HOLY FAMILY NURSING AND MIDWIFERY TRAINING COLLEGE

BEREKUM

A CLIENT/FAMILY CENTERED MATERNITY CARE STUDY ON

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BY

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

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PREFACE

Family centered maternity care study is a modern nursing approach of caring for a prenatal woman throughout pregnancy, labour and puerperium considering the fact that the client is a unique individual with special needs that the student midwife takes care of.

The care aims to offer a holistic care to an expectant mother focusing on a natural birth process, which needs very efficient nursing intervention.

The family centered maternity care enables the student midwife to put into practice all the knowledge and skills obtained during three years training to render a comprehensive midwifery care to a pregnant woman and her family. This will also help to make the client and family to be aware of certain minor disorders in pregnancy and how to manage them at home. Again, this care is undertaken in order to improve upon the student's writing skills in midwifery and to establish good interpersonal relationship between client and family.

Furthermore, the study will also help the student midwife to interact with client, identify her problems and provide appropriate management.

This is in partial fulfillment of the award of Diploma Certificate in Midwifery from the Nursing and Midwifery Council.

For the sake of confidentiality, Madam Akosua Margaret represents the name of my client.

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INTRODUCTION

Family centered maternity care study is a written document on the care offered to a pregnant woman and her family on a thoughtful understanding of the client as a unique individual with special problems and needs.

This care provides an opportunity for the student midwife to have one on one interaction with client, her family and other close members of the community and to have the chance to know what other people's perspective about pregnancy and delivery is.

The care study is divided into four (4) chapters 1, 2, 3 and 4.

Chapter one talks about assessment of client/family and it includes client profile, past and present medical history, surgical and menstrual history, past obstetric history and family's medical and socio-economic history.

Chapter two has the information on the antenatal care including our first contact and antenatal home visits.

Chapter 3 involves admission and management of client in labour from first stage to fourth stage

And chapter four is about the narration of Care given during puerperium.

WHY I CHOSE MY CLIENT

Madam Akosua was met on the 25th of November, 2021 at 11:30am during one of her routine visits to the antenatal clinic. On her turn for routine general examinations as she was approaching, noticed were made on her chewing white clay. This made me asked why she is eating the white clay and said she doesn't feel like eating any food apart from white clay. Opportunity was taken to educate her on the effect of eating white clay during pregnancy. This gave me the opportunity to take her as my client.

Introductions were made to her as a student midwife from Berekum Nursing and Midwifery training college and I'm doing my clinical practicum. It was further explained to her that she will be taken care of through antenatal till she delivers. Antenatal book were glanced through and she was gravida 3para 2 all alive with 36weeks plus 5days gestation which was her six antenatal visit and had a good past obstetric. She also did not have any medical condition which could make her pregnancy, labour and puerperium eventful. It was also realized she has never used any family planning methods before and this caught my attention and I decided to take her as my client in order to educate her.

My intentions were then made known to her, she was glad and pledged her full support for the study, and we exchanged phone numbers and asked for the location of her house and promised to pay her a visit within the week.

LITERATURE REVIEW

Literature review is a comprehensive summary of previous research on a topic. It is a text of scholarly paper, which includes the current knowledge including substantive findings as well as theoretical and methodological contributions to a particular topic. It is most often associated with academic oriented literature, such as reviews found in academic journal, textbooks, articles and other published and unpublished materials.

In my study, some of my reviews were taken from the antenatal record book, dictionary and midwifery text books and are on the topic, pregnancy, labour and puerperium.

PREGNANCY

Fraser and Cooper (2009) states that as soon as pregnancy is confirmed, many physiological changes take place in the body and return to its pre-pregnancy state during puerperium due to the effect of certain hormones namely oestrogen and progesterone. These hormones are responsible for the major changes that take place during pregnancy. Even though these hormones have their own effects by causing the minor disorders that occur during pregnancy, they are one way or the other an advantage for the mother and the growing fetus since the fetus depend solely on the mother for survival when in utero.

According to Fraser and Cooper (2008) variety of care that are rendered to the expectant mothers and their entire families includes history taking, physical examination (head to toe examination and abdominal examination i.e. inspection, palpation and auscultation), laboratory investigation (urine, blood and stool), administration of routine drugs (folic acid, ferrous and multivitamin), Sulphadoxine Pyrimethamine as malaria prophylaxis and tetanus diphtheria, education on minor disorders, danger signs of pregnancy, diet, travelling, rest and sleep, exercise ,personal and environmental hygiene, birth preparedness and complication readiness.

Perry (2006), states that pregnancy is a period of physical and psychological preparation for child and parenthood. According to him parent visit ideally begins soon after the first missed menstrual period to ensure good health of the expectant mother and fetus. He also said that, normal pregnancy lasts for about 40 weeks or 280 days and the period of pregnancy has been divided into trimesters. The first trimester begins from week 1 through to week 13, and the second trimester from week 14 through 26 and the third trimester from 27 through 40 weeks. A pregnancy is considered to be at term when it advances from 38 to 40 weeks.

The Ghana Health Service (2008) also stated that, antenatal care is the health care and education given to pregnant women during pregnancy to prevent complications and to promote health care. It went on to state some objectives of pregnancy of which some are as follows;

1. To promote and maintain the physical, mental and social health of mother and baby by providing education to the pregnant mother on nutrition, rest, sleep, personal hygiene, family planning, immunization, danger signs, STI, HIV/AIDS and birth preparedness.
2. To detect and treat high risk conditions arising during pregnancy whether medical, surgical or obstetrical.
3. To ensure the delivery of a full-term healthy baby with minimal stress or injury to mother and baby.
4. To help prepare the mother to breastfeed successfully, experience normal puerperium and take good care of the child physically, psychologically and socially.
5. To ensure safe delivery and postpartum health.

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

pregnancy last for about 40 weeks or 280 days and healthcare providers refer to early, middle and late pregnancy as trimesters.

Tiran (2008) also stated that pregnancy is the condition of having a developing embryo or fetus within the body. It is the state from conception to the delivery of the fetus. The normal duration is about 280 days, 40 weeks or 9 months 7 days counted from the first day of the last normal menstrual period to delivery.

Tiran stated that during this period, psychological changes occur due to the effects of oestrogen and progesterone which provide nutritive and protective environment for the developing embryo and also prepares the breast for lactation.

Verralls (third edition) said that, towards the end of pregnancy, rising levels of the hormone relaxin effect softening the collagenous content of the cervix.

Ojo (2006) said that when pregnancy occurs, menstruation seizes and return some weeks or months after delivery. The hormone progesterone and oestrogen and produced in large quantities which exert some action on the various systems of the pregnant women. The most outstanding of these changes is the growth which occurs in the uterus.

According to Fraser and Cooper (2009), the anatomical and physiological, the peritoneal sac is greatly distorted as the uterus enlarges and rises out of the pelvis, carrying

the other anatomical parts with them. The increasing tension exerted on the broad ligaments cause them to become longer and wider and the anterior and posterior folds open out so they are no longer in apposition and can therefore accommodate the greatly enlarge uterine and ovarian arteries and veins.

The myometrium, during pregnancy increases in cell number due to the cell division (hyperplasia). Also, there is increase in size of myometrial cell (hypertrophy) under the influence of oestrogen. During the latter half of pregnancy, the uterus expands directly owing to distension of muscle cell by the growing fetus and placenta.

The endometrium, after the embedding of the blastocyst, there is thickening and increased vascularity of the lining of the uterus or decidua. Under the influence of progesterone and oestrogen there is increased decidualization that is thicken or increased vascularity of the lining of the uterus which is most marked at the fundus. The decidua is believed to maintain the decreased uterine activity during pregnancy.

LABOUR

Tiran (2008) defines labour as the process by which product of conception are expelled from the uterus through the birth canal. She continued that labour normally occurs spontaneously at term that is between 38th and 42nd weeks of pregnancy.

The fetus should present with vertex and once started, the contractions should increase in strength and frequency without interruption or artificial stimulation until baby and placenta and membranes have been completely expelled by the maternal effort through the vagina.

Furthermore, Fraser and Cooper (2009) say labour in the physical sense, may be described as the process by which the fetus, placenta and membranes are expelled through the birth canal. Also, normal labour occurs between 37th and 42nd weeks gestation and also states further that the transition from pregnancy to labour is a sequence of events that often begins gradually. This book also outlined three stages of labour as;

First stage; This starts when the cervix dilates from 0cm, in the presence of rhythmic contractions, and is complete when the cervix is dilated (1Ocm).

Second stage; it begins when the cervix is fully dilated and is complete when the baby is born.

Third stage; the third stage talks about the separation and expulsion of placenta and membranes; it also involves the control of bleeding. It lasts from the birth of the baby until the placenta and membranes have been expelled.

PUERPERIUM

Fraser and Cooper (2009) stated that puerperium starts immediately after delivery of the placenta and membranes and continue for six weeks after which all the systems in the woman's body will recover from the effects of pregnancy and return to their non-pregnant state. Myles also strikes 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.

Ghana Health Service (2008), defined post-natal period (puerperium) as the period from delivery to six weeks after delivery. The protocol further stated the purpose of post-natal clinic that is, to maintain the physical and psychological wellbeing of the mother and child. It also stated some care to be rendered up to six weeks postpartum. These are;

1. Giving education on family planning.
2. Inspection of the vulva and perineum for tear, swelling and pus.
3. Inspection of the pad for bleeding and lochia, its smell and quantity.
4. Palpating the uterus for signs of involution.
5. Inspection of pallor.

In addition, Perry (2006) defines postpartum period as the interval between the birth of the newborn and the return of maternal reproductive to their normal non-pregnant state. The American academy of pediatrics (2014) cited in their provider guide; essential care for every baby, that all babies must be given eye care by instillation of tetracycline/chloramphenicol.

According to this book, partograph is a recommended tool by the World Health Organization (WHO) for monitoring, documenting and managing labour. WHO also states some important of partograph;

1. Gives a complete picture of the condition of the mother, baby and the progress of labour.
2. Provides guidelines on when labour is no longer ‘normal’ and on management for these situations

Dutta (2011) also explains the immediate care of the newborn that;

1. Air passage (oropharynx) should be cleared of mucus and liquor by gentle suction when the head is delivered.
2. Apgar rating at 1 minute and at 5 minutes is to be recorded.
3. Clamping and cutting cord; the cord is clamped by two Kocher’s forceps, the nearer one is placed 5cm away from the umbilicus and is cut in between.

Fraser and Cooper (2009) also said something about warmth as part of the immediate care. According to them the baby should be dried to prevent evaporation from his wet skin and then given to mother to maintain warmth. Warm wrappers are placed on the baby, if necessary, skin to skin contact.

Identification two record date and sex. An indelible pen should be used and the writing should be cleared and legible.

Dutta (2013) mention that, a quick check is made to detect any abnormalities and the baby is wrapped with a dry warm towel.

Varneys (2014) also states, the physical examination and the management of the fourth stage of labour, Varneys states that;

1. Vital signs should be checked regularly every 5 to 15 minutes.
2. Evaluate vaginal bleeding very 5 to 15 minutes immediately after birth.
3. Evaluate the uterus every 5 to 15 minutes by assessing the position and tone.

4. Evaluate the bladder immediately after the third stage and at least 30 minutes after birth.
5. Evaluate the perineum immediately after birth or after the third stage of labour.

Eye drops/ointment to prevent eye infections and also administering of vitamin K injection to prevent hemorrhagic disease of the newborn as well as cord dressing.

Again, 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;

1. Lochia rubra; it is seen in the first 3 days and consist of blood, decidua and trophoblastic debris and may contain some smell clots. It is bright red in colour.
2. Lochia serosa; it is seen during the next 4 to 9 days, it consists of old blood serum, leucocytes and tissue debris. It is pinkish in colour.
3. 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 to 14 days.

CHAPTER ONE

ASSESSMENT OF CLIENT AND FAMILY

1.0 INTRODUCTION

This chapter consists of detailed information on assessment of client and family which includes client personal history, social history, habit of daily living, family history, medical history, surgical history, menstrual history, past obstetric history and present obstetric history.

1.1 PERSONAL HISTORY

Madam Akosua, gravida three Para two all alive (G3P2A) is a thirty-one-year-old woman born on 15th February, 1990 whose hometown is Bawku in the Upper East Region but resides at Nkrankrom. She is dark in complexion and measure 160cm tall. She is the last child of Mr. Dasanab Musah and Mrs. Mary Sumale. she has no formal education. Madam. Akosua is married to Mr. Kwaku Awenaba who she lives with at Nkrumakrom. Mr. Kwaku Awenaba is a young man of 33 years of age. He has formal education up to the primary level and he is now a farmer. The couple have 2 children who are all boys. Mrs. Akosua is a Christian who fellowships at Pentecost church with her husband and their children. According to client she has only one sexual partner who is her husband. She speaks Twi and her next of kin is her husband. Client does not smoke nor drink.

1.2 HABITS OF DAILY LIVING

Client's daily activities are as follows; she usually goes to bed between 8pm to 8:30pm and wakes up at 4am and sometimes 5:00 am. She sleeps not less than 8 hours at night. She empties her bladder 4 times and can sometime be more depending on amount of fluid taken before bedtime. She empties her bowel once a day and sometimes once in two days. Madam Akosua's favorite meal is 'Akple' with 'Ayoyo' soup. Her two boys are too young so she does most the house

chores in the house like,' [sweeping, washing of her cooking utensils and preparing breakfast for the family. After preparing breakfast and seeing the children off to school she prepare and then go to the farm. On Saturdays she usually wakes up around 6am to wash the family clothes after which she do general cleaning in the house, On Sunday as usual she wakes up prepares breakfast while her husband iron their dress for church. After they return from church, commencement of 'Akple' with 'Ayoyo' preparation then follows as it is the family favorite meal.

Her hobby is watching Ghanaian movies.

1.3 MEDICAL HISTORY

According to Madam Akosua, she has not suffered any illness like Hypertension, diabetes mellitus, Liver or kidney disease, epilepsy, anemia, asthma, sickle cell, urinary tract infection or mental disorder before. She has never been admitted in the hospital and currently she has no kwon allergy to food or drugs and has never been transfused with blood before but she normally complains of headache which is treated on an out-patient department. She is not on any drug except for the routine antenatal drugs.

1.4 SURGICAL HISTORY

She has never been involved in road traffic accident; she has never sustained injury to the pelvis, femur or rib. She has never undergone any surgeries like caesarean section, myomectomy, hysterectomy, salpingectomy, mastectomy or appendectomy before. She has also not been transfused with any blood product, example whole blood, platelet or plasma before. She has no tattoo on her body.

1.5 FAMILY MEDICAL HISTORY

According to Madam, she is the last born of Mr. Kwaku Awenaba the father and Mrs. Mary Sumale the mother. Both mother and father are all alive and very healthy. She added that, the father is a farmer and mother is a trader and they support her financially when the need arises. She confirmed that her family has no history of hypertension, diabetes mellitus, sickle cell,

heart disease, mental illness, birth defect but she has number of people who had twins same as her husband but has no history of twin gestation in his family. There are no food or drug allergies and there is no blood related illness in the family. None has not been transfused with any blood product, example whole blood, platelet or plasma before.

1.6 MENSTRUAL HISTORY

Mrs. Akosua Margaret said she experienced her menarche when she was 18years. She has 28 days' cycle and bleeding normally lasts for 6 days. The flow is usually moderate with no menstrual pain. According to her, during menstruation she observes her personal hygiene by bathing at least twice daily, she uses Proper sanitary pad and changes the pad as soon as she realizes it is soaked. She could not tell her last menstrual period.

1.7 PAST OBSTETRIC HISTORY

PREGNANCY

According to client, she has got pregnant twice and has no spontaneous or induced abortion. She carried her previous pregnancies to term without any major complication except for some minor ones like nausea and vomiting, frequent micturition and leg cramps. Client has received the three doses of tetanus diphtheria injection in the previous pregnancies and took all the doses of Sulphadoxine Pyrimethamine. Madam Akosua attended antenatal care (ANC) regularly at Pentecost Clinic, Kasapin.

LABOUR

According to client, she went into labour when pregnancy was at term, labour progressed well and she had a spontaneous vaginal delivery. Duration of labour was normal with moderate blood loss. She added that all her babies were delivered per vaginum. She also added that she was not given episiotomy but only sustained a crack after delivery and she and her babies were all in good condition after delivery.

PURPERIUM

Madam Akosua said she went through puerperium successfully without any complication like puerperal infection, or breast engorgement. She practiced exclusive breast-feeding for 6months.The children had all their immunization against the childhood disease. There was no complication with her or the babies during the puerperium. Her menstrual period resumed 3months postpartum. She had support from husband, mother and other relatives. She has not used any family planning method before.

1.8 PRESENT OBSTETRIC HISTORY

According to the records in the antenatal book Madam Akosua started attending antenatal clinic on the 30th June, 2021. Last menstrual period was not known. She has done an ultrasound scan which revealed that 12th December, 2021 is her expected date of delivery. Client was I n good condition.

Record showed that her medical, surgical, family, drug and contraceptive histories were taken at her first visit to the clinic.

Some few vital signs and laboratory investigations were also done and the result are as follows;

Temperature	36.5 degree Celsius
Pulse	87 beats per minute
Respiration	22 cycles per minute
Blood Pressure	97/60 millimeter per mercury
Weight	47 kilograms
Blood rhesus	Positive
Urine alumni	Negative
Glucose 6Phosphate Dehydrogenase	No defect
Sickling	Negative

Antibody screening for HIV	Negative
Stool test	No abnormality detected

Information obtained showed that physical examination was done. Appearance was neat and gait was normal. First and second doses of Sulphadoxine Pyrimethamine have been taken on the 21st September, 2021 at 29 weeks' gestation and 19th October, 2021 at gestation 32 weeks respectively.

CHAPTER TWO

ANTENATAL CARE

2.0 INTRODUCTION

Antenatal Care is the care rendered by midwives to their client during pregnancy to ensure that both the foetus and maternal health are in good condition. It also gives information about first contact with client, home visits made and nursing care plan on problems identified.

2.1 FIRST INTERACTION WITH CLIENT

My first interaction with Madam Akosua was on the 25th November, 2021 with gestational age 36 weeks, during her 6th visit to the antenatal clinic at Pentecost Clinic, Kasapin. This happened during her turn for routine general examination. As she walked in, observations were made. Facial expression was good and general appearance was neat. As she approached, she was chewing white clay and said it helps to prevent nausea. This gave the opportunity to educate her on the effect of eating white clay which is worm infestation and also told her it can lead to anemia.

This opportunity led me to introduce myself as a student midwife from Nursing and Midwifery Training College, Berekum who is on clinical experience and expressed my desire to take her as my client for the case study.

The following vital signs were checked and recorded as follow;

Temperature	36.5 degree celsius
Pulse	80 beats per minutes
Respiration	20 cycle per minutes
Blood Pressure	119/70 milliliters of mercury
Weight	72 kilogram

A clean specimen bottle was given to client to void into it for urine test. It was explained to her that midstream urine was needed. After she had returned with the urine sample, hands were washed and dried with clean towel. Gloves were worn and urine reagent strip was dipped into the urine for about half a minute and the result were compared to the corresponding colour chart on the strip container. The results for both protein and glucose were negative and the urine was clear and not offensive. Hands were washed with soap under running water and dried. Results recorded in the antenatal book.

Laboratory investigations carried out were her hemoglobin level which was 11.0g/dl. There were no malaria parasites found in her blood and the HIV test was done and the results were negative. Madam Akosua was encouraged to empty her bladder if she had the urge after procedure for physical examination from head to toe has been explained to her and her consent was sought.

Privacy was provided, client was assisted to undress and then wear a gown given to her and unto the couch for examination. Hands were washed with soap under running water and dried with clean towel.

On the Head and neck, client hair was neatly braided. Lice and dandruff were absent on the scalp. There was no edema and rashes on the face. The sclera was checked for jaundice and the conjunctiva for pallor but none was detected. The nose and the ears were examined for pain and discharge but none were examined for pain and discharge but none were present. The lips were examined for dryness, pallor, sore and cracks but none were detected. Clients were engage in conversation and there was absence of halitosis, the gum was inspected for bleeding which was also absence and the tongue was neither pale nor coated. The neck was inspected and palpated for enlarge lymph node and distended veins but none was present.

The breast was exposed to check for sizes, shape, signs of pregnancy, dimpling and nipple retraction and condition of the skin. One breast was covered and she was asked to put the

hand of the part to examine under her head. The breast was palpated systematically in a circular manner using the inner aspect of the finger and client was reminded of self-examination every week about menses.

Nipples were squeezed gently for fluid [colostrum] and were examined for odour, blood and clean with cotton wool swab. The same examination was done on the other breast and no abnormality was noted. Breastfeeding history was asked and her desire to breastfeeding was positive as her children were breastfed.

The back examined for spinal or vertebrae abnormalities and sacral edema but none was detected.

On the extremities, client upper extremities were inspected for equality, edema of the finger, nail beds for capillary refilled and pallor of the palms and no abnormality was detected. The lower extremities were also inspected for edema, equality, tenderness in the calf muscle and varicose veins but none was detected.

Abdominal Examination

On inspection, the abdomen was medium in size and ovoid in shape. Linear nigra was present and scars and straie gravidarum were absent.

On fundal palpation; before performing the palpation, the palm was rubbed together to prevent triggering contraction. Standing at the right-hand side of the woman, the fundus was palpated with both palms and foetus was felt occupying the upper pole of the uterus. The fundus was at xiphisternum.

The symphysio fundal height is measured in centimeters and a measuring tape is used in the taking the measurement. The zero end of the tape measure was placed on the fundus of the

uterus and the tape measure was extended to the upper boarder of the symphysis pubis and the symphysio fundal height was obtained as 33 centimeters.

On pelvic palpation; both hands were placed closely together and pointing downwards and inwards below the umbilicus, the presentation was cephalic as the head of the foetus could be balloted in between the two hands and the lie was longitudinal with right occipito -anterior as foetal position. This was done when I was facing the lower limbs of the client at right hand side.

On lateral palpation; both hands were placed closely together and pointing downwards and inwards below the umbilicus, the presentation was cephalic as the head of the foetus could be balloted in between the two hands and lie was longitudinal with right occipito-anterior as foetal position. This was done when facing the lower limbs of the client at right hand side.

Descent; the anterior shoulder was first located using two fingers. The upper of the symphysis pubis was located. Five fingers were admitted between the anterior shoulder and the upper border of the symphysis pubis indicating descent of $5/5^{th}$ above the pelvic brim.

On auscultation; a feotoscope was rubbed in the palm to make it warm and was placed at area where the back was located to listen to the foetal heartbeat. While listening to the foetal heartbeat, one hand was placed at the maternal radial pulse to ensure that it's not the maternal pulse being listened to. The foetal heart rate was checked for minute and recorded as 130 beat per minute.

Vulva Examination

Permission was sought to inspect the genital area and she agreed. Hands were washed with soap under running water and dried with clean towel. Gloves were worn. The vulva was inspected for edema, scars, genital warts, rashes, discharges and varicose vein but none were present. The mons pubis was well shaved. Client was encouraged to continue practicing good

vulva hygiene. Client was asked to assume lateral position and sit up before getting out of bed. Hand washing was done and dried with clean dry towel.

All findings were recorded in client's antenatal book and communicated to her. Clients was educated on good nutrition and exercise. She was asked not to lift object that are heavy and avoid prolong standing and also educate her on the need for rest and sleep. Client took the third dose of Sulphadoxine Pyrimethamine and routine drugs given were;

Tablet Ferrous Sulphate	I daily for 30 days
Tablet Folic Acid	1 daily for 30 days
Tablet Multivitamin	I daily for 30 days

She was reminded of her date of appointment which was 2nd December,2021. Client was asked to report to the clinic if any abnormality was observed.

Permission was sought from Madam Akosua for home visit and it was granted and then directions to her house as well as her contact numbers were asked for. She was informed on the next antenatal visit which was on the 27th November, 2020.

2.2 FIRST ANTENATAL HOME VISIT

Mrs. Akosua was visited in her house for the first time on the 27th November, 2021 around 3:00pm, at Nkrumakrom where she lives.

This visit gave the opportunity to know her house, family, and the relationship between her and relatives. It also helped to assess her health condition, identify any risk factor and to give the necessary educations. Mrs. Akosua was already there waiting for my arrival when the vehicle arrived at the destination. She welcomed me and we went together to her house.

PHYSICAL ENVIRONMENT

The purpose of the visit was communicated to her that it was to know where she stays, to know the family, and also to check on her health status.

She lives in a compound house which is built with cement block and roofed with aluminum sheet, there was neither wall nor gate. The compound was not cemented but the surrounding environment was neatly swept. The compound has five completed rooms of which there are four tenants, client and husband occupied one single room with pouch. She keeps her rubbish in a box at a corner and farm produce in the pouch. The house was not painted. There was a bathroom within the house. Each room is well ventilated, windows had louvers and net. There is bore-hole in the next house where they fetch water. They have a good drainage system and their source of light is electricity.

Permission was asked from client to see both bathroom and the toilet and they were all neat. After the inspection client was congratulated for keeping her environment clean. She was encouraged to continue keeping both her own personal hygiene and good environmental sanitation as this will help improve their health. Client was educated on birth preparedness and complication readiness. She was told that her pregnancy had advanced and labour can set in any time so she has to assemble all the necessary items including her own personal items. Mrs. Akosua was asked if she was given the list of things needed for the delivery and she responded yes. She was asked to mention some of the items she bought and to my surprise, she showed me all the items she has already purchased and packed ready for labour. She was congratulated for her preparedness.

Client was asked how she will get to the clinic when any emergency arises. She answered that two of her neighbors' own taxi and they can convey her to hospital when the need arises. She was encouraged to make arrangement for some compatible blood donor who will donate to her when the need arise. She was also educated on signs of true labour; example contractions which become severe, appearance of show, lower abdominal pain and waist pain.

Danger signs of pregnancy such as bleeding per vagina, severe headache among others were discussed as well. She was however advised to report quickly to the hospital if she experiences any of them. With further communication, she made a complain of backache and not able to sleep well. She was encouraged to sleep on a firm mattress to prevent sagging and help her sleep well and use chairs with back rest in order to sit up straight.

PSYCHOSOCIAL ENVIRONMENT

When we got to the house, there was a woman sitting in front of her door who was introduced as her mum, pleasantries were exchanged to which the mum responded well. Client took me to her pouch where she handed a seat and offered pure water on a tray. Greetings were exchange and Mrs. Akosua was very happy for the visit. Her husband's where about was enquired and she told me he has not return from farm yet. while we were still talking, there was a little boy who woke up from sleep and came to her, and she told me that is her second born and also added that her mum we saw in front of her door was the one who takes care of the children any time she is not around, upon hearing this, it was noticed that client has a good relationship with her mum and the co tenant in the house which they are all happy about the pregnancy and expecting to see the new baby .Some were even saying it a girl and some also saying it a boy again. They made me laugh seeing them happily. A promise was made to visit again and was thanked for her cooperation.

2.3 SECOND ANTENATAL HOME VISIT

On the 5th December, 2021. Client was reminded of next the 2nd visit which she agreed and got there at 3:30pm, She warmly welcomed and congratulated me for being able to identify the way to the house. Client offered me water to drink and a seat. She was preparing food for her children so this made me wait for her to finish. After she was done, we exchanged pleasantries and client was asked if she has any complained. She confirmed she did not feel it

since she started practicing what she was asked to do. Before this visit, she was called to know whether the lower back pain and sleep pattern has improved or not, and client said she was able to sleep because the lower back pain has reduced and leg pain has reduced. Later, she was engaged in a conversation which was based on baby care, breast feeding, immunization and nutrition. Much emphasis was laid on birth preparedness and complication readiness, family planning after child birth, environmental sanitation and good personal hygiene. she was then asked if there is any problem or complain to which she said no but looking at the house chores she does, it came to thought that she will feel tired at times, so she was asked if she gets time to have siesta at least two hours a day and she replied no. so she added that because her husband goes to farm early, she needs to get her children ready so, her husband can send them to school and after that she continue with some of the works she does. She was also encouraged to sleep at least 8 hours in the night and 2hours in the day. After these, client was reminded of her next visit to the clinic and bid her a goodbye.

2.4 SUBSEQUENT VISIT TO THE CLINIC

On the 2nd December, 2021. Early in the morning around 6:00am, Mrs. Akosua was called on phone to remind her of the routine antenatal visit which she told me she would be coming. She reported to the antenatal clinic at 7:00am and at that time her gestation was 38 weeks. She appeared cheerful and neatly dressed. We exchanged greetings. Client was asked how the whole family is faring she said they were all doing well. She was allowed to join the other pregnant colleagues and listen to the morning talk. After that, she was taken through the necessary procedure and the routine examinations with the following readings;

Temperature	36.2 degrees Celsius
Pulse	76 beat per minute
Respiration	18 cycles per minute
Blood pressure	110/70mmHg

Weight	67.5kg
Urine Glucose	negative
Urine protein	negative

It was explained that physical examination will be done on her and she agreed. She was asked to empty her bladder and was assisted onto the examination couch and privacy ensured. Hands were washed and general physical examination was carried out with no abnormalities detected. Her abdomen appeared ovoid and foetal movement was noticed. Abdominal examination was done, Symphysio fundal height measured 38cm, fetal heart rate was 145beats per minutes, presentation was cephalic, lie was longitudinal, and descent of head was $5/5^{th}$. Findings were recorded and communicated to her. She complained of having heart burns and pain in the lower leg. She was advised not to eat spicy and fatty foods, she should eat slowly rather than eating too fast, to eat in bits and to wait for some time after eating, before going to bed. Client was told of reduction of weight and she attributed it to the heart burns. She said since she does not feel comfortable after eating, she decided to be taking tea, mashed kenkey and porridge, and most at times she does not eat to be satisfied. She was reassured that she will be fine. She was also told that it is due to pregnancy hormones working on the smooth muscles. She has then encouraged complying with the education given to reduce heart burns and she was educated on how good nutrition during pregnancy helps. Her next visit was communicated to her and she was told to expect my visit after closing. She was given the following routine drugs and she went home.

1 Tablet Folic Acid 5mg daily x 30days

2 Tablet Fersolate 20mg daily x 30days

2.5 NURSING CARE PLAN DURING ANTENATAL PERIOD

Nursing care plan is a written plan of actions or an outline of care that the midwife provides for their client. It provides direction for individualized care of a client. In my care study, my

client and her family were assessed trough a thorough history taking and observation to know their problems, identified problems were analyzed and diagnosed, care was planned, implemented and evaluated.

PROBLEMS IDENTIFIED DURING ANTENATAL

ACTUAL PROBLEMS

On the 02 /12/2021, client complained of;

1. Heart burns
2. Pain in lower leg

On the 27 /11/2021, client complained of;

3. Lower back pain
4. Insomnia

On then 05/12/2021, client complained of;

5. Fatigue

On the 08/12/2021, client complained of;

6. Misconception about family planning

SHORT TERM OBJECTIVES

1. Client will be able to relieve of heart burns within 48.

2. Client will be able to cope with back pain within 48hours.
3. Client sleep pattern will be improved within 48 hours.
4. Client will be able to relieve of fatigue within 48 hours.
5. Client leg pain will be reduced within 48 hours.
6. Client and partner will choose a desired family planning method within 48hours.

LONG TERM OBEJECTIVE

Client will go through pregnancy successfully without any complication to herself and the fetus.

NURSING CARE PLAN DURING ANTENATAL

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES	NURSING ORDERS	INTERVENTION	DATE/ TIME	EVALUATION	SIGN
27/11/2021 at 3:30pm	Backache related to changing position due to advancement of the gravid uterus.	Client backache will be subsiding within 48 hours as evidence by client verbalizing that the backache has subsided.	1. Reassure client 2. Explain the cause of pain to client 3. Encourage client to alternate sitting and standing. 4. Encourage client to support the back with pillows when lying down. 5. Encourage partner to do sacral massage for client. 6. Serve prescribed analgesics for example tablet paracetamol 1g when necessary.	1. Client was reassured that the pain she is feeling can be managed. 2. The cause of pain was explained to client that it is due to relaxation of the ligaments 3. Client was encouraged to alternate sitting and standing. 4. Client was encouraged to support her back with pillows when lying down. 5. Client partner was encouraged to do sacral massage for client. 6. Tablet paracetamol 1g was served	29/11/2021 at 3:30pm	Goals fully met as evidence by: client verbalizing that her backache has subside.	**A.K.S**

NURSING CARE PLAN DURING ANTENATAL

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES	NURSING ORDER	INTERVENTION	DATE/ TIME	EVALUATION	SIGN
27/11/2021 at 3:30pm	Insomnia related to lower back pain	Client's sleeping pattern will improve within 48 hours as evidence by client verbalizing that she was able to sleep for at least 8 hours in the night and 2 hours during the day.	1. Reassure client. 2. Explain the cause of insomnia to client. 3. Advice client to lift lighter objects rather than heavy objects. 4. Encourage client to support her back with pillows when lying down. 5. Encourage client to warm bath at night before going to bed. 6. Encourage client to take prescribed analgesics when necessary.	1. Client was reassured that her sleeping pattern will improve as soon as possible. 2. The cause of insomnia was explained to client that it is due to relaxation of the ligament which is causing the back pain. 3. Client was advised to lift objects that are light rather than heavy objects. 4. Client was encouraged to support her back with pillows when lying down. 5. Client was encouraged to have warm bath at night before going to bed to induce sleep. 6. Prescribed analgesics such as paracetamol 1g was served.	29/11/2021 at13:30pm	Goals fully met as evidenced by client verbalizing that she was able to sleep at least 8 hours in the night and 2 hours in the day.	A.K.S

NURSING CARE PLAN DURING ANTENATAL

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES	NURSING ORDERS	INTERVENTION	DATE/ TIME	EVALUATION	SIGN
02/12/2021 at 7:00am	Heartburn related to effect of progesterone on the smooth muscles of the gut and cardiac sphincter	Client will be relieved of heartburns within 48 hours as evidence by client verbalizing that she does not feel the heart burns anymore.	1. Reassure client 2. Explain the cause of heart burns to client. 3. Encourage client to eat food free of spices and to eat less fatty foods. 4. Encourage client to eat in bits and at regular intervals. 5. Encourage client to avoid lying down immediately after eating. 6. Encourage client to use extra pillows.	1. Client was reassured of competent care. 2. It was explained to client that the heart burn was as a result of dilatation in the gastrointestinal tract by progesterone hormone causing regurgitation of food. 3. Client was encouraged to eat food free of spices and less fatty foods. 4. Client was encouraged to eat in bits and at regular intervals. 5. Client was encouraged to avoid lying immediately after eating. 6. Client was encouraged to sleep on extra pillows.	04/12/2021 at 7:00am	Goals fully met evidenced by the client verbalizing that the heart burn has subsided.	A.K.S

NURSING CARE PLAN DURING ANTENATAL

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVE	NURSING ORDERS	INTERVENTION	DATE/ TIME	EVALUATION	SIGN
05/12/2021 at 3:00PM	Fatigue related to overwork at home	Client will feel less tired within 48 hours as evidenced by client verbalizing that she now feels tired at home.	1. Reassure client 2. Explain the cause of the fatigue to client. 3. Encourage client to get a support person. 4. Plan activities with client. 5. Encourage client to sleep at least two hours a day. 6. Encourage client to store frequently used items within easy reach	1. Client was reassured that everything possible will be done to help her situation. 2. It was explained to client that the fatigue is due to lack of rest. 3. Client was encouraged to invite someone to stay with her. 4. Activities were planned with client. 5. Client was encouraged to sleep at least two hours a day. 6. Client was encouraged to store frequently used items within easy reach to avoid bending and reaching.	08/12/2021 at 3:00pm	Goal fully met as evidenced by client verbalizing that she feels less tired.	A.K.S

NURSING CARE PLAN DURING ANTENATAL

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES	NURSING ORDER	INTERVENTION	DATE/ TIME	EVALUATION	SIGN
02/12/2021 at 07:00AM	Leg cramps related to poor circulation of blood in the legs.	Client leg pain will reduce within 48 hours as evidence by client verbalizing that she does not feel much pain.	1. Reassure client 2. Explain the cause of the leg cramps to client. 3. Advise client to alternate standing sitting. 4. Encourage client to elevate legs when sitting or when lying down 5. Encourage client to walk around the house often in order to improve venous return. 6. Advise client to take prescribed analgesics	1. Client was reassured her pain can be managed. 2. It was explained to client that the pain she feels is as a result of dilatation of the blood vessels caused by the hormone progesterone which has led to poor venous return. 3. Client was advised to alternate standing and sitting to avoid pooling of blood in the dilated blood vessel. 4. Client was encouraged to elevate legs on a pillow when lying down and to also elevate legs when sitting. 5. Client was encouraged to take a walk around the house often to enhance venous return. 6. Client was advised to take prescribed tablet paracetamol 1g when necessary.	04/12/2021 at 07:00am	Goals fully met as evidenced by client verbalizing that she does not feel much pain.	A.K.S

NURSING CARE PLAN DURING ANTANATAL

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES	NURSING ORDERS	INTERVENTION	DATE/ TIME	EVALUATION	SIGN
08/12/20201 at 2:20pm	Knowledge deficit related to inadequate information on family planning	Client and partner will be able to choose a desired family planning method within 10 days as evidenced by the couple making an informed choice.	1. Educate client on family planning methods. 2. Educate couple on advantage and disadvantages of family planning. 3. Correct all misconceptions about family planning. 4. Encourage the couples to ask questions. 5. Help couples to make an informed choice. 6. Refer couples to support group as needed	1. client was educated on family planning methods such as natural and artificial methods. 2. The couples were educated on advantage and disadvantages of family planning as in preventing unintended pregnancy, preventing sexually transmitted infection. 3. Misconception such as family planning causing death and was corrected. 4. The couples were encouraged to ask questions and questions were answered appropriately. 5. The couples were helped to make an informed choice. 6. The couples were referred to see other couples who have gone through the family planning process successfully.	08/12/2021 at 2:20pm	Goals fully met as evidenced by the couple making an informed choice.	A.K.S

CHAPTER THREE

INTRAPARTAL CARE

3.0 INTRODUCTION

This chapter entails a detailed narration on the client's admission during labour, and management of first, second, third and fourth stages of labour. It also involves immediate care of the baby, summary of labour notes and nursing care plan during labour.

3.1 ADMISSION AND MANAGEMENT OF FIRST STAGE OF LABOUR

A call was received from client on the 11th December 2021 at 5:00am which she complained of waist pain which started at midnight. She was asked further questions to ensure she is truly in labour. Client was asked whether show has been seen, membranes raptured or not, and whether the pain was regular. To all the questions asked, client responded yes except the membranes being intact. She was reassured and asked to come to the clinic with all her items for delivery. Preparation was made quickly to meet her at the clinics. She came to the hospital in accompany of a relative, they were welcomed and offered a seat. Her antenatal book was taken to glance through and given to the midwife on duty to also look through, the gestation was 39weeks and 2days, all antenatal investigations were done. Client was asked of the onset of the pain and she said it started at 12:00am that same day. She also confirmed she took her last meal at 6:00pm. She was reassured that there are skillful and specialized staffs that am going to work together with to ensure she deliver safely. Procedure was explained to client to perform head to toe examination on her and to go and urinate for urine testing as well. A container was given to her for the urine. Examination equipment and tools were arranged. After she came, she was taken to the examination couch for the examination. Client was made to assume a comfortable position. At this time, explanation was made to her on the lower abdominal pain that it's due to uterine contractions and she will be relieved after

delivery, she was encouraged to breathe through the mouth anytime she feels the pain. Vital signs were checked and recorded as:

Temperature	36.8 Degrees Celsius
Blood pressure	130/80mmHg
Pulse	82 beats per minute
Respiration	20cycle per minute

After vital signs were checked, her blood sample was taken to the laboratory for full blood Count, cross matching and grouping. The urine which she brought was used for urine test and results are as follow;

Protein	negative
Sugar	negative
Acetone	negative
Specific gravity	1.030
PH	6.0
Leukocytes	negative
Nitrite	negative
Urobilinogen	normal
Occult blood	negative
Bilirubin	negative

Urine testing items were discarded, hands were washed and dried, and Findings were communicated to her and documented as well.

And client was helped to assume a dorsal position after her permission has been sought to perform a physical examination. Examination was done on client by standing on her right side. Her scalp was examined for infections like lice and dandruff. Eyes for pallor, abnormal discharges and yellowish discoloration of the sclera, ear and nose were checked for abnormal

discharges, neck for enlargement of lymph nodes, breast was examined for lumps and masses, skin for rashes, legs for edema and varicose veins but no abnormality was found.

On abdominal examination, the abdomen was ovoid in shape and medium in size with no scars of previous caesarean section on it but striaegravidarium was present. The symphysio-fundal height was measured from the fundus to the symphysis pubis which measured 38cm. Linea nigra was present. On palpation, the lie was longitudinal, presentation was cephalic and position was right occipito anterior, descent was $4/5^{th}$. On auscultation, the fetal heart rate was 145 beat per minute. Contractions were 3 in 10 lasting for 32, 35.

Client's consent was sought again to perform vagina examination on her which she agreed. A tray for vaginal examination was brought with the following items;

A galipot containing savlon solution

Gallipot containing sterile cotton wool swabs

Sterile gloves

Receiver for used swabs

Mackintosh and towel

Mackintosh apron.

She was assisted into a dorsal position with her knees flexed, a mackintosh apron was worn, hands washed with soap and water, dried with a clean towel and sterile gloves worn. Five cotton wool swabs soaked in a savlon solution were used to swab the vulva; four pieces of cotton wool swabbed the labia majora and minora by dropping them into the left hand. The last cotton swabbed the vestibule using the right hand after parting the labia with the left hand. She was informed that my two fingers are going to be inserted into her vagina to know the state of her cervix, the procedure is uncomfortable but she should bear with me and client agreed. The right middle finger was inserted into the vagina first and pressed downwards followed by my index finger and the cervix was located, Membranes were intact, vagina was

moist and warm, the cervix was soft and thin and was 4cm dilated at 5:30am, the sacrum was well curved and ischia spines were blunt and sacral promontory was not touched, Moulding could not be assessed because of the intact membranes. Fingers were stained with a thin mucus and vagina discharge after withdrawal from the vagina. A sterile perineal pad was applied to the vulva and client was advised not to be touching the perineal pad frequently to prevent infection.

She was also encouraged to change the pad by time it gets soiled and advised to wash her hands before and after changing her perineal pad and to urinate 2-3 hours or whenever she feels like voiding. Client then complained of waist and lower abdominal pain. It was explained to her that it was due to contraction together with the head descent. She was encouraged to breathe through the mouth anything she is having contractions. Used items on the tray were discarded, gloved hands were dipped in 0.5% chlorine solution and discarded the gloves, hands were washed and dried and client assisted to get out of the bed. Client then asked me when she would possibly deliver her baby and cervical dilatation board was used to explain the progress of labour to allay fear and anxiety as client looks anxious. Client was informed that she is in the active stage so she may feel more contractions as this will cause further dilatation of the cervix as well as the head descent.

She was advised to assume a comfortable position preferably left lateral, all fours, knee-chest or walking around to aid fetal descent. She was encouraged to ask questions and issues worrying her to ensure she does not become worried. Client was admitted at 5:30am and her name was entered into the admission and discharge book and the ward state as well. All findings were plotted on the partograph and every information written in the nurse's note.

It was further explained to her that uterine contractions, fetal heart rate and maternal pulse will be checked every 30 minutes, blood pressure and vaginal examination 4 hourly, temperature and urine 2 hourly. Client was made comfortable in the first stage room for

monitoring. Client was served with voltic water and encouraged to take sips of it to prevent dehydration. A chair was taken and sat beside client to involve her in conversation and whenever she complains of waist pain, she was reassured. She was given series of sacral massages and a pail was made available so she can empty her bladder. She was encouraged to do deep breathing exercise with contractions so to conserve energy to push when she is fully dilated. Blood results were ready and results were 12.0g/dl.It was communicated to client.

PREPARATION FOR BIRTH

The midwife in charge who would supervise labour and delivery and also assist in the care of the baby was identified as the skilled helper whereas the unskilled helper happened to be the friend who accompanied her to the clinic and would run errand when the need arises. Emergency plan was reviewed as the telephone numbers for referral were pasted on the wall in the delivery room; doctor was informed as well as ambulance driver was also called to inform him to be on standby to attend emergency when needed. The delivery area was cleaned and a good source of light was ensured with emergency portable light present and functioning. The resuscitation table was checked, cleaned and all equipment and instruments were assembled and tested for their function. The delivery pack and the emergency drug were made available. Client's abdomen, chest and hands were all washed ready for skin to skin.

3.2 MANAGEMENT OF FIRST STAGE OF LABOUR

AT 6:00AM

Procedure was explained to client to check fetal heart rate, contractions and pulse and result were as fellows;

Fetal heart rate	138bpm
Contractions	3 in 10s lasting for 33-36seconds
Pulse	74 bpm

At 6:30am

Fetal heart rate	140 bpm,
Contractions	3 in 10s lasting 34-37 seconds,
Pulse	74 bpm

At 7:00am

Fetal heart rate	142bpm
Contractions	3 in 10s lasting 34-37 seconds
Pulse	74 beat per minutes.

At 7:00am

Fetal heart rate	141bpm
Contractions	3 in 10s lasting 35-38 seconds,
Pulse	76bpm

Client was congratulated for her effort and progress of labour was communicated to her. She was involved in a conversation as a form of diversional therapy and was encouraged to take more water to prevent dehydration.

AT 7:30am

Fetal heart rate	144bpm
Contractions	3 in 10s lasting 37-40seconds
Pulse	78bpm

At 8:00am

Fetal heart rate	142bpm
Contractions	3 in 10s lasting 38-40seconds
Pulse	80bpm

Client was offered another 500mls of chilled voltic water to continue sipping to prevent dehydration because the first water got finished. She was reassured and encouraged not to push prematurely but rather breathe through her mouth.

At 8:30am

Fetal heart rate	140bpm
Contractions	4 in 10s lasting between 41-42 seconds
Pulse	82bpm

9:00

Fetal heart rate	138bpm
Contractions	4 in 10s lasting 42-44 seconds
Blood pressure	120/80mmHg
Pulse	88bpm
Temperature	36.6-degree Celsius
Cervical dilatation	8cm
Urine volume	300mls
Protein and glucose	negative
Descent	1/5
Membranes	Intact.

Procedure was explained to her for vagina examination to be done. Items were brought close to her bed and the examination was performed under the supervision of the midwife, at this time cervical dilatation was 8centimetres which was also confirmed by the midwife. The head descent was $1/5^{th}$, membranes still intact.

At 9:30am

Fetal heart rate	140bpm
Contractions	5 in10s lasting 45-48 seconds
Pulse	88bpm

AT 10:00am

Fetal heart rate	142bpm

Contractions	5 in 10 lasting 44-46 seconds
Pulse	84bpm
AT 10:30am	
Fetal heart rate	140bpm
Contractions	5 in 10 lasting42-46 seconds
Pulse	80bpm
AT 11:00am	
Fetal heart rate	138bpm
Contractions	5:10 lasting 45-67seconds
Pulse	94.

Findings were plotted on the partograph. Immediately after checking client's vital signs, the membranes raptured spontaneously 11:25am as client complained bearing down sensation. Hands were washed and dried with sterile gloves worn and vaginal examination was done to exclude cord prolapsed. Liquor was clear, Moulding was 2++, presentation was cephalic and cervical dilatation was 10cm. Client was cleaned and a sterile pad applied on the vulva. Madam Akosua was quickly transferred to the second stage room to confirm the true signs of second stage which include, stretching of the perineum, gapping of the anus, and bladder drawn up onto the abdomen. Signs were confirmed

and delivery trolley which was already set up after admitting her was brought closer. Upper shelf containing the following packed in the delivery set;

Delivery pack containing; four clean towels

Two artery forceps

Two sterile drapes

Gallipot with sterile cotton wool swabs `

Sterile cord scissors

Receiver for placenta

Episiotomy scissors,

Penguin

Uterine catheter

sterile drapes

gallipot with sterile gauze for baby's eye.

Lower shelf containing;

Bed pan

A receiver for used swabs

Container with syringes and needles

Fetoscope

A syringe containing oxytocin drug in a covered container

Extra perineal pad

Antiseptic lotion

Sterile gloves

Small cup containing water and bulb syringe

Cord clamp

Two clean cot sheets

Lidocaine

Identification band

Measuring jug

Examination gloves

Mackintosh

All the other needed accessories were assembled for the second stage.

Client complained of severe bearing down sensation, she was reassured and continued to monitor the process. The assistant checked her vital signs and temperature was 36.6-degree Celsius, maternal pulses was 88 beats per minutes, and respiration was 22cpm, blood pressure was 120/80mmHg. On abdominal palpation, descent was $0/5^{th}$. Fetal heart rate was 151bpm with good volume rhythm, contractions-5 in 10s lasting 52secs.

3.3 MANAGEMENT OF SECOND STAGE OF LABOUR

After vaginal examination was carried out, Client was told that she was due to deliver her baby and can deliver any moment from now. She was encouraged for going through the first stage successfully and encouraged to cooperate throughout the remaining care. She was also told her baby will be delivered onto her abdomen and this will initiate bounding between her and the baby. Client was assisted to assume a lithotomy position which she preferred. The bed was protected with mackintosh, bed sheet and delivery mat. Apron, a pair of boots,

facemask, goggles, and hands were washed and dried with a clean towel and a pair of sterile gloves was donned. Client perineum was swabbed with savlon solution including her upper thigh and pubis. A sterile towel was used to drape her. Clean perineal pad was applied to the anal region to prevent contamination of the delivery field with faeces. The assistant was asked to check client's vital signs as well as fetal heart rate and recorded as FHR-150, maternal pulse- 80, BP-124/90, contractions 5 in 10s lasting 54secs. Client was encouraged to push with each contraction and rest when it wears off. Client was congratulated each time she made an effort to bear down when contractions are present, as she pushed, she was noticed raising her buttocks and she was told not to raise her buttocks to prevent perineal tears. Flexion was maintained by placing the middle and index fingers on the head exerting a gently downward pressure to allow the smallest diameter to distend the perineum. This was done to prevent tearing of the perineum. This flexion was maintained until the sub occipito-bregmatic diameter (9.5cm) distended the perineum. As crowning took place, she was asked to stop pushing and pant to prevent rapid expulsion of the head. The head was delivered gently by extension allowing the sinciput, face and chin to sweep the perineum and the face was born. The face was clean with sterile cotton soaked in normal saline. The baby's neck was felt for cord around it but there was none. After waiting for restitution and external rotation of the head to take place, indicating internal rotation of the shoulders, bringing it into the anterior posterior diameter, hands were placed on each side of the baby's head over the ears. Downward traction was applied to deliver the anterior shoulders; upwards traction to deliver the posterior shoulder and the rest of the body was delivered by lateral flexion on to the mother's abdomen along the curve of carus. An alive female infant was delivered at 11:45am on 11th, December 2021 who cried lustily after birth. Baby was quickly cleaned and dried up and shown to mother for identification of sex, baby was put on mother's abdomen to establish skin to skin contact and was covered with a clean dry cot sheet to provide warmth. The cord

was clamped with two artery forceps, the first at the length of 3 centimeters from the umbilicus and the second 2 centimeters away from the first clamp, cord was covered with a gauze to prevent splashing of blood and cut in between, separating baby from the mother, and baby was placed skin to skin on mother's chest. Madam Akosua abdomen was palpated gently to rule out presence of undiagnosed twin but nothing was detected. The assistant gave injection oxytocin 10units intramuscularly at 11:46am. The baby Apgar score assessed at first (1) minute 8/10 and the first 5minutes 9/10. The baby was shown to her mother and she identified the sex as a female and she was congratulated and thanked for her co-operation.

IMMEDIATE CARE OF THE BABY

The immediate care of the baby started when the head was born, the eyes were cleaned with sterile cotton wool swabs from the inner canthus outwards. The mouth and nostrils were suctioned with penguin to clear the air way of mucous or liquor. Baby's neck was felt for cord around neck but there was none. Cord was clamped, covered with gauze to prevent splash of blood and cut to separate baby from mother. They were dried up quickly and was placed skin to skin on mother's chest. Apgar score assessed for the first and fifth minute were 8/10, 9/10 respectively, Baby was shown to mother to identify sex which was female. An identification band bearing the name of client, sex of baby, date and time of birth as well as weight was put on the baby's wrist for identification; injection vitamin k 1mI was given to the baby intramuscularly at the left thigh to prevent bleeding. The baby's cord was observed for bleeding The Apgar score assessment was follows;

Indication	First Minute	Fifth minute
Appearance	2	2
Pulse2	2	2
Grimace	1	2
Activity	1	1

Respiration	2	2
Total	8	9

3.4 MANAGEMENT OF THIRD STAGE OF LABOUR

After the baby was delivered, abdomen was palpated to rule out any undiagnosed twin but nothing was detected. Client was informed that the placenta will be delivered. Injection oxytocin 10 units were given to her thigh. Her bladder was emptied by encouraging client to void. Her uterus was palpated to feel for contraction which was present. After seeing a gush of blood and length of cord increased which indicated placenta separation the cut end of the cord was placed in a kidney dish near client perineum to receive placenta and membranes. The artery forceps were held firmly and horizontally to the perineum with the cord in between the index and middle fingers of the right hands, the other hands were placed above the symphysis pubis with palms facing the abdomen to prevent uterine inversion. The placenta was expelled by control cord traction at 12:00pm and quickly examined but no abnormalities were found. The placenta was kept for further examination and uterus was rubbed to expel clots. Blood lost was 150mls. The vulva, vagina and perineum were all examined for tears and laceration and only the vagina sustained a crack. The uterus was well contracted, she was cleaned and perineal pad was applied. She was told to change perineal pad when soiled, and urinate frequently to aid in involution of the uterus. Client was assisted into the fourth stage room for observation. She was made comfortable in bed and was assisted to initiate breastfeeding. Delivery instruments were decontaminated in 0.5% chlorine solution for ten minutes washed and dried them ready for sterilization. Gloves discarded, Hands were then washed and dried. The delivery outcome was plotted on the partograph and as well as documented in the delivery book.

3.5 EXAMINATION OF THE PLACENTA

The placenta and its membranes were thoroughly examined on a flat surface for its completeness. On inspection, the placenta was normal with no extra lobes. The cord had two arteries and a vein and there was Wharton's jelly on it. The cord was centrally situated and fetal surface was grayish blue. The placenta was held by the cord upwards and the membranes allowed to hang and membranes were spread. The amnion and chorion were all intact. The placenta was placed upside down to view the maternal surface and it was dark red in colour with cotyledons present; with no infarct. The weight of the placenta was 500grams; length of cord was 48cm. The placenta was disposed into a bucket made to receive it. The working flat surface, bed and trolley were cleaned with 0.5% chlorine solution. Used disposable items were discarded and instruments were decontaminated in 0.5% chlorine solution for 10minutes, washed, rinsed, dried and later sterilized. All findings were documented appropriately.

3.6 MANAGEMENT OF FOURTH STAGE OF LABOUR

This stage involves close observation of both mother and baby for the first six hours after delivery to detect any abnormality or changes in their condition. Post- delivery vital signs were checked and recorded. Client and baby were transferred into the lying-in ward for further observations.

MOTHER

Madam Akosua's vital signs were checked and recorded on the partograph every 15 minutes for the first 2 hours, 30minutes for 1 hour and every hour for the next 3 hours. Uterus was palpated and it was well contracted and fundal height of 17cm above the symphysis pubis, her perineal pad was observed again and the bleeding was moderate. Client was advised to change her perineal pad whenever it is soiled, urinate frequently and to breast feed

the baby. Vitamin A capsule 200,000 international units orally was served to mother and to repeat twenty-four hours' time.

Client's vital signs taken and recorded after delivery were as follows;

Temperature	36.8 degree Celsius
Pulse	86 beats per minute
Respiration	24 cycles per minute
Blood pressure	110/80mmHg

Baby was also observed and the skin was pink and she was active. Breathing pattern was normal, suckling reflex present and the umbilical cord was not bleeding.

Breastfeeding was initiated within the thirty minutes after delivery and baby passed meconium again at 12:15am, both mother and baby were in good condition and made comfortable in bed.

PREVENTION OF DISEASE

This was done within the first 90 minutes to prevent infections such as ophthalmic neonatorium a condition which is notifiable, neonatal tetanus and hemorrhagic disease of the newborn therefore the following treatments were given.

The babies were cared for using tetracycline from inner to the outer canthus; the umbilical cord was dressed with chloherzidine gel. Vitamin Kl was given after the examination. Hands were washed and dried with a clean towel.

3.7 EXAMINATION OF THE BABY

After delivery, baby was examined from head to toe to detect any abnormality and early intervention. Procedure was explained to Madam Akosua and after she agreed, a tray was set for the examination which contains; gallipot with sterile cotton wool swabs, cord ligature, cord scissors, receiver and gloves. Door and windows were closed, light put on, plastic apron worn, hands washed and dried and examination glove don. Baby was examined on a protected flat

surface in the presence of the mother. Baby was exposed and, on an inspection, skin was pink, limbs were flexed, respiration was good and she was active as well. The head has a normal size with caput succedaneum or cephal hematoma. The fontanels were not bulging or sunken. The posterior fontanels accommodated only a finger and anterior one two fingers. Client was advised not to apply hot water on the head. The face was normal without any birth mark, swelling or redness. Eyes were without discharge; sclera was white and conjunctive was also pink. The nose has normal size with two patent nares. The lips and tongue were pink, no tongue tie, no false teeth and cleft lip or palate.

The neck has no enlarged lymph nodes and the rise and fall of the chest was normal and rhythmic. The breast was normally situated. The upper extremities were equal with no extra digit and there was a good capillary refill. The abdomen was round and soft with umbilical cord centrally situated without any bleeding. The vulva was inspected and labia majora covered the labia minora. Anal region was patent since baby has already passed meconium. Lower extremities were also equal without extra digit or webbed foot. Baby was examined and spine was normal without any detection of missed vertebrae or spinal vertebrae.

After the examination, baby was wrapped and given to the mother, hands washed and dried and all findings were communicated to her. Mother was advised to use only cotton and spirit to clean baby's cord, wash hands before and after dressing the cord and to start bathing baby after the cord is off. The examination area was cleaned and items discarded.

3.8 SUMMARY OF LABOUR NOTES

Madam Akosua G3P2 had a spontaneous vagina delivery to a live female infant on the 11/12/2021 at 11:45 am. An injection oxytocin 10 unit was given on her thigh after the delivery of the baby. Placenta and membranes were carefully delivered by control cord traction at 12: 00 am. The following are the findings of the baby, mother and placenta.

THE DURATION OF LABOUR FOR THE STAGE WERE AS FOLLOWS

First stage	6hours
Second stage	15minutes
Third stage	6minutes
Total duration	6hours 21minutes

CONDITION OF BABY AT BIRTH

After birth, baby was wrapped with warm cot sheet and was sent to mother side to start breastfeeding and her general condition was satisfactory.

The following findings were obtained and recorded as;

Temperature	36.2 degree Celsius
Apex heart rate	138 beat per minute
Respiration	40cycles per minute
Head circumference	32 centimeters
Baby's weight	2.8 kilograms
Length	50centimeters
General condition of baby	Satisfactory
Meconium	Passed
Urine	Passed
Sex	Female

CONDITION OF MOTHER AFTER DELIVERY

Temperature	36.8 C
Pulse	82 beats per minute
Respiration	24cycles per minute
Blood Pressure	120/80mmHg
State of uterus	well contracted
Lochia drainage	moderate
Fundal height	17cm
Perineum	Intact
Blood loss	150mls
General condition	satisfactory

CONDITION OF PLACENTA AND MEMBRANES

Condition of placenta	health and intact
Lobes	complete
Membranes	intact
Cord insertion	centrally situated
Maternal surface	dark red
Fetal surface	grayish blue
Arteries	two
Vein	one
Weight of placenta	500grams

NURSING CARE PLAN DURING LABOUR

PROBLEMS IDENTIFIED DURING LABOUR

ACTUAL PROBLEMS

On the 11/12/2021, client complains of;

1. Lower abdominal pain

2. Frequency of micturition

3. Waist pain

4. Client was observed being anxious

POTENTIAL PROBLEM

On the 11/12/2021, client complains of;

5. Risk for perineal trauma

6. High risk for dehydration

SHORT TERM OBJECTIVE

1. Client will be able to cope with lower abdominal pain throughout labour.
2. Client will be able to cope with frequent micturition throughout labour.
3. Client will be able to cope with waist pain by the end of labour.
4. Client will be relieved of anxiety within 1 hour.
5. Client will be able to maintain normal fluid volume within 1 hour

LONG TERM OBJECTIVE

To ensure that client goes through labour safely and deliver an alive healthy baby without any complication to both mother and baby.

NURSING CARE PLAN ON LABOUR

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVE	NURSING ORDERS	INTERVENTION	DATE/ TIME	EVALUATION	SIGN
11/12/21 at 5:00am	Lower abdominal pain related to contraction of the uterus	Client will be able to cope with lower abdominal pain throughout labor as evidenced by client coping with labor pains till delivery of baby.	1. Reassure client 2. Explain the cause of pain to client. 3. Help client to assume a comfortable position. 4. Encourage client to breathe through the mouth during contractions. 5. Provide diversional therapy for client.	1. Client was reassured that the labour pains will stop after delivery. 2. It was explained to client that the labour pains was due to strong uterine contractions. 3. Client was helped to lie on her left side to make her feel comfortable. 4. Client was encouraged to breathe through the mouth during contractions and rest after the contractions. 5. Client was involved in a conversation to divert her attention from the pain.	11/12/21at 10:25am	Goals fully met as evidenced by client coping with pain till delivery of the baby.	A.K.S

NURSING CARE PLAN ON LABOUR

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVE	NURSING ORDERS	INTERVENTION	DATE/ TIME	EVALUATION	SIGN
11/12/21 at 6:00am	Frequency of micturition related to pressure of fetal head on the bladder.	Client will be able to cope with frequency of micturition throughout labor as evidenced by midwife observing that client coped with frequent micturition throughout labor.	1. Reassure client 2. Explain the cause of frequency of micturition to client. 3. Encourage client to urinate frequently 4. Serve client with a warm bedpan 5. Check urine for sugar, protein, acetone and volume.	1. Client was reassured that the frequency of micturition will stop after she delivers. 2. It was explained to client that it was due to the fetal head pressing on the urinary bladder to reduce capacity in labour. 3. Client was encouraged to urinate intermittently 4. Client was served with warm bedpan to urinate in. 5. Urine was checked for protein, acetone and sugar as well as volume with good results.	11/12/21at 10:25am	Goals fully met as evidenced by the midwife observing that client coped with frequent micturition throughout labor.	A.K.S

NURSING CARE PLAN ON LABOUR

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES	NURSING ORDERS	INTERVENTION	DATE/ TIME	EVALUATION	SIGN
11/12/21 at 6:00am	Waist pain related to further descent of fetal head into the pelvis	Client will cope with waist pain until delivery of baby as evidenced by student midwife observing that client was able to cope with waist pain throughout labour.	1. Reassure client that pain will be relieved after delivery. 2. Explain the cause of pain to client. 3. Help client to assume a comfortable position. 4. Give the client sacral massage. 5. Provide a diversional therapy for client.	1. Client was reassured that the waist pain will be relieved after the birth of her baby 2. Client was educated that the waist pain was as a result of the fetal head descent. 3. Client was assisted to alternate from left lateral to all fours and knee chest positions. 4. Sacral massage was done for client to relieve her of the waist pain. 5. Clients was engaged in a conversation to divert her attention from the pain.	11/12/21 at 10:25am	Goals fully met as evidenced by student midwife observing that client was able to cope with the waist pain throughout labor.	A.K.S

NURSING CARE PLAN ON LABOUR

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES	NURSING ORDERS	INTERVENTION	DATE/ TIME	EVALUATION	SIGN
11/12/21 at 5:30am	Anxiety related to unknown outcome of labour.	Client's anxiety will be allayed within 1 hour as evidenced by student midwife observing that client remained calm throughout labour.	1. Reassure client 2. Explain every procedure to client before performing any task. 3. Communicate all findings to client. 4. Introduce client to mothers who have successfully gone through labour and deliver 5. Encourage client to ask questions on issues worrying her and answer every question tactfully.	1. Client was reassured that she is in competent hands. 2. Every procedure was explained to client before performing tasks to gain her cooperation. 3. Findings like cervical dilatation, fetal heart rate and contractions were communicated to client. 4. Three women who have a successful delivered were introduced to client to boost her confidence that she can deliver safely. 5. Client was encouraged to ask questions on issues worrying her and her questions were tactfully answered to make her calm.	11/12/21 at 6:30am	Goals fully met as evidenced by student midwife observing that client remained calm throughout labour.	A.K.S

NURSING CARE PLAN DURING LABOUR

Date/ Time	Nursing Diagnosis	Nursing Objective	Nursing Order	Nursing Intervention	Date/ Time	Evaluation	Sign
11/12/21 at10:30am	High risk for fluid volume deficit (dehydration) related to profuse sweating.	Client will maintain normal fluid volume within 30 minutes as evidenced by midwife observing clients intact skin turgor.	1. Reassure client that she is in competent hands. 2. Serve client with copious fluids. 3. Improve ventilation by opening windows and on fans. 4. Maintain fluid intake and output chart and balance it. 5. Observe client for signs of dehydration such as dry mouth.	1. Client was reassured that she is in competent hands. 2. Client was served with water and IV normal saline was slowly titrated on client. 3. Windows were opened and fans were on to improve ventilation. 4. Fluid intake and output chart was maintained and balanced. 5. Client was observed for signs of dehydration.	11/12/21 at 12:00am	Goal fully met as evidenced by midwife observing clients intact skin turgor.	A.K.S

CHAPTER FOUR

CARE DURING PUERPERIUM

4.0 INTRODUCITON

This chapter describes the management of both mother and baby from the day of delivery up to six weeks postpartum. It starts immediately after the complete expulsion of the placenta and membranes and subsequent control of hemorrhage. In this stage, all reproductive organs return to their pre- gravid state except the breast since lactation is established.

4.1 DAY OF DELIVERY

Baby Ama Margaret was born on Saturday, 11/12/21 at 11:45am, and after delivery, Client and her baby were observed 6 hours at the lying-in ward. Mother's temperature, pulse, respiration, blood pressure was closely monitored every 15 minutes for the first two hours, every 30 minutes for the next one hour and hourly for the next three hours after which it as checked every four hours.

Client was encouraged to continue massaging her own uterus and report any bleeding per vaginum, ambulate, void frequently. Rest and sleep were emphasized. She was then served with rice and kontomire.

Her first vital signs were checked and recorded as follows:

Temperature	36.6 degree Celsius
Pulse	86 beat per minute
Respiration	24 cycles per minute
Blood pressure	110/85 mmHg
Fundal height	17cm
Uterus	well contracted
Urine	twice

Lochia was red (rubra) and flow was small. Perineum was intact. She was educated to feed baby on demand, 2 hourly or at least eight to twelve times daily to ensure adequate feed and to also serve as a method of family planning, it again increases bonding between mother and child. She was told to change perineal pad frequently and wash hands before breastfeeding the baby and after attending natures call. Head to toe examination was done and no abnormalities were detected. She was asked to take her bath.

4.2 SUBSEQUENT CARE OF THE BABY

This is a care given to the baby six (6) hours after delivery. This consists of bathing the baby, dressing of the cord and also monitoring of vital signs.

Baby bath

Requirements

Methylated spirit in sterile gallipot

Surgical gloves

Sterile water in a gallipot

Baby's Soap

Baby's Sponge

Baby oil, Comb, savlon, pomade, diaper, socks, dress, cap

Sterile cotton in a galipot or wrapped

Basin

Towels: 1 big towel and 3 small ones

Cot sheets 2

Apron

Disposable gloves

Mackintosh

2 jugs containing warm and cold water each

Two receptacles for used water and dirty linen

A receiver for used swab.

A tray for cord dressing.

24 hours after delivery, mother was told that baby will be bathed for the first time and after that topped and tail will be done until the cord comes off before she can start bathing the baby procedure was explained to her.

All items to be used for the procedure were assembled, as above. Fans were put off and light turned on, privacy was provided by closing windows.

A plastic apron was put on. Hands were washed with soap under running water and dried with clean towel. Gloves were worn and the baby was put on a safe flat surface protected with mackintosh and was undressed. Baby was then wrapped with a cot sheet and examined thoroughly. Water was mixed afterwards and temperature tested with my elbow. The head was exposed for it to be bathed. The eyes were cleaned (wiped) with clean cotton wool swabs soaked in clean water from inner canthus to the outer canthus and the face cleaned gently with damp face towel and dried. The nape of the baby's neck was supported with one hand. The head was supported and the baby's ears plugged with thumb and middle finger to prevent water from entering the ears. The head was then washed with soapy sponge, rinsed in the bathing basin and dried up with a towel. Baby was then lifted off flat surface, supporting at the nape of the neck and the body resting in the elbow and brought to the edge of the basin and soap rinsed off baby's hair and dried. Baby was then put on protected flat surface and exposed. The arms and front of trunk were

washed paying attention to the skin folds. Then baby was turned with one arm supporting the chest with one hand holding the distal arm of the baby. The back was washed down to the feet, paying attention to the skin folds. Baby was supported firmly and immersed in a bath of

warm water and rinsed thoroughly. She was then placed on the flat surface covered by a bath towel. A small towel was used to dry baby, paying attention to the skin folds. Baby oil as well applied on her and powder. A diaper was put on and the baby dressed and wrapped with cleaned cot sheet after which the hair is combed.

Below findings were recorded during the head-to-toe examination;

Fontanels	soft and pulsating
Eye	clear with no discharge
Nose	normally situated with no discharge
Mouth	there was no abnormalities
Neck	no nodules
Ears	normally positioned with no discharged or warts
Hands	equal with no extra digits
Chest and abdomen	normal
Vulva	well situated with the vestibule
Ureteral	patent
Legs	equal with no extra digit
Weight	2.8kg
Head circumference	30cm
Full length	50cm

CORD DRESSING

Procedure for dressing the cord was explained to the mother and the procedure was performed in her presence.

Hands were dipped in 0.5% chlorine solution, discarded my glove, washed and dried my hands. Sterile glove was worn to dress the cord. The cord was observed for bleeding which was absent, six cotton soaked with spirit, one was used to hold the clamp and the base was

cleaned in circular manner, other swabs from the base upwards using one swab at a time. The cord surface as well as the clamp was also cleaned and cord exposed to dry. Mother was advised to just bath baby without Moulding the head because as the baby grows, the brain also grows and the head expands to accommodates the brain. The baby was then given to the mother to continue with the breastfeeding and was advised not to touch or apply anything on the cord. Client was advised to use only the sterile cotton wool swab and methylated spirit given to her to dress the cord and always keep the cord exposed after dressing. She was then taught how to apply dipper below the umbilicus. Mother was encouraged to maintain baby's temperature to prevent the baby becoming too cold or too hot by dressing baby with light cotton clothing before wrapping him. Mother was encouraged to breastfeed baby exclusively and on demand or 8 to 12 times a day. She was also educated on breastfeeding problems and how she would manage the problem like breast engorgement, sore nipple and cracked nipple and to report if problem persist.

All linens and baby's belongings were packed and the surface was tidied up. Used equipment's were decontaminated in 0.5% chlorine solution for ten minutes before washing them. My hands were washed, dried and findings were documented as well as to the mother.

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

Temperature	36.2 degree Celsius
Apex heart rate	1425beat per minute
Respiration	43cycles per minute
Weight	2.8kilogram

4.3 FRIST DAY POSTNATAL AND DISCHARGE

Madam Akosua was discharged 24 hours after delivery that was 12/12/2021. Her husband and mother were present and information was formally given to them the previous evening that client and her baby would be discharged in the morning provided their conditions still

remained satisfactory. The mode of payment of the bill was explained to the client and her husband.

As at this time client complained of lower abdominal pain and it was explained to her that it was because the uterus was contracting in order to return to its non-pregnant state. Client was reassured that her pain can be managed. She was told to continue breast feeding the baby and to apply warm compress to reduce the pain.

Procedure was explained and head to toe examination was conducted on mother and baby.

BABY

On examination general appearance of baby was pink, no sign of cord bleeding and the weight was 2.7kg. Meconium was passed 2 times and urine was passed 3 times respectively. No abnormality was detected on baby. Client was educated to breastfeed baby exclusively for 6 months without adding any food or water as this will help in the involution of the uterus. It was also explained to her that breastfeeding will help build a strong immunity for the baby in order to prevent infection because breast milk contains the right proportion of nutrients for the baby. Client was also told to breast feed from both breast and to allow one breast to be empty before changing to the other one as it will help prevent breast engorgement. She was though to break the wind after feeding to prevent accumulation of gas in baby's stomach. She was taught how to properly fix baby to the breast. She was also reminded to wash her hands before and after breastfeeding her baby and after changing baby's diapers. She was informed to change baby's diapers whenever it is soiled with either faeces or urine in order to prevent infection and sore buttocks in the neonate. Client was told to top and tail baby and not to bath her until the cord is off.

Baby should be dressed in clean clothes possibly the cotton-made ones and also put baby in a well –ventilated room to prevent heat rashes. Madam Akosua was advised to clean baby's cord twice daily with cotton and spirit and not to cover the cord with diapers and should not

apply any ointment or herb to the cord. She was also advised not to use warm compress on baby's head as the anterior fontanels will close by 18th month and the posterior fontanels too at 6th week post-partum. Client was reminded on the need to immunize the baby on the scheduled days at the child welfare clinic. She was also educated on the danger signs in neonates such as; infected umbilical cord, swollen abdomen, excessive cry accompanied by refusal to feed and skin rash with fluid in it. If any of these signs is seen in the baby, client should quickly report to the clinic as these signs indicate serious illness in the baby. Vital signs checked and recorded as;

Temperature	36.0degree Celsius
Apex heart rate	132 beats per minutes
Respiration	40 cycles per minutes
Weight	2.7kilograms
Meconium and Urine	2 and 3 times respectively

MOTHER

Client was also examined from head to toe after explaining procedure and privacy provided. On breast

Examination, the breast was full and colostrum expressed. On abdominal examination, abdomen was soft and uterus well contracted with fundal height of 16 cm. Lochia was red with moderate flow. Client was thought to perform Kegel exercise. Second dose of vitamin A was served. Education was done on nutrition especially the need to take in more fluid ;(for example, water), fruits like orange to prevent constipation and protein diet to help repair worn out tissues. Client pass stool once this morning.

Mother was also educated on the flow of lochia and the changes that will occur in the color of the lochia. She was told to change her perineal pad frequently and wash her hands before and after changing her perineal pad. She was also advised to at least bath twice daily to prevent

infection to the child and herself and the need to warm sits bath to heal perineal crack. She was told not to apply any ointment to her perineum. Client and support person were advised to maintain a good environmental hygiene by making sure her compound is clean to prevent any ailment to the newborn child or herself. She was encouraged to put on a well-fitting brassier to support her lactating breast, position and attach baby to breast well to prevent engorgement of the breast, also to put on cotton underwear and always wash and dry them in the sun or iron them before putting on. Having enough rest and sleep to regain her strength and to recover from stress of pregnancy and labour was also encouraged. Client and husband were told to resume normal sexual activity six weeks after child birth because all organs of the reproductive systems would have regained their tone and condition by that time if all things be equal. Madam Akosua and her husband were counseled again on family planning and its importance to the baby, mother and as well as the whole family since they were having certain misconceptions concerning it. The various types of family planning methods, mechanism of action, effectives, benefit and side effects were all explained to them. All misconceptions were once again corrected and they were asked to decide on the method they would like to practice at the sixth week postnatal clinic visit.

She was reminded to register her baby at the birth and death registry after naming the baby. Her mother together with the husband was asked to help her in the household chores and carrying of the baby. She was reminded on postnatal exercises especially abdominal and pelvic exercise in other to help with the involution of the uterus, drainage of lochia and regain of muscle tone. She was taught how to do the Kegel exercise. Important of sleeping in treated mosquito net was emphasized on. Douching and use of other chemicals to wash the vagina was discouraged since good personal hygiene is enough to help in the healing of the crack sustained during delivery. Client was educated on danger signs of puerperium such as feeling severe headache, and having offensive lochia and among others. Client was asked if she has

emptied her bowel and bladder. She was encouraged to report any time she identifies any of these. Client was advised to take only the prescribed drugs and to report to the hospital anytime she encounters and problems. Client and her relatives were informed that the next visit to their house will be on the seven days and during my visit, the top and tail and the cord dressing of the baby will be done by me. The relatives thanked me and promised to adhere to all the educations given. Mother's vital signs checked and recorded as:

Temperature	36.6 degree Celsius
Pulse	76 beat per minute
Respiration	18 cycles per minute
Blood pressure	110/70 mmHg
Fundal height	16cm
Bowel	once
Urine	three times

The doctor came on rounds at 9:00am and after that she examined client and saw that everything was normal; client was then discharged. Upon discharge, the following drugs were prescribed;

Tablet paracetamol 1000mg tid x 3days

Tablet Metronidazole 400 tid x 5days

Capsule Amoxicillin 500mg x 5days

Tablet folic Acid 5mg daily x 30days

Tablet Fersolate 200mg tid x 30days

Tablet Multivite 200mg tid x 30days

Client was educated on how to take her medications and the possible side effects she should expect. After the bill and everything was settled, client was assisted in packing of the

belongings and they were escorted to the taxi brought by the husband. Good bye was bid to them and assured them of my visit.

4.4 POST NATAL HOME VISIT

FIRST POST NATAL HOME VISITS

Client was visited in the on the 12/12/21 at 4: 00pm. Client welcomed and offered me a seat as usual. Upon arrival client's mother was about to dry washed clothing's whiles client was preparing to top and tail baby. The family was doing well; was told the baby woke up many times during the night to feed which made her mother unable to have enough sleep. Client was reassured and told to continue to feed the baby on demands and more at night.

She was encouraged to sleep and rest during the day when baby is asleep. Client's family members were also told to assist client in caring for the baby. She was asked whether she still feel the abdominal pain and she said the pain has subsided. Observation was made how she will do the top and she was supervised to do it well.

The cord was dressed with methylated spirit and sterile cotton wool swabs under aseptic techniques, Permission was asked to carry out examination on her which she agreed. She was asked to empty her bladder and she did. On examination her hair was well kept, she had no puffy face and conjunctiva was pink and no discharges from the eyes and ears. She was able to move her neck freely with no restriction. On palpation the breast was normal in shape and size and full with breast milk. The abdomen was palpated and no abnormality was found, the fundal height was 15cm. Vulva was inspected as well as her perinea pad, there were no abnormalities on the vulva and Lochia was rubra with moderate flow and without any offensive smell. The findings were communicated to her and documented. Vital signs were as follows;

Temperature	36.1degrees Celsius
Pulse	72beat per minute

Respiration	18 cycles per minute
Blood pressure	110/70mmHg
Fundal height	16cm
Urine	three times
Lochia	Rubra
Condition of the uterus	Contracted
Breast	Lactating

The baby was examined from head to toe. General condition was good; color was pink, no sign of cord bleeding or infection detected. Baby passed meconium twice and with frequent passage of urine as mother confirm. Mother was encouraged to breast feed baby exclusively and to cover baby always to prevent heat loss. Client was reminded of her next visit. Baby's vital signs checked and recorded as follow;

BABY

Temperature	36.7degree Celsius
Apex beat	132beat per minutes
Respiration	42cycle per minute
Skin colour	Pink
Cord bleeding	No
Cord	Drying
Suckling	Yes
Weight	2.7 kilograms

Stool colour Dark yellowish.

SECOND DAY POSTNATAL HOME VISIT

Madam Akosua was visited in the house for the third time at 7:30am on the 13th December, 2021 to check up on how they were faring. She said she slept well when the baby was well as fed. Perineal pad was inspected. Lochia was small with red colour. She took her bath after everything in the evening. Nothing abnormal was detected during head-to-toe examination. Symphysio fundal height was 15cm and findings from assessment were recorded as; Temperature 36.0degree Celsius, Pulse 78bpm, Respiration 19bpm, Blood pressure 110/70mmHg. No abnormality was found during head-to-toe examination.

BABY

Baby was top and tailed. The cord was dressed with cotton wool with methylated spirit. She was dressed up and findings after assessment were;

Temperature 36.2degree Celsius,

Apex beat 128bpm,

Respiration 40cpm,

Weight 2.6kg,

Skin colour pink,

Cord bleeding No,

Cord Shrinking,

Suckling Yes,

Stool colour Dark yellowish.

In the evening, at 4:00pm client was visited again and findings were not different from the morning visit. All findings were explained to her understanding. She was once again reminded of next visit and was thanked for her cooperation.

BABY

Temperature	36.2 Degrees Celsius
Apex beat	128beat per minute
Respiration	40cycles per minute
Weight	2.6kilograms

MOTHER

Temperature	36.7 Degree Celsius
Pulse	78beat per minute
Respiration	22cycles per minute
Blood pressure	110/70mmHg
Fundal height	15cm
Bladder	three times
Bowel	once

Findings were communicated to client and the midwives as well. She was thanked for her cooperation and reminded her of next evening visit. Client was accompanied to the gate and bid them goodbye. In the evening client was visited again and findings were not different from the morning visit. The mother was advised not to apply anything on the cord and encouraged to continue with post-natal exercise and exclusive breast feeding. She was reminded of another visit the following day.

THIRD DAY POSTNATAL VISIT

Madam Akosua was visited in the house for the third time at 7:30am and 4:30pm on the 14th December, 2021 to check up on how everyone was faring. Client said she was able to have some sleep during the day. Client and family were congratulated for taking good care of themselves. She was educated on different kinds of position to assume when breastfeeding and also encouraged to breastfeed baby on demands. Madam Akosua was asked to empty her

bladder. Client said she had emptied her bladder four times upon returning from the clinic and had moved her bowel once. Client granted me the permission to do the usual head to toe examination.

On examination, there were no abnormalities detected. The client and family were educated on good personal hygiene. Vital signs were checked and recorded as follows;

BABY

Temperature	36.8 Degree Celsius
Apex beat	127beat per minute
Respiration	40cycle per minute
Bowel frequency	twice
Urine passed	4 times
Weight	2.5kg

MOTHER

Temperature	36.4 Degree Celsius
Pulse	80 beat per minute
Respiration	20cycles per minute
Blood pressure	110/70mmHg
Fundal height	14cm
Urine	4 times
Bowels	once

In the evening client was visited again findings were not different from the morning visit. Madam Akosua was educated on family planning, danger signs in the newborn such as breathing difficulties, cyanosis, persistent vomiting and fever. Client and family were congratulated and permission was sought to leave.

FOURTH DAY POSTNATAL HOME VISIT.

On the 15th December, 2021 client was visited at 7:00am, Mother and baby were in good health as client confirm her sleep pattern has been restored. Physical examination from head to toe was carried out on baby with no abnormality detected. Baby was topped and tailed and the cord dressed with methylated spirit and sterile cotton wool swabs under aseptic technique. The cord looked almost dry at this time so client was told to keep an eye on it because it can fall at any moment. Urine and stool were passed normally. Stool color changed to brownish yellow at this time. Her vital signs checked and recorded as follows;

Temperature 36.2degree Celsius, apex-130bpm, Respiration 40cpm, Weight 2.5kg, Skin colour Pink, Cord no bleeding, Suckling Yes.

The mother was also examined and few rashes were identified on the neck of client. She was asked what happened and she said because she has been feeling hot especially when the sun is scotching and she stays in the room. Client also added that she does not always open the windows because of the fear that baby will lose heat. She was reassured and told it was due to poor ventilation in the room so she should open the windows and put on the fan to cool the room. Client was advised to do savlon bath and wear cotton made clothing. The lochia was rubra and uterus was well contracted with fundal height of 13cm. Client was encouraged to continue breastfeeding baby on demands and have enough rest. Her vital signs checked and recorded as follows

: Temperature 36.7degree Celsius, Pulse 82beat per minute, Respiration 21cycles per minute, Blood pressure 120/80millimeters of mercury.

FIFTH POSTNATAL HOME VISIT

On 16/12/2021 at 5:00am, client and baby were visited for the fifth postnatal visit. Mother and baby were in good health as well as the whole family but client complained of back pain. On her explanation, it was noticed that, client do not properly sit well when

breastfeeding baby. Educations were made to client on how to put baby to breast when using the lower chair. Routine examinations were done and rashes do not have any fluid in them. Client was encouraged to continue using savlon in her bath and to wear light clothing's. Fundal height was 12cm. Uterus well contracted.. The perineal pad was inspected and the flow was scanty and pink in colour (serosa) and not offensive. Findings were recorded and communicated to her. . Her vital signs were checked and recorded as follows: Temperature 36.3degree Celsius, Pulse 78bpm, Respiration 20cpm, Blood pressure 100/60mmHg.

Client was encouraged to perform postnatal exercise to regain her strength. Exclusive breast feeding was emphasized. Client emptied her bowel and bladder once and four times respectively. Baby was examined from head to toe with no abnormality. Urine and stool was passed normally. Baby's cord looked gangrene at this time. Top and tail was done, cord dressed and baby made comfortable. The baby's vital signs were checked and recorded as follows; Temperature 36.8 degree Celsius, Apex 130bpm, Respiration 42cpm, Weight 2.6kg . Client was reminded that the care will end on the seventh day during her second postnatal visit

SIXTH POSTNATAL HOME VISIT

Sixth day postnatal home visit was made to client and baby on 17/12/2021 at 7:00am. After explaining procedure to mother and also washed and dried my hands, physical examination was done on baby with no abnormality detected. Client called to inform the baby's cord had fallen the previous night so she was told that hence forth, baby can be bathed. Client was made to bath and dressed baby under my supervision and she was congratulated and encouraged to always bath baby at least twice daily even after my termination of care with her tomorrow. The umbilical area was cleaned with methylated spirit and sterile cotton wool swabs under aseptic technique. Stool was brownish yellow color. Vital signs were checked and recorded as; Temp 36.4 degree Celsius ,Apex 120,Repiration 40, skin colour pink ,cord

off. During the examination of the mother, her general condition was good and rashes subsided, there was no other abnormalities detected. Her pad was inspected and her lochia was pinkish and uterus well contracted with fundal height of 11cm. Breast milk was flowing well, urine and stool passed four and once respectively. Vital signs checked and recorded as Temp 36.7 degree Celsius, pulse 98, respiration 18, Blood pressure 112/70

She was again informed of my termination of care the next day and she would be handed over to the public health nurse for continuity of continuity of care.

SEVENTH POST NATAL HOME VISIT

The last visit for the week was on 18th December, 2021at 8:00am. The condition of mother and baby were very good. Head to toe examination was done after explaining the procedure to her. Permission was sought and perineal pad was inspected. Lochia was creamy white (Alba) but very little and not offensive. Nothing abnormal was detected. Symphysio fundal height was 10centimeters when checked, temp 36.2 degree Celsius, Pulse 80,Respiration 18, Blood pressure 120/80 .

Baby was bathed by the mother and cord stump dressed and it went on well, under supervision. Head to toe examination was done and no abnormality was found. Weight was 2.8 kilograms Temp 36.5, Apex 146cm, Respiration 41cpm, and skin colour pink. All the findings were explained to the client and she was educated on the importance of visiting the clinic for the first weeks post-natal.

FIRST POSTNATAL VISIT TO THE CLINIC

On the 19/12/2021 at 7:00am, client and baby reported to the clinic for the first postnatal visit which was my last day of providing care to client. She was accompanied by her mother who they were warmly welcomed and offered a seat. Client dressed in a white garment with a pony hair style and looked cheerful. Client's mother was congratulated for her support and

encouraged to continue in order to reduce workload on client and enhance more rest and sleep. Baby was also neatly dressed and looked beautiful of which baby were carried by me.

They were warmly welcomed once again and offered a seat to make them comfortable. They were all happy to see me, client was asked how both were faring and answered in affirmation. The antenatal clinic were busy with postnatal assessment on going which client were ask to come first for her routine assessment. Mother vital signs were checked and recorded as follow;

Temperature 36.3 degree Celsius

Pulse 74 beat per minutes

Respiration 18 cycles per minutes

Blood pressure 119/70mmHg

Weight 50kilograms

Symphysio fundal height 9centemeters

She was asked to take specimen of urine as she went to empty bladder. Her urine was tested and it was negative for both protein and sugar. Hemoglobin level was 11.8grams per deciliter. Privacy was provided and she was helped onto the examination bed and head to toe examination was performed after assisting her to undress. Client's hair looked very nice, the eyes and nose were inspected and no abnormality was found. The conjunctiva was neither pale nor jaundiced. Breasts were examined but there was no abnormal mass, soreness of the nipples and engorgement present. The upper and lower extremities were inspected and no abnormality was present. On abdominal examination, the spleen was not enlarged and there was no tenderness after palpating the liver. The vulva was examined for infection, and lochia flow was alba. No abnormality was found in all. Findings were communicated to Madam Akosua and she was commended for her cooperation and she was also thanked as well.

Baby was also examined from head to toe. The conjunctiva was not pale; neither was there jaundice of the sclera nor eye discharges. The ears and nose were inspected as well as the lips and mouth, but no abnormality was found. The umbilical stump was neatly healed. Baby's weight was 2.9kg when checked. Baby vital signs checked and recorded as;

Temperature	36.6 degree Celsius
Apex heart rate	126 beat per minutes
Respiration	38 cycles per minutes
Weight	2.9 kilogram.

Client was educated to maintain good personal hygiene in other to avoid infection, and encouraged to exclusively breastfeed the baby till the end of six months. She was advised to register the baby that the birth and death registry. Client and family were very grateful to me for the help and care offered to them and they were also congratulated for taking good care of themselves and the baby, client mother was appreciated for the support. She was also taken to Child Welfare Clinic and was introduced to the Public Health Nurse who was present at the clinic by then for continuity of care.

Client was also encouraged to attend the six weeks' postnatal clinic for examination, growth monitoring and immunization of the baby. She was taken to the family planning unit for counseling on the various methods of family planning, with emphasis on lactational amenorrhea. The advantages and disadvantages of the methods were explained to her. Client was helped to make an informed choice and she chose lactational Amenorrhea and also said she will prefer implanon after the sixth month of exclusive breastfeeding.

Madam Akosua and her mother were thanked for their cooperation throughout the period of care. Good health and God's protection was wished. They were escorted to the gate to take car and off, they went home.

SECOND POST NATAL VISIT TO THE CLINIC

According to the midwife -in-charge, on the 21st January, 2021, Madam Margaret visited the clinic with the baby and was warmly welcomed by the midwife in-charge. Mother and baby were in healthy condition and had no complaints.

Hemoglobin level of mother was 11.8g/dl as checked and urine test for protein and sugar were negative.

Physical examination was carried out and no abnormality detected. Breast was lactating well, uterus had undergone involution and menstruation had not yet commenced and no lochia seen. Baby's general condition was good on head to toe examination; baby's posterior fontanels was closed. Client was handed over to the child health care unit for baby's immunization (against polio, diphtheria, tetanus, hepatitis B given to children at six weeks. He was also given pneumococcal and rotavirus vaccine for protection against pneumonia and diarrhea respectively. These were recorded in the baby's record booklet. They were then handed over to the family planning unit to ensure continuity of care. Client was educated to consult them in case of any problem. All findings were communicated to client. Client was educated to consult them in case of any problem. All findings were communicated to client and she was congratulated.

4.5 NURSING CARE PLAN DURING PUERPERIUM

ACTUAL PROBLEMS

On the 12/12/2021,client complained of

1. Lower abdominal pain
2. Sleep disturbances

On the 15/12/2021 client complained;

3. Skin rashes.

On the 16/12/2021, client complained of;

4. Back pain

POTENTIAL PROBLEM

On the 11/12/2021,

5 .Risk for puerperal infection

NURSING DIAGNOSIS

1. After pain related to involution of the uterus.

2. Insomnia related to care and demand of baby at night

3. Skin rashes related to poor room ventilation.

4. Back pain related to poor posture during breast feeding

5. Risk for puerperal infection related to crack in the perineum.

SHORT TERM OBJECTIVES

1. Client's abdominal pain will reduce within 24hours.

2. Client sleep pattern will be restored within 48hours.

3. Rashes on client's skin will subside within 48hours.

4. Client back pain will be reduced within 48 hours.

5. Client will be free from puerperal infection throughout the early puerperium.

LONG TERM OBJECTIVES

To ensure that mother and baby goes through a normal puerperium without complication.

NURSING CARE PLAN ON PUERPERIUM

DATE AND TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES	NURSING ORDERS	NURSING INTERVENTION	DATE AND TIME	EVALUATION	SIGN
12/12/21 At 8:00am	After pain related to involution of the uterus	Client's abdominal pain will reduce within 24hours as evidence by client verbalizing that the pain has reduced.	1. Explain the cause of the pain to client and reassure her. 2. Encourage client to continue breastfeeding her baby. 3. Advise client to apply warm or cold compresses alternatively to her lower abdomen twice daily. 4. Encourage client to empty the bladder regularly. 5. Serve prescribed analgesics.	1. The cause of pain was explained to client that it was because the uterus was contracting in order to go back to its non-pregnant state, she was also reassured that it will subside. 2. Client was encouraged to continue breastfeeding her baby on demand and every 2-3hours to establish lactation and enhance involution. 3. Client was advised to apply warm compress to her lower abdomen morning and evening to enhance blood circulation and cold compress to reduce pain. 4. Client was encouraged to urinate intermittently to keep her bladder empty as much as possible. 5. Prescribed tab paracetamol 1000 gram 3 times daily was served.	13/12/2021 At 800am	Goals fully met as evidenced by client verbalizing that the pain has reduced.	A.K.S

NURSING CARE PLAN ON PUERPERIUM

DATE AND TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES	NURSING ORDERS	NURSING INTERVENTION	DATE AND TIME	EVALUATION	SIGN
16/12/2021 At 5:00pm	Back pain related to poor posture during breast feeding.	Client's back pain will reduce within 48 hours as evidenced by client verbalizing that the pain has reduced.	1. Reassure client 2. Explain the cause of pain to client. 3. Teach client how to assume good posture during breast feeding 4. Advise client to support the back with pillows when sitting 5. Serve prescribed analgesics	1. Client was reassured that the pain can be managed. 2. It was explained to client that the pain was as a result of poor body posture during breast feeding. 3. Client was taught to sit upright and lean against a chair or wall when breast feeding. She was also told to put palm under baby's buttocks and fix baby well to the breast. 4. Client was advised to support the back with pillow when sitting on chair or bed. 5. Prescribed Tablet Paracetamol 1000 gram was served.	18/12/2021 At 5:00pm	Goals fully met as evidenced by client verbalizing that the pain has reduced	A.K. S

NURSING CARE PLAN ON PUERPERIUM NURSING CARE PLAN ON PUERPERIUM

DATE AND TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES	NURSING ORDERS	NURSING INTERVENTION	DATE AND TIME	EVALUATION	SIGN
13/12/21At 8:00am	Insomnia related to care and demand of baby at night.	Client sleep pattern will restore within 48 hours as evidenced by client verbalizing that she was able to sleep at least 2hours in the day and 8 hours at night.	1. Reassure client. 2. Teach client to properly attach baby to breast when feeding. 3. Advice client to give baby expressed breast milk after each feeding. 4. Encourage client to sleep when baby is asleep. 5. Teach client other comfortable positions of breastfeeding.	1. Client was reassured that she will be able to sleep. 2. Client was taught to properly attach baby to breast during breast feeding. 3. Client was advised to give baby top up breast milk after each feeding to ensure baby is satisfied before putting her to sleep. 4. Client was encouraged to sleep anytime baby is asleep whether day or night. 5. Client was taught how to lie down and breastfeed baby.	15/12/201 At 8:00am	Goal fully met as evidenced by client verbalizing that she was able to sleep at least 2 hours in the day and 8 hours at night.	A.K. S

NURSING CARE PLAN ON PUERPERIUM

DATE AND TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES	NURSING ORDERS	NURSING INTERVENTION	DATE AND TIME	EVALUATION	SIGN
15/12/2021 At 8:00am	Skin rash of mother related to poor room ventilation.	Client will have intact skin integrity throughout care as evidenced by student observing that client skin remained intact throughout care.	1. Reassure client. 2. Advise client to open windows and put on fan in the room. 3. Encourage client to wear cloths made with cotton. 4. Advise client to have antiseptic baths. 5. Advise client not to apply any concoction to the rash.	1. Client was reassured that the rashes will subside. 2. Client was advised to open windows and put on fan to cool the room. 3. Client was advised to wear cotton made clothing to absorb the sweats. 4. Client was advised to have savlon bath. 5. Client was advised not to apply any concoction to the rash.	18/12/21 At 9:00am	Goals fully met as evidenced by student observing that client's skin integrity remained intact throughout care.	A.K.S

NURSING CARE PLAN ON PUERPERIUM

DATE AND TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES	NURSING ORDERS	NURSING INTERVENTION	DATE AND TIME	EVALUATION	SIGN
11/12/21 At 11:00am	Potential for puerperal infection related to perineal crack and lochia drainage.	Client will be free from puerperal infection throughout care as evidenced by student observing that client did not develop infection throughout the care.	1. Advise client to bath at least twice a day. 2. Encourage client to change her pad when soiled. 3. Encourage client to wash her hands after changing her perineal pad and visiting the toilet. 4. Advise client to do warm sitz bath twice daily. 5. Advice client to clean the anus from front to back after emptying the bowel. 6. Advise client to take prescribed antibiotic	1. Client was advised to bath at least morning and evening. 2. Client was encouraged to change her perineal pad when it is soiled. 3. Client was encouraged to wash hands after visiting the toilet. 4. Client was advised to do warm sitz bath to facilitate perineal wound healing. 5. Client was advised to clean her anus from front to back after emptying her bowels. 6. Prescribed Amoxiclav 625mg bd for 7 days was served.	18/12/21 At 9:00am	Goals fully met as evidenced by client not developing any infection throughout care.	A.K.S

4.6 TERMINATION OF CARE

The temporal relationship between client and the student midwife ended on the seventh day post-delivery of client. Termination of care started when client was first met at Pentecost clinic, Kasapin on 25th /11/2021. She was informed that the care will be temporal and it will end on the seventh day after her child birth. During the fifth and sixth postnatal home visit client and family were reminded that the care will end on the 18/12/2021 where she will be handed over to my senior in charge then to the public health nurse for continuity of care. On the 18/12/2021, client reported to the clinic for her first postnatal visit. After the routine examination were conducted on her, she was educated on family planning, immunization of baby until 5 years, exclusive breast feeding and the need to register her baby after she has been named. She was asked to report to the clinic anytime she or her baby has any problem.

Client was formally handed over the in charge in the clinic for the six weeks postnatal then to the public health nurse for continuity of care on the 18/12/2020. Client and her mother were thanked for their support and cooperation. They were informed of my visit to them which will be occasional and client was told she can be contacted anytime for assistance.

4.7 SUMMARY

This family centered maternity care was conducted on Madam Akosua a 31-year-old Gravida 3 Para 2 alive. She was first met at Pentecost clinic, Kasapin on the 25th /11/2021 when she was 36 weeks pregnant. She started antenatal at 17weeks of gestation, on the 30/06/2021 at Pentecost clinic, Kasapin. Routine examination was carried out on her during antenatal, labor and puerperium which were all normal. Certain minor disorders were identified during pregnancy such as insomnia, lower back pain, fatigue, misconception about family planning and leg pain. All her problems were managed successfully. Her labor and delivery were managed with a partograph without complication. She went into labor spontaneously on the 11/12/2021 and was admitted to the labour ward at 5:30am, she went through a normal safe

delivery on the same day at 11:45am to a live female infant who weighed 2.3kilograms at birth, the placenta and membranes were expelled after delivery of the baby with moderate blood loss. Placenta and membranes were examined and they were healthy and intact, perineum states were intact without any infection. Client was discharged home on 12/12/2021 at 11:00am after baby was given Bacillus Calmette Guerin and Oral Polio vaccine. Client was educated on care of the baby, personal hygiene, breast feeding and resumption of sex. Regular visit was made to assess both mother and baby's condition up to the seventh day post-delivery; this was done morning and evening for the first three days and daily for the rest of the visits. On every visit, the vital signs were checked including lochia, perineum, uterus, lactation and others. Care of the baby and importance of child welfare clinic was emphasized, there were no abnormalities detected and she was handed over to the in charge of the antenatal care and the public health nurse for continuity of care on 18/12/2020.

4.8 CONCLUSION

The family centered and maternity care is a systematic process by which quality nursing care is given to a woman as a unique individual with peculiar needs and her family in their home setting. Before this care can be successful, a Strong relationship must be established with client and her family. The care also needs a lot of hard work, commitment and sacrifice because it involves taking care of not only one person but a whole family. This care has given me the opportunity as a student midwife to be able to develop a good interpersonal relationship with client and it has also helped me to put the knowledge acquired through my training into practice. The knowledge made me gained a lot of experience from this care study and this will help me in my practice as a midwife. In a nutshell, have learnt a lot, the problems encountered during pregnancy, labour and puerperium and how to find solutions to them. The knowledge acquired has given me a better understanding in caring for a client and

this will be transferred to others in the cause of my career as a midwife which will go a long way to help reduce maternal and neonatal mortality rate in the country.

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APPENDIX I

MOTHER'S ANTENATAL

DATE	WEIGHT (KG)	BLOOD PRESSURE	URINE FOR PROTEIN/ SUGAR	GESTATIONAL AGE IN WEEKS	FUNDAL HEIGHT (CM)	PRESENTA-TION	DESCENT OF FETAL HEAD	FETAL HEART RATE (FH)	TREATMENT GIVEN	COMPLAIN	SIGN
30/06/21	47kg	102/69mmHg	negative/ negative	17weeks	-	Cephalic	-	+	Routine drugs	Nausea and headache	P.D
04/08/21	48kg	100/70mmHg	negative/ negative	21weeks+ 6days	22cm	cephalic	-	+	Routine drugs	headache	S.A.D
21/09/21	50kg	109/71mmHg	negative/ negative	29weeks	26cm	Cephalic	-	140bpm	Routine drugs.	Feels well	HAN
02/11/21	49kg	110/69mmHg	negative/ negative	32weeks	28cm	Cephalic	-	134bpm	Routine drugs.	Headache	M.A.O

MOTHER'S ANTENATAL

DATE	WEIGHT (KG)	BLOOD PRESSURE	URINE FOR PROTEIN/ SUGAR	GESTATIONAL AGE IN WEEKS	FUNDAL HEIGHT (CM)	PRESENTA-TION	DESCENT OF FETAL HEAD	FETAL HEART RATE (FH)	TREAT-MENT GIVEN	COMPLAIN	SIGN
16/11/21	50kg	120/72mmHg	negative/ negative	34+2weeks	31cm	Cephalic	5/5th	136bpm	Routine drugs.	Client complains of heart burns	M.A.O
25/11/21	49kg	119/70mmHg	negative/ negative	36weeks+ 5days	33cm	Cephalic	5/5th	134bpm	Routine drugs	Feels wells	Philo.
02/12/21	50kg	108/69mmHg	negative/ negative	37weeks+ 4days	31cm	Cephalic	5/5th	138bpm	Routine drugs	L.A.P	A.K.S
09/12/21	52kg	110/60mmHg	negative/ negative	38weeks	34cm	Cephalic	5/5th	136bpm	Routine drugs	Waist pains	A.K.S
11/12/21	52kg	130/80mmHg	negative/ negative	39weeks	37cm	Cephalic	5/5th	140bpm	Routine drugs	Lower abdominal pains	A.K.S

ITN Given

TETANUS IMMUNIZATION	PREVIOUS TT		TD 1 Yes TD 2 and TD 3			
	CURRENT TT 4th dose		09/10/2021		Date	
					02/11/2021	
INTERMITTENT PREVENTIVE TREATMENT (IPT)FOR Malaria	1ST dose SP* 3 tabs (Directly Observed Therapy) 30/06/21	Gestation age In weeks 17 weeks	2nd dose (1 month after 1st dose (Directly Observed Therapy) 04/08/2021	Gestation age In weeks 22 weeks	3rd dose (1 month after 2nd dose (Directly Observed Therapy)21/09/21	Gestational age in weeks 29weeks
	4th dose 3 tabs (Direct observed therapy)02/11/21	Gestation age in weeks 28weeks	5th dose 3 tabs (Direct Observed Therapy)25/11/21	Gestation age in weeks 36weeks+4days	6th dose 3 tabs (Direct Observed)16/12/20	Gestational Age in Weeks 37weeks+4

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

APPENDIX II

COMPLETE DIAGNOSTIC INVESTIGATION (ANTENATAL)

DATE	SPECIMEN	IVESTIGATION	NORMAL VALUES	FINDINGS	REMARKS
30/06/21	1. Blood	Haemoglobin level	12g/dl-16g/dl	11.0g/dl	Normal
		Sickling status	Negative	Negative	Normal
		Grouping and Rhesus factor	A, B, AB, and O	O	Normal
		HIV status	Positive and	Positive	Normal
		VDRL	negative	Negative	Normal
		Hepatitis status	None reactive	Non-defect	Normal
		G6PD status	None reactive	Negative	Normal
		Sugar	Negative	Non-defect	Normal
	2. Urine	Protein	None reactive	Negative	Normal
			Negative	Negative	Normal
			Negative		
04/08/21	1. Urine	Sugar	Negative	Negative	Normal
		Protein	Negative	Negative	Normal
21/09/21	6. Urine	Sugar	Negative	Negative	Normal
	Blood	Protein	Negative	Trace	Not Normal
		Haemoglobin level	12g/dl-16g/dl	12.0g/dl	Normal
02/09/21	1.Urine	Sugar	Negative	Negative	Normal
		Protein	Negative	Negative	Normal
16/11/21	1.Urine	Sugar	Negative	Negative	Normal
		Protein	Negative	Negative	Normal
25/11/21	1.Urine	Sugar	Negative	Negative	Normal
		Protein	Negative	Negative	Normal
02/12/21	1.Urine	Sugar	Negative	Negative	Normal
		Protein	Negative	Negative	Normal
09/12/21	1.Urine	Sugar	Negative	Negative	Normal
	2. Blood	Protein	Negative	Negative	Normal
		Haemoglobin level	12g/dl-16g/dl	11.6g/dl	Low

COMPLETE DIAGNOSTIC INVESTIGATION (LABOUR)

DATE	**SPECIMEN**	**IVESTIGATION**	**NORMAL VALUES**	**FINDINGS**	**REMARKS**
11/12/21	Urine Blood	Sugar and protein Haemoglobin level	Negative 11-16g/dl	Negative 12.0g/dl	Normal Normal

COMPLETE DIAGNOSTIC INVESTIGATION (PUERPERIUM)

DATE	SPECIMEN	INVESTIGATION	NORMAL VALUE	FINDINGS	REMARK
19/12/21	Urine Blood	Sugar and protein Haemoglobin level	Negative 11.16g/dl	Negative 11.8g/dl	Normal Normal

APPENDIX III

PHARMACOLOGY OF DRUGS USED (MOTHER)

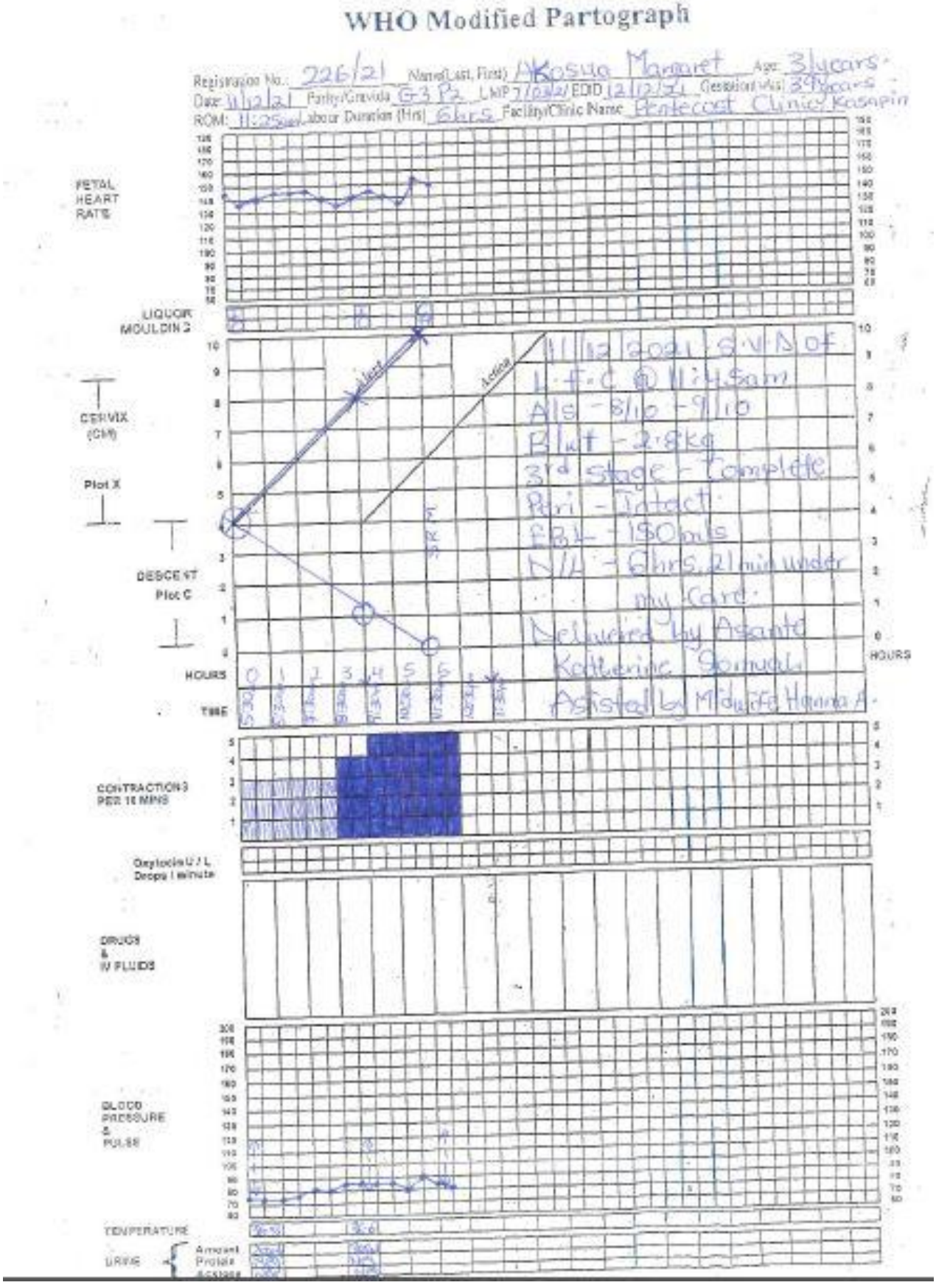
NAME OF DRUGS	CLASSIFICATION	DOSAGE	ROUTE OF ADMINISTRATION	ACTION & USE	ACTUAL EFFECTS	SIDE EFFECT OF DRUGS	SIDE EFFECT EXPERIENCED
Tablet folic acid	Haematinics	5 milligrams once daily	Orally	Proper formation and functioning of red blood cell.	Haemoglobin level increase	Nausea and vomiting	None
Tablet multivitamin	Vitamin preparation	200 milligrams twice daily	Orally	Increased appetite. Helps in the formation of red blood cell	Increase appetite.	Gastro intestinal disturbances	None
Tablet ferrous sulphate	Iron supplement	200 milligrams twice daily	Orally	Help in formation of haemoglobin and red blood	Haemoglobin level increased	Gastrointestinal disturbance	Dark stool
Tablet sulphadoxine pyrimethamine	Anti-malaria and prophylaxis	3 doses stat from 16 weeks or after quickening and the remaining doses within 4 weeks interval until she delivers.	Orally	Treatment and prevention of malaria	Malaria prevention	Itching, nausea, dizziness, headache	None
Injection tetanol	anti-tetanus	0.5 milligrams	Subcutaneously	Helps in the prevention of tetanus	Client protected against tetanus	slight fever and chills	None

PHARMACOLOGY OF DRUGS USED CONTINUED (MOTHER)

NAME OF DRUGS	CLASSIFICATION	DOSAGE	ROUTE OF ADMINISTRATION	ACTION & USE	ACTUAL EFFECTS	SIDE EFFECT OF DRUGS	SIDE EFFECT EXPERIENCED
Injection oxytocin	Oxytocic drug	10 units	Intramuscularly	Stimulate uterine contractions	Client had good uterine contractions and bleeding was controlled	Nausea and vomiting	None
Capsule vitamin A	Group A vitamin supplement	200,000 units for 2 days	Orally	Growth development, immaturity and proper sight	Normal vision and healthy skin	Vomiting	None

PHARMACOLOGY OF DRUGS USED (BABY)

NAME OF DRUGS	CLASSIFICATION	DOSAGE	ROUTE OF ADMINISTRATION	ACTION & USE	ACTUAL EFFECTS	SIDE EFFECT OF DRUGS	SIDE EFFECT EXPERIENCED
Vitamin K	Group K vitamins (coagulant)	1.0mg	Intramuscular	Production of prothrombin which aids in clotting	No bleeding	None	None
Gentamycin eye drop	Antibiotics	2 drops	Instillation	To prevent infection	Infection of the eye was prevented	None	None
Poliomyelitis	Antigen vaccine	2 drops	Orally	Production of antibodies	Baby is under observation	There may be diarrhea	None
Injection Bacillus Calmette Guerin	Antigen vaccine	0.5 Milligrams	Intradermal	Production of antibodies for prevention of tuberculosis	Baby is under observation	Blister formation	None


WHO Modified Partograph
Registration No.: 226/21 Name(Last, First) Akosua Margaret Age: 31years
Date: 11/2/21 Parity/Gravida G3 P2 LMP 7/2021 EDD 12/12/21 Gestation(Wks) 39weeks
ROM: 11:25am Labour Duration (Hrs) 6hrs Facility/Clinic Name Pentecost Clinic Kasapin
FETAL HEART RATE
LIQUOR MOULDING
CERVIX (CM)
Plot X
DESCENT Plot O
HOURS
TIME
Alert
Action
11/2/2021 S.V.D of
L.F.C @ 11:45am
Ais - 8/10 - 9/10
Wt - 2.8kg
3rd stage - Complete
Peri - Intact
EBL - 150mls
N/A - 6hrs, 21min under my Care.
Delivered by Asante Katherine Samuels
Assisted by Midwife Hanna A.
CONTRACTIONS PER 10 MINS
Oxytocin U / L Drops / minute
DRUGS & IV FLUIDS
BLOOD PRESSURE & PULSE
TEMPERATURE
URINE
Amount
Protein
Acetone

LABOR NOTES

Client G3P2 at 39weeks gestation had SVD to a live fem child at 11:45am with Apgar score of 8/10, 9/10. B/wt-2.8kg, H/C 30, FL-50cm. Vitamin K 0.5mg IM was given to baby. AMT Completed. Placenta and membranes were delivered at 12:00pm, uterus was massage to expelled blood clot. Skin to skin done, peri-inta Oxytocin 10units IM given to mother. Baby and mother were clea and comfortable in bed with good observation and monitoring

Please circle or write responses.

DELIVERY

DATE: 11/12/2021 TIME: 11:45am METHOD: (Spontaneous) / Vacuum Extraction / C/S / Other

PERINEUM: (Intact) / Episiotomy / Laceration

ANESTHESIA: (None) / Local / General

THIRD STAGE

Active Management: (Yes) / No Medication: Time 11:46am Type/Dose 10units of Oxyt

PLACENTA: TIME: 12:00pm (Complete) / Incomplete

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

BABY

Weight: 2.8kg
Sex: Male / (Female)
Baby Position: (Vertex) / Breech / Other

APGAR

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

COMPLICATIONS OF MOTHER / BABY: None / Other: Normal

FOURTH STAGE MONITORING

Frequency	Time	B/P.	Pulse	Fundus	Bleeding	Bladder
Every 15 minutes first 2 hours	12:15pm	120/80	86bpm	17cm	No active bleeding	200mls
	12:30pm	100/80	94bpm	Well Contracted		Emptied
	12:45pm	108/75	94bpm			
	1:00pm	110/80	100bpm			
	1:15pm	106/85	78bpm			
	1:30pm	110/70	74bpm			
	1:45pm	100/80	80bpm			
	2:00pm	109/76	100bpm			
Every 30 minutes For 1 hour	2:30pm	101/60	111bpm			
	3:00pm	109/60	87bpm			

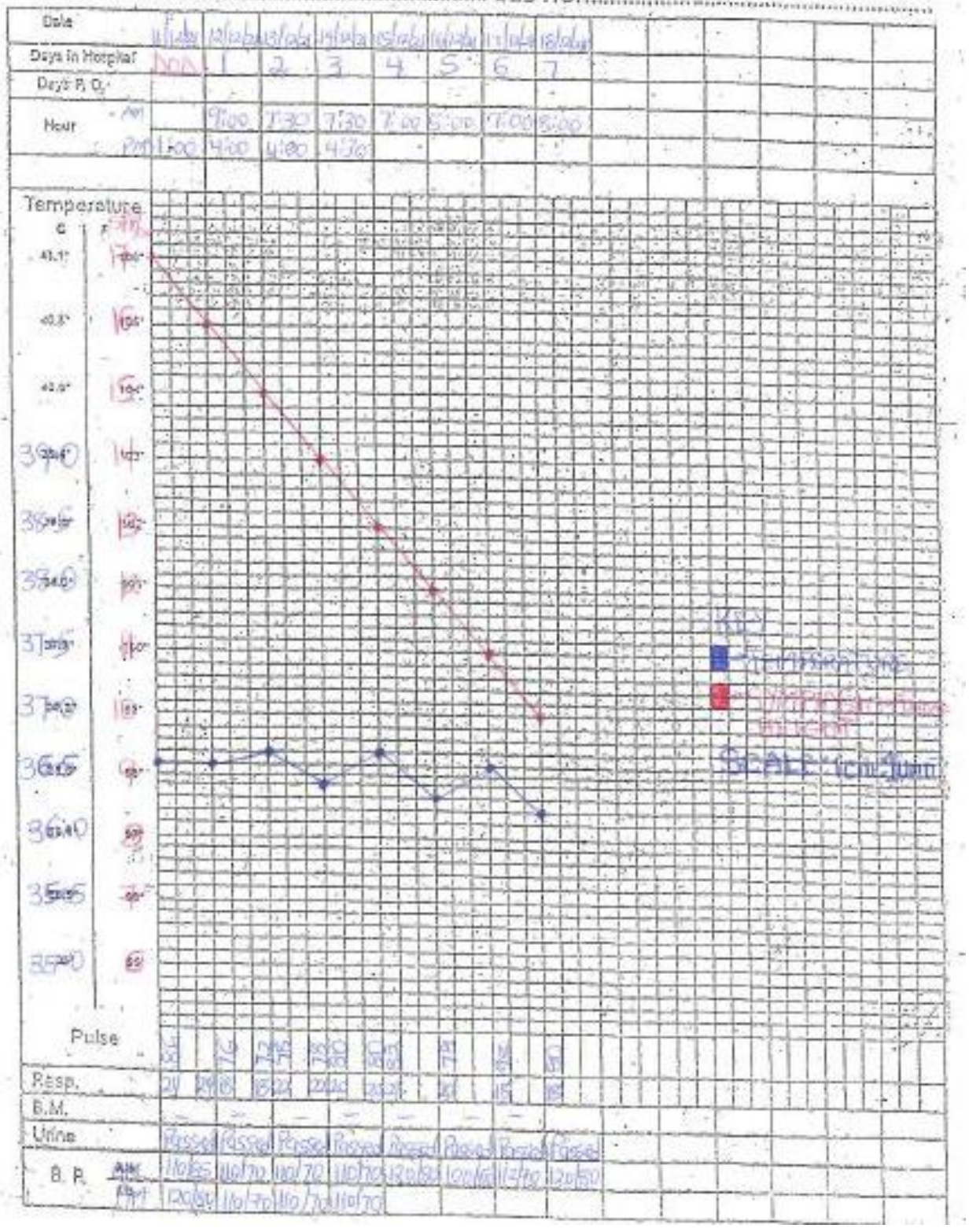
Birth Attendant Asante Katherine Samuah Date 11/12/2021

MATERNITY CHART

NAME: Madam Akosua Margaret

AGE: 31years WARD: Lying-In

IP NO.: BED NO.:

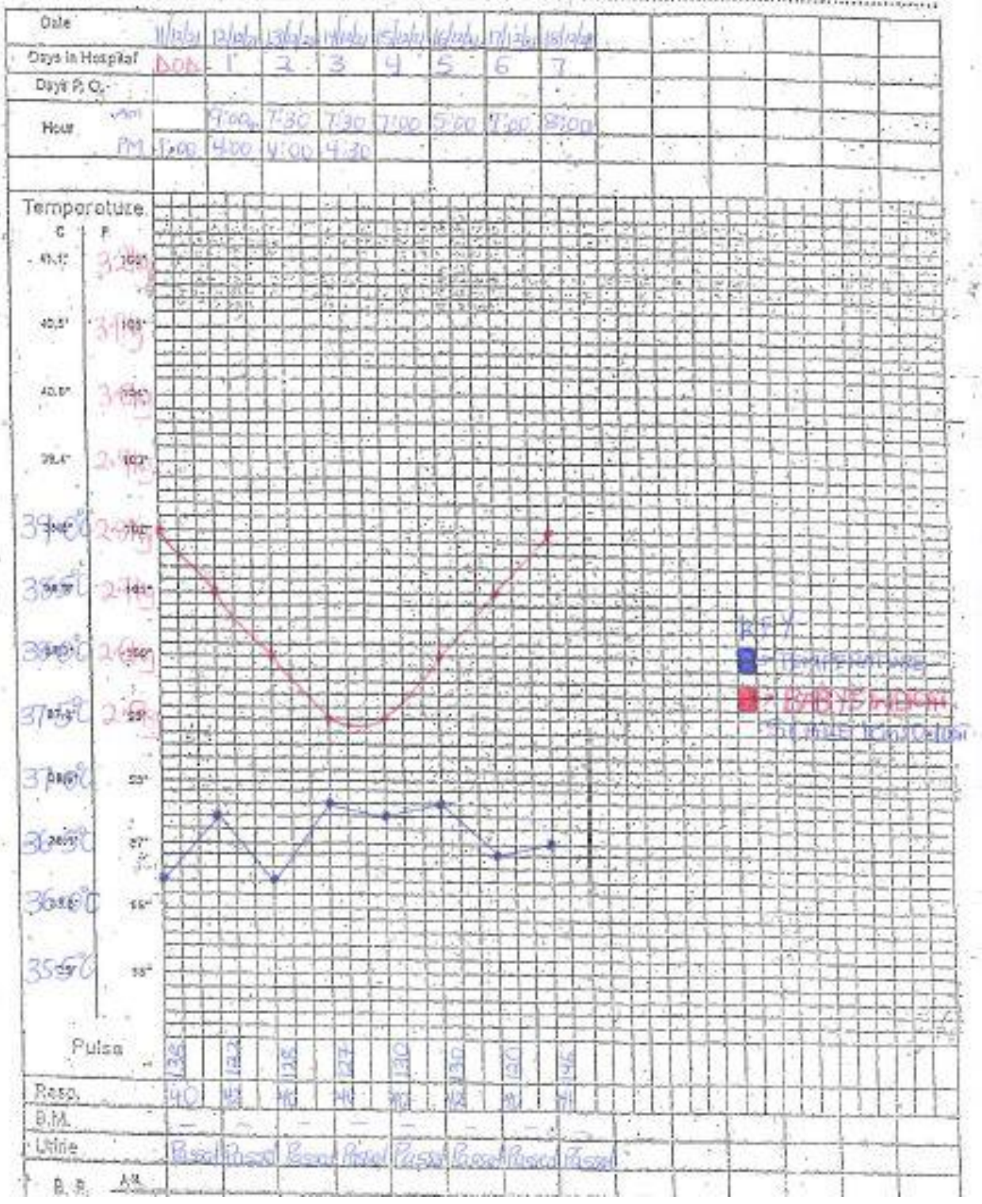


TEMPERATURE CHART

NAME: Baby Ama Margaret

AGE: New born WARD: Lying-In

IP NO.: BED NO.:



NEW BORN EXAMINATION FORM

Name: Baby Ama Margaret Date of Assessment: 11/2/2021 Time: 01:30pm

Date of Birth: 11/2/2021 Time of Birth: 11:45pm Sex: ☐ M ☑ F Age at time of Assessment (days/hrs) 1hr

Astational Age 9 Mode of Delivery: ☑ Vaginal Assisted Vaginal C-Section

APGAR: 1min 8 5min 9 Birth Weight: ☑ 3.8 kg ☐ Lenght 50 cm Head Circumference: 30 cm

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

Name of Assessor (Midwife/Doctor): Asante Katherine Samuah

1. Respiration
Rate 40c per
☐ Rate < 30 b/m *
☐ Rate < 60 b/m *
☐ 30-60 b/m
☐ Retractions *
☐ Grunting *
☐ Stridor *

2. Activity/Movement
☑ 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 Seperated *

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: 138bpm
☑ Normal (100-160)
☐ <100 *
☐ >160*

19. Femoral pulse
☑ Present
☐ Not palpable*

20. Abdomen
☑ Normal
☐ Distended*
☐ Scaphoid*
☐ Abdominal defect*
☐ Masses: _____
☐ 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 clitoris *
☐ 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

*May indicate severe disease that requires urgent referral

Diagnoses (if known) _____

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

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

NEWBORN EXAMINATION FORM

Name: Baby Ama Margaret Date of Assessment: 11/12/2021 Time: 01/04pm
Date of Birth: 11/12/2021 Time of Birth: 12:45am Sex: ☐ M ☑ F Age at time of Assessment (days/hrs) 1hr
Astational Age 3 ☑ Mode of Delivery: ☑ Vaginal Assisted Vaginal C-Section
APGAR: 1min 8 5min 10 Birth Weight: 2 kg 8 Length 50 cm Head Circumference: 30 cm
Temperature at time of Assessment: 36.2 °C Urine passed: Yes ✓ No Meconium passed: ✓ Yes No
Name of Assessor (Midwife/Doctor): Asante Katherine Sonyah

1. Respiration
Rate 40/min
☐ Rate < 30 b/m *
☐ Rate < 60 b/m *
☐ 30-60 b/m
☐ Retractions *
☐ Grunting *
☐ Stridor *

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

3. Tone
☑ Normal
☐ Floppy *
☐ Increased *

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☑ Pink all over
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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: _____

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

15. Clavicle
☑ Normal
☐ Swelling/Fracture

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

18. Heart rate
Rate: 138bpm
☑ Normal (100-160)
☐ <100 *
☐ >160*

19. Femoral pulse
☑ Present
☐ Not palpable*

20. Abdomen
☑ Normal
☐ Distended*
☐ Scaphoid*
☐ Abdominal defect*
☐ Mass: _____
☐ Other: _____

21. Back (spine)
☑ Normal
☐ Abnormal Swelling *
☐ Hairy 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 clitoris *
☐ Other: _____

24. Anus
☑ Patent
☐ Imperforate*

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

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

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

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

NEW BORN CHART

Name: Baby Ama Margaret ..... No: ..... Birth Weight: 2·8kg .....

Sex: female ..... Mother's No: 256/21 ..... Length: 50cm .....

Nature of Delivery: Spontaneous Vaginal Delivery ..... Diagnosis: Term Baby .....

Date of Birth: 11/12/2021 ..... Time: 11:45am ..... Date of Discharge: 18/12/2021 .....

Date	11/12/21		12/12/21		13/12/21		14/12/21		15/12/21		16/12/21		17/12/21		18/12/21							
No. of Days	DOB		D1		D2		D3		D4		D5		D6		D7							
Weight	2·8kg		2·7kg		2·6kg		2·5kg		2·5kg		2·6kg		2·7kg		2·8kg							
	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM
Temperature	36·2°C	36·2°C	36·0°C	36·7°C	36·2°C	36·2°C	36·8°C	36·8°C	36·7°C		36·8°C		36·4°C		36·5°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 Extremities Genitalia — N·A·D																					

SIGNATORIES

THE STUDENT MIDWIFE

NAME: ASANTE KATHERINE SOMUAH

SIGNATURE: .....

DATE: 25th September, 2022.

MIDWIFE-INCHARGE OF PENTECOST CLINIC, KASAPIN.

NAME: FLORENCE ASOR

SIGNATURE: .....

DATE: 6th October, 2022.

THE SUPERVISOR

NAME: MISS ERNESTINA MENSAH

SIGNATURE: .....

DATE: 07/10/2022

THE PRINCIPAL

NAME: MONICA NKRUMAH

SIGNATURE: .....

DATE: 14/10/2022