HOLY FAMILY NURSING AND MIDWIFERY TRAINING COLLEGE

BEREKUM

A CLIENT/FAMILY CENTERED MATERNITY CARE STUDY ON

MADAM DASAAH COMFORT

BY

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A CLIENT/FAMILY CENTERED MATERNITY CARE STUDY SUBMITTED TO THE NURSING AND MIDWIFERY COUNCIL OF GHANA IN PARTIAL FULFILMENT TOWARDS THE AWARD OF LICENSE TO PRACTICE AS A PROFESSIONAL REGISTERED MIDWIFE

(DIPLOMA)

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TABLE OF CONTENT

Contents

PREFACE

Family Centered Maternity Care Study is a systematic approach used in rendering holistic obstetric care to the expectant mother and her family based on a thoughtful understanding of the client as a unique individuals with specific problems. The care is given to the client during pregnancy, labour and to the end of the six weeks postnatal [puerperium].

Its necessity is to provide physical, social, psychological, spiritual, and mental wellbeing of the client and how the family can adapt to the pregnancy and ways to welcome the new member in the family.

It helps to provide adequate knowledge on theoretical and practical aspect in the management of client during pregnancy, labour and puerperium by ensuring patient confidentiality. Also, ways of using the nursing care plan to provide appropriate nursing interventions to solve problems identified. The use of partograph in the management of first stage of labour, the various maneuvers used in delivery and skills for professional academic development. This also help in partial fulfillment for the award of a professional certificate by the Nursing and Midwifery Council of Ghana at the end of the three-year course.

The client/family centered maternity care study helps the student midwife to put into practice the knowledge and skills acquired theoretically in caring for pregnant women and their family. The reason for carrying out such a study is to give the student midwife a maximum opportunity to put in to practice what she has learnt in the classroom and be able to assess herself whether she has understood the course. The care study also gives the client the opportunity to express her feeling and voice out any problem that may be bothering her. This enable the student midwife to manage and help her to come out of such problem.

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INTRODUCTION

The family centered maternity care study is a nursing care, attention and education given to an expectant mother, her family and the community as a whole.

The care addresses the needs of an expectant mother and her family considering the physical, psychological and socio-economic aspect. The student midwife therefore uses her knowledge acquired in the classroom to care for the woman in her home environment based on the thoughtful understanding of the client as a unique individual with specific problems and needs.

This is a client and family centered maternity care rendered to Madam Dasaah Comfort, a 32 year old woman who is gravid 4 para 3AA during her period of antenatal, labour and puerperium. The whole interaction started at the antenatal clinic on the 9th November, 2022.She was 36 weeks of gestation. Client taken care for during pregnancy, labour and puerperium. During this period information that was gathered from client and her family was carefully analyzed and care rendered based on this information. All problems that were identified was skillfully managed with the nursing process.

This care study is based on four chapters. Chapter one talks about her general background including social, family, medical and surgical, menstrual, past and present obstetric histories.

The second chapter also talks about the antenatal care of the client and all other care that was rendered until she went into labour.

The third chapter is also based on labour from the time client was admitted, the management till the end of the first six hours after delivery.

The last chapter is on puerperium up to sixth week of postpartum.

At the end of each chapter, a care plan was drawn to identify problems and to solve them without complication to mother and baby.

LITERATURE REVIEW

PREGNANCY

Ricci, (2016) said that, the client is usually the first person to suspect pregnancy. Her suspicion is often based on the fact that she has missed her period. The amenorrhea occurs because, after implantation of the fertilized ovum, the increase secretion of estrogen and progesterone by the ovary converts the endometrium of the uterus to decidua of pregnancy and menstruation ceases.

He further mentioned that, the morning sickness, continuous enlargement of the breasts, fetal movement, painless contractions, and others are some of the signs and symptoms that occurs at different stages of pregnancy.

From the National Safe Motherhood Service Protocol (2008), antenatal care is defined as a health care and education given during pregnancy. Antenatal services are important part of preventive and promotive healthcare. Some of the aims of antenatal care include the following,

1. To promote and maintain the physical, mental and social health of the mother and baby by providing education to the pregnant mother on nutrition, rest, sleep,

   Personal hygiene, family planning, immunization, danger signs of pregnancy,

   STI/HIV/AIDS and birth preparedness and complication readiness.
2. To ensure the delivery of a full term healthy baby with minimal stress or injury to mother and baby.
3. To ensure safe delivery and a healthy post-partum period
4. To detect and treat high risk conditions arising during pregnancy, whether medicals, surgical or obstetric.

Focused antenatal care is practiced to promote and render quality health care to the pregnant woman. It aims to provide comprehensive and individualized care. As much as possible, all care

activities e.g.; history, physical examination and treatment should be provided by the same care provider to the pregnant woman and this creates or builds trust between the care giver and the client. One-on-one teaching or health talk dependent on the client's need is given. It also enhances good interaction between the health provider and the client. The number of times a client needs to attend antenatal care clinic may vary. For the uncomplicated pregnancy, it is recommended that at least four antenatal care visits should be made. During the antenatal care clinic, the client goes through personal information and history taking process, physical examination from head to toe to exclude any abnormality, abdominal inspection, and palpation to detect the lie, presentation and position of the fetus, auscultation and measurement of the symphysio fundal height. Laboratory and other investigations such as hemoglobin level estimation, sickling, blood grouping, VDRL, HIV, G6PD, hepatitis B tests and urine testing to exclude protein and glucose are carried out. Tetanus diphtheria injections are given based on the recommended protocol and routine drugs served as well. Client goes through all these processes till term when labour sets in.

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

1. To support and encourage a family’s health and psychological adjustment to child bearing.
2. To monitor the progress of pregnancy
3. To detect, treat or manage any complications in pregnancy
4. To monitor the progress of pregnancy

5. To ensure thee pregnant women delivers safely without any injury to both mother and baby.

   Some cares rendered at ANC include; antenatal exercises, physical examination, urine testing, administration of some drugs such as sulphadoxine pyrimethamine, tetanus toxoid injection, and also birth preparedness and complication readiness before birth.

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

Ojo (2006) explains pregnancy as a term used to describe the period in which a developing embryo grows in the uterus. When pregnancy occurs, menstruation ceases and returns some weeks or months after delivery. Some hormones exert some action on the various systems of the client. The most outstanding of these changes is the growth which occurs in the uterus. The lining of the uterus undergoes changes due to the effect of these hormones and the uterus itself grows to accommodate the growing embryo. She further explained antenatal care as an advice, supervision and attention a pregnant woman receives to ensure;

a) Good health, where applicable, early detection and treatment of abnormalities which may affect her health or that of the baby.

b) A pleasant child-bearing experience and adequate preparation for labour and lactation.

c) A live, healthy baby at the end of pregnancy

However, the first trimester is said to start from the first day of conception to the 13^{th} week. The second trimester also beings from the 14^{th} week to the 24^{th} week and the third trimester begins from 25^{th} week to the 40^{th} week of gestation.

The main aim of focused antenatal care include;

- Birth preparedness and complication management
- Prevention of diseases
- Early detection and management of complication
- Health promotion

The services provided under focused antenatal care include

1. Comprehensive history taking
2. Examination of the pregnant mother
3. Laboratory investigation

4. Malaria prevention
5. Assessment of fetal and maternal condition
6. Tetanus immunization

The benefit of focus antenatal care includes;

- Individualized care, education and counseling more turn to client needs
- Comprehensive care that is all care and services provided by the same provider
- Same provider provides care to the client during all visit
- Promotion of partner or support person involvement
- Recommended antenatal care and treatment protocols are observe.

From above, it can be deduced that pregnancy affects the physical and physiological wellbeing of the woman. It is therefore important that focused Antenatal Care be employed to

help deliver maximum health care to pregnant woman

Fraser & Cooper (2013) Pregnancy is the period when the fertilized ovum embeds in the maternal uterus until it is born thus the state of conception till the delivery of the foetus. The normal duration is 280 days or 40weeks counting from the last day of the menstrual period, she further states that uterine blood flow in pregnancy supplies the myometrium, endometrium and placenta, with the latter receiving nearly 90% of the total uterine blood flow near term. It further states that, the anatomical and physiological adaptations occurring throughout pregnancy affect virtually every body system. The timing and intensity of the changes vary between systems but all are designed to support foetal growth and development and prepare the mother for birth and motherhood. The uterus protects and supports the foetus, placenta and amniotic fluid. For most of the 40 weeks of pregnancy, the uterus expands to accommodate the growing foetus and remains relatively quiescent, yet at the time of labour it is able to contract regularly and forcibly

to expel the foetus due to its unique properties of contractility and elasticity. She also says, the vagina also increases vascularity which results in the violet colour characteristic of Chadwick's sign. There is increased volume of vaginal secretions due to high level of oestrogen resulting in thick, white discharge known as leucorrhoea. Larger amount of glycogen is deposited in the vaginal epithelium due to high oestrogen availability. The glycogen is metabolized to lactic acid by the lactobacillus acidophilus, (Doderlein's bacillus), and this leads to increase vaginal acidity.

LABOUR

While Baker and Kenny (2017) define labour as the process by which the uterus empties its contents after 37 weeks of gestational age. It entails the contractions and retractions of uterine muscles fibers, the dilatation of cervical os and the expulsion of the fetus, liquor amnii, placenta and its membranes. They also state that, through a continuous process, labor is divided into four stages for descriptive purposes and they are;

- First stage of labor; which begins from the regular uterine contractions to full dilatation of cervical os. It last for 12 to 14 hours in primigravida and 6 to 12 hours in multigravidae. The first stage of labor comprises if painful uterine contractions, progress dilatation of cervical os, formation of upper and lower segment formation of fore waters and sometimes rupture of membranes.
- Second stage of labor; starts from full dilatation of cervical os to the complete expulsion of the fetus and liquor amnii. It usually last for 0ne hour in primigravida and 5 to 30 minutes in multigravidae. It comprises of strong uterine contractions, descent of the fetus into the pelvis, and the birth off the baby.

- Third stage of labor; entails complete expulsion of placenta and membranes usually 5 to 15 minutes after birth of the baby. The other feature of 3rd stage of labor apart from detachment expulsion of placenta and its membranes is the control of bleeding.
- The fourth stage of labor; is advisable for mother and baby to remain under the care of the midwife for at least 6 hours after birth regardless of the birth setting. Much of this time is used for observation of the mother and baby, cleaning up and completion of records. During the fourth stage, uterine contractions, blood loss and vital signs are checked for every 15 minutes for the first 2 hours, every 30 minutes for the next 2 hours and every 1 hour for the remaining 2 hours. Head to toe examination is done on the baby and first baby bath is done after six hours.
- Perry (2013) stated that five factors affect the process of labour and birth. These are the Passenger which is the fetus and placenta, Passageway which is the birth canal, Powers which is the contractions, Position of the mother and Psychological responds. He further identifies the stages of labour as follows; the first stage of labour begins with the onset of regular uterine contractions, effacement, dilatation of the cervix and progress in descent of the presenting part. The first stage of labour has been divided into three phases namely; the latent phase where there is more progress in effacement of the cervix and a little increase in descent. Active phase and transitional phase where there are more rapid dilation of the cervix and increase rate of the descent of the presenting part. The second stage of labour; this stage begins with full cervical dilation (10 centimeters) and complete effacement and ends with the baby's birth. He continued that, the second stage takes an average of 20 minutes for multiparous women and 50 minutes for nulliparous women. The third stage of labour which lasts from the birth of the fetus until the placenta is delivered. He stated that the placenta normally separates with the third or fourth strong contractions after the infant has been born. The duration of the third stage may be as short

as 3-5minute although up to 1 hour is considered within the normal limits. Lastly, the fourth stage of labour last for 6 hours after delivery of the placenta. It is the period of immediate recovery when homeostasis is re-established. It is an important period of observation for complication such as bleeding.

Ojo (2006) defines labour as the process by which the uterus empties its content after the 28th week of pregnancy. It entails the contraction and retraction of the uterine muscle fibers, the dilation of the cervical os and the expulsion of the baby, liquor amnions, placenta and its membranes.

Konar (2013) states labor as a series of event that takes place in the woman's genital organs in an effort to expel the viable products of conception off these womb through the vagina to the outside world. Under rest and ambulation; if membranes are intact, the woman is allowed to walk around. This attitude prevent vena cava compression and encourage descent of the head. Ambulation can reduce duration of labor, need of analgesia and improves mother's comfort. If, however, they further went on to state that assessment of progress of labor and partograph recording are also done. Partograph are tools that allow labor progress to be graphically recorded and visually assessed. They aid in early detection of abnormal labor progress and credited by some of the decreasing rates of prolonged labor, oxytocin use, caesarian sections and intrapartum morbidity and mortality as compared to usual care. Use of partograph is initiated during presumed active first stage.

According to Mayes (2011) labour is divided into three stages; first stage of labour: from the onset of regular uterine contractions, accompanied by effacement of the cervix and dilatation of the os, to full dilatation of the os. In primigravidae, this stage last for 12-14hours and in multigravida it last for 6-10hours, second stage of labour: from full dilatation of the os uteri to

the birth of the baby. This stage last for 60minutes in primigravidae and up to 30 minutes in multigravida. Third stage of labour: from the birth of the baby to the expulsion of the placenta and membranes. It last 5-30minutes with active management in primigravidae and or 5-15minutes with active management in multiparous.

PUERPERIUM

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

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

- Immediate puerperium; the first 24hours after delivery.
- Early puerperium; in between the second and seventh day after delivery
- Late puerperium; from the second week to the sixth after childbirth.

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

a) The reproductive organs returns to the non-pregnant state

- Lactation established
- Establishment of bond between baby and parents.

b) The mother recovers from the stresses of pregnancy and delivery, and assumes the responsibility for the care and nurturing of the infant.

The main aim of management during puerperium is to

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

Ojo (2006) states that, puerperium is the period between delivery of the newborn and the return of the maternal reproductive organ to the pre-gravid state. It further explains that during puerperium the bruises heal and the genital organs and any other organ which underwent changes during pregnancy returns to the pre-gravid state. Lactation is also established during this period. This period lasts between 6 to 8 weeks

Perry (2013) defined postpartum period as the interval between the birth of the newborn and the return of the maternal reproductive organs to their normal non pregnant state. He said that the term puerperium refers to the six weeks period elapsing between the termination of labour and the return of the reproductive organs to their normal condition. This includes both the progressive changes in the breast for lactation and involution of the internal reproductive organ. He also enumerates that, there are 3 types of lochia namely: lochia rubra: it is seen in the first 3 days and consists of blood, decidua and trophoblastic debris and may contain some small clots. It is bright red in colour. Lochia serosa: it is seen during the next 4-9 days. It consists of old blood serum, leucocytes and tissue debris. It is pinkish in colour. Lochia Alba: it is seen after 10 days

and consists of leucocytes, decidua, epithelial cells and cervical mucus. It is white in colour and continues for 10-14 days.

Fraser & Cooper (2012) states that, puerperium begins immediately after delivery of the placenta and membranes and continues for six (6) weeks. The expectation is that by 6th week after birth, all the systems affected by the pregnancy in the woman's body would have recovered and returned to their non-pregnant state except the breast because of lactation. Myles also striked the difference between exercise and healthy activity verses rest, relaxation and sleep. Exploring each person's level of activity will encourage advice in relation to appropriate exercise and by association, nutritional intake and rest or relaxation and sleep. Undertaking regular pelvic floor exercise is of benefit to the woman's long-term health.

Mayes (2011) stated that puerperium starts from the end of third stage of labour to six weeks of delivery. It states some aims of postnatal care as;

- To promote and monitor the woman's and the infant's physical wellbeing.
- To assist the woman with the successful establishment of her infant feeding
- To educate the woman and her family in the needs and development of the infant
- To foster good family relationships
- To enhance the woman's confidence in her ability to fulfill her role as a mother

WHY CLIENT WAS CHOSEN

Madam Dasaah Comfort G4P3^{AA} 32 years of age with 36 weeks gestation reported to the antenatal clinic on the 9th of November, 2022 at Fiaso Chps Compound in the Techiman districtof Bono East Region Ghana.

Client was chosen because she was always complaining of waist pain and headache. She also met the criteria for a client \ family centered maternity care study thus a multiparous woman with no bad obstetric history and a regular ANC attendant. Introduction was made to her as a student of Holy Family Nursing and Midwifery Training College- Berekum who is here for practical experience. On examination, no abnormality was detected. A glanced was made through her antenatal book and a chat with her revealed that her previous pregnancy, labour and puerperium were uneventful. Introduction was made and the client and family centered care study was explained to her and the idea of using her as a client for the study was made known to her which she agreed to it and she was introduced to the in-charge.

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CHAPTER ONE

1.0 INTRODUCTION

This chapter talks about information of the client and her family that include menstrual history, habits of daily living, past and present obstetric histories.

1.1 PERSONAL AND SOCIAL HISTORY

Madam Dasaah Comfort, a 32-year-old G4P3 and comes from Jirapa, a town in the Upper West region of Ghana. She currently stays at Fiaso a small village near Forikum in the Techiman district of Bono East region of Ghana. She is fair in complexion, measures 155 centimeters in height, and weighs 79 kilograms. She is 32 years old and was born on the 4th June, 1990. Madam Dasaah Comfort is married to Mr Moses Baladong. Her husband is a farmer, and she is a hair dresser by profession. They are both Christians and worship with the Church of Pentecost. She said that, she had her formal education up to JHS. The couple is blessed with three children, two males and a female. The eldest is 8 years follows by 6 years and last is 4 years. They all attend Fiaso primary school. Her next of kin is her husband, Mr.Moses Baladong. She speaks dagaree and Twi.

1.2 FAMILY HISTORY

Madam Comfort said she is the third born of her parents. According to her, she has six siblings and they are all girls. She also stated that all her siblings are alive. Her parents are Mr. and Mrs. Dasaah who lives in Jirapa in the Upper West region of Ghana.

According to her, none of her family members is suffering from any genetic disease such as; hypertension, heart disease, asthma, diabetes, epilepsy, mental illness or sickle cell neither is there anybody in the family suffering from infectious diseases such as Tuberculosis and

leprosy. There is no history of congenital abnormalities such as cleft palate, extra digits and webbed feet but have multiple pregnancy in their family.

She said that, her husband does not also have any known family medical history such as hypertension, heart disease, asthma, diabetes mellitus, mental illness or sickle cell. The death that has occur in both family are mostly natural. Her husband is capable of taking care of her needs and that of her children.

1.3 MEDICAL HISTORY

Madam Comfort had never suffered from any medical condition such as hypertension, diabetes mellitus, measles, sickle cell disease and hepatitis. Madam Comfort has no history of STIs and she is not on any permanent medication. She has no known allergies to food or any drug.

1.4 SURGICAL HISTORY

Madam Comfort has never undergone any surgical procedure that involves the breast or pelvis. She has also not been involved in any road traffic or motor accident which could have affected her pelvis, spine or reproductive organs. She has neither had blood transfusion nor donated blood. There was no scar indicating any surgical procedure done on her.

1.5 MENSTRUAL HISTORY

According to madam Comfort she had her menarche at the age of 15. She has a 28 days cycle. She sometimes experiences menstrual cramps which she does not seek any medical treatment but rather cope with the pain. The duration of her menses is 5 days. She added that she experiences normal flow. She uses sanitary pad and changes it 2 times a day. Her last menstrual period was 21st February,2022 and her expected day of delivery was calculated as 28th November,2022. Also per her scan it was 29th November 2022.

1.6 CLIENT'S LIFESTYLE AND HOBBIES

Madam Comfort normally wakes up around 5:30am and prays before she leaves her bed. She then cleans and tidy up the environment, brush her teeth with pepsodent toothpaste. She goes to fetch water. She cleans her teeth twice a day and bath twice in a day.

She normally empties her bowels once or twice daily and her bladder any time she has the urge to void. She prepares breakfast for the family and prepares her children for school as well. She then goes to her saloon, which is just in front of her house at around 8am and comes back to the house when she is done with work. She prepares supper and they eat around 6:00 pm. She sleeps around 9 pm. Madam Comfort's favorite food is Tuozafi with okra soup. Madam Comfort`s hobbies are chatting with her husband and watching telenovelas on television. She eats three times daily. She does her laundry on Saturdays. She worships with the Church of Pentecost. She neither drinks alcohol nor smokes. She said she lives in harmony with her neigbhours.

1.7 PAST OBSTETRIC HISTORY

PREGNANCY

Madam Comfort G4P3AA, has been pregnant for four times and has never had any abortion or miscarriage in her previous pregnancies. She never experienced any abnormalities such as ante partum haemorrhage, pregnancy induced hypertension, hyperemesis gravidarum, and severe anaemia among others in all her pregnancies, Madam Comfort said she experienced constipation, backache and frequency of micturition in her previous pregnancy but the pregnancy was successfully carried to term.

Madam Comforts had received tetanus toxoid injection in her previous pregnancy and all the 3 doses of intermittent preventive treatment of malaria (sulphadoxine pyrimethamine) in her pregnancy.

LABOUR

Madam Comfort went into labour at term which progressed to spontaneous vagina deliveries without any complications. She gave birth to all her children in the facility. She couldn't recall their actual weights but could tell their weights were normal.

The 3rd stage was also normal and placenta and its membranes were completely expelled within a few minutes after every delivery. Estimated blood loss was normal with no tear. She also added that the duration for labour for her children did not exceed 18 hours. Madam Comfort said her babies always cry immediately after birth. No congenital abnormalities like cleft palate, extra digits among others were notice. She was healthy after delivery.

PUERPERIUM

Madam Comfort went through puerperium without any complications. According to her, she resumed her normal menstruation after 6 months. She breastfed her baby exclusively for six months and weaned her children completely from the breast at 2 years. She does not use any artificial family planning method. She was healthy throughout her puerperium.

Her children are completely immunized against all the childhood preventable diseases. The health condition of her children at the time of interaction with her was satisfactory. Her husband supported her throughout the pregnancy, labour and puerperium.

1.8 PRESENT OBSTETRIC HISTORY

Madam Comfort attended her first antenatal clinic at the Fiaso Chps Compound on the 4thMay, 2022, with 14 weeks gestation. According to Madam comfort her last menstrual period was 21/02/2022 and expected date of delivery is 28th November 2022, per her first scan the expected date of delivery was 29/11/22. Detailed information about her personal, menstrual, obstetric, lactation, medical, surgical, family and contraceptive histories were taken. Her height was 155 cm and weight 79 kg. Her Vital signs were checked and recorded as follows:

Blood pressure	-	110/60 millimeter of mercury (mmHg)
Pulse	-	84 beats per minute (bpm)
Respiration	-	22 cycle per minute (cpm)
Temperature	-	36.5 degrees Celsius (^{0}C)

The following laboratory investigations were done and the results recorded as follows:

Haemoglobin level	-	11.2g/dl
Blood group	-	O
Rhesus	-	Positive
Sickling	-	Negative
Urine (Protein and glucose)	-	Negative
Blood film for malaria	-	No malaria parasites were seen
VDRL	-	Negative
HIV status	-	Negative
HBSAG	-	Negative
G6PD	-	No Defect

A head to toe examination conducted revealed no abnormalities. She looked very healthy. Madam Comfort had no complains. She was served the following routine drugs:

Tablet folic acid	-	5mg daily x 30days
Tablet ferrous sulphate	-	200mg dailyx30days

She was encouraged to visit the facility when she is due. She was educated on the danger signs of pregnancy, nutrition, hygiene, rest and exercise, birth preparedness and complications readiness. She was also encouraged to be a regular attendant and was informed about her next visit. She should report any time she had a problem even before the next visit.

She had already taken 5 doses of sulphadoxine pyrimethamine and four dose of tetanus diphtheria (TD4) when she was met

CHAPTER TWO

2.0 INTRODUCTION

Chapter two talks about the antenatal care given to the client. This includes the first contact with the client, subsequent visits to the clinic, home visits during the antenatal period and the care plans written to solve problems encountered by the client. The aim of antenatal care is to monitor the progress of pregnancy and to optimize maternal and fetal health.

2.1 FIRST CONTACT WITH THE CLIENT

First contact with client was on the 9th November, 2022 during one of her scheduled antenatal visits at the Fiaso Chps Compound. Client was 36 weeks pregnant at the time of the visit. She was attending her fifth antenatal visit. Client was selected during the health education session on birth preparedness and complication readiness plan. Client was calm and quite during the discussion and contributed less to the topic. She was greeted and an introduction was made as a student midwife from Holy Family Nursing and Midwifery Training College, Berekum on a seven weeks clinical practice. Her antenatal book was collected and glanced through and it was found out that she fell within the criteria. She was informed that she would be taken as a client for care study and nursed during her pregnancy, labour and puerperium. Client was pleased to be used for the care study and readily agree.

Her weight was 85 kg. Haemoglobin level was 11.8g/dl.

Her vital signs taken were recorded as following;

Temperature	36.6^0C
Pulse	82bpm
Respiration	20cpm
Blood pressure	100/60mmHg

A specimen bottle was used to take the mid-stream urine to test for protein and sugar but they were negative.

The reason to take her as a client was expressed to her and she agreed and was glad. All procedures to be carried out was explained to her understanding and she agreed for them to be done. She was thanked and assured confidentiality.

Madam Comfort was sent to the palpation room and the midwife in-charge was told that she was the client chosen for the care study and she consented to it. Client was offered a seat and explanation was made to her on physical examination in other to promote comfort since. Vital signs and midstream urine were already done at the table.

Permission was sought to conduct head to toe examination and she agreed to it. All the necessary requirement needed for the examination were ready in the room. She was assisted to assume a supine position. Hands were washed with soap under running water and dried with a clean dry towel. Client was asked to empty the bladder, she was shown to the examination room and privacy was ensured.

On physical examination, it was started from the head. The hair was checked for the presence of dandruff, lice and rashes of the scalp and none of these were seen. She was then congratulated and encouraged to keep it up. Her face was checked for puffiness and rashes but none was found. The sclera of the eyes were checked for jaundice and the conjunctiva, for pallor and discharges but none was seen. The nose were checked for discharges and the lips for cracks and pallor, mouth for halitosis, teeth for tooth decay, completeness of the teeth ,the tongue for pallor. The ears were examined for discharges and checked if they were in alignment with the contour of the eyes. There were no discharges from the ears and the neck for enlarged lymph nodes and distended vein to rule out abnormalities like goiter but no abnormalities was detected. As the examination was going on, she was engaged in conversation to avoid boredom. Client was asked to put her right hand under the head for breast examination. The

breast were examined for lump and the armpit for axillary nodes but none was found. It was situated normally with prominent nipple and the areolar for dark pigmentation. Cotton wool was put on the nipple and was squeezed to check for the colour of the breast milk which was yellowish. She was asked to do the same thing to examine the left breast. She was taught on how to perform self-breast examination and to report to the clinic of any deviation from normal.

The upper limbs were examined for equality and alignment. The fingers were checked for extra digit, dirt and grown nails, palms for pallor and all these were absent. The lower limbs were examined for equality , varicose vein, edema ,tenderness in the calf muscle and no abnormality was detected. She was then assisted to turn her back for inspection of the vertebrae column for abnormality like curvature of the spine at the sacral region, lesion or edema but none was detected. She was assisted to turn to supine position.

ABDOMINAL EXAMINATION.

Inspection: On inspection, the shape of the abdomen was ovoid, medium in size and there was the presence of linear nigra and Striae gravidarum. The abdomen was inspected for scars from previous caesarean section and there was none detected.

Measurement of symphysio-fundal height**:** The upper border of the symphysis pubis was located for measuring the fundal height. Zero mark of the measuring tape was placed on the abdomen along the midline of the fundus to the upper border of the symphysis pubis and extended to the contours of The symphysio-fundal height measured 35centimeters and the gestational age was 36weeks.

Fundal palpation: standing right to Madam Comfort, the palms were rubbed together to provide warmth to prevent induction of contractions. The palms were placed on each

side of the fundus ,curved around the top of the fundus to determine what lies in the upper pole. A soft mass was felt which indicate the buttocks of the foetus.

Lateral palpation: lateral palpation was done with each palm on each side of the uterus midway between the symphysis pubis and the fundus, the uterus was stabilized with a hand and palpation was done through there midline to the lateral side of the abdomen to locate the fetal back in a rotatory manner . The other hand was also used to stabilize the uterus and the procedure was repeated. The right lateral palpation done at the right side of the mother, indicated the fetal back(smooth part).This will help to position the fethoscope to listen to the fetal heart rate and fetal limbs(rough part),were located to the left side of the mother. The fundus was at the xiphisternum.

Pelvic palpation**:** facing the feet of Madam Comfort, she was asked to bend her knees slightly and breathe out slowly to make her relax. The palms were place on either side of the lower abdomen, hands directing towards the symphysis pubis as the thumbs were almost meeting, and a hard mass was felt indicating the head of the foetus.

Descent of the fetal head**:** location of the anterior shoulder was made two figures. The symphysis pubis was located and with the ulna border just above the symphysis and the anterior shoulder, five fingers covered the head indicating descent of $5/5^{th}$ and the position was right occipito anterior. Therefore, from the above, it was deduced that, lie was longitudinal, the presentation was cephalic.

On auscultation**:** Fethoscope was warmed and placed at the area where the fetal back closer to the head located to listen to the fetal heartbeat. One hand was placed at the maternal radius to differentiate between maternal pulse and the fetal heart rate. It was checked for one minute and recorded as 135 beat per minute with good rhythm.

On vulva examination**:** Permission was sought to inspect the vulva and it was granted. She was draped to provide privacy. Hands were washed and dried. Disposable gloves were

worn on both hands and the vulva and perineum were examined for abnormal discharges ,rashes, genital warts, ulcers, scares and varicose veins. The labia majora was examined for same size and shape, redness, swelling and tenderness and there was no abnormality detected.

The client was asked to lie laterally and sit up before getting out of the bed. Madam Sarah was thanked for her cooperation and findings were communicated to her. All equipment were decontaminated appropriately. The gloves were removed and discarded. Hands were washed with soap and under running water and dried with clean towel and all findings recorded into her antenatal book. She was asked for any complains and question. Client gave no complains, she was educated to have enough rest and sleep.

She was also encouraged to take her drugs as prescribed and also to report to the clinic if she is not feeling well. She was also informed of home visits which she agreed and her phone number with the directions to her house were taken. The day for the first home visit was scheduled on the 10th November, 2022. She was thanked for her cooperation and the following drugs were given to her:

Tablet Ferrous Sulphate 200mg daily for 30days.

Tablet Folic acid 5mg daily for 30days.

She was told of her next visit 17th November, 2022.She was educated on danger signs of pregnancy.

2.2FIRST ANTENATAL HOME VISITS

On 10th November, 2022 around 12:54pm first antenatal home visit was undertaken. The main purpose for the visit was to assess her general health, home environment, relationship with others and her needs. The journey to her house was a walking distance , was accompanied by one staff who already knew the house and is not far from the facility about , the house is behind the Pentecost church in the town. On arrival, a

check was made around the house before entering, client lives in a compound house made with cement blocks and roofing sheet, she has made a wooding structure which she and her family baths in, the floor was roughly cemented and neatly scrubbed. There was no toilet facility found, as well as source of water. The environment was well cleaned. Client was greeted and rapport was established. The purpose of the visit was made after introduction. During the interaction it was identified that she lives in one room with the children. The husband joins occasionally. Her mother lives with her but she was not around on arrival. She kept her utensils and drinking water in a small room in the house. She said that there was no source of water in the house but they rather fetch water from the community's borehole. They have a barrel which was neatly covered outside the house which she fetches water into it. She also confirmed that there is no toilet facility in the house. She mentioned that they go to toilet at the public toilet in the community. She does her cooking in front of the house because their kitchen is not fully finished. She was asked about the preparations she had made after the previous discussion on birth preparedness and she identified some blood donors, transportation and she said she had already discussed it with three taxi drivers in the town and is ready to bring her when labour sets in. She also said she has saved money in case of anything. Her husband and mother will be around when labour sets in. Her items for delivery were crossed- checked since she already said she bought everything on the layette such as sanitary pad, clothing, mackintosh, night grown , cot sheet, baby's dress, baby oil, baby soap and towel, napkin etc. She was encourage on the need to continue eating adequately nourished diet. Education was given to her on the signs of true labour which were painful regular and rhythmic uterine contractions which will be felt as tightening discomfort or actual pain, a blood stained mucoid discharge from the vagina and there may be rupture of membranes. She was encouraged to visit the facility immediately she experienced any of these signs

and take her drugs as prescribed. She was asked if she had any problem, she complains of lower abdominal pain. She also complained of frequency urination. It was explained to her that the pains were as a result of the fetal head descending and the stretching of pelvic ligaments and the frequency micturition is because of the fetal head pressing on the bladder. She was educated on the need to rest and sleep and was reminded on her next visit to the facility for antenatal care as scheduled and the next home visit to be 15th November, 2022. She was then thanked and permission was sought to leave and was granted happily

2.3 SECOND ANTENATAL HOME VISIT

Madam Comfort was visited again on 12th November, 2022 at 4:00pm. Her husband had gone to farm. She was greeted and rapport was established. She was asked of her health and that of her family which she confirmed they were doing well. The aim of the visit was to inquire about her health and to assess if client had adhere to the advice given on the first visit. During the interaction, Madam Comfort complains of loss of appetite,fatigue and constipation,but she was reassured that her complains can be managed. she was feeling well and she looks healthy. Education on the need to practice exclusive breast feeding after birth was made known to her. She was encouraged to report as soon as she notice any signs of true labour which was discussed during the first visit.Client layette was inspected. Permission was sought to leave and promised to see her during her next visit to the facility.

2.4SEBSEQUENT VISIT TO THE CLINIC

On the 15th November, 2022, Madam Comfort visited the clinic, she was welcomed and a seat was given. Greetings were exchange. She was taken through the routine examination after explaining procedure to her.

The following were the findings:

Temperature 36.5 degree Celsius

Blood pressure 100/70mmHg

Respiration 20cycle per minute

Weight 85kilograms (Kg)

She was given a sample bottle to obtain midstream urine to test for sugar and protein and the result were negative . She was sent to the palpation room for examination. She was assisted to position herself on the examination bed and privacy was ensured. Hands were washed with soap under running water, dried with a clean hand towel. Physical examination was done from head to toe and no abnormality was detected. This was done under the supervision of the midwife in-charge.

On abdominal inspection, the shape was ovoid with linea nigra and striae gravidarum. On abdominal palpation she was 37weeks ,the symphysis- fundal height was 36centimeters(cm), lie was longitudinal, presentation was cephalic, descent was $4/5^{th}$ and the position was left anterio posterior. The fetal heart rate was 139 bpm with good volume and rhythm on auscultation .

She was helped out from the examination bed, findings were communicated to her and was congratulated. She was encouraged to ask questions. She has no question but she complained of loss of appetites, fatigue and constipation. She was educated to eat in bit but frequently. She was also encouraged to report to the facility if there are signs of true labour like severe abdominal pain, blood stained with mucoid discharge from the vagina and if she encounters problems. She was given the following medications:

Tablet Ferrous Sulphate 200mg twice daily for 14 days.

Tablet Folic acid 5mg daily for 14days.

Tablet paracetamol 1gram for 5days.

2.5 NURSING CARE PLAN DURING ANTENATAL

PROBLEMS IDENTIFIED

Madam Comfort complained of:

On 10th November, 2022 at 9:00am. Lower abdominal pain

On 10th November, 2022 at 9:00am. Frequency of micturition

On 12th November, 2022 at 2:00pm. Loss of appetite

On 12th November, 2022 at 2:00pm. Constipation

On 12th November, 2022 at 3; 00pm. Fatigue

SHORT TERM OBJECTIVES

1. Client will cope with her lower abdominal pain till the end of pregnancy.
2. Client will cope with frequency of micturition until delivery.

3. Client will be able to take in half of food served meeting her nutritional needs within 48 hours

4. Client will regain her normal bowel movement once a day within 48 hours

5. Client's fatigue will be reduced within 24hours.

LONG TERM OBJECTIVES

Client will go through Antenatal, labour and puerperium successfully without any complications to both the mother and baby.

TABLE A: NURSING CARE PLAN DURING ANTENATAL

DATE/ TIME	NURSING DIAGNOSIS	OBJECTIVE/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
10/11/22 9:00 am	Lower abdominal pain related to descent of fetal head.	Client will cope with her lower abdominal pain throughout the pregnancy as evidenced by client verbalizing that there is reduction in the pain. Midwife observing client relieved from pain.	1. Reassure client. 2. Explain the physiology of lower abdominal pain to the client. 3. Encourage client to adopt a comfortable position. 4. Encourage client to rest and sleep in between activities. 5. Serve prescribed analgesics.	1. Client was reassured that pain will reduce. 2. The condition was explained to her that is due to the descent of fetal head which is having a straining effect on the pelvic ligament. 3. Client was encouraged to adopt a comfortable position. 4. Client was encouraged to sleep in between activities. 5.1gram of paracetamol was served to client.	13/11/ 22	Goal met as evidenced by client verbalizing the reduction of lower abdominal pain .Midwife observing client was cheerful and relieved from pain.	Q.H

TABLE B: NURSING CARE PLAN DURING ANTENATAL

DATE/ TIME	NURSING DIAGNOSIS	OBJECTIVE/OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
10/11/22 9:00am	Frequency of micturition related to pressure of the presenting part on the urinary bladder.	Client will cope with frequency of micturition throughout pregnancy as evidenced by client verbalizing that she is coping with it. Midwife observing client condition is reduced.	1. Reassure client . 2. Educate client on the physiology of frequency of micturition to her. 3. Encourage client to reduce fluid intake at night. 4. Encourage client to empty her bladder frequently. 5. Encourage client to use chamber pot at the night.	1. Client was reassured that the situation is temporal and will resolved after delivery. 2. Client was educated on the physiology of frequency of micturition as the result of the fetal pressing on the bladder. 3. Client was educated to reduce fluid intake at night. 4. Client was encourage to urinate when she has the urge. 5. client was encouraged to use chamber pot at the night	13/11/22	Goal fully met as evidenced by client verbalizing release of frequency of micturition. Midwife observing client don't use the wash room often.	Q.H

TABLE B: NURSING CARE PLAN DURING ANTENATAL

DATE/ TIME	NURSING DIAGNOSIS	OBJECTIVE/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTIONS	DATE/ TIME	EVALUATION	SIGN
12/11/22 2:00pm	Alteration in nutritional pattern (less than body requirement) related to hormonal changes in pregnancy.	Client will be able to take in half bowl of food meeting her body requirements within 48hours evidenced by client saying she now eat to her satisfaction. Client's relative verbalizing client can now eat to her satisfaction.	1. Reassure client that her condition can be managed. 2. Involvement of client in planning of meal. 3. Educate client to practice mouth hygiene twice daily. 4. Encourage client to eat in bits but frequently. 5. Encourage relative to serve food attractively for client	1. Client was reassured. 2. Client was involved in the planning of meals. 3. Client was educated to practice mouth hygiene twice daily. 4. Client was encourage to take in smaller portion of food but at frequent intervals. 5. Client's food was served in an attractive manner by relatives.	14/11/22	Goal fully met as evidenced by client saying she can take in food to her satisfaction. Client relative testifying client can eat to her satisfaction.	Q.H

TABLE A: NURSING CARE PLAN DURING ANTENATAL CON'T

DATE/ TIME	NURSING DIAGNOSIS	OBJECTIVE/OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
12/11/22 2:00pm	Constipation related to activity of progesterone causing decreased peristalsis and relaxation of smooth muscle of the large intestine during pregnancy.	Client will be able to regain her normal bowel movement (once daily) during pregnancy as evidence by client verbalizing that she is able to empty her bowel once in a day. Client husband verbalizing client constipation is reduced .	1. Reassure client. 2. Educate client on the physiology of constipation. 3. Encourage client on mild exercises like walking around her house. 4. Educate client to take in diet rich in roughages like fruits. 5. Encourage client to increase her daily intake of fluid at least 8 glasses of water.	1. Client was reassured that she will be relieved of constipation. 2. The physiology of constipation was explained to client as relaxation of the large intestines by progesterone. 3. Client was encouraged to have some mild exercises like walking. 4. Client was educated to take in diet rich in roughages like fruits. 5. Client was encouraged to increase her daily intake of fluid at least 8 glasses of water.	14/11/22	Goal fully met as client said she was able to empty the bowel freely as before. Client husband verbalizing client can empty the bowel as before.	Q.H

TABLE A: NURSING CARE PLAN DURING ANTENATAL CON'T

DATE/ TIME	NURSING DIAGNOSIS	OUTCOME/ OBJECTIVE CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
12/11/22 3:00pm	Fatigue related to inadequate rest.	Madam Comfort's fatigue will reduce and body comfort will be restored within 24 hours as evidenced by Client verbalizing reduction in fatigue and improvement in body comfort. Midwife visualizing client feeling more comfortable.	1. Reassure client. 2. Encourage family members to help with household chores. 3.Encourage client to take up little work 4. Teach client energy conservation techniques 5. Encourage client to have more rest during the day.	1. Client was reassured that her fatigue will reduce. 2. Family members were encouraged to help with the household chores. 3. Client was encouraged to take up little work. 4.Client was taught energy conservation techniques such as sitting rather than squatting or standing while washing. 5. Client was encouraged to have more rest during the day.	13/11/22 3:00 pm	Goal fully met as evidenced by Client verbalizing reduction in fatigue and improvement in body comfort. Midwife visualizing client feeling more comfortable.	Q.H

CHAPTER THREE

LABOUR

3.0 INTRODUCTION

This chapter talks about labor and it involves; management of first stage of labour, management of second stage of labor, immediate care of the baby at birth, active management of the third stage of labor, examination of the placenta and membranes and management of the fourth stage of labor.

3.1 ADMISSION AND MANAGEMENT OF LABOUR

On the 27th of November, 2022 at 8:30pm, Madam Dasaah Comfort reported at Fiaso Chps Compound with the history of regular painful rhythmic uterine contractions and the presence of mucoid blood stain vaginal discharge (show). She was accompanied by her mother and husband. They were welcomed and they were offered a seat. Before examination, the antenatal care record book was collected and read through quickly. History of labour was taken from client and client said labour pains started 2 hours ago which was around 6:00pm. Client said membranes had not ruptured nor was she bleeding but she could feel fetal movement and the appearance of show. Enquiries were made to know if client took any medicine or concoction but she answered no. During history taken, client said she saw show at 7pm. According to Madam Dasaah Comfort pain intensified around 7:00 pm she decided to come to the ward. The process of labour was explained to her and she was encouraged to ask any question that might be bothering her mind. Client complained of severe waist pains and lower abdominal pains. She was educated on deep breathing exercise. She encouraged to cope with it since true labour had started and would be relieved after delivery. Client was

reassured that she is in the hands of a competent student midwife as well as the staff midwife as a supervisor.

She was taken to the labour room. Explanation on every procedure was given to gain her cooperation. Her consent was sought.

Client's Haemoglobin level was checked and it was 11.3g/dl.

Her vital signs were checked and recorded as follows;

Temperature	36.8^{o}c
Pulse	86 beat per minute
Respiration	22 cycles per minute
Blood pressure	100/70mmHg

Privacy was provided. Explanation was given on procedure for physical examination from head to toe. Consent was sought from client. Client was asked to empty her bladder. There was 100mls, clear and amber urine. Midstream urine was tested for protein, sugar and acetone and findings were negative. Client was assisted to undress and cloth was wrapped helped unto the examination couch. Hands were washed with soap under clean running water and dry with towel. Client was examined under the supervision of the midwife in-charge with no abnormalities detected.

INSPECTION: Client abdomen was ovoid in shape in size. There was no scars. Striae gravidarum, linear nigra and foetal movement were present.

PALPATION: Client abdomen was palpated and symphysio fundal height was 37cm and the gestational age was 38 weeks. Lie was longitudinal, presentation was cephalic, and descent was 3/5th.

AUSCULTATION: The foetal heart rate was 134 beats per minute with good volume and in regular rhythm. After the auscultation, hands were warmed by rubbing both palms together in order to check for contractions. Contractions were 3 in 10 minutes lasting for 38 second.

VAGINAL EXAMINATION: This was done to ascertain the extent of dilatation of the cervix, presentation, moulding and status of membrane. The procedure was explained to her, permission was sought. Client was helped to lie in dorsal lithotomy position, privacy was ensured. Hand were washed with soap under running water, dried with clean towel. Sterile gloves were worn. Client was asked to flex her knees. The vulva was inspected for scars, genital warts, sores and oedema, varicosities and vaginal discharge and all these were absent. The vulva was swabbed with five cotton wool swabs immersed in savlon solution. The vulva was swab starting from the labia majora, minora and vestibules with a swab and disposed each at a time. Client permission was sought. The middle and the index finger of the right hand was inserted into the vagina gently but firmly pressing downwards to relax the vaginal wall and muscles. The index finger was then inserted. The vagina was moist and warm. The cervix was soft, thin and well applied at the presenting part. The cervix os was 4 centimetres dilated. The membranes were intact and no moulding. Client was made comfortable, cleaned the vulva and a new perinea pad was applied onto the vulva. Client was asked to lie on the left hand side.

The sacral promontory was not reached. The sacrum was well curved, the ischial spines were blunt and sub pubic angle accommodated two fingers in the arch.

Client was asked to lie on her left lateral side to prevent supine hypotension syndrome. Gloved hand were immersed in 0.5% chlorine solution and were removed by turning them inside out and were disposed into plastic container. Hands were thoroughly washed with soap under clean running water and dried with a clean dried towel. All findings and the progress of

labour were explained to client. The dilatation board was used to explain the cervical dilatation and progress of labour to her. Client was thanked for her cooperation. All findings were recorded on a partograph and communicated the midwife-in-charge which she also confirmed the findings. Client was then told she is in active labour and would be monitored with the partograph for a safe delivery. As part of general education, she was educated not to reuse a pad when it fall and change it whenever it gets wet. She was also educated on deep breathing exercise and to take in deep breaths when contractions set in. She was encouraged to empty her bladder frequently and walk around to aid descent of the presenting part consequently cervical dilatation.

3.2PREPARATION FOR BIRTH

A helper was identified, both skilled and unskilled helper. With the skilled helper, the midwife-in-charge was informed about the progress of client's labour. She was told that her assistance will be needed when the baby does not breathe. She will supervise throughout the procedure and a ward assistant was also asked to assist in the care (Essential Care). The unskilled helper was clients relative (mother). The duty of client relative was to provide emotional support to the client and also to run errands in case client is in need of food. The emergency plan was reviewed; thus a taxi driver was informed to be alert in case of emergency.

The area for delivery was also prepared. The source of light was checked and a portable lamp was made available. Mother was informed that in order to provide warmth to the baby, windows and doors would be closed, fans would be put off. Madam Comfort was assisted to wash her hands, chest and abdomen to prepare for skin-to-skin contact. The resuscitation area was made clean and the equipment were checked to be adequate and functioning properly. The delivery sets and emergency drugs were made available.

3.3 MANAGEMENT OF FIRST STAGE OF LABOUR

The first stage of labour is from the onset of labour to full dilation of the cervix. This stage normally last up to 12 hours. Client was put on partograph on admission when client was 4cm dilated. The fetal heart rate, contractions and maternal pulse were checked every 30 minutes, temperature, blood pressure, descent as well as vaginal examination were done 4 hourly and the results plotted on the Partograph.

Madam Dasaah Comfort was asked whether she has any problem. She complained of tiredness, frequent micturition and said she was also anxious about the outcome of labour. She was reassured that she was in the hands of competent midwives so she should not be afraid. She was also told that she will have normal labour with a healthy baby without any complication after delivery. The physiology behind the frequent micturition was explained as a result of the descending foetal head pressing on the bladder. She was encouraged to breathe through the mouth and not to bear down when there are contractions to prevent oedema of the cervix. She was encouraged to wash her hands to prevent infections and also encouraged to walk around the bed and lie on her left side to prevent supine hypotension syndrome. She was taught deep breathing exercises with demonstration. Madam Comfort performed the exercise indicating her understanding. She was encouraged to drink more water. She was asked to take in lights nutritious diet in bits as it will help her from becoming dehydrated. She was encourage to urinate whenever she had the urge to enhance effective contraction and descent of the foetal head. Bedpan was provided for her to empty the bladder when there is the urge.

At 1:00am, she was assisted to assume a lithotomy position for vaginal examination. On vaginal examination, the vagina was warm and moist, membranes were still intact cervix was 8cm dilated with a well applied presenting part, moulding was (0), and descent was $2/5^{th}$. On auscultation foetal heart rate was 140 beats per minute contractions timed were 3 in 10 lasting 44 seconds. These findings were confirmed by the midwife in charge.

Vital signs were checked and recorded as:

Temperature	37.2 ^{0}C
Pulse	84 beats per minutes
Respiration	23 cycles per minutes
Blood pressure	130/80mmHg

The following investigation were also done and recorded as follows**:**

Urine for albumin	Negative
Urine for acetone	Negative
Urine for glucose	Negative

Urine passed was 100mls. Client was cleaned up, a new pad was applied to the perineum. She was made comfortable in bed for further monitoring and observation. All findings were communicated to client and recorded on a partograph. Client verbalized that her anxiety reduced.

SETTING OF TROLLEY

The delivery trolley was set with following items on the top and bottom shelf as:

TOP SHELF

- A galipot with sterile cotton wool swabs
- Episiotomy set containing sterile equipment
- One sterile cord scissors
- Two sterile artery forceps
- One sterile gown for midwife
- Sterile cot sheets
- Four sterile drapes
- A sterile receiver for placenta

- Membrane pierce
- A pair of sterile gloves

BOTTOM SHELF

- Container with syringe containing 10 units of oxytocin
- Identification band
- Swabbing lotion
- Examination gloves
- Measuring jug
- 2 cord clamps
- Perinea pad
- 2 urethral catheters of different sizes
- Urine bag
- Lidocaine
- Fetoscope
- bedpan

Madam Comfort was informed that the baby would be delivered onto her abdomen to promote warmth and bonding and to initiate breastfeeding.

There was spontaneous rupture of membranes with clear liquor at 3:00am. Vaginal examination was due already and so was done to rule out cord prolapsed, it was noticed that the cervix was fully dilated, foetal heart rate was 140beats per minute, descent was $0/5^{th}$, moulding was (++), maternal pulse 85 beats per minute, BP 130/80mmHg, Temperature 36.5 degree Celsius and contractions were 4 in 10 lasting 45 seconds.

At 3:05am, client complained of severe bearing down sensations with the uterine contractions becoming more expulsive. The anus was gaped and perineum bulging indicating 2^{nd} stage.

The in-charge was informed of the progress of labour and was asked to confirm it. She assessed her and confirmed full cervical dilatation which marked the beginning of 2nd stage of labour. Client was told that, she has successfully passed the first stage of labour. She was encouraged to bear down well when she is asked to. The trolley was taken to the bed side. Madam Comfort was asked to breathe through the mouth. The first stage lasted for six hours.

3.4 MANAGEMENT OF SECOND STAGE OF LABOUR

Second stage of labour starts from the full dilatation of the cervix till the delivery of the baby. All procedure to be done were explained to Madam Comfort. Reassurance was given. She was told she is in safe hands and she will go through the second stage successfully like she did in the first stage. Client was assisted into the lithotomy position as she preferred. Clients head was also supported with a pillow. The second stage was explained to her. She was encouraged to push with each contraction and breathe through the mouth when the contraction wears off. Protective clothing such as rubber apron, boots, goggles, mask and a scarf were worn. Hand hygiene was done. The trolley was pushed near the delivery bed at the right side of the client. Surgical gloves worn. Client was reassured to allay anxiety. A perinea pad was placed to the anus to prevent fecal matter from contaminating the delivery field hence infecting the baby. All observation was confirmed by the midwife in -charge

Client complained of tiredness. It was explained to her that it is related to increased energy demand during labour. Tiredness will be resolved after delivery. Progress of labour was communicated to her and reassured. The middle finger of the right hand was placed on the advancing head so that the smallest diameter of the head distends the perineum. When the head crowned she was asked to stop pushing and pant so that head could be delivered and prevent perinea tear. The head was delivered by holding the parietal eminences, the face and chin to sweep slowly over the perineum to be delivered. The baby's eyes were cleaned with

sterile gauze from the inner canthus to the outer canthus to prevent infection using one gauze for each eye.

The mouth and nose were also wiped gently with sterile gauze. There is no cord around neck. Restitution took place followed by external rotation of the head indicating that the head is in the anterior posterior diameter of the pelvic outlet. The hands were placed on the sides of the baby's head over the ears and with gentle downward traction to deliver the anterior shoulder. Then the baby was pulled up with lateral flexion baby was delivered on the abdomen of the mother at 3:15am. A live female was delivered. Baby cried lustily. Client was congratulated for her good maternal effort and cooperation.

3.5 IMMEDIATE CARE OF THE BABY

The immediate care of the baby started as soon as the head was born. Following the birth the head, each eyes was cleaned with gauze from the inner cantus to the outer cantus to prevent infections. The face was also cleaned with sterile gauze. The airway was then cleared with a bulb syringe. The mouth was suctioned first followed by the nose to prevent baby from aspiration which can cause obstruction in the airway. The baby cried shortly after delivery, the first minute Apgar score was 8/10. Quickly the liquor was cleaned off the baby with a clean dry sheet to keep the baby warm. A dry sterile cot sheet was used to cover her. The cord was clamp with a cord clamp and an artery forceps and it was cut in between the two to with a cord scissors to separate baby from mother. The baby was put to breast while on the mother's abdomen to help initiate breastfeeding and promote bonding. An identification band inscribed with the mother's name, sex of baby, time and date of delivery was placed on the baby's wrist. Fifth minute Apgar score was assessed as 9/10. A live female child was born at 3:15am on the 28/11/22.

3.6 MANAGEMENT OF THIRD STAGE OF LABOUR

The procedure was explained to Madam Comfort for her cooperation. Immediately the baby was delivered, the uterus was palpated to exclude second twin, At 3:16am ten unit of injection oxytocin was given intramuscularly on the left thigh to aid contraction of the uterus and separation of the placenta and its membranes and control bleeding. The method of delivering the placenta was done by control cord traction and counter pressure.

The cord was re-clamped with a forceps closer to her vulva and a receiver placed in between her thighs. The bladder was checked and it was empty. The non-dominant hand was placed on the fundus to feel for contractions. Immediately there were contractions, the non-dominant hand was placed above on the symphysis pubis with the palm facing the mother's abdomen with counter traction of the uterus to prevent inversion. At the same time, the clamped cord was held in the dominant hand and a gently downward traction was applied to the cord. The counter pressure with the non-dominant hand at the supra pubic area was applied to the cord.

The process was repeated until the placenta was visible at the vulva. Both hands were released to receive the placenta at the introitus. It was twisted gently to ensure complete delivery of the membranes. At 3:20am the placenta and its membranes were delivered. A quick examination of the placenta was done for completeness of lobes and membranes and the presence the two arteries and one vein to exclude any retained products of conception before it was placed in the receiver for thorough examination later. The uterus was massaged through the abdomen until it was well contracted. Blood clots were expelled. The vulva was cleaned. A sterile gauze was placed around the middle and index finger of the right hand to examine for tears and lacerations. The birth canal was examined. There was no tear or laceration of the perineum, vaginal wall and cervix. Client was congratulated and made comfortable by wiping all blood and liquor stains from her body. A clean perinea pad was applied. Estimated blood loss was 150mls. Madam Comfort and her baby were made

comfortable in bed and was covered with a piece of cloth to ensure skin-to-skin contact to promote bonding, provide warmth to the baby and initiate breastfeeding for 1 hour.

Client's mother was told about the sex of the baby and she was allowed to visit her. Madam Comfort urinated and it was 150mls,and she was also engouraged to urinate frequently to help the uterus to contract well. She was told also to report any bleeding immediately. She was also told that she will be taken to the lying-in-ward where she will be monitored for the next six hours. All findings were recorded on the partograph.

3.7 EXAMINATION OF THE PLACENTA AND MEMBRENES

A thorough inspection of the placenta and membranes is done in order to ensure that no part of it being retained during delivery. The cord was of normal size and the cut edge of the umbilical cord had two arteries and one vein surrounded by Wharton's jelly. The cord insertion was central. In the sluice room, the placenta was immersed in 0.5% chlorine solution to make it safer for handling. The placenta was held by the cord with the membranes and hand was placed in it. The membranes were examined for completeness and it was intact. The placenta was then cupped in the hand to examine the maternal surface, the lobes fit together without any gab and the fetal surface was shiny and bluish grey

. There were no white patches and no blood vessels radiating into the membranes.

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 length of the cord was checked and it was a normal length. The fetal surface was viewed and the cord was situated at the centre of the placenta with one vein and two arteries and no abnormality was detected. Hand were dipped in chlorine solution before discarding. The instruments and equipments used were soaked in 0.5% chlorine solution for 10 minutes. After that, it was washed, rinsed and dried and repacked for sterilization. Hands were then washed with soap and clean running water and dried with a dry clean towel.

3.8 MANAGEMENT OF THE FOURTH STAGE OF LABOUR

The fourth stage of labour is a period of close observation of mother and baby for the first six hours after delivery to early detect any deviation from normal. Madam Comfort finished skin to skin at the labour room before being taken to the lying-in-ward for further observation. This stage includes prevention of disease, examination of the new born, management of the mother's condition and the baby.

During this period, mother and baby were assessed every 15 minutes for two hours, 30 minutes for 1 hour and hourly for 3 hours.

Hands were washed and cord was dressed with methylated spirit and cotton. The baby was put to breast. She was further asked to report when she observes any bleeding, discharge and redness of the cord.

Hands were washed with soap water and dried with a clean towel. All findings recorded on the Partograph but the first readings were as follows;

Temperature	36.7^0C
Pulse	74 beats per minute
Respiration	22 cycles per minute
Blood pressure	110/60 millimetre of mercury
Symphysio fundal height	18cm

Madam Comfort was encouraged to void frequently and change her perinea pad when soiled. She was served with porridge with bread to restore energy loss. After eating, she was assisted to fix her baby girl to the breast to ensure suckling, to stimulate milk production and also the release of oxytocin from the posterior pituitary gland to help in the contraction of the uterus. The baby was observed to be suckling well and Madam Comforts had a worried facial expression. When asked, she complained of "afterpains" so she was reassured. The

physiology of “afterpains” was explained to her. She was encouraged to continue breastfeeding despite the pains since it helps in involution of the uterus. Client was told to assume any position that is comfortable to her. She was served with Tablet Paracetamol 1 gram stat. She was also taught how to massage the uterus on her own to keep it contracted and report any excessive blood loss.

The baby’s breathing and colour were checked every 15 minute, temperature was also checked every 15minutes by feeling the baby’s feet and all were normal. Other vital signs and condition of the baby were also checked and recorded as follows;

Temperature	36.9^0 C
Apex beat	140bpm
Respiration	40cpm
APGAR score	8/10, 9/10
Abnormalities	None
Condition of baby	Satisfactory

Madam Comfort was encouraged to have enough rest, feed the baby on demands and always wash her hands before and after feeding the baby and after changing her perinea pad.

3.9 EXAMINATION OF THE NEWBORN

A head to toe examination was performed on the new born under a good lightening in the presence of the mother with 60 minutes. The procedure was explained to Madam Comfort and she consented. Hands were washed with soap under running water and cleaned with a clean dry towel. Sterile gloves were worn and the baby was wrapped and put on a warm, flat and safe surface. The baby was exposed systematically as it was examined from head to toe. On observation, the baby’s colour was pink all over.

THE HEAD, FACE: The head and scalp were normal with no caput succedaneum, bulging or sunken fontanels. The eyes were examined for the presence of eye balls, for jaundice, discharge and redness but no abnormality was found.

NOSE: The nose was inspected for size and shape and examined for deviated or absence of septum but the septum was normal. The nostrils were inspected for patency and discharges and the mucosa for polyps. No abnormality was detected.

MOUTH: The mouth was examined by gently taping the toe. The baby cries, mouth and the tongue, gum and palate were inspected and there was also no false tooth noticed. There was no cleft palate or cleft lip, or tongue tie.

EARS: 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 it 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 42cpm. The space between the nipples was noted and the nipples were in alignment. The abdomen was round with no bleeding from the umbilical cord. The cord was examined and there was one vein and two arteries.

UPPER EXTREMITY: Hands and arms were inspected for symmetry, movement and paralysis, and the palm for the number of palmer creases. Shape and color of nail beds were inspected for reflexes (grasping, Moro) and they were normal. Hands were again examined for clubbing, extra or missing digits, nail growth and webbing and no abnormality was detected.

GENITALIA AND ANUS: The genital area was examined. The vagina and the anus was patent.

LOWER EXTREMITY: The length and movement of the limbs were also noted. The digits were counted to be normal and separate to exclude webbing. The feet were examined for any disability. The lower limbs were also examined for congenital dislocation of the hip but no abnormality was detected.

SPINE: The spine was also examined with baby lying in prone position. The back was palpated for swelling, dimpling, hairy patches to exclude spinal bifida.

The baby was weighed and the weight was 3.5kg, head circumference was 34centimeters, length 51centimeters.Vitamin K 1milligram was given to baby intramuscularly to prevent bleeding.

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

3.10 PREVENTION OF DISEASES

This was done within the first 90 minutes to prevent infections such as opthalmia neonatarum, and haemorrhagic disease of the new born and therefore the following treatment were given. Immediately the head was born, the eyes were cleaned with cotton wool swabs from inner cantus outwards. Tetracycline eye ointment was applied to the baby's eye. Cord was dressed with methylated spirit in the presence of the mother. Injection vitamin K 1milligram was given intramuscularly on baby's thigh. Baby was dressed and a cap, shocks were put up. Baby was covered with a sheet to provide warmth. Other assessments were recorded as head circumference 34cm, full length 51cm and weight 3.5kg.

SUMMARY OF LABOUR

On 28th November, 2022; at 3:15am, Madam Comfort had spontaneous vaginal delivery to a live female child. At 3:16am, injection oxytocin10 unit was given intramuscularly. APGAR score first minute was 8/10, fifth minute 9/10. At 3:20am the placenta and membranes were completely delivered by controlled cord traction and counter pressure. Baby weighed 3.5kg. Perineum was intact, estimated blood loss was 150mls.

CONDITION OF MOTHER AT BIRTH

Blood pressure	100/70 millimetres per mercury
Pulse	76 beat per minute
Respiration	22cycles per minute
Temperature	36.8^0 C
Symphysio fundal height	18 centimetres
Uterus	Contracted
Lochia	Red (rubra)
Perineum	Intact
Estimated blood loss	150mls
Condition	Satisfactory

CONDITION OF BABY AT BIRTH

Temperature	36.9 degree Celsius
Apex beat	140 beats per minute
Respiration	42cycle per minute

Other assessments were recorded as follows:

Sex	Female
Birth weight	3.5 kilograms

Full length	51 centimetres
Head circumference	34 centimetres
Meconium	Passed
Urine	Passed
Abnormalities	No abnormalities detected
Condition	Satisfactory

First Minute Apgar score

Appearance	2
Grimace	1
Pulse	2
Activity	1
Respiration	2
Total	**8/10**

Fifth Minute Apgar score

Appearance	1
Grimace	2
Pulse	2
Activity	2
Respiration	2
Total	**9/10**

3.11 CARE PLAN DURING LABOUR

PROBLEMS IDENTIFIED

On 27th November, 2022, Madam Comfort complained of;

- At 9pm .Lower abdominal pains.
- At 11:30pm .Anxiety.

On 28th November,22, madam comfort complained of ;

- At 1:30am .Frequent micturition.
- At 2:30am. Fatigue.
- At 3am. Risk of infection.

SHORT TERM OBJECTIVES

- Madam Comfort will cope with lower abdominal pain within 1hours.
- Client will be relived of anxiety within 30 minutes
- She will understand the physiology of frequent micturition and cope with it
- Madam comfort will be relieve from fatigue within 6 /after delivery
- Client will show no sign of infection within 72 hours

LONG TERM OBJECTIVE

Madam comfort will go through all the stages of labour successfully without any form of complication to both mother and baby.

TABLE 1: LABOUR CARE PLAN

DATE/ TIME	NURSING DIAGNOSIS	OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
27/11/22 9:00 pm	Lower abdominal pains related to strong uterine contractions.	Madam Comfort will cope with the labour pains within an hour as evidence by 1. Client verbalizing that she is coping with labour pains 2. Midwife observing that client is coping with labour pain.	1. Reassure client that she will be relieved after labour. 2. Educate client on the physiology of lower abdominal pains. 3. Perform sacral massage. 4. Encourage client to do deep breathing exercise with contraction. 5. Encourage client to empty her bladder frequently 6. Educate client on ambulation and position	1. Client was reassured that she will be relieved of pain after delivery. 2. Client was informed that the discomfort she was feeling was due to contractions, which was essential for delivery of the baby. 3. Sacral massage performed. 4. Client was encouraged to perform deep breathing exercise with contractions. 5. Client was encouraged to empty her bladder frequently, 6. Client ambulated and lied in the left position.	27/11/22 10:00 pm	Goal met as midwife observed that client was coping with the pain. Midwife observing that client is coping with labour pains.	Q.H

TABLE 2: LABOUR CARE PLAN

DATE/ TIME	NURSING OBJECTIVE	OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
27/11/22 11:30pm	Anxiety related to unknown outcome of labour.	Madam Comfort will be relieved of anxiety within 30 minutes as evidence by 1. Client verbalizing that she is no more anxious. 2. Midwife observing that client is calm.	1. Reassure client she is in the hands of competent midwives. 2. Educate client on the effect of anxiety on labour. 3. Explain the stages of labour to the client. 4. Explain every procedure to be carried on client. 5. Update client with progress of labour. 6. Allow her to ask questions and answer her appropriately.	1. Client was reassured that she was in the hands of competent midwives. 2. Client was educated on effect of anxiety on labour. 3. The stages of labour were explained to the client. 4. Every procedure carried on client was explained to her. 5. Client was updated with progress of labour. 6. Client asked questions and was answered appropriately.	28/11/22 12:00am	Goal met as client said she was no more anxious. Midwife observing that client is calm and relax.	Q.H

TABLE 3: LABOUR CARE PLAN

DATE/ TIME	NURSING PROBLEMS	OBJECTIVE/OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
28/11/22 1:3am	Frequency of micturition related to descending foetal head exerting pressure on the bladder.	Client will understand physiology of frequent micturition and cope with it as evidence by client verbalizing that she is coping with the situation. Midwife verbalizing client is copping with her situation.	1. Reassure client that she is in the hands of competent midwives. 2. Explain the physiology of frequent micturition of labour. 3. Serve bedpan whenever client needs. 4. Encourage client to take liberal fluids to prevent dehydration. 5. Educate client to maintain good personal and perinea hygiene to prevent ascending infection to the uterus	Client was reassured that she was in the hands of competent midwives. 2. Physiology of frequent micturition was explained to her. 3. Bedpan was served whenever client needs it. 4. Client was encouraged to take liberal fluids to prevent dehydration. 5.Client was educated to maintain good personal and perinea hygiene to prevent ascending infections to the uterus	28/11/22 3:30am	Goals fully met as evidence by client verbalizing that she now understands physiology of frequent micturition and is coping with it. Midwife verbalizing client is copping with situation .	Q.H

TABLE 4: NURSING CARE PLAN DURING LABOUR

DATE/ TIME	NURSING DIAGNOSIS	OBJECTIVE/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
28/11/22 2:30am	Fatigue related to stress of labour	Madam Comfort will be relieved of fatigue within 2 hours after delivery as evidenced by client verbalizing that she is no more tired. The midwife will observe the client is no more tired after 2 hours.	1.Reassure Madam Comfort that she will be relieved of her fatigue after 2 hours of her delivery 2. Encourage client to rest when contractions wear off. 3.Give sacral massage 4.Serve client with energy giving drinks 5. Perform all nursing activities at a go.	1. Madam Comfort was reassured that she will be relieved of her fatigue within 2hours. 2. Client was encouraged to rest when contractions wear off. 3.Sacral massage was given 4. Client was served with energy drinks 5. All nursing activities were performed at a go.	28/11/22 8:30am	Goal fully met as client verbalized that she was relieved of fatigue. Midwife observing the client well be relieved from tiredness after 6 hours .	Q.H

TABLE 5: LABOUR CARE PLAN

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
28/11/22 3:00am	Risk of infection related to mishandling of perinea pad.	Client will show no sign of infection within 72 hours as evidenced by: 1. The midwife reporting that client showed no sign of infection e.g. pyrexia. 2. Client verbalizing she has no complains like pyrexia.	1. Reassure client that she will go through labour without infections. 2. Encourage client to wash hands with soap under clean water before and after changing her pad. 3. Educate client not to use pad when it falls. 4. All procedures should be performed aseptically. 5. Educate client to change pad when soiled.	1. Client was reassured that she will go through labour without infection. 2. Client washed hands with soap under clean water before and after changing her pad. 3. Client did not use pad when it fell on the floor. 4. All procedures were performed aseptically. 5. Client changed pad when soiled.	30/11/22 10:00am	Goal met as midwife reported that there was no sign of infection. Client verbalizing she has no complaints like pyrexia.	Q.H

CHAPTER FOUR

PUERPERIUM

4.0 INTRODUCTION

This chapter consists of the care given to the mother and the baby from the day of delivery till the second postnatal visit.

4.1 DAY OF DELIVERY

Madam Comfort was sent to lying-in after delivery. She was made comfortable in bed with her baby. She was encouraged to empty her bladder frequently in order to prevent the occurrence of postpartum haemorrhage. She was encouraged on early ambulation to promote effective circulation and massage the uterus.

Madam Comfort was also educated to change her perinea pad frequently when soaked to help prevent infections and was taught to wash hands with soap under running water after removing her pad, before and after visiting the toilet and before breastfeeding the baby. Madam Comfort was served with bread and milo. The vital signs were monitored every 15 minutes for 2 hours, 30 minutes for an hour and hourly for another 3 hours. She was encouraged to breastfeed frequently and practice exclusive breastfeeding. Madam Comfort was encouraged to eat balanced diet. Madam Comfort was also told to report any abnormal bleeding. Head to toe examination was done on the mother and no deviation was detected.

MOTHERS VITAL SIGNS

Temperature	37.1 degree Celsius
Pulse	74beat per minute
Respiration	21cycles per minute

Blood pressure 120/70milimetres of mercury

4.2 VITALS SIGNS FOR THE BABY

Temperature 36.6 degree Celsius

Respiration 41 cycle per minute

Apex beat 132 beat per minute

4.2 Subsequent care of the baby

Baby was monitored continuously and the condition of baby was fine throughout. Immediately after the baby bath, cord was dressed and was also checked for bleeding. Baby was dressed and wrapped in a warm cot sheet to keep baby warm to prevent hypothermia. Baby's temperature was maintained by wrapping baby well and also the temperature was assessed. Client was advised to always dress the cord with methylated spirit and cotton . His breathing rate was also checked and was within the normal range.

Madam Comfort was educated to breastfeed the baby frequently at least 8 to 12 times in a day. She was educated on proper hand washing and also on the essential care of the new born such as cord care. When she observes any danger signs such as irregular breathing rate, jaundice, fever, she should report immediately to the nearest health facility.

FIRST BABY BATH

Bathing of the baby was done six hours after delivery. Madam Comfort's consent was sought before the baby was bathed and she accepted. She was asked to watch closely in order to enable her know how to bath them at home. Requirements needed for the procedure were gathered.

Procedure was explained to the mother on how to bath the baby and all items to be used were assembled, plastic apron was worn. Cold and hot water were mixed and temperature tested with the elbow. Hands were washed with soap under running water, dried and gloves were worn. Baby was placed on a protected flat surface. Baby was undress after which she was

wrapped with a cot sheet. The part of baby to be bathed was exposed at a time to prevent hypothermia. Quick head to toe examination was done in front of the mother, but no abnormality was found. Each eye were cleaned from the inner cantus out followed by the baby's face and was dried. The nape of the neck was supported with one hand protecting the ears with the middle finger and the thumb. Baby's head was washed with soapy sponge still supporting the nape and the body resting on the elbow with head lifted to the edge of the basin. Soap was rinse off the head and dried. Baby was placed back on protected flat surface and exposed. Arms and front of the trunk were washed paying attention to the skin folds. Baby's back was turned with one arm supporting the chest with the hand holding the distal arm of the baby. The back was washed down to the feet paying attention to the skin folds. Baby was firmly supported and rinsed thoroughly from the trunk to the limbs. Baby was placed on flat surface and covered with a clean cot sheet. She was wiped with a small towel to dry, paying attention to the skin folds. Baby was smeared with pomade and dressed, socks and cap put on. She was then wrapped in a different cot sheet and given to the mother to breast feed.

Cord dressing

The cord was dressed by wrapping the baby in a towel to keep her warm. A tray containing six cotton wool swabs in a gallipot with methylated spirit and a receiver for used swabs was set. Hands were thoroughly washed again with soap and under running water and dried with towel. Surgical gloves were worn and the cord was exposed. It was then inspected for bleeding but there was none detected. The tip of the cord was held with one swab. The base of the cord was cleaned with another cotton wool swab and was discarded. The whole cord was cleaned using six cotton wool swabs from the base upwards. The tip of the cord was cleaned with the swab that was used to hold it. The cord was exposed for some few minutes for it to dry. The baby was dressed, wrapped and given to the mother to breastfed. The used

material were discarded according to infection prevent protocol. Gloves were removed and disposed off. Hands were washed with soap and water. Mother was also advised to apply methylated on it and avoid touching. Findings were communicated to the mother, reported to the midwife in charge an

EDUCATION TO MOTHER ON THE BABY

It was explained to her family that the fontanels will naturally close. She was educated on exclusive breastfeeding of the baby on demand and to wash her hands before touching the baby to prevent sending infection to the baby. She was educated to clean the cord with cotton and spirit and always keep the cord dry. She should report if the clamp goes off, sees the cord bleeding or any other abnormal sign on the cord and on the baby in general. She was educated and assisted on how to position herself and to fix the baby well to the breast. Client was educated to complete all the immunizations by the time the child attains 18 months. She was also educated to register the baby at the Birth and Death registry. The child was immunized with polio`0' vaccine two drops per mouth and BCG vaccine 0.05ml was administered intra-dermal to the right upper arm. Madam Comfort was educated not to apply anything on the injection site, she was also told that the baby may have slight fever and swelling at the site of injection which continues a small wound**.**

4.4 FIRST DAY POST-DELIVERY (DAY OF DISCHARGE)

On, 28th November, 2022 was the first day after delivery and her baby looked healthy with no abnormality detected after head to toe examination was done. Her vital signs were checked and recorded as follows:

Temperature	36.2 degree Celsius
Blood pressure	110/70mmHg
Respiration	20cycle per minute

Pulse 79beat per minute

Baby vital signs was check and recorded as:

Temperature $36.8^{o}c$

Apex heart rate 134beat per minutes

Respiration 44cycle per minutes

Weight 3.5kg

The uterus was well contracted, symphysio fundal height 18cm.The lochia was red (rubra) and the amount was moderate and not offensive. She complained of after pain, the physiology of after pain was explained to her that during the first 12hours of postpartum uterine contractions remain regular, strong and coordinated, before their regularity and strength decrease with involution. She was also told that it is provoked by full bladder so she was encouraged to empty her bladder frequently if she had the urge. She was encouraged to practice exclusive breastfeeding and also feed on demand. Education was given on the importance of breastfeeding to the mother, baby and the family as a whole. She was encouraged to change her perineal pad when soiled and not to reapply perineal pad when it falls to prevent ascending infections to the uterus. Baby passed meconium and was dark green in colour. She was informed of her discharge and encouraged to register the baby at birth and death registry.

She was given

Tablet Folic Acid 5mg 1 daily for 30days

Tablet Paracetamol 1g tid 5days

Syrup Iron (iii) 10mls twice daily for 30days

She was helped to pack. She was informed on intended postnatal visit for the period of one week. It was explained to her that she will be visited at home for seven days, morning and

evening for the first three days then once daily from the fourth day going which will be started the next day. She gave her full consent. She was thank and was seen off.

4.5 FIRST POST NATAL HOME VISIT

On 29th November, 2022, at 7; 10am and 5:00pm respectively, Madam Comfort was visited in her house. Both mother and baby looked healthy on arrival. Rapport was established, client was asked about her after pain and she said it has reduced and feel more comfortable now. She was informed that head to toe examination will be done on herself and the baby. Hands were washed and dried. The baby was topped and tailed and head to toe examination was done and no abnormality was detected. Baby passed meconium and urine during the procedure. The cord was also dressed with sterile cotton wool swabs and methylated spirit using aseptic technique. The cord was clean, dry and not offensive. The baby was dressed, wrapped and given to the client's sister. Madam Comfort was asked to empty 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 and symphysio fundal height was 17 centimetres. The perineum was clean, dry and intact, lochia was small, red and not offensive. Mother's vital signs were checked and recorded as follows.

	Morning	**Evening**
Temperature	36.8degree celsius	36.7degree Celsius
Pulse	82beat per minute	78beat per minute
Respiration	21cycle per miute	23cycle per minute
Blood pressure	120/70mmHg	110/70mmHg

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

	Morning	**Evening**
Temperature	36.8degree celsius	36.7degree Celsius
Apex heart rate	134beat per minute	138beat per minute
Respiration	40cycle per minute	42cycle per minute
Weight	3.4kilogrames	

Baby was given to the mother to breastfeed and she was able to suckle well. Client was asked if she had any question or problem and she complained of not being able to sleep well. She was reassured, encouraged to take naps in the afternoon and sleep when even baby is asleep or when possible.

Madam Comfort was educated on danger signs of the new born such as difficulty in breathing, cyanosis, persistent vomiting, fever, crying weakly, unable to feed and yellowing of the eyes, palms and soles of the feet. Client and family were congratulated. Permission was granted to leave. She was informed of the next visit to the house which was the next day.

4.6 SECOND DAY POSTNATAL HOME VISIT

Madam Comfort was visited at the home twice to check on how she and the baby was doing on 30th November 2022 at 7:00am and 5:00 pm respectively. Rapport was established. Madam Comfort and baby were well and problem on the previous day has subsided. Permission was sought to examine both the mother and baby. Head to toe examination was also done on Madam Comfort and no abnormality was detected. Her perineum was clean and the lochia was found to flow moderately, the colour was red (rubra) and without bad odour. The symphysio fundal height was 16 centimeters. Her vital signs were checked and recorded as follows:

	Morning	Evening
Temperature	37.2degree Celsius	36.6degree Celsius
Pulse	76beat per minute	82beat per minute
Respiration	22cycle per minute	19cycle cycle per minute
Blood pressure	120/70mmHg	110/60mmHg

The baby was top and tailed general examination was carried out and no abnormality was present. The cord was neatly dressed with no abnormality detected. The baby has passed stool and was brownish yellow and urine according to the mother.

Baby vital signs were taken and recorded as follows:

	Morning	Evening
Temperature	36.5degree Celsius	36.6 degree Celsius
Apex heart beat	128 beat per minute	134 beat per minute
Respiration	45 cycle per minute	43 cycle per minute
Weight	3.3 kilograms	

Permission was sought to leave and client was very grateful and appreciated the care that was given to them.

4.7 THIRD DAY POSTNATAL HOME VISIT.

On 1st December, 2022 the third day postnatal visit was made to Madam Comfort house at 7:00am in the morning and 5:00pm in the evening, she was greeted. Mother and baby were doing well. Permission was sought to inspect client's perineal pad and it was pink, moderate in flow without any offensive smell. Her breasts were lactating well. Client complained of engorgement of the breast and the physiology behind the engorgement was explained to her. Symphysio fundal height 15centimeters. Her vital signs were checked and recorded as follows:

	Morning	Evening
Temperature	37.0degree Celsius	37.1degree Celsius
Pulse	83beat per minute	79beat per minute
Respiration	20cycle per minute	22cycle per minute
Blood pressure	120/80millimeters of mercury	110/70millimeter of mercury

The baby was top and tailed and general examination was carried out and no abnormality was present. The cord was neatly dressed with no abnormality detected. The baby also passed stool and urine.

Baby's vital signs and other assessment were taken and recorded as follows:

	Morning	Evening
Temperature	36.5degree Celsius	37.0degree Celsius
Apex heart beat	129beat per minute	137beat per minute
Respiration	40cycle per minute	43cycle per minute
Weight	3.2kilograms	

4.8 FOURTH DAY POSTNATAL HOME VISIT

The fourth day post natal home visit was made to Madam Comfort's house at 7:00am on 2nd December, 2022

Rapport was established. The health status of the mother was inquired and she said the engorged breasts had subsided and baby was also doing well. Lochia was pink (serosa) with scanty flow without odour on inspection. Head to toe examination was done and everything was normal. Madam Comfort complained again about the breast engorgement. Symphysio fundal height was 14centimeters. Her vital signs were checked and recorded as follows:

Temperature	36.7degree Celsius
Pulse	72beat per minute
Respiration	21cycles per minute

Blood pressure 110/80millimeter of mercury

General examination was carried out, no abnormality was found. The cord was neatly dressed and no abnormality was detected. The baby had passed stools that were yellow in colour and had yellow urine. Baby's weight was 3.2kg.The client had no complains.

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

Temperature 36.8 degree Celsius

Apex heart beat 118 beat per minute

Respiration 44cycles per minute

4.9 FIFTH DAY POSTNATAL HOME VISIT

The fifth postnatal home visit was made on 3rd December, 2022 at 7:00am. Rapport was established. When I arrived, the mother and child were both in good health. Baby's cord was off and the stump was neatly dressed cotton wool and methylated spirit and was left to dry. Madam Comfort said the baby cried a lot, she was reassured that the crying of the baby will reduced when she feeds the baby on demand and changes its napkin frequently because babies have lusty cry to evoke attention. After the head to toe examination, no abnormality was detected. Inspection of the lochia was done and the colour was pink (serosa) without any bad odour and flow was scanty. Symphysio fundal height of Madam Comfort was 13 centimeters. Client's vital signs were checked and recorded as follows:

Temperature 36.3degrees Celsius

Pulse 78beat per minute

Respiration 20cycle per minute

Blood pressure 100/60milliter of mercury

Baby was topped and tailed, head to toe examination was done and no abnormalities were found. The baby's weight was 3. 3kg.

Vital signs were taken and recorded as follows:

Temperature	37.1degrees Celsius
Apex heart beat	136beat per minute
Respiration	46cycles per minute

Madam Comfort was reminded of the next visit and she was very grateful. Permission was sought to leave.`

4.10 Sixth day postnatal home visit

The sixth day postnatal home visit was done on 4th December, 2022 at 7:00am. Rapport was established. Mother and baby were both in a healthy condition and Madam Comfort said the baby's crying had minimized and now sleeps a lot. On head to toe examination, no abnormality was detected. Her breast was lactating well. Inspection of the lochia was done and the colour was pink (serosa), flow was scanty without any bad odour. Madam Comfort said the baby has pass stool that morning before arrival. Symphysio fundal height was 12centimetres.

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

Temperature	36.7degree Celsius
Pulse	81beats per minute
Respiration	21cycles per minute
Blood pressure	110/60millimeters of mercury

Baby's vital signs were recorded as

Temperature	36.8 degree Celsius
Weight	3.4kilograms
Apex heart rate	121beat per minutes
Respiration	42cycle per minutes

Education was given to her on the importance of ensuring good personal hygiene and the need to feed the baby frequently on demand. She said she appreciated that a lot, she was thanked for her cooperation. She was reminded and told that the next day was going to be the last home visit, permission was sought to leave.

4.11 SEVENTH DAY POSTNATAL HOME VISIT.

The seventh day post natal home visit was done on 5th December, 2022 at 7:30am. Rapport was established. Mother complained of skin rashes on her baby's body but education was given to her on the dresses and items being used on the baby. On head to toe examination no abnormalities were detected. Her breast was lactating well. Symphysio fundal height was 11centimetres. Inspection of the lochia was done and the colour was pink (serosa), flow scanty without any bad odour. Madam Comfort said the baby has pass stool that morning before arrival.

Client's vital signs were checked and recorded as follow as:

Temperature	36.2degrees Celsius
Pulse	78beat per minute
Respiration	20cycles per minute
Blood pressure	110/60millimeter of mercury

Baby was already top and tailed, head to toe examination was done and no abnormality was found on the baby. The stump was then dressed and the area was cleaned and dried. Baby's weight 3.5kilograms.

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

Temperature	36.8degrees Celsius
Apex heart beat	130beat per minute
Respiration	47beat per minute

She was educated on the danger signs of the baby and the need to seek early care. She shows appreciation to the care given to her. She was thanked for her cooperation, permission was sought to leave.

4.12 FIRST POSTNATAL VISIT TO THE CLINIC.

On 6th December, 2022 at 10:00am, Madam Comfort and her baby accompanied by her mother came to the health facility. A seat was offered to the client. She was healthy. Procedure to be carried out was explained to her and she consented. Madam Comfort was asked to empty her bladder before the examination. She was given a specimen bottle to collect midstream urine to check for protein and sugar and all tested negative. Head to toe examination was done and everything was normal. Lochia was checked and it was flowing, the colour was pink. Haemoglobin level was 11.8g/dl.

Client vital signs was checked and recorded as:

Temperature	36.7^{o}c
Pulse	84bpm
Respiration	20bpm
Blood pressure	110/70mmHg

Procedure to be carried out on Madam Comfort was explained to her. Privacy was provided and was assisted to lie on the couch for head to toe examination. Hands were washed with soap under running water and dried with a clean towel. Head to toe examination was done on her. On the head, hair was neat and tied with a ribbon, conjunctiva was not pale, no discharges from the eyes, nose and ears. There was no abnormality detected in the mouth and there was absence of enlarged nodes on the neck. Breast was lactating well, no engorgement, sore or cracked nipples were detected. The abdomen was firm: there was no tenderness, no scars, no enlarged liver or spleen on examination. The fundal height was palpated and was 10cm

There was no oedema, varicosities and tenderness in the calf. The perineum was intact and there was no offensive vaginal discharge, she was thanked for the cooperation and helped to dress up.

Head to toes examination was done on the baby and no abnormalities were detected. Umbilical stamp was healed. Baby's weight was 3.6kg.she was also educated on the importance of the child welfare clinic and finally handed over to the child welfare clinic and to the in-charge midwife for continuity of care. Baby's vital signs was checked and recorded as:

Temperature	36.6^{o}c
Apex heart beat	140bpm
Respiration	40cpm

4.13 SECOND POSTNATAL VISIT TO THE CLINIC (SIX WEEKS POSTNATAL EXAMINATION)

According to the midwife in charge, Madam Comfort reported to the clinic on the 9thJanuary , 2023 for six week postnatal examination. A general head to toe examination was carried out on her and the baby and no abnormalities detected. Madam Comfort`s midstream urine was collected for protein and acetone laid and it was negative. Mother and baby were in healthy condition and had no complains.

Madam Comfort`s uterus was not palpated and her breast was lactating well. She had not resumed menstruation when asked. She was educated to continue to practice breastfeeding on demand since that can serve as family planning and prevent unplanned pregnancy until she resumes menstruation before considering the other family planning methods.

On examining the baby, the posterior fontanelle was closed and the umbilical stump was completely healed. The baby`s weight was 4.5kg. Their vital signs were checked and recorded as follows:

Mother

Temperature	36.4 degree Celsius
Respiration	23cycle per minutes
Pulse	82beat per minute
Weight	72.5kilogram
Blood pressure	110/70mmHg

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

Temperature	36.6 degree Celsius
Respiration	40cycle per minutes
Apex beat	132beat per minutes

Physical examination was done and no abnormality was detected, breast were lactating well, uterus was not palpable, no lochia and menstruation has not commenced.

Baby general condition was good from head to toe examination. Client was handed over to public health nurse in charge at the health Centre for baby immunization against polio, diphtheria, pertussis, tetanus, and haemophilus influence type B given to children at six weeks. They were handed over to the child welfare clinic, family planning unit to ensure continuity of care and was educated to consult them in case of any problem. Client was congratulated.

PROBLEMS IDENTIFIED DURING PUERPERIUM

1. On 28th November, 2022 client complained of after pain
2. On 28th November, 2022, client complained of backache
3. On 5th December , 2022, client reported of skin rashes on the baby's body
4. On 29th November, 2022, client reported of insomnia

5. On 1st December, 2022, client complained of engorged breast

SHORT TERM OBJECTIVES

1. Client will experience reduced after pain within 3 hours
2. Client backache will relieve within 24hours
3. Client's baby will have normal skin integrity within 48 hours
4. Client will be able to have adequate sleep within 24 hours
5. client will be relieved of engorged breast within 24 hours

LONG TERM OBJECTIVES

Both client and baby will go through puerperium successfully.

NURSING CARE PLAN DURING PUERPERIUM TABLE

DATE / TIME	NURSING DIAGNOSIS	NURSING OBJECTIVE /OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE / TIME	EVALUATION	SIGN
28/11/22 at 8:40am	After pain related to involution of the uterus.	Client will experience reduced pain within 3 hour as evidenced by client verbalizing the reduction of after pain. Midwide verbalizing client pain has been reduced.	1. Reassure client that the pain will be relieved when she continues breastfeeding her baby. 2. Explain to client the physiology of after pain during the puerperium. 3. Tell client to apply warm compress to the abdomen to relieved pain. 4. Encourage client to urinate frequently to enable the uterus to contract. 5. Encourage client on postnatal exercise to encourage quick involution of the uterus. 6. Serve tablet paracetamol 1g to client PRN	1. Client was reassured and she was encouraged to continue breastfeeding. 2. It was explained that due to involution of the uterus through breastfeeding that's why she is experiencing the pains. 3. Warm compresses was applied unto her lower abdomen to relieve the pain. 4. Client was encouraged to urinate frequently when she has the urge to. 5. Client was encouraged on postnatal exercises to encourage quick involution of the uterus. E.g. brisk walking 6. Client was served paracetamol 1g PRN	28/11/22 at 11:40am	Goal was fully met as client verbalized reduction in the after pain. Midwife verbalizing client face shows there is no pain.	Q.H

NURSING CARE PLAN DURING PUERPERIUM

DATE / TIME	NURSING DIAGNOSIS	NURSING OBJECTIVE	NURSING ORDERS	NURSING INTERVENTION	DATE / TIME	EVALUATION	SIGN
28/11/22 at 9:00am	Impaired comfort body(Backache) related to poor posture during breastfeeding	Client will be relieved of backache within 24 hours as evidenced by client verbalizing that backache has reduced. Midwife observing client position shows that she is relieved from backache .	1. Reassure client of reduction in pain 2. Educate client to support her back with pillows when breastfeeding and to sit with her back straight. 3. Teach client on correct position and attachment of baby to breast. 4. Encourage client to sit on a straight chair or lean against the wall during breastfeeding 5. Serve prescribed analgesics(paracetamol)	1. Client was reassured that her pain will be reduced. 2. Pillows were used as support and education was given as to her on how to sit during breastfeeding. 3. Client was taught to put baby's head in her brachial region and let baby's abdomen to touch hers while baby's body is straPight and allow more areola into the mouth. 4. Client was encouraged to sit or lean against a flat surface when breastfeeding baby to prevent backache. 5. Tablet paracetamol 1g was given when needed.	29/11/22 at 9:00am	Goal was fully met as client verbalized a relieved backache. Midwife obersivg client is relieved from pain.	Q.H

NURSING CARE PLAN DURING PUERPERIUM

DATE / TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES /OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE / TIME	EVALUATION	SIGN
5/12/22 at 9:00am	Skin rashes on baby related to excessive heat.	Baby will have normal skin integrity within 48 hours as evidenced by client verbalizing that baby's skin rashes has resolve. Midwife observing that baby is having normal skin integrity.	1. Reassure client that the rashes will dry off. 2. Educate client on the need to dress baby with light cotton clothing if weather is warm. 3. Encourage client not to scratch the rashes to prevent infection. 4. Encourage and teach mother how to apply prescribed powder and oil e.g. Listerine powder and Shea butter. 5. Encourage mother to open windows for good ventilation in the room.	1. Client was reassured that the rashes will disappear. 2. Client was educated to dress baby with light cotton clothing if weather is warm. 3. Client was educated not to scratch the rashes as it will cause more pain and infection. 4. Mother was taught how to use the medications given for the rashes. That is the Vaseline and Listerine powder. 5. Mother was encouraged to open the windows for good ventilation during the day instead of turning on the fan.	2/12/22at 8:00am	Goal was fully met as client verbalized that baby's skin rashes has resolved . Midwife observing that baby is having a normal skin integrity.	Q.H

NURSING CARE PLAN DURING PUERPERIUM

DATE / TIME	NURSING DIAGNOSIS	NURSING OBJECTIVE/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE / TIME	EVALUATION	SIGN
29/11/22 at 8:00am	Insomnia related to excessive crying of baby at night.	Client will have at least six to eight hours sleep at night within 24 hours as evidenced by client verbalizing she now has adequate sleep. Relative confirming client sleep for at least 1 hour in the day and 6 hours in the night.	1. Reassure client that her condition can be solved. 2. Encourage family members to support client in various house chores. 3. Educate client to plan her activities and sleep at least two hours during the day when the baby sleeps. 4. Encourage client to breastfeed baby on demand and before going to bed and change wet clothes. 5. Teach client to empty one breast completely before offering another for the baby to be well satisfied.	1. Client was reassured to allay her anxiety about baby crying at night. 2. Family members were encouraged to lend a helping hand to client. 3. Client's daily activities were planned so she will have enough rest during the day. 4. Client was encouraged to breastfeed baby regularly and especially on demand and to change wet clothing. 5. Client was encouraged and taught to empty one breast completely before offering the second one for baby to be satisfied.	30/12/22at 8:00am	Goal was fully met as client verbalized that she can sleep for at least six to eight hours. Client relative confirming client can sleep at least 6 hours at night.	Q.H

NURSING CARE PLAN DURING PUERPERIUM

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
30/11/22 at 9:00am	Impaired body comfort (breasts engorgement) related to incomplete emptying of breasts.	Client will be relieved of breast engorgement within 24 hours as evidenced by client verbalizing relieve of engorgement. Midwife verbalizing client is relieved from pain.	1. Reassure client that the pain will be relieved. 2. Explain the causes of painful breast to client. 3. Encourage client to breastfeed baby exclusively and on demand. 4. Teach client on positioning and fixing of baby to breasts. 5. Apply warm compress to the breast to relieve the engorgement. 6. Encourage her to allow the baby to empty one breast completely before offering the other. 7. Give prescribed analgesics to relief pain	1. Client was reassured and comfortable because the problem will resolve. 2. The causes were explained as either being poor attachment or incomplete emptying of one breast 3. Client was encouraged to breastfeed baby exclusively and on demand. 4. Positioning of baby to breast was taught and demonstrated. 5. Warm compress was applied to the breast to relieve the engorgement. 6. She was encouraged to completely empty one breast before offering the other. 7. Tablet paracetamol 1g was given to relief the pain.	2/12/22 9:00am	Goal was fully met as client verbalized a relieved in breast engorgement. Midwife verbalizing client breast engorgement is relieved after complete emptying of the breastmilk.	Q.H

SUMMARY AND CONCLUSION

This Client / Family centered care study was rendered to madam Comfort who comes from Jirapa a town in the Upper West region of Ghana, but stays at Fiaso in the Techiman district. A 32year old gravida 4 para 3 who was an attendant at Fiaso Chps Compound for antenatal care was chosen among the lot because she was the client who fell within the criteria for clients to be chosen for the care study. Friendship was then established to render effective care throughout pregnancy, labour and puerperium.

Minor problems that were encountered during the period of pregnancy, labour and puerperium were all managed using the nursing process. Her successful antenatal care, labour and puerperium were due to the early assessment and analysis of her problems, proper counselling and education. She had a spontaneous vaginal delivery to a live female child on the 28th November 2022 at 3:15am without any complications. All the appropriate care was rendered to her and the baby. She was also educated appropriately.

She had intensive puerperal care and all visits and examinations were carried out on her as required and hence she had a normal and safe puerperium. The baby also received all appropriate immunizations required at birth for the prevention of any diseases or complications. She was finally handed over to the midwife in charge for the continuity of care. There was proper and accurate documentation of all activities and procedures carried out on her and the baby for proper and easy reference.

The Client / Family Centered Care Study have served as a managerial tool and step for managing any pregnant woman through antenatal, labour and puerperium and therefore should be sustained.

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APPENDIX I

PHARMACOLOGICAL DRUGS FOR MOTHER

NAME OF DRUG	CLASSIFICATION	DOSAGE	ROUTE	USE AND ACTION	ACTUAL EFFECT	SIDE EFFECT	SIDE EFFECT EXPERIENCED
Tablet multivitamin	Vitamin preparation	200 milligram daily	Orally	Increased appetite and helps in the formation of red blood cells.	Increased appetite	Gastrointestinal disturbances	No side effect observed.
Tablet Ferrous sulphate	Iron supplement	200 milligram once daily	Orally	Helps in the formation of red blood cells.	Increased hemoglobin level.	Gastrointestinal disturbances. Dark stools.	Dark stools.
Tablet Folic Acid	Vitamin preparation	5 milligram once daily	Orally	For the formation, functioning and maturation of red blood cells.	Increased hemoglobin level	Nausea and vomiting	No side effect observed.
Tablet Paracetamol	Analgesic and anti-pyretic	1 gram 3 times daily	Orally	Relieve pain and Reduce body temperature	Pain relieved	Prolonged use may cause liver damage.	No side effect observed.

PHARMACOLOGICAL DRUGS FOR MOTHER CONT'D

NAME OF DRUG	CLASSIFICATION	DOSAGE	ROUTE	USE AND ACTION	ACTUAL EFFECT	SIDE EFFECT	SIDE EFFECT EXPERIENCED
Tablet Sulphadoxine pyrimethamine	Anti-malarial and Malaria prophylaxis	3 tablets stat 1st dose at 16 weeks or after quickening and other doses at 4 weeks interval until delivery.	Orally	Treatment and prevention of malaria in pregnancy.	Malaria prevented	Itching Nausea Dizziness Headache	No side effect was observed.
Tetanus Injection	Anti-tetanus	0.5 milligrams Shot.	Subcutaneously	Provides immunity against Tetanus disease.	Tetanus prevented	Fever Chills Urticarial rash	Pain at the site.
Injection oxytocin	Oxytocic drug	10 international units	Intramuscularly	Stimulates uterine contractions	Uterine contractions stimulated	Nausea Vomiting	No side effects observed.

PHARMACOLOGICAL DRUGS FOR BABY

NAME OF DRUG	CLASSIFICATION	DOSAGE	ROUTE	USE AND ACTION	ACTUAL EFFECT	SIDE EFFECT	SIDE EFFECT EXPERIENCED
Injection vitamin k	Coagulant(Group K Vitamins)	1mg	Intramuscular	Production of prothrombin. Aids in clotting.	No bleeding	Risk of hemolysis in people with G6PD deficiency.	No side effects observed.
Tetracycline eye ointment	Antibiotic	Length of 0.5-1cm	Conjunctival	To prevent eye infection.	No eye infection was prevented.	Transient stinging	No side effect observed.
Oral polio vaccine	Antigen vaccine	2 drops	Orally	Production of antibodies to prevent poliomyelitis	Poliomyelitis still under observation.	Diarrhea Fever	No side effect observed.
Injection Bacillus Calmette Guerin (BCG)	Antigen vaccine	0.05 milligrams	Intradermal.	Production of antibodies against tuberculosis	Still under observation.	Blister formation and fever	Blister observed

APPENDIX II

COMPLETED DIAGNOSTIC INVESTIGATIONS

ANTENATAL

DATE	SPECIMEN	INVESTIGATION	NORMAL VALUES	FINDINGS	REMARKS
04/05/2022	Blood Urine	Haemoglobin level Protein Sugar	12g/dl-16g/dl Negative Negative	12.5g/dl Trace Negative	Normal Normal Normal
04/05/2022	Blood	HIV/AIDS Blood Group Rhesus Factor Hepatitis B Sickling G6PD	Non-Reactive A, B, AB, O Positive, Negative Negative Negative Non –Reactive	Non-Reactive O Positive Negative Negative	Normal Normal Normal Normal Normal
12/10/2022	Blood Urine	Haemoglobin level Protein Sugar	12 g/dl-16 g/dl Negative Negative	12.2g/dl Negative Negative	Normal Normal Normal
09/11/2022	Blood Urine	Haemoglobin level Protein Sugar	12 g/dl-16g/dl Negative Negative	11.8g/dl Negative Negative	Normal Normal Normal

LABOUR

DATE	SPECIMEN	INVESTIGATION	NORMAL VALUES	FINDINGS	REMARKS
27 / 11 / 2022	Blood	Haemoglobin level	12 g/dl-16 g/dl	11.3 g/dl	Normal
	Urine	Protein	Negative	Negative	Normal
		Sugar	Negative	Negative	Normal
		Acetone	Negative	Negative	Normal
		Colour	Amber	Amber	Normal

PUERPERIUM

DATE	SPECIMEN	INVESTIGATION	NORMAL VALUES	FINDINGS	REMARKS
06/ 12 / 2022	Blood	Haemoglobin level	12 g/dl-16 g/dl	11.8 g/dl	Normal
	Urine	Protein	Negative	Negative	Normal
		Glucose	Negative	Negative	Normal

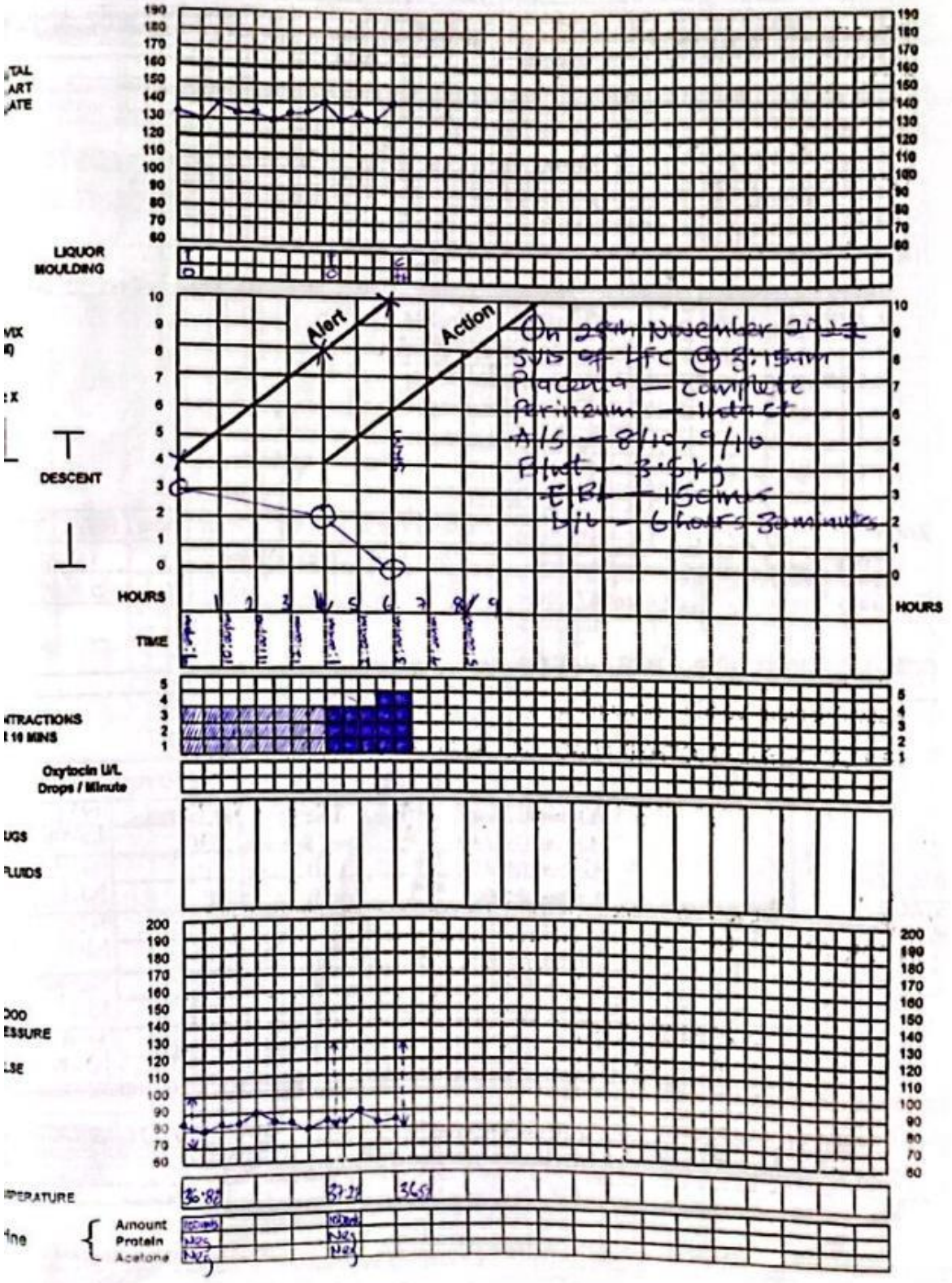
APPENDIX III

ANTENATAL RECORD

DATE	Weight (Kg)	Blood Pressure (mmHg)	Urine/ Protein/ Sugar	Gestational age (weeks)	Fundal Height (cm)	Presentation	Descent	Foetal heart rate(bpm)	Supply of iron &Folic Acid Tabs (wks.)	Complains And treatment	Name & Sign
4/05/22	79	96/60	Trace/Negative	9	-	-	-	-	Cap iron III Polymaltose	-fatigue	J.K
8/06/22	81	100/80	Negative/Negative	14	-	-	-	-	Cap iron III Polymaltose	Frequent micturition	
6/7/22	81	100/70	Negative/Negative	18	17	-	-	134	Cap iron III Polymaltose	Heart burns	J.k
3/8/22	82	110/80	Negative/Negative	22	20	-	-	140	Cap iron III Polymaltose	No complains	E.M
31/8/22	82	110/80	Negative/Negative	26	24	-	-	138	Cap iron III Polymaltose	No complains	E.M
12/10/22	84	100/70	Negative/Negative	32	31	Cephalic	-	140	Cap iron III Polymaltose	Waist pains	E.M
09/11/22	85	100/60	Negative/Negative	36	35	Cephalic	-	145	Cap iron III Polymaltose	No camplains	Q.H
17/11/22	85	110/60	Negative/Negative	37	36	Clicepha	5/5	144	Cap iron III Polymaltose	Lower abdominal pains	Q.H

WHO Modified Partograph

Registration No 82/22 Name (Last, First) Dasagh Comfort Age 32yrs
Date 27/11/22 Parity/Gravida 3/4 LMP 21/2/22 EDD 28/11/22 Gestation (wks) 38
ROM (Time, Date) [illegible] Labour Durable (Hrs) [illegible] Facility/Clinic Name Fiaso chip compound



LABOR NOTES Client G4P3^{AA} delivered spontaneously to a live female child with an apgar score of 8/10, 9/10 1unit of oxytocin was given IM to the mother, placenta and its membranes were completely expelled the uterus was gently massaged to expel blood clots. Vitamin K injection was given to the baby 1m. Eye care and cord care were done aseptically, mother was clean up and sent to the lying in ward. Breastfeeding was initiated, mother and baby were made comfortable in bed and reassured.

Please circle or write responses.

DELIVERY

DATE: 28/11/22 TIME: 3:15am METHOD: (Spontaneous) / Vacuum Extraction / C/S / Other

PERINEUM: (Intact) / Episiotomy / Laceration

ANESTHESIA: (None) / Local / General

THIRD STAGE

Active Management: (Yes) / No Medication: Time 3:16am Type/Dose Oxytocin 10 unit

PLACENTA: TIME: 3:20am (Complete) / Incomplete

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

BABY

Weight: 3.5 kg

Sex: Male / (Female)

Baby Position: (Vertex) / Breech / Other

APGAR

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

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

FOURTH STAGE MONITORING

Frequency	Time	B/P.	Pulse	Fundus	Bleeding	Bladder
Every 15 minutes first 2 hours	4:00am	100/60	79	18 cm	No bleeding	Nil 150mls
	4:15am	100/70	78	Well contracted	11	
	4:30am	110/75	76	11	11	Nil Nill
	4:45am	120/80	79	11	11	
	5:00am	110/70	72	11	11	Nil Nill
	5:30am	100/60	78	11	11	
	5:45am	110/60	87	11	11	120mls Nill
	6:15am	110/60	78	11	11	
Every 30 minutes For 1 hour	6:45am	110/70	84	11	11	Nil 100mls
	7:05am	120/70	82	11	11	

Birth Attendant: Hameeda Quansah assisted by Victoria Asomaning (Midwife In-Charge) Date: 28/11/22

MATERNITY CHART

ME: Dasaah Comfort

E: 32 years WARD: Lying-In

IO.: 82/22 BED NO.: 6

Date	28/11/22	29/11/22	30/11/22	1/12/22	2/12/22	3/12/22	4/12/22	5/12/22	6/12/22
Days in Hospital	DOD	D1	D2	D3	D4	D5	D6	D7	D8
Days P. O.									
Hour Am	7:30	7:00	7:00	7:00	7:00	7:00	7:10	7:00	10:00
Pm	-	5:00	5:00	5:00					

Temperature

°C	°F
41.1°	18
40.5°	17
40.0°	15
39.4°	13
39.5	11
39.0	9
38.5	7
38.0	6
37.5	5
37.0	4
36.5	3
36.0	2

Key
- Symphysio fundal height
- Temperature

Scale: 1cm : 1unit

Pulse bpm	74	82 88	76 72	83 74	72	78	81	78	82
Resp. rpm	21	23 21	22 19	20 22	21	20	21	20	20
E.M.	Passed	Passed	Passed	Passed	Passed	Passed	Passed	Passed	Passed
Urine	Passed	Passed	Passed	Passed	Passed	Passed	Passed	Passed	Passed
B.P Am	120/70	110/70	120/70	120/80	110/80	100/60	110/60	110/60	110/70
Pm		120/70	110/60	110/70					

NEW BORN EXAMINATION FORM

Baby Adwoa Dasaah Date of Assessment: 28/11/22 Time: 4:15am

f Birth: 28/11/22 Time of Birth: 3:15 am Sex: ☐ M ☑ F Age at time of Assessment (days/hrs) 1

nal Age 38 wks ☐ Mode of Delivery: ☑ Vaginal Assisted Vaginal C-Section

R: 1min 8 5min 9 Birth Weight: 3.5 kg ☐ Length 51 cm Head Circumference: 34 cm

rature at time of Assessment: 36.9 °C Urine passed: (Yes) No Meconium passed: (Yes) No

of Assessor (Midwife/Doctor): Hameeda Quansah

piration
41
< 30 b/m *
< 60 b/m *
60 b/m
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7. Suck
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☐ Weak
☐ Absent

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

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

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

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

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

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

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

16. Clavicle
☑ Normal
☐ Swelling/Fracture

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

18. Heart rate
Rate: 132
☑ Normal (100-160)
☐ <100 *
☐ >160*

19. Femoral pulse
☑ Present
☐ Not palpable*

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

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

22. Limbs
☑ Normal
☐ Abnormal _____

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

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

24. Anus
☑ Patent
☐ Imperforate*

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

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

indicate severe disease that requires urgent referral

oses (if known) Normal Baby

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

NEW BORN EXAMINATION FORM

Name: Baby Adwoa Dasaah Date of Assessment: 28/11/22. Time: 4:15a

Date of Birth: 28/11/2022 Time of Birth: 2:15am Sex: ☐ M ☑ F Age at time of Assessment (days/hrs) 1

Astational Age 3☒ wks ☐ Mode of Delivery: ☑ Vaginal Assisted Vaginal C-Section

APGAR: 1min 8 5min 9 Birth Weight: 3.5 kg ☐ Length: 51 cm Head Circumference: 34 cm

Temperature at time of Assessment: 36.9 °C Urine passed: (Yes) No Meconium passed: (Yes) N

Name of Assessor (Midwife/Doctor): Hameeda Quansah

1. Respiration
Rate 41
☐ Rate < 30 b/m *
☐ Rate < 60 b/m *
☑ 30-60 b/m
☐ Retractions *
☐ Grunting *
☐ Stridor *

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

3. Tone
☑ Normal
☐ Floppy *
☐ Increased *

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

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

6. Cry
☑ Normal
☐ Shrill *
☐ Absent *

7. Suck
☑ Good
☐ Weak
☐ Absent

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

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

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

11. Eyes
☑ Normal
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☑ Normal (size / shape/position).
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☑ Normal
☐ Swelling
☐ Webbed
☐ Other: _____

16. Clavicle
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☐ Maases: _____
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☑ Normal
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☑ BCG ☐ Polio Immunization
☑ Antibiotics in mother
☐ Antenatal corticosteroids

*May indicate severe disease that requires urgent referral

Diagnoses (if known) Normal Baby

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

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

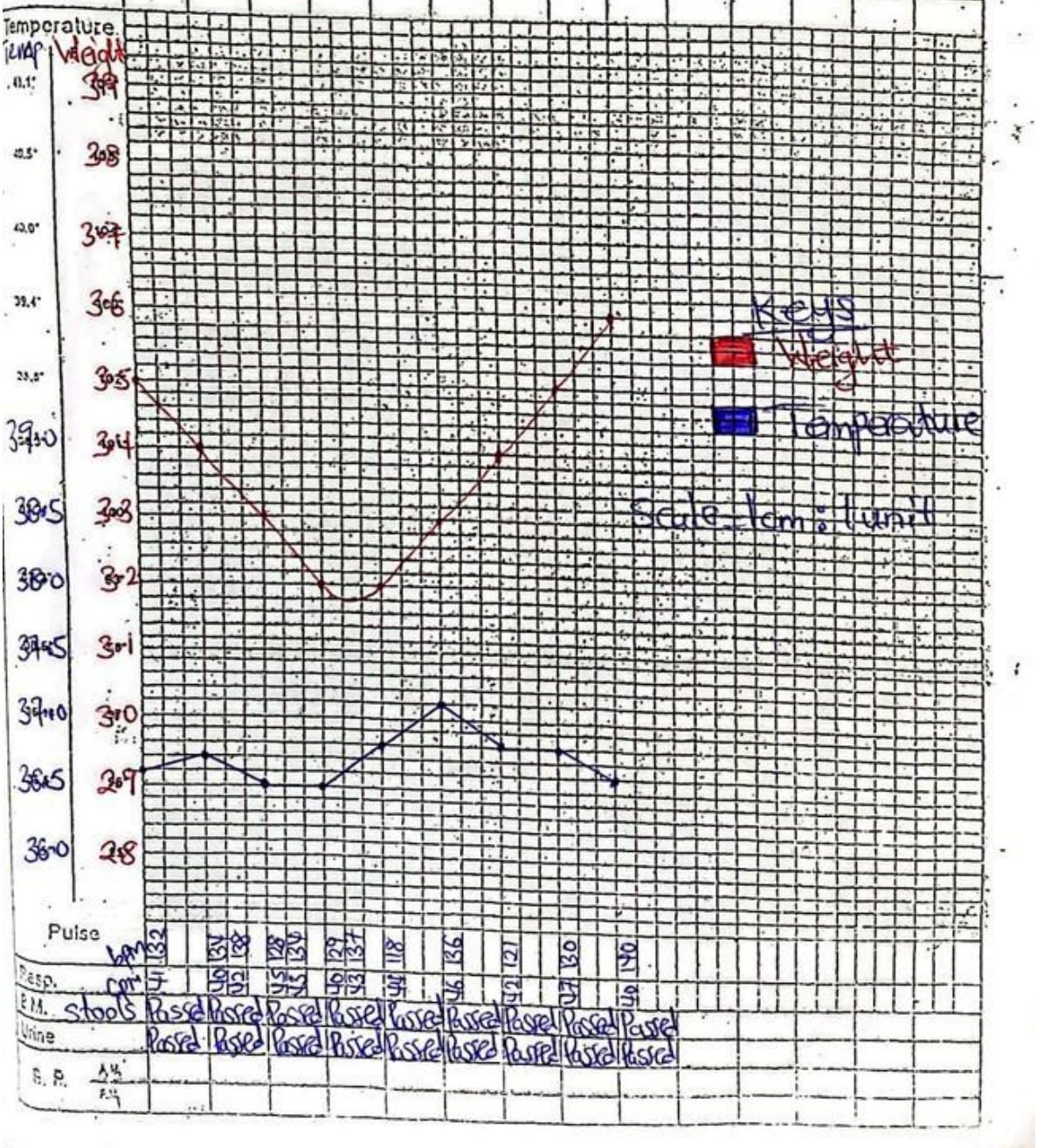
TEMPERATURE CHART

NAME: Baby Adwoa Dasaah

AGE: Newborn (Term baby) WARD: Lying-In

HOSP. NO.: 82/22 BED NO.: 6

Date	28/11/22	29/11/22	30/11/22	1/12/22	2/12/22	3/12/22	4/12/22	5/12/22	6/12/22
Days in Hospital	DOB	D1	D2	D3	D4	D5	D6	D7	D8
Days P. O.									
Hour AM	7:30	7:00	7:00	7:00	7:00	7:00	7:10	7:00	10:00
PM	-	5:00	5:00	5:00					
Temperature Temp									
Weight									
Pulse bpm	132	131	128	129	118	136	121	130	130
Resp. cpm	54	52	52	53	54	46	42	42	40
B.M. Stools	Passed	Passed	Passed	Passed	Passed	Passed	Passed	Passed	Passed
Urine	Passed	Passed	Passed	Passed	Passed	Passed	Passed	Passed	Passed
B. P. AM / PM									



NEW BORN CHART

Name: Baby Adwoa Dasaah No: 82/22 Birth Weight: 3.5 kg

Sex: Female Mother's No: 82/22 Length: 51 cm

Nature of Delivery: Spontaneous vaginal delivery Diagnosis: Term baby

Date of Birth: 28/11/22 Time: 3:15 am Date of Discharge: 28/11/22

Date	28/11/22		29/11/22		30/11/22		1/12/22		2/12/22		3/12/22		4/12/22		5/12/22		6/12/22					
No. of Days	DOD		D1		D2		D3		D4		D5		D6		D7		D8					
Weight	3.5kg		3.4kg		3.3kg		3.2kg		3.2kg		3.3kg		3.4kg		3.5kg		3.6kg					
	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM
Temperature	36.6°C		36.7°C	36.8°C	36.5°C	36.6°C	36.5°C	37.0°C	36.8°C		37.1°C		36.8°C		36.8°C		36.6°C					
Stools	Passed		Passed	Passed	Passed	Passed	Passed	Passed	Passed		Passed		Passed		Passed		Passed					
Urine	Passed		Passed	Passed	Passed	Passed	Passed	Passed	Passed		Passed		Passed		Passed		Passed					
Remarks	Head Neck Trunk		No abnormalities detected																			

SIGNATORIES

THE STUDENT MIDWIFE

NAME: HAMEEDA QUANSAH

SIGNATURE: .....

DATE: June 20, 2023

THE MIDWIFE IN-CHARGE (FIASO CHPS COMPOUND)

NAME: MS. VICTORIA ASOMANING

SIGNATURE: ..... (for)

DATE: 14/07/2023

SUPERVISOR

NAME: MS. ERNESTINA MENSAH

SIGNATURE: .....

DATE: 21-06-2023

THE PRINCIPAL

NAME: MONICA NKURUMAH

SIGNATURE: ..... (A)

DATE: 14/07/2023