected and the flow was scanty and pink (serosa) in color and not offensive. Her vital signs were also checked and recorded as;

| | |
|----------------|------------|
| Temperature | 36.0 |
| Pulse | 79bpm |
| Respiration | 20cpm |
| Blood pressure | 110/60mmHg |

Head to toe examination was done and no abnormality was detected. The cord stump was clean, dry and not offensive. The baby was looking active and fine. Madam Ameyaa was asked to bath baby and clean the umbilical stump with cotton wool swab and methylated spirit under supervision and it was done well. The baby's vital signs were checked and recorded as;

| | |
|-----------------|--------|
| Temperature | 36.3 |
| Apex heart beat | 140bpm |
| Respiration | 42cpm |
| Weight | 3.2kg |

Urine

Passed

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

SEVENTH POSTNATAL HOME VISIT

The seventh day postnatal home visit was done on 30th December, 2021 at 7:00am. Greetings were exchanged with client and her family and a seat was offered in client's room. Mother and baby were both in a healthy condition. On examination, no abnormalities were detected. Her breast was lactating well. Symphysis-fundal height was 9cm. Inspection of the lochia was done and the colour was pink (serosa) normal flow without any bad odour. Madam Ameyaa said the baby has pass stool that morning before arrival.

Client's vital signs were checked and recorded as follows;

| | |
|----------------|--------------------|
| Temperature | 36.2 ^{0C} |
| Pulse | 80bpm |
| Respiration | 21cpm |
| Blood pressure | 120/70mmHg |

Baby was already bathed, head to toe examination was done and no abnormality was found on baby. The stump was then dressed and the area was clean and dry.

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

| | |
|-----------------|--------------------|
| Temperature | 36.6 ^{0C} |
| Apex heart beat | 135bpm |
| Respiration | 40cpm |
| Weight | 3.3kg |
| Cord | Clean |
| Urine | Passed |

She was educated on the danger signs in baby like high body temperature, foul smell from the cord and the need to seek early care. She said, she appreciate that a lot, and she was thanked for her cooperation, she was reminded that, today was her postnatal visit to the clinic. Permission was sought to leave.

4.11 FIRST POST NATAL VISIT TO THE CLINIC

Madam Ameyaa arrived at the clinic with her baby accompanied by her sister on the 31st December, 2021. They were offered a seat and then asked about their health and they were fine including the baby. All procedures to be carried out were explained to Madam Ameyaa. Her vital signs were checked and recorded. Her midstream urine specimen was collected and tested for protein and sugar but all were absent. Her haemoglobin level measured 13.0g/dl. Madam Ameyaa's weight was 69kg. She was helped to lie on the couch for a head to toe examination having emptied her bladder. On inspection the hair was well kept, there were no discharges from eye, nose, the conjunctiva was not pale, the sclera had no yellow discoloration and the mouth was clean. The ears were not discharging, neck was palpated for swollen lymph nodes but no abnormality was detected. The breast was examined and no abnormality was found and was

lactating well with no engorgement. On abdominal examination, the uterus was not palpable and no enlargement of any abdominal organ. The vulva was inspected and there were no varicose vein, edema and bad odor. The Lochia was pale (serosa) in color with scanty flow and odorless. The extremities were free from any edema. All findings were communicated to her. Her vital signs were checked and recorded as follows;

| | |
|----------------|--------------------|
| Temperature | 36.0 ^{0C} |
| Pulse | 76bpm |
| Respiration | 20cpm |
| Blood pressure | 120/70mmHg |

The baby was also examined from head to toe and everything was normal. Baby's vital signs was checked and recorded as follows;

| | |
|-----------------|--------------------|
| Temperature | 36.4 ^{0C} |
| Apex heart beat | 137bpm |
| Respiration | 41cpm |
| Weight | 3.4kg |
| Urine | Passed |
| Stool | Yellowish Colour |

All the information was recorded in the post natal records. The mother was educated on good intake of well-balanced diet since this would improve her health status and also to produce more

breast milk. She was also educated on family planning for her to have an informed choice so that during the six weeks post natal visit she could make a right choice. She was also advised to visit the child welfare clinic for the baby to complete all the immunization scheduled. She was thanked for her cooperation and also all the time spent together. She was very happy and was handed over to the midwife in-charge for continuity of care.

4.12 SECOND POST NATAL VISIT TO THE CLINIC

Madam Ameyaa reported to the facility at 9:00am on the 1st February, 2022. She came alone with her baby and they both looked nice and active. Every procedure to be carried out was explained to her. She was asked to empty her bladder and midstream urine was taken and tested for sugar and protein and the result was negative. Her haemoglobin level was 13.0g/dl. Her vital signs were taken and recorded as follows;

| | |
|----------------|--------------------|
| Temperature | 36.5 ^{0C} |
| Pulse | 78bpm |
| Respiration | 20cpm |
| Blood pressure | 110/60mmHg |

Baby's vital signs was checked and recorded as;

| | |
|-----------------|--------------------|
| Temperature | 36.6 ^{0C} |
| Apex heart beat | 134bpm |
| Respiration | 40cpm |
| Weight | 4.0kg |

Urine Passed

Stool Yellowish

Baby was given the due immunization at the Child Welfare Clinic by the midwife in charge. The baby was immunized against Pneumonia, Diphtheria, Pertussis, Tetanus, Hepatitis B, Hemophilus influenza B (5 in one vaccine).

The following vaccines were given:

| Vaccine | Dosage | Route of administration |
|----------------|---------|-----------------------------|
| Polio 1 | 2 drops | Oral |
| Rotavirus 1 | 1.5ml | Oral |
| DPT-HepB Hib | 0.5ml | Intra-muscular, left thigh |
| Pneumococcal 1 | 0.5ml | Intra-muscular, right thigh |

Madam Ameyaa and her baby were sent to the child welfare clinic for immunization as well as family planning unit after which they were handed over to the public health nurse for continuity of care.

4.13 CARE PLAN DURING PUERPERIUM PROBLEMS IDENTIFIED DURING PUERPERIUM

Client complained of

1. After pain
2. Loss of appetite
3. Inadequate sleep

4. Backache

SHORT TERM OBJECTIVES

1. Client after pains will be relieved within 24 hours after labor.
2. Client will regain her normal appetite within 24hours
3. Client will sleep at least 6 hours within 24hours.
4. Client will be relived of backache within 24 hours after labor.

LONG TERM OBJECTIVES

Client will go through pregnancy, labor and puerperium successfully without any complication to her and the baby.

| DATE/ TIME | NURSING DIAGNOSIS | NURSING OBJECTIVES/ OUTCOME CRITERIA | NURSING ORDERS | NURSING INTERVENTION | DATE/ TIME | EVALUATION | SIGN |
|-----------------------|--|--|--|---|-----------------------|---|-------------|
| 23/12/21 9:00 am | After pains related to involution of the uterus. | Client's after pains will be relieved within 24 hours as evidenced by 1. Client verbalizing that the pain has resolve. | <ol style="list-style-type: none"> 1. Reassure client that pain is temporal 2. Encourage client to empty her bladder frequently. 3. Encourage client to continue breastfeeding the baby. 4. Explain the physiology of after. 5. Serve prescribed analgesic. | <ol style="list-style-type: none"> 1. Client was reassured 2. Client was encouraged to empty her bladder frequently. 3. Client was encouraged to continuously feed the baby on demand. 4. Explain the physiology of after pains was explained to client. 5. Prescribed analgesic was served (tab paracetamol 1 gram tidx3) | 24/12/21 9:00am | Goal fully met as client verbalized that her pain was relieved. | |

| DATE/ TIME | NURSING DIAGNOSIS | NURSING OBJECTIVE/ OUTCOME CRITERIA | NURSING ORDERS | NURSING INTERVENTION | DATE/ TIME | EVALUATION | SIGN |
|-------------------------|---|--|--|---|-----------------------|---|-------------|
| 28/12/21 1 8:00am | Backache related to exaggerated posture during pregnancy. | Client will be relieved of backache within 24 hours as evidenced by Client verbalizing that backache will resolve. | <ol style="list-style-type: none"> 1. Reassure client that, pain will relieve. 2. Teach client how to position herself when breast feeding. 3. Encourage client to wear well-fitting or supportive brassier. 4. Encourage client to attach baby properly during breastfeeding. 5. Serve prescribed analgesics. (Paracetamol). | <ol style="list-style-type: none"> 1. Client was reassured that she will be relieved of the pains 2. Client was encouraged to support back with pillow when sitting to breastfeed baby. 3. Client was encouraged to wear well-fitting brassier 4. Client was encouraged to fix the baby properly to the breast 5. Paracetamol 1g tid was served as prescribed. | 29/12/21 8:00am | Goal fully met as client said her pain has stopped. | |

| DATE/ TIME | NURSING DIAGNOSIS | NURSING OBJECTIVE /OUTCOME CRITERIA | NURSING ORDERS | NURSING INTERVENTION | DATE/ TIME | EVALUATION | SIGN |
|-----------------------|--|---|--|--|-----------------------|---|-------------|
| 30/12/21 | Loss of appetite related to stresses of labour | Client will regain her normal eating pattern within 24 hours as evidence by 1 .client verbalizing that she is able to eat. 2. Support person observing client eats half of meal served. | 1. Reassure client 2 .Encourage client to practice oral hygiene to help increase her appetite. 3 .Served client's favourite food. 4. Served client's food attractively and plan diet with client 5.Administer vitamin supplement | 1. Client was reassured that she will gain her normal eating pattern. 2. Client was encouraged to brush her teeth at least twice daily to increase her appetite. 3. Client was served with food with light soup and meat. 4. Client's food was served attractively by garnishing the food. 5 .Vitamin supplement such as folic acid, multivitamin were administered. | 31/12/21 | Goal fully met as client verbalizes that she is able to eat half meal severd. | |

| DATE/ TIME | NURSING DIAGNOSIS | NURSING OBJECTIVE/O UTCOME CRITERIA | NURSING ORDERS | NURSING INTERVENTION | DATE/ TIME | EVALUATION | SIGN |
|-----------------------|--|--|---|--|-----------------------|---|-------------|
| 25/12/21 8:00am | Sleeping pattern disturbance (Insomnia) related to night breast feeding. | Client will sleep at least 3 hours sleep at night and 2 hours in the day within 24hours as evidenced by client verbalizing it. | <ol style="list-style-type: none"> 1. Explain the importance of night breast feeding to her. 2. Encourage her to feed the baby on demand. 3. Encourage her to sleep when baby is asleep. 4. Encourage relatives to support her. 5. Encourage client and family members to reduce the number of visitors. | <ol style="list-style-type: none"> 1. Importance of night breast feeding was explained to her. 2. Client was encouraged on the essence of feeding on demand. 3. She was encouraged to sleep when baby was asleep. 4. Her relatives were encouraged to help her. 5. Client was encouraged to rest enough during the day. | 25/12/21 8:00am | Goal fully met as evidenced by client verbalizing that, client can sleep. | |

TERMINATION OF CARE

Madam Ameyaa and her family were made aware on the first time of interaction that the care would be terminated during the postnatal review visit where she and her baby would be handed over to the public health nurse in- charge for continuity of care.

Madam Ameyaa and her family were able to go through pregnancy, labour and puerperium successfully through all the education and care given to them. After examination both client and baby were handed over to the public health nurse for continuity care. Profound gratitude was expressed to the client and the family for their total cooperation. They were also grateful for the care and support.

SUMMARY AND CONCLUSION

The study was carried out on Madam Ameyaa, a 25year old woman who was gravida 2 Para 1 alive. She was met at Glory Prince of Peace Maternity Home/Clinic on 24th November, 2021 during antenatal session and pregnancy was 36 weeks old. She was in good health when we met.

The cordial relationship that existed among the client, family and staff of the clinic aided to educate them on personal, environmental health, maintenance as well as other health related issues. She had successful antenatal period and entered labor on the 22nd December, 2021. She was monitored throughout the stages of labor to resolve all her problems by the use of nursing process and she delivered spontaneously of a healthy baby girl on 23rd December, 2021. Mother and baby were discharged a day after delivery in good condition on the 24th December, 2021.

Mother and baby were visited for seven days after delivery. They were monitored until they were handed over to the community health nurses for continuity of care in good health .Our interaction ended after one week of post natal care.

In conclusion, the care has helped the student midwife to gain knowledge and experience. It is an effective means of monitoring pregnancy, labor, delivery and puerperium. This helps to promote a good relationship between the student midwife, the client and the family

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APPENDIX I

| DATE | WEIGHT (KG) | BLOOD PRESSURE | URINE FOR PROTEIN AND SUGAR | GASTATION IN WKS | FUNDAL HEIGHT | PRESENTA TION | DES CEN T | FETAL HEART RATE | COMPLAINS | TREAT MENT | REMAR K |
|----------|----------------|-------------------|---|---------------------|------------------|------------------|-----------------|------------------------|------------------|------------------|------------|
| 12/07/21 | 50kg | 90/58 | Neg/Neg | 10weeks+1da y | - | - | - | - | No complains | Routine drugs | well |
| 17/08/21 | 52kg | 1250 | Neg/Neg | 16weeks | 13cm | - | - | - | No complains | Routine drugs | good |
| 14/09/21 | 52kg | 100/60 | Neg/Neg | 24weeks | 23cm | Cephalic | - | 136bpm | No complains | Routine drugs | well |
| 13/10/21 | 54kg | 90/50 | Neg/Neg | 28weeks | 26cm | Breech | - | 134bpm | Loss of appetite | Routine drugs | good |
| 13/11/21 | 54kg | 90/60 | Neg/Neg | 32weeks | 33cm | Cephalic | 5/5th | 138bpm | No complains | Routine drugs | well |
| 04/12/21 | 55kg | 110/50 | Neg/Neg | 36weeks | 35cm | Cephalic | 5/5th | 134bpm | No complaints | Routine drugs | good |
| 11/12/21 | 55kg | 110/70 | N eg/Neg | 36weeks+3da ys | 35cm | Cephalic | 5/5th | 137bpm | backache | Routine drugs | well |
| 18/1221 | 56kg | 110/80 | Neg/Neg | 38weeks | 36cm | Cephalic | 5/5th | 138bpm | waist pain | Routine drugs | good |

APPENDIX II

COMPLETE DIAGNOSTIC INVESTIGATION

| DATE | SPECIMEN | INVESTIGATION | NORMAL VALUES | FINDINGS | REMARKS |
|-------------|-----------------|----------------------|-----------------------|-----------------|----------------|
| 17/08/21 | Blood | Haemoglobin | 11.4-16g/dl | 14.1g/dl | Normal |
| | | Blood group | A, B, AB, O | O | Normal |
| | | Rhesus factor | Positive/Negative | Positive | Normal |
| | | Sickling | Negative | Negative | Normal |
| | | G6PD | Reactive/Non-reactive | Non-reactive | Normal |
| | Urine | Protein | Negative | Negative | Normal |
| | | Glucose | Negative | Negative | Normal |
| 14/9/21 | Urine | Protein | Negative | Negative | Normal |
| | | Glucose | Negative | Negative | Normal |
| 13/10/21 | Urine | Protein | Negative | Negative | Normal |
| | | Glucose | Negative | Negative | Normal |
| 04/12/21 | Urine | Protein | Negative | Negative | Normal |
| | | Glucose | Negative | Negative | Normal |
| 11/12/21 | Urine | Protein | Negative | Negative | Normal |
| | | Glucose | Negative | Negative | Normal |

COMPLETE DIAGNOSTIC INVESTIGATION CONTINUED

| DATE | SPECIMEN | INVESTIGATION | NORMAL VALUES | FINDINGS | REMARKS |
|-------------|-----------------|----------------------|----------------------|-----------------|----------------|
| 11/12/21 | Urine | Protein | Negative | Negative | Normal |
| | | Glucose | Negative | Negative | Normal |
| | Blood | Hemoglobin | 11.4-16g/dl | 14.1g/dl | Normal |
| 18/12/21 | Urine | Protein | Negative | Negative | Normal |
| | | Glucose | Negative | | Normal |
| 22/12/21 | Urine | Protein | Negative | Negative | Normal |
| | | Glucose | Negative | Negative | Normal |
| | Blood | Haemoglobin | 11.4-16g/dl | 14.1g/dl | Normal |
| 25/12/21 | Urine | Protein | Negative | Negative | Normal |
| | | Glucose | Negative | Negative | Normal |

APPENDIX III

PHARMACOLOGY OF DRUGS USED (MOTHER)

| NAME OF DRUGS | CLASSIFICATION | DOSAGE | ROUTE OF ADMINISTRATION | ACTION & USE | ACTUAL EFFECTS | SIDE EFFECT OF DRUGS | SIDE EFFECT EXPERIENCED |
|-----------------------------------|---------------------|---|-------------------------|--|---------------------------------------|---------------------------------------|-------------------------|
| Tablet ferrous sulphate | Iron supplement | 200 milligram once daily | Orally | Proper formation and functioning of red blood cell. | Hemoglobin level increase | Diarrhea and black stool. | None |
| Tablet folic acid | Vitamin preparation | 5 milligram daily once daily | Orally | It helps in iron absorption of iron. | Increase formation of red blood cells | Nausea and vomiting | None |
| Tablet multivitamin | Vitamin preparation | 200 milligram once daily | Orally | Increased appetite. Helps in the formation of red blood cell | Increase appetite. | Gastro intestinal disturbances | Constipation |
| Tablet sulphadoxine pyrimethamine | Malaria prophylaxis | 3 tablets start at 16weeks/ after quickening and repeated at 4 weeks interval | Orally | Treatment and prevention of malaria | Prevention of malaria | Nausea, itching, dizziness, vomiting. | None |

till delivery.

PHARMACOLOGY OF DRUGS CONTINUED

| NAME OF DRUGS | CLASSIFICATION | DOSAGE | ROUTE OF ADMINISTRATION | ACTION & USE | ACTUAL EFFECTS | SIDE EFFECT OF DRUGS | SIDE EFFECT EXPERIENCED |
|----------------------|----------------------------|-----------------------------|--------------------------------|---|---|---|--------------------------------|
| Injection tetanol | anti-tetanus | 0.5 milligram | Subcutaneously | Helps in the prevention of tetanus | Client protected against tetanus | slight fever and chills | None |
| Injection oxytocin | Oxytocic drug | 10 units in 1 milligram | Intramuscularly | Increase uterine contraction and controlling of bleeding. | Increase uterine contraction and controlling of bleeding. | Hypotension and hyper stimulation of the uterus | None |
| Tablet Paracetamol | Analgesic and antipyretic | 100 milligram 3 times daily | Orally | Helps to reduce increased body temperature and pain | Pain was reduced | Liver damage | None |
| Capsule vitamin A | Group A vitamin supplement | 200,000 units for 2 days | Orally | Growth development and proper sight | Normal vision and healthy skin | Vomiting | None |

PHARMACOLOGICAL DRUGS USED (BABY)

| DRUGS | CLASSIFI- CATION | DOSAGE | ROUTE | ACTION AND USE | ACTUAL EFFECTS | SIDE EFFECTS | SIDE EFFECT EXPERIENCED |
|---|-----------------------------|--------------------|---------------------|--|--|--------------------------|------------------------------------|
| Vitamin k | Group K vitamins | 0.5 milligram | Intramuscular ly | Production of prothrombin. Aids in clotting | No bleeding | None | None |
| Chloramph enicol eye drop | Antibiotics | 2 drops | Instillation | To prevent infection | Infection of the eye was prevented | None | None |
| Oral polio vaccine 0 | Antigen vaccine | 2 drops | Orally | Production of antibodies | Baby is under observation | There may be diarrhea | None |
| Injection Bacillus Calmette Guerin | Antigen vaccine | 0.05 milliliter | Intradermal | Production of antibodies and prevention of tuberculosis | Baby is under observation | Blister formation | None |

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| | | | | | | | |
|--|--|--|--|--|--|--|--|

PHARMACOLOGICAL DRUGS USED CONTINUED

| DRUGS | CLASSIFI- CATION | DOSAGE | ROUTE | ACTION AND USE | ACTUAL EFFECTS | SIDE EFFECTS | SIDE EFFECT EXPERIENCED |
|------------------------------------|-----------------------------|---------------|-----------------|--|--|--------------------------|------------------------------------|
| Pentavale nt(5 in 1) vaccine | Antigen | 0.5milliliter | Intramuscularly | Stimulate the production of antibodies against Diphtheria, Tetanus, haemophilus, influenza, hepatitis B, pertussis | Low grade fever | None | None |
| Pneumoc occal vaccine 1 | Antigen | 0.5milliliter | Orally | Stimulate the production of antibodies against streptococcal infection | Redness at the site of injection and fever | None | None |
| Polio vaccine 1 | Antigen vaccine | 2 drops | Orally | Production of antibodies against | Baby is under observation | There may be diarrhea | None |

| | | | | | | | |
|---------------------|-----------------|---------------|--------|----------------------------|---------------------------|----------|------|
| | | | | poliomyelitis | | | |
| Rotavirus vaccine 1 | Antigen Vaccine | 1.5milliliter | Orally | Immunity against rotavirus | Baby is under observation | Vomiting | None |

PARTOGRAPH

MATERNITY CHAT

NEWBORN EXAMINATION FORM

TEMPERATURE CHART

SIGNATORIES

STUDENT

Name: LOURDES KONADU

Signature

Date

MIDWIFE- IN- CHARGE

Name: Mrs. PUALINA ADOMA

Signature.....

Date.....

SUPERVISOR

Name: Miss MONICA BOAGYE

Signature

Date

PRINCIPAL

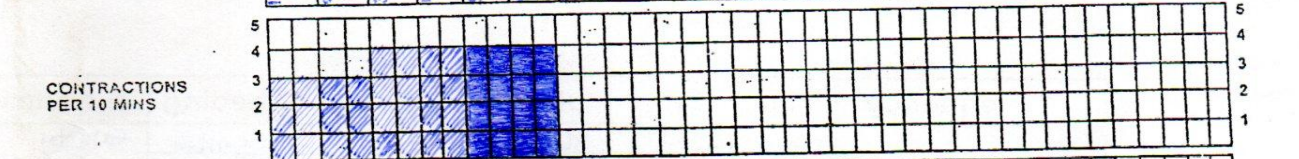
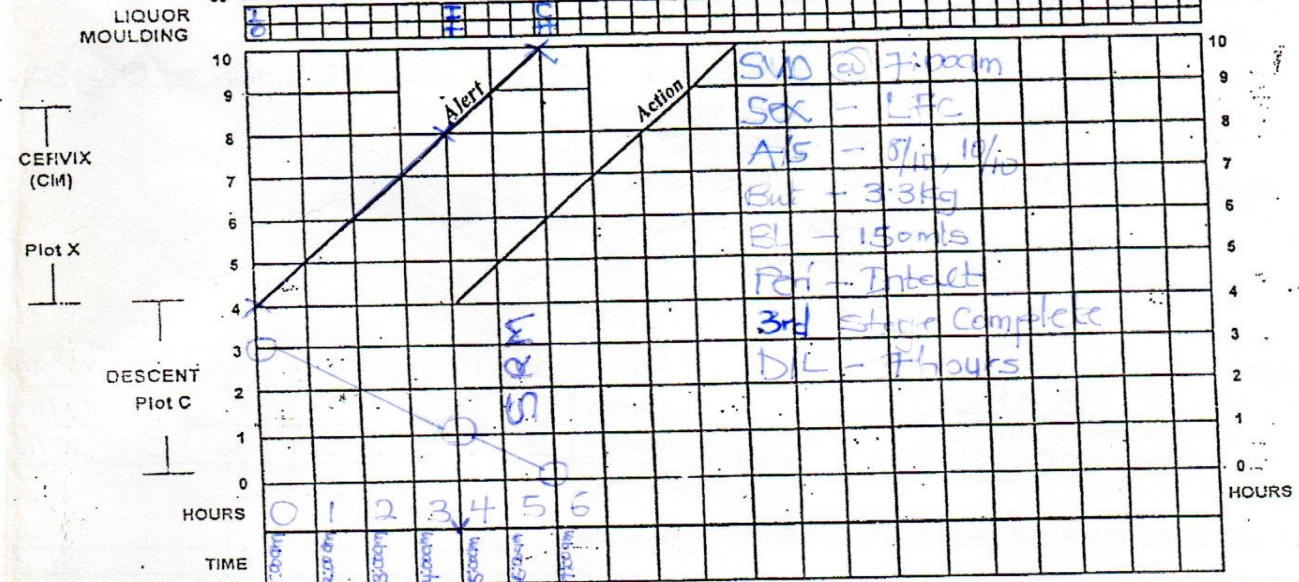
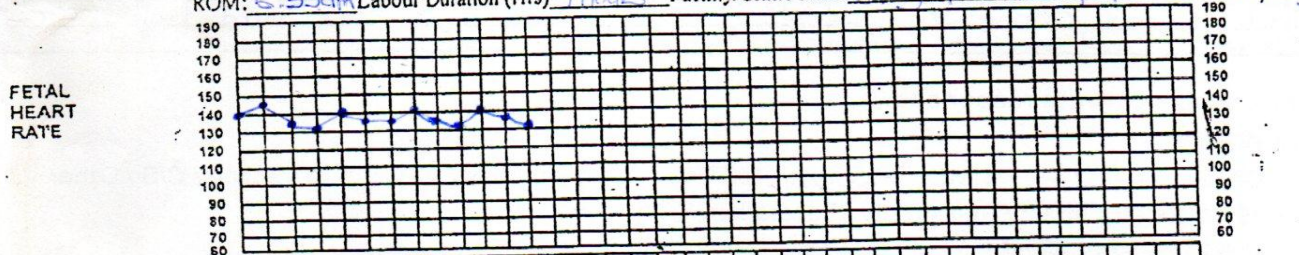
Name: MONICA NKURMAH

Signature

Date

WHO Modified Partograph

Registration No.: 1439/21 Name (Last, First) Amelida Grace Age: 25 years
 Date: 23/12/22 Parity/Gravida 1/2 LMP 15/3/21 EDD 22/1/22 Gestation (wks) 39 wks
 ROM: 6:55am Labour Duration (Hrs) 7 hours Facility/Clinic Name Glory Prince of Peace Maternity Home

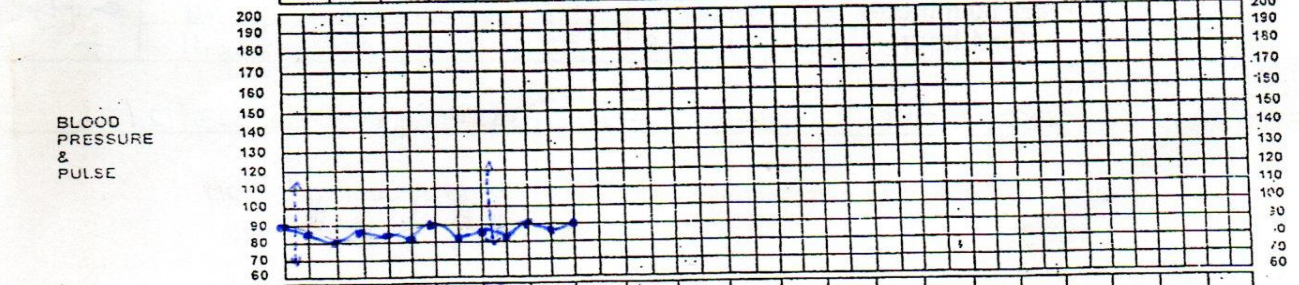


Oxytocin U/L Drops / minute

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
|---|---|---|---|---|---|---|---|

DRUGS & IV FLUIDS

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| | | | | | | | |
|--|--|--|--|--|--|--|--|



TEMPERATURE

| | | | | | | | |
|------|------|------|------|------|------|------|------|
| 36.5 | 36.5 | 36.5 | 36.5 | 36.5 | 36.5 | 36.5 | 36.5 |
|------|------|------|------|------|------|------|------|

URINE

| Amount | Protein | Acetone |
|--------|---------|---------|
| 100ml | NEG | NEG |
| 100ml | NEG | NEG |
| 100ml | NEG | NEG |
| 100ml | NEG | NEG |

LABOR NOTES

Client G.P. with 39 weeks; came to the facility accompanied by the Sister-in-law and complained of lower abdominal pains and painful contractions. Client had SVD to a L.P. with A/S - 8/12/10, Bwt - 3.3kg, HC - 33cm FL - 49cm. Perineum intact. IM Oxycotin of 10unit given. Placenta was delivered with control cord traction. Cord care done Vitamin K was given. Care was done as well as breastfeeding was initiated. Uterus was massaged and it was contractions. Bladder was emptied. Mother and baby were cleaned and made comfortably in bed.

Please circle or write responses.

DELIVERY

DATE: 23/12/21 TIME: 7:00am METHOD: Spontaneous / Vacuum Extraction / C/S / Other
 PERINEUM: Intact / Episiotomy / Laceration
 ANESTHESIA: None / Local / General

THIRD STAGE

Active Management: Yes / No Medication: Time 7:10am Type/Dose 10 units of Oxytocin
 PLACENTA: TIME: 7:05am Complete / Incomplete
Small (Less than 250 cc)
 BLOOD LOSS AMOUNT: Moderate (250-499 cc)
 Large (more than 500 cc)
 Significant for mother

APGAR

BABY

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

| Time | Color | Breath | Heart | Tone | Reflex | TOTAL |
|------|----------|----------|----------|----------|----------|--------------|
| 1min | <u>2</u> | <u>2</u> | <u>2</u> | <u>1</u> | <u>1</u> | <u>9/10</u> |
| 5min | <u>2</u> | <u>2</u> | <u>2</u> | <u>2</u> | <u>2</u> | <u>10/10</u> |

COMPLICATIONS OF MOTHER / BABY: None / Other:

FOURTH STAGE MONITORING

| Frequency | Time | B/P. | Pulse | Fundus | Bleeding | Bladder |
|--------------------------------|---------|--------|-------|------------|----------|---------|
| Every 15 minutes first 2 hours | 7:30am | 120/70 | 80 | 16 | 150mls | empty |
| | 7:35am | 110/60 | 70 | Contracted | Small | - |
| | 7:50am | 120/70 | 85 | Contracted | Small | empty |
| | 8:05am | 110/70 | 72 | Contracted | Small | - |
| | 8:20am | 112/74 | 69 | Contracted | Small | empty |
| | 8:35am | 118/73 | 72 | Contracted | Small | - |
| | 8:50am | 110/62 | 81 | Contracted | Small | empty |
| Every 30 minutes For 1 hour | 9:05am | 115/68 | 78 | Contracted | Small | - |
| | 9:30am | 120/70 | 69 | Contracted | Small | empty |
| | 10:05am | 108/65 | 72 | Contracted | Small | - |

Birth Attendant Kencidu Louides / Gyamfua Comfort Date 23/12/21

MATERNITY CHART

NAME: Grace Ameyadi
 AGE: 25 years WARD: Luther - In
 IP NO.: 1439/21 BED NO.: 2

| Date | 13/12/21 | 14/12/21 | 15/12/21 | 16/12/21 | 17/12/21 | 18/12/21 | 19/12/21 | 20/12/21 | 21/12/21 | |
|------------------|------------|----------|----------|----------|----------|----------|----------|----------|----------|--|
| Days in Hospital | D0 | D1 | D2 | D3 | D4 | D5 | D6 | D7 | D8 | |
| Days P, O. | | | | | | | | | | |
| Hour | Am 7:00 | 7:00 | 7:00 | 7:00 | 7:00 | 7:00 | 7:00 | 7:00 | 7:00 | |
| | Pm 4:00 | 4:00 | 4:00 | 4:00 | 4:00 | | 7:00 | 7:00 | 7:00 | |
| Temperature | | | | | | | | | | |
| Pulse | 88 | 74 | 76 | 70 | 79 | 60 | 60 | 77 | | |
| Resp. | 18 | 18 | 17 | 20 | 20 | 21 | 21 | 21 | | |
| B.M. | | | | | | | | | | |
| Urine | Pass | Pass | Pass | Pass | Pass | Pass | Pass | Pass | | |
| B. P. | 120/60 | 110/60 | 110/60 | 110/60 | 110/70 | 120/70 | 110/60 | 120/70 | | |
| | | 111/62 | 110/70 | 120/65 | 113/73 | | | | | |

NEW BORN EXAMINATION FORM

Name: Baby Ameyaci Date of Assessment: 23/12/21 Time: 8:00am
 Date of Birth: 23/12/21 Time of Birth: 7:00am Sex: M F Age at time of Assessment (days/hrs) 1 hour
 Gestational Age 37-42 Mode of Delivery: Vaginal Assisted Vaginal C-Section
 APGAR: 1min 5min 10 Birth Weight: 3.3 kg Length: 49 cm Head Circumference: 33 cm
 Temperature at time of Assessment: 36.5 °C Urine passed: Yes No Meconium passed: Yes No
 Name of Assessor (Midwife/Doctor): Lourdes Konadu

| | | | |
|---|---|---|---|
| <p>1. Respiration Rate <u>40</u> <input type="checkbox"/> Rate < 30 b/m * <input type="checkbox"/> Rate < 60 b/m * <input checked="" type="checkbox"/> 30-60 b/m <input type="checkbox"/> Retractions * <input type="checkbox"/> Grunting * <input type="checkbox"/> Stridor *</p> <p>2. Activity/Movement <input checked="" type="checkbox"/> Spontaneous symmetric movements <input type="checkbox"/> Reduced/Absent Movement in ≥ 1 limb * <input type="checkbox"/> No Movement</p> <p>3. Tone <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Floppy * <input type="checkbox"/> Increased *</p> <p>4. Colour <input checked="" type="checkbox"/> Pink all over <input type="checkbox"/> Pink body but blue hands/feet <input type="checkbox"/> Blue all over * <input type="checkbox"/> Pale * <input type="checkbox"/> Jaundiced *</p> <p>5. Cord <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Red. draining pus <input type="checkbox"/> Bleeding</p> <p>6. Cry <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Shrill * <input type="checkbox"/> Absent *</p> | <p>7. Suck <input type="checkbox"/> Good <input type="checkbox"/> Weak <input type="checkbox"/> Absent</p> <p>8. Head swelling <input type="checkbox"/> Caput succedaneum <input type="checkbox"/> Cephalhaematoma <input type="checkbox"/> Subgaleal hemorrhage <input checked="" type="checkbox"/> No swelling</p> <p>9. Sutures <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Overlapping <input type="checkbox"/> Fused <input type="checkbox"/> Widely Separated *</p> <p>10. Fontanel <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Sunken * <input type="checkbox"/> Raised * <input type="checkbox"/> Wide (>5cm)*</p> <p>11. Eyes <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Subconjunctival-bleed <input type="checkbox"/> White-pupil or cornea <input type="checkbox"/> Eye discharge <input type="checkbox"/> Other _____</p> <p>12. Ears <input checked="" type="checkbox"/> Normal (size / shape/position) <input type="checkbox"/> Abnormal: _____</p> <p>13. Mouth <input type="checkbox"/> Normal <input type="checkbox"/> Cleft palate <input type="checkbox"/> Cleft Lip <input type="checkbox"/> Other: _____</p> | <p>15. Neck <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Swelling <input type="checkbox"/> Webbed <input type="checkbox"/> Other: _____</p> <p>16. Clavicle <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Swelling/Fracture</p> <p>17. Chest <input type="checkbox"/> Normal (Shape/movement) <input type="checkbox"/> Abnormal _____</p> <p>18. Heart rate Rate: <u>135</u> <input checked="" type="checkbox"/> Normal (100-160) <input type="checkbox"/> <100 * <input type="checkbox"/> >160*</p> <p>19. Femoral pulse <input checked="" type="checkbox"/> Present <input type="checkbox"/> Not palpable*</p> <p>20. Abdomen <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Distended* <input type="checkbox"/> Scaphoid* <input type="checkbox"/> Abdominal defect* <input type="checkbox"/> Maases: _____ <input type="checkbox"/> Other _____</p> <p>21. Back (spine) <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Abnormal Swelling * <input type="checkbox"/> Hairly patch over spine <input type="checkbox"/> Abnormal dimple <input type="checkbox"/> Abnormal curvature</p> | <p>22. Limbs <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Abnormal _____</p> <p>23. Genitalia Male Genitalia <input type="checkbox"/> Normal <input type="checkbox"/> Undescended testes <input type="checkbox"/> Abnormal meatus <input type="checkbox"/> Hernia <input type="checkbox"/> Other: _____</p> <p>Female Genitalia <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Fistula(meconium/urine through abnormal opening in vagina) * <input type="checkbox"/> Large clitoria * <input type="checkbox"/> Other: _____</p> <p>24. Anus <input checked="" type="checkbox"/> Patent <input type="checkbox"/> Imperforate*</p> <p>25. Resuscitation provided <input type="checkbox"/> One: <input type="checkbox"/> Suction/stimulation <input type="checkbox"/> Bag and mask <input type="checkbox"/> Endotracheal Tube <input type="checkbox"/> Ventilator/CPAP</p> <p>26. Services provided <input checked="" type="checkbox"/> Vitamin K1 given <input checked="" type="checkbox"/> Eye care provided <input checked="" type="checkbox"/> Cord care provided <input checked="" type="checkbox"/> Breastfeeding initiated <input type="checkbox"/> Breastfeeding established <input type="checkbox"/> Immunization (BCG/Polio) <input type="checkbox"/> BCG <input type="checkbox"/> Polio Immunization <input type="checkbox"/> Antibiotics in mother <input type="checkbox"/> Antenatal corticosteroids</p> |
|---|---|---|---|

*May indicate severe disease that requires urgent referral
 Diagnoses (if known) Spontaneous vaginal delivery
 Classification: (Overall assessment) Normal Baby with a Problem Danger Sign/ <1500g/ severe Jaundice
 Plan: Routine Care Problem. Continue supportive in-patient care Urgent Referral / Advanced Care Discharge

NEW BORN EXAMINATION FORM

Name: Baby Ameyaa Date of Assessment: 24/12/21 Time: 3:00pm
 Date of Birth: 23/12/21 Time of Birth: 7:00am Sex: M F Age at time of Assessment (days/hrs) 1 day
 Gestational Age 37wks Mode of Delivery: Vaginal Assisted Vaginal C-Section
 APGAR: 1min 8 5min 10 Birth Weight: 3.3kg Length 49 cm Head Circumference: 33 cm
 Temperature at time of Assessment: 36.5 °C Urine passed: Yes No Meconium passed: Yes No
 Name of Assessor (Midwife/Doctor): Larcks Kanadi

| | | | |
|---|--|--|---|
| <p>1. Respiration</p> <p>Rate</p> <input type="checkbox"/> Rate < 30 b/m * <input type="checkbox"/> Rate < 60 b/m * <input checked="" type="checkbox"/> 30-60 b/m <input type="checkbox"/> Retractions * <input type="checkbox"/> Grunting * <input type="checkbox"/> Stridor * <p>2. Activity/Movement</p> <input type="checkbox"/> Spontaneous symmetric movements <input type="checkbox"/> Reduced/Absent Movement in ≥ 1 limb * <input type="checkbox"/> No Movement <p>3. Tone</p> <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Floppy * <input type="checkbox"/> Increased * <p>4. Colour</p> <input checked="" type="checkbox"/> Pink all over <input type="checkbox"/> Pink body but blue hands/feet <input type="checkbox"/> Blue all over * <input type="checkbox"/> Pale * <input type="checkbox"/> Jaundiced * <p>5. Cord</p> <input type="checkbox"/> Normal <input type="checkbox"/> Red, draining pus <input type="checkbox"/> Bleeding <p>6. Cry</p> <input type="checkbox"/> Normal <input type="checkbox"/> Absent * | <p>7. Suck</p> <input checked="" type="checkbox"/> Good <input type="checkbox"/> Weak <input type="checkbox"/> Absent <p>8. Head swelling</p> <input type="checkbox"/> Caput succedaneum <input type="checkbox"/> Cephalhaematoma <input type="checkbox"/> Subgaleal hemorrhage <input checked="" type="checkbox"/> No swelling <p>9. Sutures</p> <input type="checkbox"/> Normal <input type="checkbox"/> Overlapping <input type="checkbox"/> Fused <input type="checkbox"/> Widely Separated * <p>10. Fontanel</p> <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Sunken * <input type="checkbox"/> Raised * <input type="checkbox"/> Wide (>5cm) * <p>11. Eyes</p> <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Subconjunctival bleed <input type="checkbox"/> White pupil or cornea <input type="checkbox"/> Eye discharge <input type="checkbox"/> Other <p>12. Ears</p> <input checked="" type="checkbox"/> Normal (size / shape/position). <input type="checkbox"/> Abnormal: _____ <p>13. Mouth</p> <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Cleft palate <input type="checkbox"/> Cleft Lip <input type="checkbox"/> Other: _____ | <p>15. Neck</p> <input type="checkbox"/> Normal <input type="checkbox"/> Swelling <input type="checkbox"/> Webbed <input type="checkbox"/> Other: _____ <p>16. Clavicle</p> <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Swelling/Fracture <p>17. Chest</p> <input checked="" type="checkbox"/> Normal (Shape/movement) <input type="checkbox"/> Abnormal <p>18. Heart rate</p> <p>Rate: <u>132</u></p> <input checked="" type="checkbox"/> Normal (100-160) <input type="checkbox"/> <100 * <input type="checkbox"/> >160 * <p>19. Femoral pulse</p> <input checked="" type="checkbox"/> Present <input type="checkbox"/> Not palpable * <p>20. Abdomen</p> <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Distended* <input type="checkbox"/> Scaphoid* <input type="checkbox"/> Abdominal defect* <input type="checkbox"/> Maases: _____ <input type="checkbox"/> Other: _____ <p>21. Back (spine)</p> <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Abnormal Swelling * <input type="checkbox"/> Hairy patch over spine <input type="checkbox"/> Abnormal dimple <input type="checkbox"/> Abnormal curvature | <p>22. Limbs</p> <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <p>23. Genitalia</p> <p>Male Genitalia</p> <input type="checkbox"/> Normal <input type="checkbox"/> Undescended testes <input type="checkbox"/> Abnormal meatus <input type="checkbox"/> Hernia <input type="checkbox"/> Other: _____ <p>Female Genitalia</p> <input type="checkbox"/> Normal <input type="checkbox"/> Fistula(meconium/urine through abnormal opening in vagina) * <input type="checkbox"/> Large clitoria * <input type="checkbox"/> Other: _____ <p>24. Anus</p> <input checked="" type="checkbox"/> Patent <input type="checkbox"/> Imperforate * <p>25. Resuscitation provided</p> <input checked="" type="checkbox"/> One <input type="checkbox"/> Suction/stimulation <input type="checkbox"/> Bag and mask <input type="checkbox"/> Endotracheal Tube <input type="checkbox"/> Ventilator/CPAP <p>26. Services provided</p> <input type="checkbox"/> Vitamin K1 given <input type="checkbox"/> Eye care provided <input checked="" type="checkbox"/> Cord care provided <input checked="" type="checkbox"/> Breastfeeding initiated <input checked="" type="checkbox"/> Breastfeeding established <input checked="" type="checkbox"/> Immunization (BCG/Polio) <input type="checkbox"/> BCG <input type="checkbox"/> Polio Immunization <input checked="" type="checkbox"/> Antibiotics in mother <input type="checkbox"/> Antenatal corticosteroids |
|---|--|--|---|

*May indicate severe disease that requires urgent referral

Diagnoses (if known) Spontaneous vaginal delivery

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

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

TEMPERATURE CHART

NAME: Roly Araya

AGE: New born WARD: Lying-in

IP NO.: 1429/21 BED NO.: 2

| Date | 23/12/21 | 24/12/21 | 25/12/21 | 26/12/21 | 27/12/21 | 28/12/21 | 29/12/21 | 30/12/21 | 31/12/21 |
|------------------|---------------|--------------|--------------|--------------|--------------|--------------|--------------|--------------|--------------|
| Days in Hospital | D0 | D1 | D2 | D3 | D4 | D5 | D6 | D7 | D8 |
| Days P. O. | | | | | | | | | |
| Hour | Am 7:00 Pm | 7:00 4:00 | 7:00 4:00 | 7:00 4:00 | 7:00 4:00 | 7:00 4:00 | 7:00 4:00 | 7:00 4:00 | 7:00 4:00 |
| Temperature | | | | | | | | | |
| C | 40.5 | 40.5 | 39.5 | 39.5 | 38.5 | 38.5 | 39.5 | 39.5 | 39.5 |
| F | 104.5 | 104.5 | 103.5 | 103.5 | 101.5 | 101.5 | 103.5 | 103.5 | 103.5 |
| Pulse | 130 | 135 136 | 138 140 | 130 140 | 130 132 | 136 | 140 | 145 | 155 |
| Resp. | 40 | 40 42 | 44 42 | 41 43 | 41 44 | 40 43 | 40 | 40 | 40 |
| B.M. | Pass | Pass | Pass | Pass | Pass | Pass | Pass | Pass | Pass |
| Urine | Pass | Pass | Pass | Pass | Pass | Pass | Pass | Pass | Pass |
| D.P. | AM PM | | | | | | | | |

NEW BORN CHART

Name: BABY AMEYAA

No:

Birth Weight: 3.3kg

Sex: FEMALE

Mother's No: 1439/21

Length: 49cm

Nature of Delivery: SPONTANEOUS VAGINAL DELIVERY

Diagnosis: TERM BABY

Date of Birth: 23RD DECEMBER, 2021 Time: 7:00am

Date of Discharge: 24TH DECEMBER, 2021

| Date | 23/12/21 | | 24/12/21 | | 25/12/21 | | 26/12/21 | | 27/12/21 | | 28/12/21 | | 29/12/21 | | 30/12/21 | | 31/12/21 | | |
|-------------|---|----|----------------------|----|----------------------|----|----------------------|----|----------------------|----|----------------------|----|----------------------|----|----------------------|----|----------------------|----|--|
| | AM | PM | AM | PM | AM | PM | AM | PM | AM | PM | AM | PM | AM | PM | AM | PM | AM | PM | |
| No. of Days | <u>DD</u> | | <u>D₁</u> | | <u>D₂</u> | | <u>D₃</u> | | <u>D₄</u> | | <u>D₅</u> | | <u>D₆</u> | | <u>D₇</u> | | <u>D₈</u> | | |
| Weight | <u>3.3kg</u> | | <u>3.2kg</u> | | <u>3.1kg</u> | | <u>3.0kg</u> | | <u>3.0kg</u> | | <u>3.1kg</u> | | <u>3.2kg</u> | | <u>3.3kg</u> | | <u>3.4kg</u> | | |
| Temperature | <u>37.9</u> | | <u>37.9</u> | | <u>37.9</u> | | <u>37.8</u> | | <u>37.8</u> | | <u>37.9</u> | | <u>37.9</u> | | <u>37.9</u> | | <u>37.9</u> | | |
| Stools | <u>Passed</u> | | <u>Passed</u> | | <u>Passed</u> | | <u>Passed</u> | | <u>Passed</u> | | <u>Passed</u> | | <u>Passed</u> | | <u>Passed</u> | | <u>Passed</u> | | |
| Urine | <u>Passed</u> | | <u>Passed</u> | | <u>Passed</u> | | <u>Passed</u> | | <u>Passed</u> | | <u>Passed</u> | | <u>Passed</u> | | <u>Passed</u> | | <u>Passed</u> | | |
| Remarks | <p><u>Head</u> <u>Neck</u> <u>Trunk</u> <u>Gentle</u> <u>ladder limbs</u></p> <p><u>No Abnormality detected</u></p> | | | | | | | | | | | | | | | | | | |

SIGNATORIES

STUDENT

Name: LOURDES KONADU

Signature 

Date 11/10/2022

MIDWIFE- IN- CHARGE

Name: PUALINA ADOMA

Signature 

Date 12/10/2022

SUPERVISOR

Name: MONICA BOAKYE

Signature 

Date 12/10/2022

PRINCIPAL

Name: MONICA NKURMAH

Signature 

Date 13/10/2022

ACADEMIC CO-ORDINATOR - NURSING
HOLY FAMILY NURSING & MIDWIFERY
2019/2020