

HOLY FAMILY NURSING AND MIDWIFERY TRAINING COLLEGE

BEREKUM

A FAMILY CENTERED MATERNITY CARE STUDY ON

ACKAH DORCAS

BY

SAKOE FAITH

4122190120

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AS A PROFESSIONAL REGISTERED MIDWIFE**

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PREFACE

The client/family centered maternity care study is a systematic process in which nursing care is given to a pregnant woman and her family and the community, beginning from the period of Antenatal care through to labour and a successful puerperium. The client centered maternity care helps the client/family to allay any anxiety during the pregnancy till the time of puerperium.

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

Again, there is confidentiality in whatever the client says which helps build a strong inter personal relationship between the health care and the client where by the client won't hesitate to express her feeling and asking of questions.

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

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INTRODUCTION

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

This care study was written on Madam Ackah Dorcas a 26-year-old Gravida 3 Para 2 all alive. Who was met on the 9th November, 2022 at the antenatal clinic of Aggie Maternity Home (Berekum) during clinical attachment? She was 36 weeks pregnant and that was her 8th visit to the antenatal clinic. She caught attention as a result of the fact that she complained of midwives not attending to her and she has been in queue for a long while having fever, for which she was reassured of appropriate management plan and selected for the care study. She was managed from 36 weeks of pregnancy till 37+4 days brought labour and early puerperium.

Thorough assessment and physical examination were done on her with expected and clear explanation of all procedures to her. She had normal pregnancy. Home visits were also carried out to assess her environment and community in which she lived. The family was also involved in the care throughout the period. This interaction continued through her delivery and puerperium and finally ended on 23rd December, 2022 during the 3rd day post-delivery where she was handed over to the public health nurse in-charge for continuity of care. In all, the care lasted for about 7 weeks from 7th November, 2022 to 23rd December, 2022. Her condition at the beginning and termination of interaction was satisfactory.

This writes up is in 4 chapters.

Chapter one entails assessment of client and family which includes the past and present obstetric history, menstrual history, medical / surgical histories and habits of daily living. This chapter is about assessment of the client and her family, which involves gathering of data from the client and her family information was acquired through observation, interview, medical, records and antenatal records. This information helps the student's midwife to provide holistic care for the client and family taking into consideration the physical, psychological and spiritual needs.

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

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

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

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

This report includes termination of care, summary and conclusion, bibliography, appendices and signatories. The source of information was from the client records, textbooks and her family. The client will be called Madam Ackah throughout this project.

LITERATURE REVIEW

PREGNANCY

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

According to Marshall J. And Raynor M. (2014), pregnancy is a period of having an embryo in the uterus. During the period of pregnancy, there are some anatomical and physiological changes that affect every system in the body due to the alteration of pregnancy hormones like progesterone, estrogen, and human chorionic gonadotropin. Some of these physiological changes are nausea and vomiting, constipation, heartburns, headache, leg cramps, frequent micturition, anorexia and waist pains which occurs as minor disorders of pregnancy. The hormonal effects also cause a change in the woman's emotional state. This helps in the development of the fetus, prepares the expectant mother for labour as well as puerperium. The book further explains that every pregnancy is a unique experience for every woman. It is therefore important for the midwife to have knowledge and understanding of the minor disorders of pregnancy in order to educate the woman to understand the physiology of that disorder and how to manage it. Some Signs of pregnancy include; Possible (presumptive) signs: Early breast changes (unreliable in multigravida), amenorrhea, morning sickness, bladder irritability, quickening. Probable signs:

Presence of human chorionic gonadotrophin (HCG) in urine and blood, softened isthmus (Hegar's sign), bluing of vagina (Chadwick's sign), pulsation of fornices (Oslander's sign), uterine growth, changes in skin pigmentation, Braxton Hicks contractions, ballottement of fetus. Positive signs: visualization of gestational sac by transvaginal and transabdominal ultrasound, auscultation fetal heart sound by transvaginal and transabdominal ultrasound, fetal heart sounds by Doppler and fetal stethoscope. Fetal movement both palpable and visible, visualization of fetus by ultrasound scans. The aim of antenatal care is to monitor the progress of pregnancy to optimize maternal and fetal health. To achieve this, the midwife critically evaluates the physical, psychological and sociological effects of pregnancy on the woman and her family. This process requires engagement by the Midwife, as outlined below; Developing a trusting relationship with the woman. Providing a holistic approach to the woman's care that meets her individual need. Making a comprehensive assessment of the woman's health and social status, accessing all relevant sources of information. Promoting an awareness of the public health issues for the woman and her family. Exchanging information with the woman and her family, enabling them to make informed choices about pregnancy and birth. Being an advocate for the woman and her family during her pregnancy, supporting her right to choose care appropriate for her own needs and those of her family. Identifying potential risk factors and taking the appropriate measures to minimize them. Timely sharing of information with relevant agencies and professionals. Accurate, contemporaneous documentation of assessments, plans, care and evaluation. Recognizing complication of pregnancy and appropriately referring women to the obstetric team or relevant professionals or other organizations. Preparing the woman and family to meet the challenges of labour and birth and facilitating the development of a birth plan. Facilitating the woman to make an informed choice about methods of infant feeding and giving appropriate and

sensitive advice to support her decision. Offering parenthood education with a planned programme or on an individual basis.

According to Konar H. (2015), pregnancy last between nine and ten months. The duration of pregnancy is divided in three trimesters

First trimester 1st week- 12th weeks

Second trimester 13th week- 28th weeks

Third trimester 29th week – 40th weeks

Fraser & Cooper (2013) Pregnancy is the period when the fertilized ovum embeds in the maternal uterus until it is born thus the state of conception till the delivery of the foetus. The normal duration is 280 days or 40weeks counting from the last day of the menstrual period, she further states that uterine blood flow in pregnancy supplies the myometrium, endometrium and placenta, with the latter receiving nearly 90% of the total uterine blood flow near term. It further states that, the anatomical and physiological adaptations occurring throughout pregnancy affect virtually every body system. The timing and intensity of the changes vary between systems but all are designed to support foetal growth and development and prepare the mother for birth and motherhood. The uterus protects and supports the foetus, placenta and amniotic fluid. For most of the 40 weeks of pregnancy, the uterus expands to accommodate the growing foetus and remains relatively quiescent, yet at the time of labour it is able to contract regularly and forcibly to expel the foetus due to its unique properties of contractility and elasticity. She also says, the vagina also increases vascularity which results in the violet colour characteristic of Chadwick's sign. There is increased volume of vaginal secretions due to high level of oestrogen resulting in thick, white discharge known as leucorrhoea. Larger amount of glycogen is deposited in the

vaginal epithelium due to high oestrogen availability. The glycogen is metabolized to lactic acid by the lactobacillus acidophilus, (Doderlein's bacillus), and this leads to increase vaginal acidity.

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

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

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

pregnancy to ensure that, maternal and fetal health are normal. The aim of focus antenatal is to detect early and treat any abnormalities, prevent complications, promote health and educate mothers on complication readiness.

LABOUR

According to Konar (2015), labour is characterized by the presence of regular uterine contractions with cervical effacement and dilatation, descent and expulsion of products of conception. Konar also describes labour as normal if it fulfills the following criteria; spontaneous in onset and at term, with vertex presentation, without undue prolongation, natural termination with no aid and without any complications affecting maternal and/or baby's health. He stated under rest and ambulation; if the membranes are intact, the patient is allowed to walk. The attitude prevents venacaval compression and encourages descent of the head. Ambulation can reduce the duration of labour is monitored electronically of analgesic drug (epidural analgesia) is given, she should be in bed.

He further went on to state that, assessment of progress of labour and partograph recording are also done. Partograph is the tool that allows labour progress to be graphically recorded and visually assessed. They aid in the early detection of abnormal labour progress and are credited by

some for decreasing rates of prolonged abnormal, oxytocin use, caesarean sections and intrapartum morbidity/ mortality as compared to usual care. Use of the partograph is initiated during presumed active labour.

Marshall J. & Raynor M. (2014) says immersion in a warm bath or birthing pool can be an effective form of pain relief for laboring women that facilitates increased mobility with no increased incidence of adverse outcome for the woman or fetus. The midwife should invite the woman who is mobile to have a bath or shower whenever she wishes during labour.

Elizabeth (2013) says series of event that takes place in the genital organs in an effort to expel the viable product of conception out of the womb through the vagina into the outer world is called labour. She added that labour is said to be normal if it fulfill the following: Spontaneous in onset and at term

With vertex presentation

Without undue prolongation

Natural termination with minimal and without having any complications affecting the health of the mother and baby. She continues to say that management of labour aims at minimal observation with minimal active intervention. The idea is to maintain the normalcy and detect any deviation from normal at the earliest possible movement.

PUERPERIUM

According to Marshall J. and Raynor M. (2014) puerperium starts immediately after delivery of the placenta and membranes and continues for six weeks. It further states that the overall

expectation is that by the end of the sixth weeks after birth all the system in the woman's body will have recovered from the effects of pregnancy and the process of parturition.

He also added that, the average amount of discharge for the first 5-6 days is estimated to be 250mls. Normal duration may extend up to 3 weeks.

Henderson and Redshaw (2013) state that, the falling progesterone levels affect the alimentary tract. The smooth muscle tone gradually improves throughout the body, and symptoms of heartburn the woman may have experienced should resolve. Constipation may however remain a common problem during the postnatal period.

Konar H. 2015) also defines puerperium as the period following childbirth during which the body tissues, especially the pelvic organs revert back approximately to their pre pregnant state both anatomically and physiologically. He further explained that, lochia is the vaginal discharge for the first fortnight during puerperium. The discharge originates from the uterine body, cervix and vagina. Depending on the variation in the colour of the discharge, it is named as:

Lochia Rubra: consists of blood, shreds of fetal membranes and decidua, vernix caseosa, lanugo and meconium. It is red in color and it last for the first 1-4 days. Lochia Serosa:

consists of less red blood cells but more leukocytes, wound exudate, mucous from the cervix and microorganisms. It lasts for 5-9 days and it is yellowish or pink or pale brownish.

Lochia Alba: contains plenty decidua cells, leukocytes, mucous, cholesteryl crystals, fatty and granular epithelial cells. It lasts for 10-15 days and it is pale white in color.

The American Academy of Pediatrics (2014) stated the essential Care for Every Baby as all babies must be given eye care by instillation of tetracycline/chloramphenicol eye drops/ointment to prevent eye infections and also administering of vitamin k injection to prevent haemorrhagic disease of the newborn as well as cord dressing.

WHY CLIENT WAS CHOSEN

Madam Ackah Dorcas was seen at Aggie Maternity Home as a client on one of her usual antenatal visit to the hospital. On our first contact, her facial expression alerted me that there was something wrong with her so I did approached her with a smile and asked of what's eating her up, she said she was bothered about the outcome of labour and delivery. Assurance of competent care was given to her to allay fear and anxiety. Introduction of self was made as a student midwife from Holy Family Nursing and Midwifery Training College, Berekum, who is on clinical practice and the interest to select her for the study. She agreed and said she was glad. After going through her antenatal booklet, she was qualified to be used for the care study, thus a multiparous woman with no complication in her previous pregnancy, labour, and puerperium and also in her 36th gestational week

CHAPTER ONE

CLIENT'S / FAMILY ASSESMENT

1.0 INTRODUCTION

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

1.1 PERSONAL SOCIAL HISTORY

Madam Ackah is a 26-year-old woman gravida 2 para 1 from Magazine behind Apraku sawmill in the Bono Region of Ghana. Client speaks Twi and English. She is dark in complexion with height of 160 centimetres tall and weighs 65 kilograms at booking. Client is a Christian, had her former education and got to the Senior high school level and is currently working as a Trader. Client is married to Mr. Owusu Issac a 31-year-old man who is fair in complexion. He is a maison. They are both Christians who speak English and Twi. Client has two children alive. Her next of king is Madam Suzzy Owusu her sister. Client does not drink alcohol or smoke. She lives with her husband and with neighbours in a good relationship.

1.2 FAMILY HISTORY

Client was born to Mr. Nketiah Paul and Mrs. Benewaa Comfort and is the second born of five children. Both parents of client are alive and from Sampa in the Bono Region. All five siblings are living in different places. According to client, there is no history of twin pregnancy, and no known history of conditions like hypertension, diabetes, congenital abnormalities or mental illness in the family.

1.3 MEDICAL HISTORY

According to madam Ackah, she has never had any chronic illness, like hypertension, heart disease, sickle cell disease, diabetes mellitus, measles, liver cirrhosis, respiratory disorder, epilepsy, and Anaemia. She only said she sometimes suffers minor headache, fever and abdominal disturbances which she visits the clinic immediately to seek for medical treatment at OPD basis. She has no known allergy to food or any drug.

1.4 SURGICAL HISTORY

According to client, she had never undergone any surgical procedure and also mentioned that she has never sustained any injury or road traffic accident that called for any abdominal or spine surgery or affected her pelvis or subsequent effect on pregnancy and labour. On examination, there was no scar indicating previous laparotomy such as caesarean section or appendectomy. She has neither received blood transfusion nor donated since she was born

1.5 MENSTRUAL HISTORY

According to client, she had her menarche when she was 13 years old and her menses last for 5 days during every month. She added that, she does not encounter any abdominal pain and dysmenorrhea. She said the colour of her menstrual blood was dark red and has 28 days menstrual cycle. She also said that she changes her pad twice daily and when soaked as well, indicating she

has normal menstrual flow. Her last menstrual period (LMP) was 14th February, 2022 and her expected day of delivery (EDD) was calculated as 21st November, 2022.

1.6 HABITS OF DAILY LIVING/HOBBIES AND LIFESTYLE

According to client, she wakes up around 6:00am. She says her daily morning prayers with her husband and carries out any daily activity for daily living like brushing of teeth with tooth brush and pepsodent, emptying of bowel at least twice daily and bathing. She does her normal chores such as sweeping, cleaning and also prepares breakfast for her husband and children before husband leaves for work when he is around. She said her breakfast is usually tom brown with powered nido with either bread and egg or bread alone. She also said that she does not prepare lunch frequently for the family in the afternoon because she is always not home. In the evening, she mostly prepares banku with okro soup for supper.

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

1.7 PAST OBSTETRICAL HISTORY

Pregnancy: Madam Ackah gravida 2 para 1 all alive, went through all her pregnancy successfully with no complications and said she has never had abortion or still birth and her pregnancies went to term. She has a male and a female child. The interval between her first child and her second

child is 3 years, The birth weight of the first child was 3.5kg and the second child was 3.1kg According to her, she experienced some of the minor disorder of pregnancy such as nausea and vomiting, backache, leg cramps and frequency of micturition which she never reported to the hospital because she was thought during education that they are all normal physiological changes in pregnancy which will resolve as the pregnancy advances.

She attended antenatal clinic nine (9) times during her previous pregnancies and received two doses of tetanus immunization and all the doses of Sulphadoxine Pyrimethamine for her first pregnancy and also received 3rd dose of tetanus immunization and all doses of Sulphadoxine Pyrimethamine for her second pregnancy on direct observation therapy (DOT). All investigation carried on her were normal.

Labour Madam Ackah delivered her children spontaneously per vagina at the hospital. She further stated that the duration for her deliveries did not exceed 18 hours. Client's children were delivered at Aggie Maternity Home, The male weighed 3.5kg at birth from records followed the second born female who weighed 3.1kg at birth from records. She also said she has never had any perineal tear or been given episiotomy during her previous delivery. She added that she had never experienced post-partum haemorrhage. Her placenta was delivered completely with no retained product of conception. She said her estimated blood loss for her previous delivery was moderate. Her children had no birth injuries, asphyxia or jaundice. They were active at birth and healthy.

Puerperium: Madam Ackah went through her previous periods of puerperium successfully with no complication such as secondary postpartum haemorrhage. Client also stated that her children did not have any congenital birth defects like cleft palate or extra digits among others. She started breastfeeding her child within 60 minutes after birth and continued breastfeeding her for six

months exclusively before she introduced her to other foods together with the breast milk. She also said that each of her child weaned off breast milk at the age of 1 year 6 months. Client also stated that her children were fully immunized against the preventable disease. Since her mother wasn't available at that time to support her, the husband was always supporting her taking care of the baby and doing house chores. In relation to family planning, she said she was using the natural family planning as her method for family planning.

1.8 PRESENT OBSTETRIC HISTORY

According to Madam Ackah's antenatal card, her first antenatal visit was on 13th April, 2022 at 9:00am. Her last normal menstrual period was recorded as 14th February, 2022 and expected date of delivery was 21st November, 2022. Her gestational age was 13 weeks. Her vital signs weight and laboratory investigations on that day were as follows:

Vital Signs

Temperature	-	36.5 ⁰ c
Pulse	-	86bpm
Respiration	-	24 cpm
Weight	-	69kgs
Blood Pressure	-	110/70mmHg
Height	-	160centimetres

Laboratory Investigations

Sickling	Negative (-)
Blood group	AB
Rhesus factor	Positive (+)
Urine for pregnancy test	Positive (+)
HIV.....	Negative (-)
HEP-B.....	Negative (-)
VDRL.....	Non-reactive
Protein in urine	Negative (-)
Glucose in urine.....	Negative (-)
G6PD.....	No Defect
Haemoglobin.....	12.8g/dl

Head to toe examination was done on her and it was recorded in her antenatal book that her pelvis was adequate and also no abnormality was detected on her. Client was met on her 9th antenatal visit. She had taken 5 doses of sulphadoxine pyrimethamine and four dose of tetanus diphtheria (TD4) when she was met. She was given the following routine drugs;

Caps iron III daily for 30 days. Tablet Folic Acid daily for 30 days. Client was still attending antenatal clinic regularly before she was met and all her complains addressed.

CHAPTER TWO

ANTENATAL CARE

2.0 INTRODUCTION

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

2.1 FIRST CONTACT WITH CLIENT

Madam Ackah was met for the first time on Wednesday 9th November, 2022 when she was 36 weeks gestation and it was 9th (ninth) visit to the antenatal clinic at Aggie's maternity Home around 9:55am. Introduction was made as a student midwife from Holy Family Nursing and Midwifery Training College (Berekum) who has been stationed at the facility for 7 weeks clinical and to write a care study on a chosen client. The desire to take her as a client was expressed to her, she agreed and was glad. All the procedures to be carried out on her were explained to her understanding and she agreed for them to be done. She complained of Anxiety and also being in the queue for a long time and more over it was not her day of visit to the antenatal. She explained that her previous pregnancy was not like that. Client was encouraged and told that, every pregnancy comes with a different experience hence she should try and cope with it. Her vital signs, weight together with some laboratory investigations done on her were recorded as below.

Temperature	-	36.5 ⁰ c
Pulse	-	86bpm
Respiration	-	22 cycle per minute

Weight - 69kgs
Blood Pressure - 110/70mmHg
Height - 160centimetres
Haemoglobin.....12.8g/dl

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

GENERAL HEAD TO TOE EXAMINATION

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

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

towel. Hands were rubbed together to warm them for the examination.

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

Eyes: conjunctiva was checked for pallor and the sclera checked for jaundice but the conjunctiva was pink and sclera was clear. The eyes were without discharges.

The nose was checked for discharge but there was none. The teeth, tongue and gum were clean with no cracked or dry lip, no dental caries or offensive odour. The ears were checked for discharges and dirt but there was none.

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

Breast Examination: procedure was explained to client and consent sought to do breast examination and client accepted. Both breasts were exposed and inspected for the size and shape and the condition of the skin. One breast was covered and she was asked to put the hand of the part to be examined under her head. The breast was palpated thoroughly in a circular manner with the inner aspect of the fingers and there were no masses, lump, cracks or sore nipple. The areola was press for lumps. The nipple was squeezed gently for fluid (colostrum) and was examined for odour and blood, everything was normal and cleaned with dry cotton. The same process was repeated for the other breast. She was asked of breastfeeding history and her desire to breast feed was inquired, to which client responded that she practiced exclusive breast feeding in her previous pregnancy and she is willing to continue practicing exclusive breast feeding. She was encouraged to continue wearing maternity dresses, well-fitting braziers and educated on the need to perform

breast care and self-breast examination for early detection of abnormality and treatment to prevent complication.

On the extremities: the arms were equal, hands and fingers were inspected for edema, pallor of palms and nail beds but no abnormality was detected. The lower extremities were inspected and they were free from edema, tenderness in the calf muscle, varicose veins and they were of equal sizes.

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

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

Measurement of Symphysiofundal Height: The upper border of the fundus was located and the zero mark of the tape measure was placed on it. The tape was extended along the contour of the abdomen along the midline to the symphysis pubis. The Symphysiofundal height was 32 centimeters and gestational age was 36 weeks.

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

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

On pelvic Palpation: Upon facing the woman's feet while standing at the right side of the client, she was asked to bend her knees slightly and also to breathe out slowly to help her relax. Each palm was placed on either side of the uterus just below the umbilicus, hands directing towards the symphysis pubis as the thumbs were almost meeting, and a hard mass was felt indicating the head of the foetus.

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

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

Examination of The Vulva: Permission was sought from client to examine her perineum and genital area which she permitted. Client was assisted to relax on the examination bed. She was draped to ensure minimal exposure. Hands were washed with soap under running water and dried with clean dry towel and examination gloves worn. On inspection, the vulva was neatly shaved and had no scar, oedema, genital warts and no masses were palpated at the groins. Later all findings were communicated to her. She was then thanked for her cooperation. She was helped out of the examination bed. After that she was asked whether there was any complaint but she had none. She was reminded of her next visit to the clinic which was 16th November, 2022. She gave directions to her house and was thanked. The following routine drugs were given:

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

A scheduled date for home visit on 12th November, 2022 was agreed upon

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

2.2 FIRST ANTENATAL HOME VISITS

The first home visit to Madam Ackah and her family was on the 12th November, 2022 at 2:30 pm as it was booked. The purpose of the visit was to observe client's environment, establish rapport with client her family and neighbour, assess client health status and offer a comprehensive focus antenatal care to client. A warm welcomed was given, seat was offered in her room and also water to drink which she was thanked for that. I was asked by her sister why i was there and it was made known to them that the visit was made to enquire about their wellbeing.

PHYSICAL ENVIRONMENT

A quick assessment was made on Madam Ackah environment. The house in which they live is a self-contained house. The house was built with cement blocks and was roofed with aluminium sheets. There were six rooms in the house with a detached kitchen directly opposite to the house. They had an attached place of convenience (toilet and bath). She sleeps with her husband and the children in one room and her sister in the other room. On entering her room, it was noticed she sleeps in a mosquito net. The room has two windows made with louver blades which enable ventilation and there was an adequate lighting system too. The kitchen was neat and all her things

were well organized. They have a well just behind the house from which they fetch water. She stores water in a barrel with a lid. Since their bathroom is only one, she shares it with her household. Their public toilet was inspected and it was neat as well. Her rubbish was also kept in a dustbin with a lid and burns it when full. The house was neat and client was in a good relationship with other relatives. Health education was given to client and her family on birth preparedness and complication readiness plan which includes the needs to arrange for blood in case of emergency, arrangement for transport to clinic in advance in case labour sets in, and the need to save money towards their needs during delivery. She was asked about her national health insurance card and she has registered with the National health insurance scheme. Her card was collected and inspected and noticed the expiring date was not approaching. She was asked about her items for delivery and confinement and she disclosed that she had bought almost everything. She was encouraged to get everything before the next home visit for inspection. True sign of labour was also explained to her such as regular, painful, rhythmic uterine contraction, cervical dilatation and the presence of show (that is, blood stained-mucoid discharge). She was reminded about the advantages of being prepared psychologically for labour and delivery that is being confident and thinking positively that her delivery will be successful. She was encouraged to adhere to all the information given to her during the antenatal clinic. Education on family planning was also discussed and she said she previously used the calendar method, and that she had little information on the other methods. The other method with their advantages and disadvantages were also explained to her since she had little knowledge about them, as well as the importance of birth spacing. She was encouraged to eat varieties of foods as this is more likely to let her get the required nutrient, for instance protein from animal like meat, fish, eggs and plant source like beans, and groundnut with good source of folic acid which can be found in dark green leafy vegetables examples; kontomire cassava leaves, Ayoyo

etc. she was educated to take a lot of fiber diet like brown rice, whole grain cereals, fruits and vegetables to prevent constipation. The last thing we discussed was about rest and sleep, she was thought the importance of rest and sleep to her and the unborn baby. She was then encouraged to take her routine drugs as prescribed, and was reminded on her next visit to the clinic. Permission was then sought to leave and client and family were thanked for their warm reception.

PSYCHOSOCIAL

Client was visited and the members in the community testified client was a very friendly and loving woman. Madam Ackah co-tenants said client was in good terms with her husband, relatives and the people around. After a short conversation with client, it was made known to student midwife that client has about three intimate friends of which she tries to check on to know how they are fairing daily. Apart from being friends with people, client also has a heart of gold which makes her to assist people in times they need her in any form help. Client is a children loving type so upon calling her name on arrival, all the children around rushed to call her out. After a quick assessment by student midwife, it was indicated that client was truly in good terms with her members.

SECOND ANTENATAL HOME VISIT

Madam Ackah was visited the second time on the 14th November, 2022 at 9:30am.

The aim of the visit was to ascertain if the identified helpers were still around to help, enquire about her health status and how she is coping with the physiological changes taking place and her preparation towards birth. Preparation toward delivery was still on progress. On arrival, greetings were exchanged and a warm welcome was given. After enquiring about their health, for which she responded positively.

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

She was educated to have enough rest and her family members were also encouraged to assist in household chores. She complained of Heart burns and she was also educated to maintain her personal hygiene to prevent infections. Madam Ackah was again reminded on the true signs of labour such as appearance of ‘show’ painful regular rhythmic uterine contractions and spontaneous rupture of membranes. She was asked to report to the hospital any time she sees any of the signs mentioned. She was again reminded of her next visit to the hospital on 16th November,2022. Client was thanked for her warm cooperation and bid fare well.

2.4 SUBSEQUENT VISIT TO THE CLINIC

On the 16th November, 2022 at 9:00am Madam Ackah came to the clinic, which was the second contact with her at the clinic but her 9th visit to the clinic. She was welcomed and offered a seat.

She was asked about her general condition and she confirmed she is fine. Every procedure that was going to be carried on her was explained to her. Her vital signs and weight were recorded as follows:

Temperature	36.4 degree Celsius
Pulse	82 beat per minute
Respiration	24 cycle per minute
Blood Pressure	120/60 millimetre of mercury
Weight	71 kilograms

Her haemoglobin level was checked and recorded as 12.8grams per decilitre and urine test for protein and sugar were all negative. Privacy was provided. Hand washing with soap under running water was done and dried with clean dry towel, after which she was assisted to undress and helped unto the examination bed. Having emptied her bladder physical examination started, everything from head to toe was normal. On fundal palpation, the buttocks occupied the upper pole of the uterus. The lie was longitudinal, the back of the foetus felt on the mother's right side and the abdomen and the limbs on the left side, the position was right occipitoanterior. The head occupied the lower pole with descent of 5/5th, Symphysio-fundal height was 33cm and gestational age was 36 weeks. On auscultation, foetal heart was 133bpm with good volume and rhythm. All findings were communicated to her. She complained of backache and was reassured and educated on the causes and prevention of backache. She was also told that it was as a result of the growing uterus causing a change in the posture and the influence of the hormone (relaxing) which relaxes the ligament. She was encouraged to sleep on a firm surface to maintain a good posture when lying and support her back with pillow when sleeping and sitting and should wear low heeled shoes and sandals. Madam Ackah was also encouraged to lift light objects and also rest after an activity. It

was observed that lightening has taken place enough. Client's back was examined for oedema and also spine for any abnormality but no abnormality was detected. She was informed that, her next visit to the clinic will be on the 19th of November, 2022.

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2.8 NURSING CARE PLAN FOR ANTENATAL CARE

Problems Identified during Antenatal

Client complained of:

1. Anxiety (9th November, 2022.)
2. Constipation (12th November, 2022.)
3. Heart burns (14th November, 2022.)
4. Backache (16th November, 2022.)

Short Term Objectives

1. Client's anxiety will reduce within an hour.
2. Client will regain bowel movement once daily within 24hours.
3. Client heart burns will reduce within 24 hours and cope with it throughout pregnancy.
4. Client's backache will subside within 24hours and will cope with it through out pregnancy

Long Term Objectives

Madam Ackah will be healthy throughout pregnancy, labour and puerperium successfully without any complications to both mother and baby.

NURSING CARE PLAN FOR ANTENATAL CARE

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTIONS	EVALUATION	TIME/ DATE	SIGN.
09/11/22 At 8:40 am	Anxiety related to unknown outcome of delivery.	Madam Ackah will be relieved from anxiety within an hour as evidence by: Midwife observing clients relieved from anxiety Client verbalizing that she is no more anxious.	1. Reassure client of competent care. 2. Encourage client to share fears and concerns. 3. Provide information regarding management of labour anxiety. 4. Allow client to ask questions. 5. Introduce the staff present to client.	1. Client was reassured of competent care. 2. Privacy was ensured to boost patient confidence as she shared her fears. 3. Information regarding management of anxiety in a supportive manner was given. 4. Client questions were answered. 5. Staffs were introduced to client.	Goal fully met as evidence by: 1. Nurse observing client relieved from anxiety. 2. Client accurately verbalising measures to control anxiety and less anxious.	09/11/22 At 9:40 am	S.F

NURSING CARE PLAN FOR ANTENATAL CARE CONTINUED

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES\ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	EVALUATION	DATE/ TIME	SIGN.
12/11/22 At 8:40am	Constipation related to activity of progesterone causing decreased peristalsis and relaxation of the large bowel during pregnancy.	Client will empty her bowel once daily as evidence by: 1. Client verbalizing that she is able to pass stool once daily without strains within 24hours. 2. Midwife observing normal bowel movement of at least once a day	1. Reassure client of possible measures to restore normal bowel movement. 2. Encourage client on the intake of more fluid. 3. Educate client on the intake of roughage like whole grain rice, fresh fruits and vegetables 4. Discuss the importance of fluid and dietary fibre in maintaining normal bowel activity. 5. Encourage client to do minimal exercise.	1. Client was reassured of possible measures to restore normal bowel movements. 2. Client was encouraged to take more fluid daily. 3. Client was educated to take in roughages contained foods like whole grain rice, fresh fruits and vegetables. 4. Importance of the intake of fluid and dietary fibre was discussed with client. 5. Client was sweeping with long broom and walking around.	Goal achieved as client said she had normal bowel movement.	13/11/22 At 8:40 am	S.F

NURSING CARE PLAN FOR ANTENATAL CARE

DATE/ TIME	NNURSING DIAGNOSIS	NURSING OBJECTIVES\ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	EVALUATION	DATE/ TIME	SIGN.
14/11/22 At 9:30am	Heart burns related to pressure of the growing foetus on the abdomen and relaxation of the cardiac sphincter.	Client heart burns will reduce within 24 hours and cope with it throughout pregnancy as evidence by client verbalizing she no more experience hurt burns.	<ol style="list-style-type: none"> 1. Reassure client of possible measure to get rid of heart burns. 2. Encourage client to take in more water. 3. Encourage client to sit for a while after meals before going to bed. 4. Encourage client to sit up after meals. 5. Encourage client to reduce spicy and oil food consumption. 	<ol style="list-style-type: none"> 1. Client was reassured that heartburns will resolve when managed. 2. Client was encouraged to take in at least 8 cups of water in the day. 3. Client sat for a while before going to bed. 4. Client was advised to sit for at least 2 hours after meal before lying down. 5. Client was encouraged to reduced intake of spicy and oil food. 	Goal fully met as Client verbalized that she was relieve of heartburns.	15/11/22 At 9:30am	S.F

NURSING CARE PLAN FOR ANTENATAL CARE

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES\ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	EVALUATION	DATE/ TIME	SIGN.
16/11/22 At 9:00am	Backache related to physiological changes in pregnancy.	Client's backache will subside within 24 hours as evidence by; 1. Client verbalizing that she is coping with the backache. 2. Client scoring zero on pain assessment scale.	1. Reassure client possible care to relieve backache. 2. Encourage client to have rest. 3. Encourage client to apply warm compress to the back. 4. Encourage client to support her back with pillows while lying down. 5. Encourage client to wear low heel shoe and lift light objects.	1. Client was reassured on the possible care to relieve backache. 2. Client had enough rest. 3. Client was applying warm compress to the lower back. 4. Client was supporting her back with pillows while lying down. 5. Client was wearing low heel shoe and lifting light objects.	Goal fully met as evidence by: 1. Client verbalizing that pain has reduced. 2. Client scoring zero on comparative pain assessment scale. 3. Client looking more cheerful on assessment.	17/11/22 At 9:00pm	S.F

CHAPTER THREE

LABOUR

3.0 INTRODUCTION

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

3.1 ADMISSION AND MANAGEMENT OF FIRST STAGE OF LABOUR

On Tuesday 20th November, 2022 Madam Ackah came to the facility at 11:43am with 37+4 days gestation and complained of abdominal pains she was assessed and just after the assessment, she complained that she has seen “Show” around 11:20am when she went to the washroom. She was admitted at the labour ward. On observation, her general appearance was good and her facial expression indicated that she was in pain. She was made comfortable in bed, her antenatal card was collected and glanced through to check her expected date of delivery which was calculated to be 21st November 2022. She was introduced to the other staffs present in order to make her comfortable. Procedure to be done was explained to her and consent was gained. Bedpan was served to empty her bladder and urine measured was 120mls and midstream urine collected also tested negative for both protein and glucose, her haemoglobin level checked was 13.1 gram per decilitre. Her vital signs were checked and recorded as follows:

Temperature 36.4 degrees Celsius

Pulse 82 beats per minute

Respiration 25 cycle per minute

Blood pressure 110/60mmHg

Weight 75kilogram

Hands were washed with soap under running water and dried with a clean towel. Client was assisted to undress and examined from head to toe and no abnormalities were detected. The abdomen was ovoid in shape, medium in size and fetal movements were visible on inspection. The palms were rubbed together to provide warmth and palpation was done. The lie was longitudinal, presentation was cephalic, gestational age was 37+4 days and symphysio fundal height was 34cm, descent was 3/5th above the symphysis pubis. On auscultation the fetal heart rate was heard and when counted for a full minute, it read 130 beats per minute. The contractions were timed after sitting comfortably at the right side of the client and placing the palm on the fundus. After noting the frequency and duration for 10 minutes, contractions were obtained 2 in ten minutes and it lasted less than 30 seconds. After the above examinations, permission was again sought for vaginal examination to be performed, permission was granted. She was assisted to lie in the lithotomy position with the legs parted. Hands were washed with soap under running water and dried with a clean towel. A sterile glove was then worn. On inspection of the vulva, there were no scars, rashes, warts, varicose veins and sores. Cotton swabs were soaked in savlon solution and it was used to clean the vulva. The vagina was entered with the middle finger and then followed by the index finger. On vaginal examination, the vagina felt warm, moist and slippery. The sacral promontory was not reached and the sacrum was well curved. The ischial spines were also blunt. The cervix was 4cm dilated around 12:00pm, effaced, soft and thin and well applied to the presenting part with membranes intact moulding was zero and position was right occipito- anterior. The pubic

arch was wide and the intertuberous diameter admitted all four knuckles. She was cleaned afterwards and a new perineal pad was applied. Gloves were removed and hands were washed and dried. All findings were explained to Madam Ackah and the dilatation board was shown to her explaining the progress of labour. She was encouraged to take deep breath exercise as she walks around in order to speed up the dilatation and lie on her side when she feels tired. Client complained of lower abdominal pain and she was again encouraged to empty her bladder when she has the urge as this will even help with the effective contractions and dilatation of the cervix. She was also asked to change her perineal pad and apply a new one when it gets soiled. She was cautioned not to push as this will make the cervix oedematous and prolong the labour process. She was educated on how to perform deep breathing exercise whenever she felt pains as this will help relieve her of its intensity. She was asked if she felt hungry and wanted to take in something and she said no and the information was recorded on a partograph.

PREPARATION FOR BIRTH

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

The area for delivery was prepared ensuring that it's clean, closing nearby windows and doors, drawing curtains down, testing of light and making provision for artificial lighting and switching off fans. It was ensured that the equipment needed for resuscitation is clean and prepared for resuscitation when necessary. The resuscitation equipment was assembled and tested for

functioning and they were in good condition. The equipment included suction device, ambubag and mask, head cover, stethoscope, source of light, scissors, oxygen cylinder with oxygen etc. Client was reminded that the baby would be delivered onto her abdomen and she agreed.

MANAGEMENT OF FIRST STAGE OF LABOUR

Madam Ackah was monitored continuously. The blood pressure, temperature, descent, moulding and liquor were monitored 4 hourly and recorded while the fetal heart rate, maternal pulse and contractions were monitored every 30 minutes and was recorded on the partograph. At 3:30pm, madam Ackah complained of anxiety and was really anxious looking and it was explained to her that the pains was as a result of descent of the presenting part of the fetus and uterine contractions so she was reassured to relieve her of the anxiety. It was observed that client was putting her hands at the perineal area in order to place her perineal pad correctly whenever it tried to fall. Labour progressed normally and at the next 4 hours at 4:00pm the next vaginal examination was due, contractions were 3 in 10 lasting 45 seconds and descent was 2/5th. Fetal heart rate was 136 beats per minute, temperature was 36.5 degrees Celsius, pulse was 98 beats per minute and BP was 110/80mmHg and the cervix was 7cm dilated, Urine 150milliliters

Membranes ruptured spontaneously at 5:30pm. The above information was recorded on a partograph sheet. Madam Ackah was continuously monitored on the partograph. The delivery trolley containing all the items needed was set with the following;

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

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

At 6:00pm, client complained of bearing down. Vaginal examination was done and the cervix was 10cm dilated, liquor was clear and moulding was ++ descent was 0/5th, contraction was 4 in 10minutes lasting 45 seconds and foetal heart rate was 140bpm, the perineum bulged and the anus gaped. The midwife in charge was informed of the progress of labour and was asked to confirm it and she confirmed, which marked the beginning of the second stage of labour. Fetal heart rate was 140 beats per minute, temperature was 36.6 degrees Celsius, pulse was 98 beats per minute and BP was 110/70mmHg.

3.2 MANAGEMENT OF THE SECOND STAGE OF LABOUR

After performing vaginal examination, client was informed that she was due to deliver her baby and every procedure going to be performed was communicated to her and her consent was gained. She was asked about the position she wanted and she chose the lithotomy position. Windows were closed in order to provide privacy as well as fans turned off in order to ensure warmth in the delivery room for the baby to be delivered. Protective clothing which are plastic apron, boots, face masks and sterile gloves were worn. Delivery pack was opened by the midwife in charge. Her legs were flexed and parted since lithotomy was the chosen position. The second stage was explained to Madam Ackah again that she should push with each contraction and breathe through her mouth when the contraction wears off. Client's vulva was swabbed with five cotton swabs soaked in savlon antiseptic lotion as well as the upper thighs. Sterile towel was used to drape her abdomen,

under her buttocks as well as both thighs and she was reminded that the baby will be delivered unto her abdomen. This was done in order to provide a sterile field for the baby. Madam Ackah did as she was told and pushed with each contraction. After some few minutes with effective uterine contractions and good maternal effort, the fetal head advanced. The anal area was covered with a sterile perineal pad to prevent stool from contaminating the delivery field and getting into contact with the baby's face. The index and middle fingers were used to aid flexion to prevent crack or tear of the perineum. The outlet was roomy so episiotomy was not needed. Client complained of fatigue and she was encouraged perform the deep breathing exercises and to push whenever she gets the urge to and also rest when the contractions subsides. With the contractions, the head crowned. Client was asked to stop pushing but rather breathe through her mouth to prevent rapid expulsion and with extension the sinciput, the face and the chin swept the perineum for the head to be born. Client was sweating profusely after the head was born, so she ordered for malt which was already in her bag to drink to prevent dehydration. The baby's face was cleaned with sterile gauze as well as the eyes from the inner canthus to the outer canthus. Immediately the head was delivered, feeling for cord around baby's neck was done but it was not felt. Restitution occurred and internal rotation of the shoulder which is simultaneous with external rotation of the head occurred. The fetal head was held in both palms, each palm on the parietal bones and with little downward traction, the anterior shoulder was delivered. The posterior shoulder was also delivered with upward traction. The rest of the body was delivered by lateral flexion onto the mother's abdomen. The baby cried immediately it came out. The time of delivery was noted to be 6:15pm and the sex which was male as confirmed by the client. Madam Ackah was congratulated for her effort and for the arrival of her baby.

IMMEDIATE CARE OF THE NEWBORN

Immediately the head was delivered, sterile gauze was used to clean the baby's face and eyes from the inner canthus outwards. The baby was dried thoroughly and wrapped in a dry warm sheet in order to prevent heat loss. The first minute Apgar score was assessed and it was 9/10. Within the first 3 minutes, the cord was measured 3 finger breaths from the baby's abdomen and clamped with the cord clamp and clamped again measuring 2 finger breaths from the first clamp, the cord was covered with gauze and cut in-between the clamps to separate the baby from the mother. The windows and doors were closed as well. An identification band was placed on the baby's wrist bearing the mother's name, date, baby's sex and time of delivery. Fifth minute Apgar was assessed and it was also 10/10. The baby was made warm by maintaining skin to skin with mother for an hour, during which breastfeeding was initiated.

3.3 MANAGEMENT OF THE THIRD STAGE OF LABOUR

After delivery of the baby, the procedure was explained to the client. After palpating the abdomen to rule out the presence of an undiagnosed twin, 10 units of oxytocin was given one minute after the birth of the baby intramuscularly at the thigh with the purpose of augmenting uterine contraction to aid separation and detachment of the placenta and controlled cord traction was applied. This is done in order to prevent retained placenta or retained products of conception. The cord was reclamped closer to the perineum, a receiver was placed in between client's thighs to receive the placenta and membranes. Her bladder was checked to rule out full bladder and it was palpable so client was encouraged to pass urine in order to empty the bladder to prevent bleeding. The left palm was placed on the uterus to feel for contractions, when the uterus was well contracted, the cord was held together with a forceps and with the palm facing the fundus of the uterus at the suprapubic region. Control cord traction (CCT) was applied on the cord in a

downward manner to deliver the placenta. Steady traction was maintained until the placenta was visible at the vulva. The placenta was cupped in both hands and was twisted gently to deliver it and its membranes. It was completely delivered at 6:25pm. A quick examination of the placenta was made to detect any possible retained products of conception and was then placed into the receiver afterwards. The uterus was then massaged to expel clots and to stimulate it to contract in order to prevent postpartum bleeding. The perineum, vagina and cervix were examined for possible tear and bleeding under a good source of light but there were no abnormalities. The client was taught how to perform uterine massage and was made known to her how the uterus will feel like when it contracts. A clean pad was used to clean the liquor and the blood from her body and a fresh perineal pad was applied to the vulva. She was then asked to lie on her back and cross her legs so that any bleeding could be noticed. She was also asked to empty her bladder whenever she felt the urge in order to prevent bleeding after she was sent to the lying-in ward. She was then thanked for her co-operation. Her husband was informed about the safe delivery of a baby boy as they were expecting and he was very happy. The placenta and membranes were sent to the sluice room to be examined and discarded afterwards per the protocol of the facility. The placenta and membranes were immersed in 0.5% bleach solution for ten minutes to minimize the risk of infection during its examination.

EXAMINATION OF THE PLACENTA

The placenta was placed in 0.5% chlorine solution and it was examined. The placenta was held by the cord with the membranes hanging. The membranes were checked for completeness and it was intact. The placenta was laid on a flat surface; the amnion was peeled from the chorion up to the umbilical cord to permit full visualization of the chorion. The lobes fitted together without any gap and edges also forming a uniform circle at the maternal surface and this showed that there were no

lobes missing. There were no blood vessels radiating into the membranes and there were also no white patches on the maternal surface. The cord was situated at the centre of the placenta with one vein and two arteries seen. There was no indication of abnormalities. The instruments and equipment used were immersed in 0.5% chlorine solution for 10 minutes. They were then washed, rinsed, dried and then sent for sterilization. Gloves were removed and hands were washed under running water with soap and dried with a clean towel.

3.4 MANAGEMENT OF THE FOURTH STAGE OF LABOUR

Mother

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

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

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

PREVENTION OF DISEASE

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

EXAMINATION OF THE NEWBORN

At 7:15pm, procedure was explained to the mother after one-hour skin to skin and consent was given. Measurements of the baby's head circumference were 36 centimetres, length of the baby was 48 centimetres and his weight was 3.5kg. Baby's vital signs were checked and recorded as:

Temperature	36.4 degrees Celsius
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Apex heart beat 140 beats per minute

Respiration 42 cycles per minute

Examination gloves were worn and baby was examined in front of the mother. Baby was put on a covered flat surface undressed and uncovered to visualize the general condition of the skin then covered and only the part to be examined was exposed. A detailed head to toe examination was carried out and recorded as follows:

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

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

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

On the extremities: hands and arms were inspected for symmetry, movement and paralysis, and the palm for the number of palmer creases. Fingers were examined for clubbed finger, extra digits or loss of a finger but no abnormality was detected. The length and movement of the lower limbs were noted. The digits were counted to be normal with no extra digits. The lower limbs were also examined for congenital dislocation of the hip but none was detected.

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

Genitalia and anus: the genitalia were examined, the location and patency of the urethral meatus were checked and they were all in their rightful position. Testicles were palpated if it has descended, number and position but there was no abnormality found. The anus was examined for patency and it was patent. The anus was also palpated for sphincter tone, masses, tenderness but it was normal. The baby passed meconium and urine in the process of examination.

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

SUMMARY OF LABOUR

Date and time of delivery	-	20 th November, 2022 at 6:15am
Type of delivery	-	Spontaneous vaginal delivery
Time of expulsion of placenta and membranes	-	6:25pm
Drugs given	-	injection oxytocin 10 units

DURATION OF LABOUR

1 st stage	-	6 hours
2 nd stage	-	15minutes
3 rd stage	-	9minutes
Total time	-	6 hours,24 minutes

CONDITION OF MOTHER AND BABY

MOTHER

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

Mother's condition was satisfactory

BABY

Temperature	36.4 degrees Celsius
Apex heart beat	134 beats per minute

Sex	Male
Birth weight	3.5kilograms
Length of baby	48 centimetres
Meconium	Passed
Urine	Passed
First minute APGAR score	9/10
Fifth minute APGAR score	10/10
Baby's condition was good.	

3.5 CARE PLAN DURING LABOUR

Problems identified during labour

1. Lower abdominal pains (20/11/22)
2. Anxiety (20/11/22)
3. Fatigue (20/11/22)
4. Risk of dehydration (20/11/22)
5. Risk of infection (20/11/22)

SHORT TERM OBJECTIVES

1. Client will cope with the lower abdominal pains within 4 hours and throughout labour
2. Client's anxiety will resolve within 30 minutes
3. Client will be relieved of fatigue within 2 hours.
4. Client's fluid volume will be maintained within 2 hours and throughout labour
5. Client will show no sign of perineal infection after 24 hours.

LONG TERM OBJECTIVES

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

CARE PLAN DURING LABOUR

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES/ OUTCOME CRITERIA	NURSING ODERS	NURSING INTERVENTION	EVALUATION	DATE/ TIME	SIGN
20/11/22 At 11:30am	Lower abdominal pains related to physiological processes in the first stage of labour	<p>1. Client will be able to cope with the lower abdominal pains within 4 hours and throughout labour as evidence by:</p> <p>Client showing a relaxed facial expression in between contraction.</p> <p>2. Midwife observing that client is coping with labour pain.</p>	<p>1. Reassure client that measures will be put in place to relieve her of the pain.</p> <p>2. Perform sacral massage.</p> <p>3. Encourage client to do deep breathing exercise with each contraction.</p> <p>4. Encourage client to empty her bladder frequently.</p> <p>5. Educate client on ambulation and position.</p>	<p>1. Client was reassured about measures to relieve her of pain.</p> <p>2. Sacral massage was done.</p> <p>3. Client did deep breathing exercise with contractions.</p> <p>4. Clients bladder was emptied frequently.</p> <p>5. Client was educated on ambulation and position.</p>	Goal met as midwife observed that client rested in between contractions	20/11/22 At 3:30pm	S.F

CARE PLAN DURING LABOUR CONTINUED

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES / OUTCOME CRITERIA	NURSING INTERVENTIONS	NURSING INTERVENTION	EVALUATION	DATE/ TIME	SIGN
20/11/22 At 12:00pm	Anxiety related to unknown outcome of labour.	Client's anxiety will resolve within 30 minutes as evidenced by: 1. Client verbalizing that she is no more anxious. 2. Midwife observing that the client is relaxed.	1. Reassure client of the competent care that will ensure to alleviate her anxiety. 2. Introduce successful client to the client 3. Explain the stages of labour to the client. 4. Explain every procedure to be carried on client and allow her to ask questions. 5. Update client with progress of labour.	1. Client was reassured that she could trust the midwives and rely on them for the care of her child. 2. Client was enlightened on sex determination 3. The stages of labour were explained to the client. 4. Every procedure carried on client was explained to her and questions were answered. 5. Client was updated with progress of labour.	Goal met as 1. Client said she was no more anxious and delivered successfully. 1. Midwife observing that the client is relaxed.	20/11/22 At 12:30pm	S.F

CARE PLAN DURING LABOUR CONTINUED

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES / OUTCOME CRITERIA	NURSING ODERS	NURSING INTERVENTION	EVALUATION	DATE/TIME	SIGN
20/11/22 At 7:35pm	Fatigue related to Physical stress of labour	<p>1.Client will be relieve of fatigue within 2hours and throughout labour as evidenced by: client been active during labour midwife visualising active client.</p> <p>2.Client verbalising she has been relieved of fatigue</p>	<p>1.Reassure client that she will regain her normal strength.</p> <p>2.Encourage Client to continue with relaxation techniques during contractions.</p> <p>3.Teach client to do deep breathing exercise during contractions.</p> <p>4. Encourage client to take sips of milo and drink.</p> <p>5. Encourage client to assume a comfortable position.</p>	<p>1.Client was regained of her normal strength.</p> <p>2. Client was comfortable with relaxation techniques.</p> <p>3. Client performed deep breathing exercise during contractions.</p> <p>4. Client took sips of milo and milk throughout labour.</p> <p>5. Client assumed left lateral position.</p>	Goal fully met as client was involved actively in labour	20/11/22 At 9:35pm	S.F

CARE PLAN DURING LABOUR CONTINUED

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES/ OUTCOME CRITERIA	NURSING ODERS	NURSING INTERVENTION	EVALUATION	DATE/ TIME	SIGN
20/11/22 At 7:45pm	Risk for dehydration related to loss of bodily fluid (sweating, vomiting and excessive micturation).	1.Client’s fluid volume will be maintained within 2 hours and throughout labour as evidence by: Client verbalizing that the sweating has reduced. Midwife observing that, client show no sign of dehydration	1. Reassure client. 2. Encourage client to take liquid foods to replace fluid loss. 3. Assess the hydration level of the client. 4. Measure urine output. 5.Mop client face when sweating	1. Client was reassured. 2. Client took sips of water. 3. Client’s hydration level was assessed 2 hourly. 4. 200mls of urine was measured. 5. Client’s face was mopped with clean towel when sweating.	Goal met as midwife reported that Client verbalise that the sweating has reduced. Midwife observed client showed no sign of dehydration	20/11/22 At 9:45pm	S.F

CARE PLAN DURING LABOUR CONTINUED

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	EVALUATION	DATE/TIME	SIGN
20/11/22 At 7:59pm	Risk of perineal infection related to improper handling of perineal pad.	<p>1. Client remains healthy throughout labour and puerperium as evidenced by: The midwife observing that client showed no sign of perineal infection.</p> <p>2. Client verbalising she has no signs of infections like pyrexia.</p>	<p>1. Reassure client that she will show no signs of infection.</p> <p>2. Encourage client to wash hands with soap under running water before and after changing her pad.</p> <p>3. Educate client not to use pad when it falls.</p> <p>4. All procedures should be performed aseptically.</p> <p>5. Educate client to change pad when soiled.</p>	<p>1. No sign of infection was detected on client.</p> <p>1. Client was washing her hands with soap and clean water before and after changing her pad.</p> <p>2. Client applied fresh pads when the old one falls.</p> <p>3. All procedures were performed aseptically.</p> <p>4. Client was changing her pad when soiled.</p>	<p>Goal met as the midwife observed that;</p> <p>Client shows no sign of infection.</p>	21/11/22 At 7:59pm	S.F

CHAPTER FOUR

PUERPERIUM

4.0 INTRODUCTION

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

4.1 FIRST DAY OF DELIVERY

On Sunday 20th November 2022, client and her baby were transferred to the lying in ward at 7:15pm after the one-hour continuous skin to skin. She was encouraged to empty her bladder as soon as she feels the urge to do so as to prevent postpartum haemorrhage and to change her pad when soaked.

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

During abdominal examination, her uterus was well contracted and on palpation symphysio-fundal height was 17 centimetres. Client`s lochia was inspected and it was red (rubra) without odour and moderate in flow. Client was educated on how to massage the uterus by rubbing the palm on the fundus to help it contract effectively. They were closely observed for 6 hours postpartum. She was made comfortable in bed. Vital signs were checked and recorded as follows:

Temperature	36.6°c
Pulse	82 bpm
Respiration	21cpm
Blood pressure	110/70mmhg

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

SUBSEQUENT CARE OF THE BABY

The vital signs were taken and recorded as follows:

Weight	3.5kg
Temperature	36.2°c
Apex heart beat	134bpm
Respiration	42cpm

All findings were communicated to the mother and recorded. The baby was bathed after six hours observation with warm water. Head to toe examination was done but no abnormality was detected and the cord was dressed with sterile cotton wool swab soaked in spirit. The baby was given first immunization, which was Bacillus Calmette Guerine(CG) vaccine 0.05ml intradermal at the right upper arm to prevent tuberculosis and oral polio vaccine (OPVD) 2 drops orally to prevent poliomyelitis. The baby was wrapped in a warm dry sheet to maintain body temperature and he was placed beside her mother to breastfeed him. The mother was advised not to apply anything at

the injection site. She was told that there can be tissue reaction over the area, a scar formation later indicated that the child had been immunized against tuberculosis effectively.

BABY BATHING AND CORD DRESSING

Requirement

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

The procedure was explained to mother and a tray was set. A plastic apron was worn and hands were washed with soap under running water and dried with a clean towel. Cold and hot water were mixed and temperature was tested using the elbow. Disposable gloves were worn and baby was placed on a flat surface. The baby was undressed and wrapped in a big cot sheet. The eyes were cleaned with cotton wool swabs soaked in clean water from inner cantus to outer cantus. His face was cleaned with a moderately wet face towel and dried. The baby's neck was supported with one hand using two fingers of the hand to protect the ears and the head was washed with soapy sponge. With the body resting on the inner part of the elbow and still supporting the nape of the neck, the baby was placed at the edge of the bowl to rinse the soap off the head and dried. With the baby exposed, arms and front of trunk were washed paying attention to skin folds. The baby's back was turned with one hand supporting the chest and washed back down to feet paying attention to the skin folds. The baby was rinsed off soap thoroughly and was placed in a basin of warm water with the head above the water and rinsed thoroughly. The baby was placed on a flat surface covered with clean sheet. The baby was dried by using a clean small towel paying attention to the skin folds.

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

4.2 FIRST DAY POST DELIVERY (AT CLINIC)

Sunday 20th of November 2022 at 7::15pm was the first day post-delivery. Client and her baby looked healthy. Procedure to be carried out was explained to her and consent was given. She was assisted to undress and privacy was provided by closing windows and drawing curtains. Head to toe examination was carried out on both mother and baby and no abnormalities were detected. During abdominal examination, her uterus was well contracted on palpation and symphysio-fundal height measured 17 centimetres. Client`s lochia was inspected and it was red (rubra) without odour

and moderate in flow. She was encouraged to change her perineal pad frequently to prevent ascending infections to the uterus. An enquiry about her eating and sleeping pattern was made for which she said it was resuming to normal. Client complained of after pains and told it was told the pain was a sign of involution of the uterus and it would go with time. Her vital signs were checked and recorded as follows:

Temperature	36.5°c
Pulse	72bpm
Blood pressure	110/70mmHg
Respiration	22cpm

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

Temperature	36.4°c
Apex Heart Beat	134 beats per minutes
Respiration	42cycles per minutes
Weight	3.5kilograms
Stool	Blackish Green
Suckling	Good

Urine

Passed

Cord condition

Clean and fresh

She was educated on exclusive breastfeeding on demand and the importance of breast milk to the mother and baby. She was also encouraged to feed the baby especially during the night which will serve as family planning as well as aiding in involution of the uterus. She was also educated on proper positioning and fixing baby to breast. Education on breast examination, importance of good nutrition like taking fruits, vegetables, drinking a lot of water and taking diet rich in fibre. Education on postnatal exercises, personal hygiene and family planning was done. She was reminded of immunization continuation at child welfare clinic and how to maintain the child's temperature by wrapping him and also manage common breast problems such as engorged breast, cracked nipples and mastitis. Permission was sought to also examine the baby. Hands were washed with soap under running water and dried with clean dry towel. On general examination, nothing abnormal was detected.

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

Madam Ackah was informed about her discharge and routine drugs were prescribed as per the protocol of the facility, the dosage and time drugs are to be taken was explained to her. She was assisted to pack her things and encouraged to register at birth and death registry. Client was informed about home visit for 7 days for continuity of care. She was also informed about her first postnatal visit on the 28th of November, 2022. She was discharged home at 8:15am and the following routine drugs were given to client

b Syrup Iron III polymaltose three times daily for 7 days

Table amoxicillin 300 milligrams three times daily 5 days

Table metronidazole 300 milligrams three times daily 5 days

Tablet paracetamol 1gram three times daily for 3 days

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

4.3 FIRST POSTNATAL HOME VISIT

On 21 November 2022 at 5:30pm in the evening, the first post delivery home visit was done. Madam Ackah was visited in her house. Greetings were exchanged and seat was offered. She was asked about her health and that of the entire family and a positive response was given but complained of after pain Client was informed of the procedures to be carried out and permission was granted. After washing hands with soap under running water, Madam Ackah was examined from head to toe with the symphysio-fundal height of 16 centimetres. The perineal pad was checked and the colour of the lochia was bright red with no foul smell and scanty in amount. The breast was lactating well. The conjunctiva was examined and there was no pallor. Her elimination

pattern was returning to normal as well as her eating pattern. She was asked any complaint and she had none. Her vital signs were as follows:

Temperature	36.2degree Celsius
Blood pressure	110/60millimetre of mercury
Pulse	72 beat per minutes
Respiration	20cycle per minutes

The baby was also examined from head to toe with no abnormalities detected. The baby was pink in colour, there was no sign of jaundice noted on the sclera or palm, there was no bleeding from the cord and it was clean, suckling was good, the stool colour was dark green, baby was active and sleeping pattern was good. The baby's weight was 3.4kg. Baby`s vital signs are as follows:

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

Madam Ackah was educated on family planning, danger signs of the new born such as breathing difficulties, chest in-drawing cyanosis and weak cry. Baby was topped and tailed. Client and her

mother were congratulated and permission was sought to leave. She was informed of the next home visit which is in the evening. Madam Ackah was promised another visit the following day on 23rd November,2022 and permission was sought to leave.

4.4 SECOND POSTNATAL HOME VISIT

On 22nd November, 2022 at 9:00am in the morning, Madam Ackah was visited to assess both mother and baby. On observation, the general condition of the family was good. Procedure was explained to the client and head to toe examination was conducted and no abnormalities were detected. The mother`s lochia was checked and it was bright red in colour (rubra) the flow was scanty with no offensive smell. She was congratulated on maintaining vulva hygiene. Symphysis fundal height was 15 centimetres. Mother was asked of any complaint and she had none. Client vital signs are as follows:

Temperature	37.2 degree Celsius
Blood pressure	110/64 mm/Hg
Pulse	68 beats per minute
Respiration	22 cycles per minute

The baby was also examined from head to toe and there were no abnormalities detected. The baby passed brownish yellow stool and urine. Baby was topped and tailed. The cord was clean and mother was reminded not to put anything on the cord such as chalk or herbs. The baby weighed 3.3kg. Baby was well wrapped and given to mother to breastfeed and suckling was good. Baby`s vital signs are as follows:

Temperature	36.4degree Celsius
Apex heart beat	140beats per minute
Respiration	42cycles per minute
Weight	3.3kg

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

In the evening of 22nd November at 4:15pm, 2022, Madam Ackah was offered a visit again. Greetings were exchanged and seat was offered. She was asked about her health and that of the baby and positive response was given. Client complained of severe headache and was asked mto take in more fluid and res, she was again asked to reduce stress. Permission was sought to examined mother and baby and it was granted. Head to toe examination was conducted on both mother and baby. No abnormalities detected. Baby was topped and tailed, cord dressing done and given to mother to breastfeed.

Mother's vital signs

Temperature	36.5 degree celsuis
Blood pressure	104/68mmHg
Pulse	74 beats per minutes
Respiration	20 cycles per minutes

Baby's vital signs

Temperature	36.5degree Celsius
Apex heart rate	138 beats per minutes
Respiration	40 cycles per minute.
Suckling	Good

4.5 THIRD POSTNSTAL HOME VISIT

The third home visit was on the 23rd November 2022 at 8::15am. Client and family were doing well. Procedure was explained to her. Hand washing was done and head to toe examination was done. Perineal pad was inspected and the flow of lochia was small, brownish red in colour (serosa) and not offensive. Client complained of headache. She was educated to have enough rest to relieve the headache. The symphysio-fundal height was 14 centimetres. Her vital signs were checked and recorded as follows:

Temperature	36.0degree Celsius
Pulse	82beats per minute
Blood pressure	105/66mellimeters of mercury
Respiration	21cycles per minute

Baby`s vital signs were as follows:

Temperature	36.1degree Celsius
Apex heart beat	138beats per minute
Respiration	38cycles per minute
Weight	3.2kg

Baby was also examined and topped and tailed. Baby`s cord was clean and dry, active and with good suckling. Baby`s weight was 3.2kg and client was thanked for her cooperation and support. She was asked to take her routine drugs. Permission was sought to leave.

On the 23rd November, 2022 at 5:00pm in the evening, Madam Ackah was visited as the second visit for the day. On arrival, Madam Ackah was washing her baby clothes. Greetings were exchanged and a seat was offered. Mother was asked of the headache and she verbalised it has subsided. Permission was sought for examination of mother and baby and was granted. Examination was done and no abnormality was detected. Baby was topped and tailed as well as cord dressing done. The breast was lactating well and baby`s suckling was good.

Mother`s vital signs

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

Baby's vital signs

Temperature	36.7degree Celsius
Apex heart beat	136 beats per minutes
Respiration	36 beats per minutes

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

4.6 FOURTH POSTNATAL HOME VISIT

On 24th November 2022 at 8:30am, client was visited. Both mother and baby were found in good health. Enquiry was made about her headache and she said was ok. Head to toe examination was done after seeking permission from client and everything was normal. Lochia was pink (serosa) on inspection. Symphysio fundal height measured 13 centimetres and her vital signs were as follows:

Temperature	36.8°c degree Celsius
Pulse	70beats per minute
Respiration	20cycles per minute
Blood pressure	120/80mellimeters of mercury

The baby was also examined with no abnormalities detected. The cord was well dressed, it was

dry and dark in colour and almost falling without odour. The baby passed yellowish brown stool and urine. The baby was well dressed and wrapped in a clean cot sheet and was given to the mother to breastfeed. Baby`s weight was 3.2kg. Baby`s vital signs were as follows:

Temperature	36.2 degree Celsius
Apex Heart Beat	140beats per minute
Respiration	22cycles per minutes

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

SIXTH DAY POST DELIVERY (FIFTH POSTNATAL HOME DELIVERY)

On 25th November,2022 at 4:00pm in the evening, client was visited. Greetings were exchanged after which a seat was offered. Mother and baby were both in a healthy condition. Head to toe examination was performed on the mother and there was no abnormality detected. Lochia was inspected and the colour was serosa and amount drained was scanty with no foul odour. Symphysis-fundal height measured 12 centimetres and vital signs was checked and recorded as follows:

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

Head to toe examination was done with no abnormality noted. According to client, the baby passed yellowish soft stool and urine early in the morning. The cord was dressed and it was dry and almost falling. The baby's weight was 3.3kg Vital signs were checked and recorded as follows:

Temperature	36.1 degree Celsius
Apex Heart Beat	138beats per minute
Respiration	29cycles per minute

The baby was topped and tailed paying attention to the skin folds, he was then dressed and wrapped nicely and given to the mother. Madam Ackah complained of sleeplessness and was encouraged

to sleep as soon as baby sleeps. Permission was sought to leave. Madam Ackah and family were encouraged to help in taking care of the baby.

4.9 SIXTH DAY POSTNATAL HOME VISIT

The sixth postnatal home visit was made on 26th November,2022 at 9:00am, greetings were exchanged with client and her family and a seat was offered. They were all in good health. Permission was sought and routine examination was carried out on both mother and baby from head to toe and there was no abnormality detected. Mother was lactating well. Her perineal pad was inspected and the lochia was serosa and it was scanty with no odour. Enquiry was made about her sleeplessness and she said she had at least an hour sleep after feeding her baby and her husband also confirmed. She complained of Severe back pain, she was educated on sleep and rest and the positions. Symphysis fundal height was 11 centimetres. Vital signs were checked and recorded as follows:

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

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

Temperature	36.2 degree Celsius
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Apex Heart Beat 134beats per minute

Respiration 26 cycles per minute

The baby was bathed and dressed nicely and the weight was 3.4kg. The mother was asked if she had any complains that day but she had nothing to report. She was thanked and reminded of the last visit which will be the next day.

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

On the 27th November 2022, Madam Ackah and family were visited in the morning at 8:30am which was the last visit for the week. The whole family was in good health. Enquiries about constipation and loss of appetite were made and she said she took enough diet and was able to pass stool twice. She was asked of any complaint and she had none. Procedures to be done were explained to her. Head to toe examination was done on the mother and there was no abnormality detected. The perineal pad was inspected and lochia was brownish red in colour and not offensive.

Vital signs were checked and recorded as;

Temperature 36.2 degree Celsius

Pulse 84beats per minute

Respiration 21cycles per minute

Blood pressure 111/68 millimetres of mercury

S.F.H 10cm

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

Temperature	36.8°c
Heart beat	134bpm
Respiration	44cpm
Weight	3.5 kilograms

The baby was bathed by his grandmother under supervision and the cord stump was dressed. She was educated on the importance of visiting the clinic. She was reminded of her second postnatal visit on the 2nd January, 2023. Madam Ackah and her family were congratulated and thanked for their cooperation and they in turn showed their appreciation. Explanation was given to Madam Ackah on the need to be handed over to the midwife in charge and client was reassured of midwife in charges' competency. She was also encouraged to register her child with the birth and death registry. Client and her family was thanked for their cooperation, information provided and permission was sought to leave.

4.7 FIRST POSTNATAL VISIT TO THE CLINIC

On the day of 28th November 2022 at 9:30am, Madam Ackah came to the postnatal clinic with her baby and mother. They were welcomed and a seat was offered to them. Client and baby were looking healthy and well dressed.

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

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

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

Privacy was provided and client was helped to lie on the examination bed. Hands were washed with soap under running water and dried with a clean dry towel. Head to toe examination was performed on her. On the head, her hair looked tidy. The conjunctiva was pink with no pallor or jaundice, no discharges were seen from the eyes, nose and ears. There was no abnormality detected in the mouth, and there was absence of enlarged nodes on the neck. Breast was lactating well, no

engorgement, sore or cracked nipples were present neither were there abnormal masses in the breast. On abdominal examination, the abdomen was firm, there was no tenderness, no scars, enlarged liver or spleen but rashes was found on abdomen during examination, client was asked to keep the room more ventilated by opening the lovers.. The symphysis fundal height was 9 centimeters. The vulva was examined for infection, the perineum was intact and there was no offensive vaginal discharge and the lochia was small and was alba. No abnormality was found in all examinations. She was thanked for the cooperation and was helped out of the bed. All findings were communicated to client afterwards. Her baby was also examined from head to toe. Her hair looked neat and nicely combed, sutures were present and touching each other. The conjunctiva was pink, no jaundice of the sclera and no discharges from the eyes. The ears and nose were inspected and the lip as well but no abnormality was detected. After the head to toe examination, no abnormality was detected. On examination, the cord was seen clean and dry.

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

Temperature	36.8 degrees Celsius
Apex heart beat	134 beats per minute
Respiration	44 cycles per minute
Weight	3.7kilograms

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

TERMINATION OF CARE

On the 27th December, 2022, client was handed over to the midwife in charge and the Community Health Nurses at the Child for the continuity of care during her second postnatal visit on the 2nd January, 2023. It was made known to her that, updates of her will be received from the midwife in charge and she will be called if needs arises for any information and she gladly said, she will be available anytime needed.

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

4.11 SECOND POSTNATAL VISIT TO CLINIC

On the 2nd of January, 2023 according to the midwife in-charge, Madam Ackah visited the clinic for six weeks visit. They were warmly welcome and they all looked very healthy. General examination was conducted on the client from head to toe as well as vital signs after her permission was sought. Her vital signs were checked and recorded by the midwife in-charge as follows:

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

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

Haemoglobin	12.2 g/dL
Urine protein	Negative
Glucose	Negative

Madam Ackah was sent to the palpation room where privacy was provided by drawing the curtains and closing doors and windows. She was helped to lie on the examination bed. Hands were washed with soap under running water and dried with a clean dry towel. Head to toe examination was done on her. On the head, hair was neat and well styled. The conjunctiva was pink and there were no

discharges from the eyes, nose and ear. No abnormality was found on the mouth and neck. On the breast, no abnormalities such as sore nipple, engorgement, cracked nipple and mastitis were detected and the breasts were lactating well. On examining the abdomen, no abnormality such as sub involution, tenderness, enlargement of liver and spleen was detected. No scars were found and uterus was not palpable. With the lower extremities, certain condition such as oedema was looked out for. It was detected that she showed no abnormality. Client was educated on the need to start a family planning method to prevent unwanted pregnancy. Her baby was also examined from head to toe to look out for abnormalities. On the head, the anterior fontanelles were palpated for pulsation and it was normal. The posterior fontanelle had closed. There were no discharges from the eyes and nose. The skin was nice with no rashes. The chest, upper and lower extremities were normal. The umbilical stump was inspected and it had healed. The lower extremities were normal.

The findings on the baby were as follows:

Temperature	36.2°C
Respiration	34cpm
Apex heart beat	134bpm
Weight	3.6kg

Madam Ackah and her baby were handed over to the child welfare clinic and family planning unit for the six weeks' immunization against diphtheria, pertussis, tetanus, haemophilus influenza and hepatitis B. She was encouraged to ask questions but she had none and had no complaints. She was reminded on exclusive breastfeeding, rest and sleep, exercise and nutritious diet, which would help in lactation. She was finally handed over to the public health nurse for continuity of care but

report to the facility anytime she encountered any health related problem. She was thanked for her co-operation and understanding.

4.12 CARE PLAN DURING PUERPERIUM

PROBLEMS IDENTIFIED

Madam Ackah complained of:

1. After pain (21st November,2022)
2. Headache (22nd November, 2022)
3. sleeplessness (25th November,2022)
- 4 Backache (26th November, 2022)
- 5 Skin rashes (27th November,2022)

SHORT TERM OBJECTIVES

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

2. Client's headache will be relieved after 8 hours.
3. Client would sleep well within 24 hours
4. Client would be relieved of backache within 12 hours
5. Baby would be relieved of skin rashes within 24 hours

LONG TERM OBJECTIVES

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

PUEPERIUM CARE PLAN

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	EVALUATION	DATE/ TIME	SIGN
21/11/22 At 9:00am	After pains related to uterine involution	Client's after pain pains will reduce within 12 hours as evidenced by; 1.Client verbalizing that the pain has subsided. 2.Midwife verbalising that client is relieved of afterpain	1. Reassure the client that it would dissolve with time. 2. Explain the physiological changes that take place in the uterus during puerperium. 3. Encourage client to void frequently. 4. Encourage client to do pelvic exercises. 5.Continue to breastfeed baby	1. Client was reassured that the pain was a sign of involution of the uterus and it would go with time. 2.Physiological changes that takes place in the uterus were explained to client, that is the uterus returning to its non-pregnant state 3. Client voided frequently. 4. Client did pelvic exercises e.g. Kegel's exercise 5.Client continued to breastfeed baby	Goal met as client said that pain has subsided.	21/11/22 At 9:00pm	S.F

PUERPERIUM CARE PLAN CONTINUED

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	EVALUATION	DATE/ TIME	SIGN
22/11/22 At 9:00am	Headache related to stress of labour.	Client's headache will resolve within 8 hours as evidenced by; 1. Client verbalizing she has no headache. 2. The midwife observing a relaxed facial expression.	1. Reassure client of possible care to relieve the headache. 2. Encourage client to have rest during the day 3. Encourage client relatives to give assistance to client. 4. Encourage support person to restrict visitors. 5. Administer analgesics.	1. Client was reassured of possible care to relieve. 2. Client was resting for at least 2 hours' in the day and 8 hours sleep at night. 3. Client's relatives were assisting with the household chores. 4. Client's support person limited visitors so that she can rest and sleep 5. Tablet paracetamol 1gram was administered to client	Goal met as verbalized by client that the headache has resolved and having a relaxed facial expression.	22/11/22 At 5:00pm	S.F

PUERPERIUM CARE PLAN CONTINUED

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	EVALUATION	DATE/ TIME	SIGN
25/11/22 At 9:00am	Sleeplessness related to breastfeeding and crying of baby during the night.	Client will sleep for 1 hour continuously at night after each feed as evidenced by; Client verbalizing that she is able to sleep for at least 1 hour continuously. 2. Husband confirming that client have continuous sleep at least hour at night after each feed.	1. Reassure client. 2. Encourage client to sleep in the afternoon when baby falls asleep. 3. Educate client to use kangaroo method in feeding baby. 4. Encourage client relatives to change baby's napkins when soiled. 5. Encourage client to breastfeed baby on demand.	1. Client was reassured. 2. Client was sleeping in the afternoon when the baby is sleep. 3. Client used kangaroo method in feeding baby. 4. Client relatives were changing baby's napkins when soiled. 5. Client breastfed baby on demand.	Goal fully met as client verbalizing that she can sleep well 2. Husband confirming that client sleeps at least an hour continuously at night after each feed.	25/11/22 At 10:00am	S.F

PUERPERIUM CARE PLAN CONTINUED

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	EVALUATION	DATE/ TIME	SIGN
26/11/22 At 9 :00am	Impaired comfort related to backache	Client will be relieved of backache within 4 hours as evidenced by: Client verbalising she has been relieved of backache. 2.Midwife visualising that client scoring mark on comparative pain assessment scale	1. Reassure client that she will be relieved of the pain 2. Teach client how to position herself when breastfeeding. 3.Encourage client to wear well-fitting or supportive brassier. 4. Encourage client to eat food in frequent interval but in bit. 5. Encourage client to attach baby properly during breastfeeding.	1. Client was reassured that she will be relieved of the pain. 2. Client was encouraged to support back with pillows when breastfeeding baby. 3. Client used proper types of position used in breastfeeding. 4. Client was encouraged to wear well-fitting brassier 5. Client was encouraged to fix baby properly to the breast.	Goal was met as Client reporting she has been relieved of the pain.	26/11/22 At 1:00pm	S.F

PUERPERIUM CARE PLAN CONTINUED

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	EVALUATION	DATE/ TIME	SIGN
27/11/22 At 8:30pm	Skin rash related to warm environment	Baby will be relieved of skin rashes within 24 hours as evidenced by: 1.Mother verbalising that rashes are no more. 2Midwife observing that rashes has disappear.	1. Reassure mother that rashes will disappear. 2. Explain the physiology of rash to mother. 3. encourage mother to use Johnson baby soap when bathing baby. 4.Educate mother to dress baby with cotton clothes. 5.Encourage mother to apply Baby powder on the baby's skin	1. Client was reassured that the rashes will disappear. 2. Physiology of rash was explained to mother. 3.Mother used Johnson baby soap when bathing baby. 4. Mother dressed baby with cotton clothes. 5. Mother applied baby powder to baby's skin.	Goal fully met as midwife observed skin rashes disappear	28/11/2022 At 8:30am	S.F

SUMMARY AND CONCLUSION

Madam Dorcas Ackah, a 26 years of age, Gravida 3 Para 2 (G3P2) was the client used for the Client and Family centred Maternity Care Study at Aggie's Maternity Home (Berekum). Her first antenatal visit to the facility was on 13th April, 2022 when she was 13 weeks pregnant. The first contact with client was on 9th November, 2022 for her usual antenatal visit to the clinic with gestation of 36 weeks. After a careful history taking, her main problems identified were anxiety of which it was able to be managed accordingly. All necessary laboratory investigations were carried out during and after pregnancy. On 20th November, 2022 at 11:43am, client was admitted to the labour ward with 37+4 gestational age and she had a spontaneous vaginal delivery of a live male child at 6:15pm.

She was discharged home On the next day at 8:15am and the necessary education on rest and sleep, nutrition, personal hygiene, care of the baby, breast care and breastfeeding were given accordingly. Her puerperium period was successful and all the care was given to ensure good health of both mother and baby.

On 27th November 2022, client was handed over to the community Health Nurses at the Child Welfare Clinic for continuity of care during her second visit on 2nd January, 2023.

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

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

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APPENDIX 1

ANTENATAL RECORDS

DATE	WEIG HT (KG)	BLOOD PRESSUR E	URINE FOR PROTEI N/ SUGAR	GESTATION AL AGE IN WEEKS	FUND AL HEIGH T (CM)	PRESENT A- TION	DESCE NT OF FETAL HEAD	FETAL HEAR T RATE (FH)	TREATM ENT GIVEN	COMPLAIN
13/04/22	65kg	116/69mm Hg	Trace/ Negative	13 weeks	11	-	-	-	Routine drugs	Headache

DATE	WEIGHT HT (KG)	BLOOD PRESSURE	URINE FOR PROTEIN/ SUGAR	GESTATIONAL AGE IN WEEKS	FUNDAL HEIGHT (CM)	PRESENT A- TION	DESCENT OF FETAL HEAD	FETAL HEART RATE (FH)	TREATMENT GIVEN	COMPLAINTS
9/05/22	66kg	103/60mm Hg	negative/ negative	16 weeks	16cm	-	5/5 th	143	Routine drugs	No complain
8/06/22	67kg	111/57mm Hg	negative/ negative	18weeks	17cm	-	5/5 th	141	Routine drugs	No complain
6/7/22	70kg	102/62mm Hg	Negative/ Negative	22weeks	21cm	Cephalic	5/5	150bpm	Routine drugs	No complain

DATE	WEIGHT HT (KG)	BLOOD PRESSURE	URINE FOR PROTEIN/ SUGAR	GESTATIONAL AGE IN WEEKS	FUNDAL HEIGHT (CM)	PRESENT A- TION	DESCENT OF FETAL HEAD	FETAL HEART RATE (FH)	TREATMENT GIVEN	COMPLAINTS
8/8/22	71	110/60	Negative/ Negative	26 weeks	25cm	Cephalic	5/5	153	Routine drugs	No complains
14/9/22	74	110/60	Negative/ Negative	30 weeks	29cm	Cephalic	5/5	144	Routine drugs	No complains

DATE	WEIG HT (KG)	BLOOD PRESSUR E	URINE FOR PROTEI N/ SUGAR	GESTATION AL AGE IN WEEKS	FUND AL HEIGH T (CM)	PRESENT A- TION	DESCE NT OF FETAL HEAD	FETAL HEAR T RATE (FH)	TREATM ENT GIVEN	COMPLAIN
12/10/22	74	110/70	Negative /Negative	34 weeks	33cm	Cephalic	5/5	141	Routine drugs	Anxiety

DATE	WEIGHT HT (KG)	BLOOD PRESSURE	URINE FOR PROTEIN/ SUGAR	GESTATIONAL AGE IN WEEKS	FUNDAL HEIGHT (CM)	PRESENT A- TION	DESCENT OF FETAL HEAD	FETAL HEART RATE (FH)	TREATMENT GIVEN	COMPLAINTS
09/11/22	76	120/60	Negative/ Negative	36 weeks	35cm	Cephalic	5/5	141	Routine drugs	Constipation Heartburns Backache
16/11/22	75	110/70	Negative/ Negative	37 weeks	35cm	Cephalic	5/5	144	Routine drugs	No complains

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ITN Given – 7/06/2021

TETANUS IMMUNIZATION	PREVIOUS TT		TD 1	Yes	TD 2 and	NO	
	3		TD 3		TD 4		
	CURRENT TT 4th dose		Date			Batch Number	
			8/06/22			222600620B	
INTERMITTENT PREVENTIVE TREATMENT (IPT)FOR Malaria	1 ST dose SP* 3 tabs (Directly Observed Therapy) 8/06/2022	Gestation age	2 nd dose (1 month after 1 st dose (Directly Observed Therapy) 6/07/2022		Gestation age In weeks	3 rd dose (1 month after 2 nd dose (Directly Observed Therapy)8/08/22	Gestational age in weeks
		18weeks					

	4 th dose 3 tabs (Direct observed therapy)14/9/22	Gestation age in weeks 30weeks	5 th dose 3 tabs (Direct Observed Therapy) 12/10/22	Gestation age in weeks 34 weeks		
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*NB: Sulfadoxine _Pyrimethamine – (SP) should be given to pregnant women after 16 weeks or when mother feels baby’s movement(after quickening) till delivery and should be given at least 1month after last dose

APPENDIX II

COMPLETE DIAGNOSTIC INVESTIGATIONS ON MADAM DORCAS ACKAH

DATE	SPECIMEN	IVESTIGATION	NORMAL VALUES	FINDINGS	REMARKS
13/04/22	1. Blood	Haemoglobin level	12g/dl-16g/dl	12.8g/dl	Normal
		Sickling status	Negative	Negative	Normal
		Grouping and Rhesus factor	A, B, AB, and O	AB Positive	Normal
			Positive and negative		Normal
		HIV status	None reactive	Negative	Normal
	2. Urine	VDRL	None reactive	Non-defect	Normal
		Hepatitis status	Negative	Negative	
		G6PD status	None reactive	Non-defect	Normal
		Sugar	Negative	Negative	Normal
		Protein	Negative	Negative	Normal
13/04/22	1. Urine	Sugar	Negative	Negative	Normal
		Protein	Negative	Negative	Normal

DATE	SPECIMEN	IVESTIGATION	NORMAL VALUES	FINDINGS	REMARKS
11/05/22	2. Urine	Sugar Protein	Negative Negative	Negative Negative	Normal Normal
8/06/22	Urine	Sugar Protein	Negative Negative	Negative Negative	Normal Normal
6/07/22	1. Blood 2. Urine	Haemoglobin level Sugar Protein	12g/dl-16g/dl Trace Negative	11.6g/dl Negative Negative	Normal Normal Normal
03/08/22	1. Blood 2. Urine	Haemoglobin level Sugar Protein	12g/dl-16g/dl Negative Negative	13.9g/dl Negative Negative	Normal Normal Normal

07/09/22	1.Urine	Sugar	Negative	Negative	Normal
		Protein	Negative	Negative	Normal
5/10/22	1.Urine	Sugar	Negative	Negative	Normal
		Protein	Negative	Negative	Normal
2/11/22	1.Urine	Sugar	Negative	Negative	Normal
		Protein	Negative	Negative	Normal
9/11/22	1.Urine	Sugar	Negative	Negative	Normal
		Protein	Negative	Negative	Normal
16/11/22	1.Urine	Sugar	Negative	Negative	Normal
		Protein	Negative	Negative	Normal

APPENDIX III

PHARMACOLOGY OF DRUGS FOR THE MOTHER

NAME OF DRUG	CLASSIFI- CATION	DOSAGE	ROUTE	ACTION AND USES	ACTUAL EFFECT	SIDE EFFECT	SIDE EFFECT EXPERI- ENCED
Caps iron (III) Polymaltose Complex	Haematinics	100 milligrams once daily	Orally	Aids in red blood cell formation	Increased haemoglobin level	Dark stools, diarrhoea and constipation	None observed
Folic acid	Vitamin preparation	5 milligram once daily	Orally	Proper formation and function of red blood cell	Haemoglobin level increased	Nausea and vomiting	None observed
Tetanus injection	Vaccine	0.5 milligram stat (4 th dose)	Subcutaneously	Protection against tetanus	Tetanus was prevented	Fever and urticaria rash	None observed
Tablet sulphadoxine pyrimethamine	Anti-malaria and prophylaxis	3 tablets given at 16 weeks/quickenin g's repeated at 4- week interval till delivery.	Orally	Prevention of malaria	Prevention of malaria in pregnancy	Nausea, itching, headache, Dizziness	None observed
Tablet paracetamol	Analgesics	1 gram three times daily for three	Orally	Helps to relieve pain	Pain was relieved	Prolong use causes damage to the liver	None observed

Capsule vitamin A	Group A vitamin supplement	200,000 units	Orally	Growth development and proper sight	Normal vision and healthy skin	Vomiting	None observed
NAME OF DRUG	CLASSIFICATION	DOSAGE	ROUTE	ACTION AND USES	ACTUAL EFFECT	SIDE EFFECT	SIDE EFFECT EXPERIENCED
Injection Pitocin	Oxytocic drug	10 units	Intramuscularly	Stimulate uterine contractions	Good uterine contraction and control of bleeding	Nausea and vomiting	None observed
Tablet multivitamin	Vitamin preparation	200 milligrams daily	Orally	Increases appetite. Help in the formation of red blood cell	Increases appetite	Gastrointestinal disturbance	Constipation

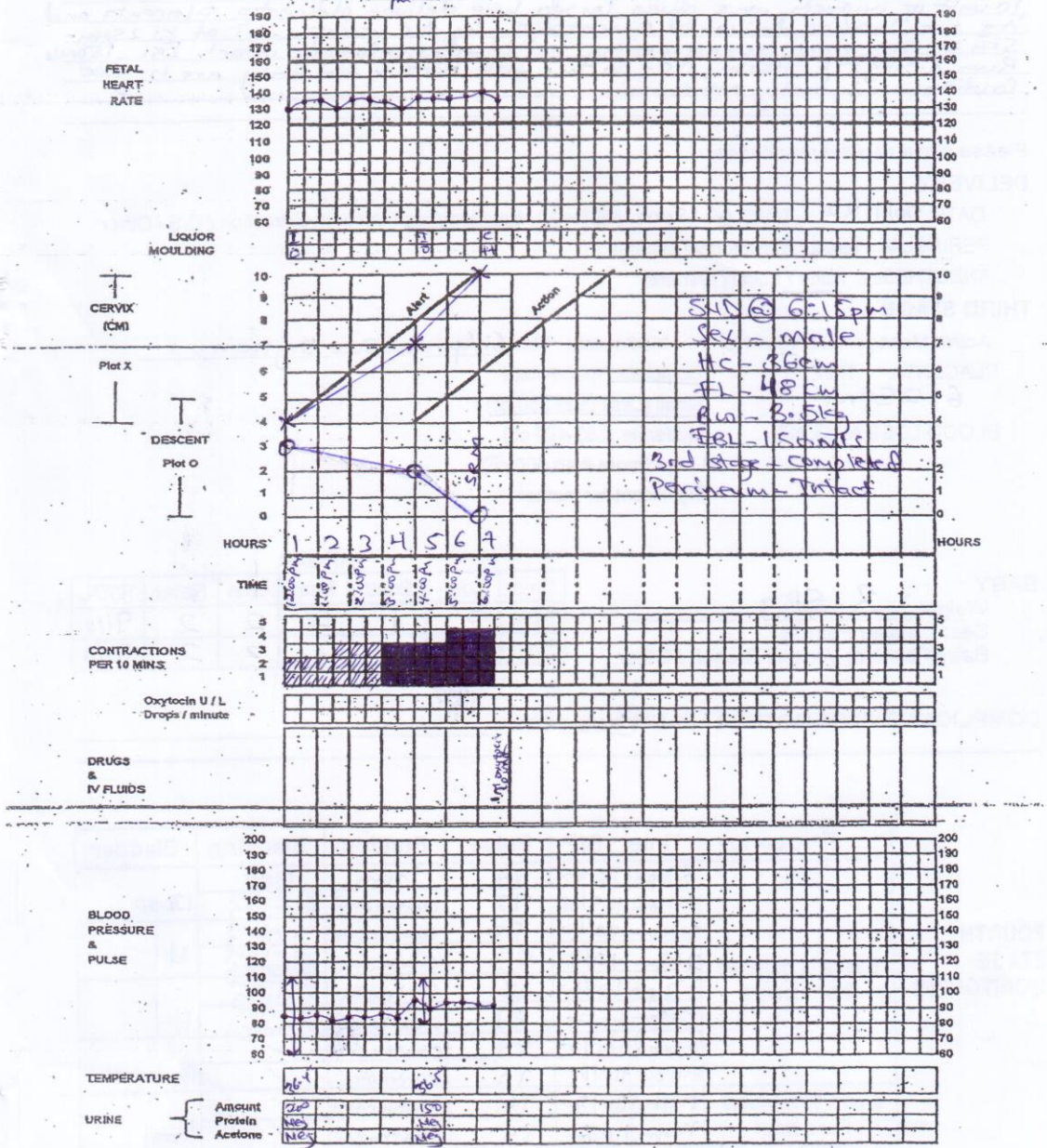
PHAMARCOLOGY OF DRUGS FOR THE BABY

NAME OF DRUG	CLASSIFI-CATION	DOSAGE	ROUTE	ACTION/ USES	ACTUAL EFFECT	SIDE EFFECT	SIDE EFFECT EXPERIENCED
Vitamin K	Coagulant	1milligram	Intramuscular	Production of prothrombin	No bleeding	None	None observed
Tetracycline eye ointment	Prophylaxis antibiotic	0.5g	Applied	Prevents eye infection	No infection observed	Nephroxicity	None observed
Polio vaccine	Antigen	2 drops	Orally	Production of antibodies against poliomyelitis	Under observation.	None	None observed
Injection Bacillus Calmette Guerin (BGC)	Antigen	0.05 Milligram	Intradermal	Vaccinates neonates against tuberculosis	Under observation	Blister formation	None observed
Pnuemo coccal	Antigen	0.5 milligram	Intramuscularly	Vaccinates neonates against pneumonia	Under observation	Redness at the side of injection and fever	None observed
5 in 1 vaccine (Pentavalent)	Antigen	0.5 milligram	Intramuscularly	Vaccinates neonates against diphtheria, pertusis (whooping` cough), tetanus, hepatitis B, haemophilus influenza type B	Prevention of childhood preventable diseases	Low grade fever	None observed

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

WHO Modified Partograph

Registration No. 607/22 Name (Last, First) ACKAH NORCAS Age 26yrs
 Date 20/11/2022 Parity/Gravida 2/3 LMP 11/01/22 EDD 21/11/22 Gestation (wks) 37wks + 4days
 ROM (Time, Date) 5:30/20/11/22 Labour Duration (Hrs) 6h24 Facility/Clinic Name AGGIE MATERNITY HOME



LABOR NOTES

Client had SVD of ALM infant on 20/11/2022 at 6:15pm. Apgar score was 9/10 with the 1st minute of delivery and 10/10 during the 5th minute. 10 unit of oxytocin was given IM to help deliver placenta. Placenta and its membranes delivered successfully by the use of C.C.T at 6:25pm. Skin to skin done, breastfeeding initiated, perineum intact. FSL 15cm, BW 3.5kg, FL 48cm, HC 36cm. Both mother and baby are in good condition and being monitored.

Please circle or write responses.

DELIVERY

DATE: 20/11/22 TIME: 6:15pm METHOD: Spontaneous / Vacuum Extraction / C/S / Other
 PERINEUM: Intact / Episiotomy / Laceration
 ANESTHESIA: None / Local / General

THIRD STAGE

Active Management: Yes / No Medication: Time 6:16pm Type/Dose Oxytocin
 PLACENTA: TIME: Complete / Incomplete
 6:25pm Small (Less than 250 cc)
 BLOOD LOSS AMOUNT: Moderate (250-499 cc)
 Large (more than 500 cc)
 Significant for mother

BABY

Weight: 3.5kg
 Sex: Male / Female
 Baby Position: Vertex / Breech / Other

APGAR

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

COMPLICATIONS OF MOTHER / BABY: None / Other:

FOURTH STAGE MONITORING

Frequency	Time	B/P	Pulse	Fundus	Bleeding	Bladder
Every 15 minutes first 2 hours	6:30pm	110/70	84	17cm	150ml	120ml
	6:45pm	109/68	75	Contracted	No active bleeding	
	7:00pm	110/60	80	Contracted	No active bleeding	Nil
	7:15pm	110/82	83	Contracted	No active bleeding	
	7:30pm	100/60	86	Contracted	No active bleeding	Nil
	7:45pm	109/70	83	Contracted	No active bleeding	
	8:00pm	105/70	84	Contracted	✓	Nil
	8:15pm	100/60	75	Contracted	✓	
Every 30 minutes For 1 hour	8:45pm	100/70	96	Contracted	✓	100ml
	9:15pm	100/60	84	Contracted	✓	

Birth Attendant Faith Satae (Student midwife) Date 20/11/2022

NEW BORN EXAMINATION FORM

Name: BABY AKWASI AKKAN Date of Assessment: 20/11/2022 Time: 7:15pm
 Date of Birth: 20/11/2022 Time of Birth: 6:15pm Sex: M F Age at time of Assessment (days/hrs) 1 hour
 Astational Age Mode of Delivery: Vaginal Assisted Vaginal C-Section
 APGAR: 1min 9 5min 10 Birth Weight: 3.3 kg Length: 48 cm Head Circumference: 36 cm
 Temperature at time of Assessment: 36.4 °C Urine passed: Yes No Meconium passed: Yes No
 Name of Assessor (Midwife/Doctor): SALCOE FAIK

<p>1. Respiration</p> <p>Rate <u>42</u></p> <input type="checkbox"/> Rate < 30 b/m * <input type="checkbox"/> Rate < 60 b/m * <input checked="" type="checkbox"/> 30-60 b/m <input type="checkbox"/> Retractions * <input type="checkbox"/> Grunting * <input type="checkbox"/> Stridor * <p>2. Activity/Movement</p> <input checked="" type="checkbox"/> Spontaneous symmetric movements <input type="checkbox"/> Reduced/Absent Movement in ≥ 1 limb * <input type="checkbox"/> No Movement <p>3. Tone</p> <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Floppy * <input type="checkbox"/> Increased * <p>4. Colour</p> <input checked="" type="checkbox"/> Pink all over <input type="checkbox"/> Pink body but blue hands/feet <input type="checkbox"/> Blue all over * <input type="checkbox"/> Pale * <input type="checkbox"/> Jaundiced * <p>5. Cord</p> <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Red, draining pus <input type="checkbox"/> Bleeding <p>6. Cry</p> <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Shriill * <input type="checkbox"/> Absent *	<p>7. Suck</p> <input checked="" type="checkbox"/> Good <input type="checkbox"/> Weak <input type="checkbox"/> Absent <p>8. Head swelling</p> <input checked="" type="checkbox"/> Caput succedaneum <input type="checkbox"/> Cephalhaematoma <input type="checkbox"/> Subgaleal hemorrhage <input checked="" type="checkbox"/> No swelling <p>9. Sutures</p> <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Overlapping <input type="checkbox"/> Fused <input type="checkbox"/> Widely Separated * <p>10. Fontanel</p> <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Sunken * <input type="checkbox"/> Raised * <input type="checkbox"/> Wide (>5cm) * <p>11. Eyes</p> <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Subconjunctival bleed <input type="checkbox"/> White pupil or cornea <input type="checkbox"/> Eye discharge <input type="checkbox"/> Other <p>12. Ears</p> <input checked="" type="checkbox"/> Normal (size / shape/position). <input type="checkbox"/> Abnormal: _____ <p>13. Mouth</p> <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Cleft palate <input type="checkbox"/> Cleft Lip <input type="checkbox"/> Other: _____	<p>15. Neck</p> <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Swelling <input type="checkbox"/> Webbed <input type="checkbox"/> Other: _____ <p>16. Clavicle</p> <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Swelling/Fracture <p>17. Chest</p> <input checked="" type="checkbox"/> Normal (Shape/movement) <input type="checkbox"/> Abnormal _____ <p>18. Heart rate</p> <p>Rate: <u>140</u></p> <input checked="" type="checkbox"/> Normal (100-160) <input type="checkbox"/> <100 * <input type="checkbox"/> >160 * <p>19. Femoral pulse</p> <input checked="" type="checkbox"/> Present <input type="checkbox"/> Not palpable * <p>20. Abdomen</p> <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Distended* <input type="checkbox"/> Scaphoid* <input type="checkbox"/> Abdominal defect* <input type="checkbox"/> Maases: _____ <input type="checkbox"/> Other _____ <p>21. Back (spine)</p> <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Abnormal Swelling * <input type="checkbox"/> Hairy patch over spine <input type="checkbox"/> Abnormal dimple <input type="checkbox"/> Abnormal curvature	<p>22. Limbs</p> <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Abnormal _____ <p>23. Genitalia</p> <p>Male Genitalia</p> <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Undescended testes <input type="checkbox"/> Abnormal meatus <input type="checkbox"/> Hernia <input type="checkbox"/> Other: _____ <p>Female Genitalia</p> <input type="checkbox"/> Normal <input type="checkbox"/> Fistula(meconium/urine through abnormal opening in vagina) * <input type="checkbox"/> Large clitoria * <input type="checkbox"/> Other: _____ <p>24. Anus</p> <input checked="" type="checkbox"/> Patent <input type="checkbox"/> Imperforate * <p>25. Resuscitation provided</p> <input type="checkbox"/> One <input checked="" type="checkbox"/> Suction/stimulation <input type="checkbox"/> Bag and mask <input type="checkbox"/> Endotracheal Tube <input type="checkbox"/> Ventilator/CPAP <p>26. Services provided</p> <input checked="" type="checkbox"/> Vitamin K1 given <input checked="" type="checkbox"/> Eye care provided <input checked="" type="checkbox"/> Cord care provided <input checked="" type="checkbox"/> Breastfeeding initiated <input checked="" type="checkbox"/> Breastfeeding established <input type="checkbox"/> Immunization (BCG/Polio) <input type="checkbox"/> BCG <input type="checkbox"/> Polio Immunization <input type="checkbox"/> Antibiotics in mother <input type="checkbox"/> Antenatal corticosteroids
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*May indicate severe disease that requires urgent referral

Diagnoses (if known) TERM BABY

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

NEW BORN EXAMINATION FORM

Name: BABY AKWASI ACKAH Date of Assessment: 20/11/2022 Time: 8:15am
 Date of Birth: 20/11/2022 Time of Birth: 6:15pm Sex: M F Age at time of Assessment (days/hrs) 1 day
 Gestational Age: 37 Mode of Delivery: Vaginal Assisted Vaginal C-Section
 APGAR: 1min 9/10 5min 10/10 Birth Weight: 3.5kg Length 48 cm Head Circumference: 36 cm
 Temperature at time of Assessment: 36.4 °C Urine passed: Yes No Meconium passed: Yes No
 Name of Assessor (Midwife/Doctor): Soko & Faith

<p>1. Respiration Rate <u>42</u> <input type="checkbox"/> Rate < 30 b/m * <input type="checkbox"/> Rate < 60 b/m * <input checked="" type="checkbox"/> 30-60 b/m <input type="checkbox"/> Retractions * <input type="checkbox"/> Grunting * <input type="checkbox"/> Stridor *</p> <p>2. Activity/Movement <input checked="" type="checkbox"/> Spontaneous symmetric movements <input type="checkbox"/> Reduced/Absent Movement in ≥1 limb * <input type="checkbox"/> No Movement</p>	<p>7. Suck <input checked="" type="checkbox"/> Good <input type="checkbox"/> Weak <input type="checkbox"/> Absent</p> <p>8. Head swelling <input type="checkbox"/> Caput succedaneum <input type="checkbox"/> Cephalhaematoma <input type="checkbox"/> Subgaleal haemorrhage <input checked="" type="checkbox"/> No swelling</p> <p>9. Sutures <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Overlapping <input type="checkbox"/> Fused <input type="checkbox"/> Widely Separated *</p>	<p>15. Neck <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Swelling <input type="checkbox"/> Webbed <input type="checkbox"/> Other: _____</p> <p>16. Clavicle <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Swelling/Fracture</p> <p>17. Chest <input checked="" type="checkbox"/> Normal (Shape/movement) <input type="checkbox"/> Abnormal _____</p> <p>18. Heart rate Rate: <u>140</u> <input checked="" type="checkbox"/> Normal (100-160) <input type="checkbox"/> <100 * <input type="checkbox"/> >160*</p> <p>19. Femoral pulse <input checked="" type="checkbox"/> Present <input type="checkbox"/> Not palpable*</p>	<p>22. Limbs <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Abnormal _____</p> <p>23. Genitalia Male Genitalia <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Undescended testes <input type="checkbox"/> Abnormal meatus <input type="checkbox"/> Hernia <input type="checkbox"/> Other: _____ Female Genitalia <input type="checkbox"/> Normal <input type="checkbox"/> Fistula(meconium/urine through abnormal opening in vagina) * <input type="checkbox"/> Large clitoria * <input type="checkbox"/> Other: _____</p>
<p>3. Tone <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Floppy * <input type="checkbox"/> Increased *</p> <p>4. Colour <input checked="" type="checkbox"/> Pink all over <input type="checkbox"/> Pink body but blue hands/feet <input type="checkbox"/> Blue all over * <input type="checkbox"/> Pale * <input type="checkbox"/> Jaundiced *</p>	<p>10. Fontanel <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Sunken * <input type="checkbox"/> Raised * <input type="checkbox"/> Wide (>5cm)*</p> <p>11. Eyes <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Subconjunctival bleed <input type="checkbox"/> White-pupil or cornea <input type="checkbox"/> Eye discharge <input type="checkbox"/> Other _____</p>	<p>20. Abdomen <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Distended* <input type="checkbox"/> Scaphoid* <input type="checkbox"/> Abdominal defect* <input type="checkbox"/> Maces: _____ <input type="checkbox"/> Other _____</p>	<p>24. Anus <input checked="" type="checkbox"/> Patent <input type="checkbox"/> Imperforate*</p> <p>25. Resuscitation provided <input checked="" type="checkbox"/> One <input type="checkbox"/> Suction/stimulation <input type="checkbox"/> Bag and mask <input type="checkbox"/> Endotracheal Tube <input type="checkbox"/> Ventilator/CPAP</p>
<p>5. Cord <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Red. draining pus <input type="checkbox"/> Bleeding</p> <p>6. Cry <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Shriill * <input type="checkbox"/> Absent *</p>	<p>12. Ears <input checked="" type="checkbox"/> Normal (size / shape/position). <input type="checkbox"/> Abnormal: _____</p> <p>13. Mouth <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Cleft palate <input type="checkbox"/> Cleft Lip <input type="checkbox"/> Other: _____</p>	<p>21. Back (spine) <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Abnormal Swelling * <input type="checkbox"/> Hairly patch over spine <input type="checkbox"/> Abnormal dimple <input type="checkbox"/> Abnormal curvature</p>	<p>26. Services provided <input checked="" type="checkbox"/> Vitamin K1 given <input checked="" type="checkbox"/> Eye care provided <input checked="" type="checkbox"/> Cord care provided <input checked="" type="checkbox"/> Breastfeeding initiated <input checked="" type="checkbox"/> Breastfeeding established <input checked="" type="checkbox"/> Immunization (BCG/Polio) <input checked="" type="checkbox"/> BCG <input checked="" type="checkbox"/> Polio Immunization <input checked="" type="checkbox"/> Antibiotics in mother <input type="checkbox"/> Antenatal corticosteroids</p>

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

NEW BORN CHART

Name: BABY AKHAI ACKAH No: 607/22 Birth Weight: 3.5kg
 Sex: MALE Mother's No: 607/22 Length: 48cm
 Nature of Delivery: SPONTANEOUS DELIVERY Diagnosis: TERM BABY
 Date of Birth: 25TH NOVEMBER, 2022 Time: 6:15 PM Date of Discharge: 28TH NOVEMBER, 2022

Date	20-11-22		21-11-22		22-11-22		23-11-22		24-11-22		25-11-22		26-11-22		27-11-22		28-11-22		
	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	
No. of Days	DOB		D1	D2	D3	D4	D5	D6	D7	D8									
Weight	3.5kg		3.4kg	3.3kg	3.2kg	3.2kg	3.2kg	3.3kg	3.4kg	3.5kg									
Temperature	36.4°C		36.2°C	36.4°C	36.4°C	36.5°C	36.5°C	36.5°C	36.6°C	36.9°C	36.2°C	36.6°C	36.8°C	36.9°C					
Stools	Passed		Passed	Passed	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	Passed	Passed	Passed			

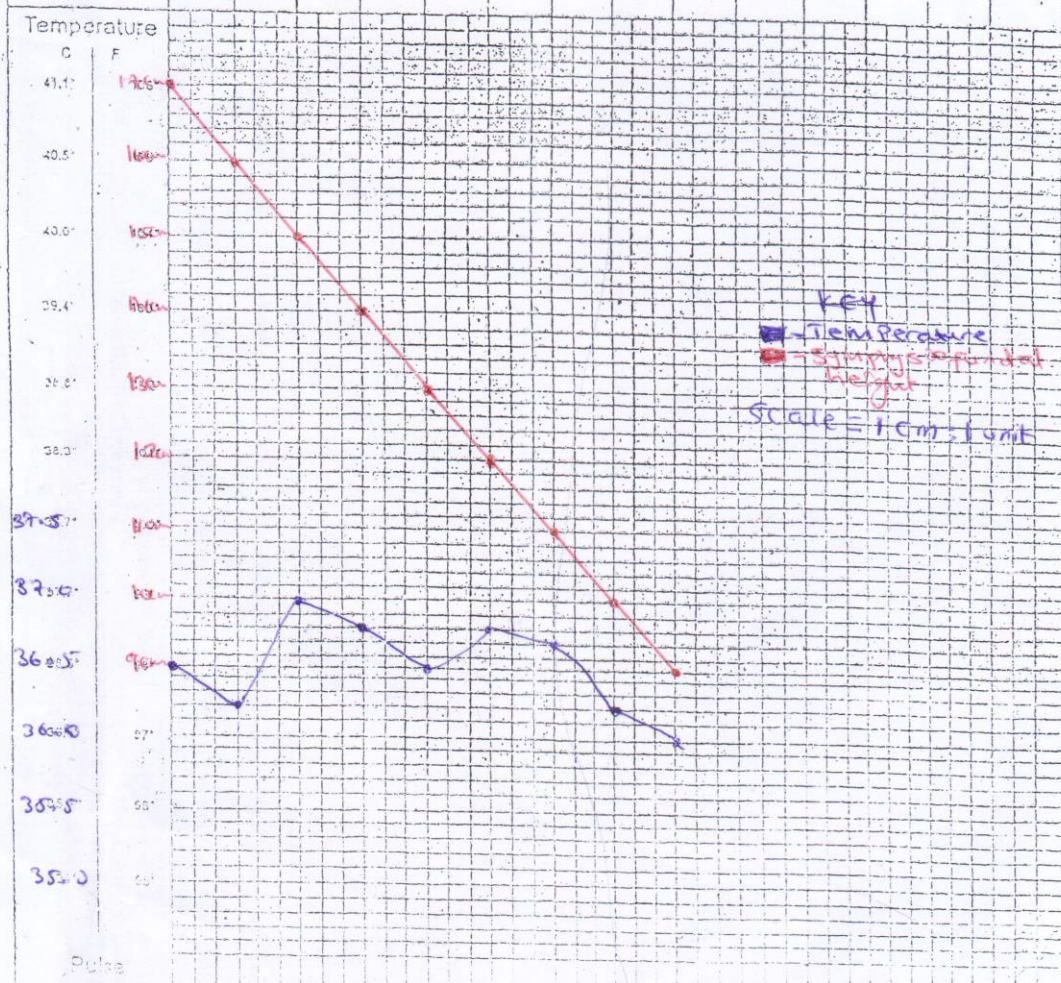
Remarks: No abnormalities detected

Head
 Neck
 Trunk
 Genitalia
 Limbs

MATERNITY CHART

NAME: ACKATH DORCAS
 AGE: 26 YEARS WARD: LYING-IN
 IP NO.: 607122 BED NO.: 2

Date	20-11-22	21-11-22	22-11-22	23-11-22	24-11-22	25-11-22	26-11-22	27-11-22	28-11-22
Days in Hospital	D0	D1	D2	D3	D4	D5	D6	D7	D8
Days P.O.									
Hour	AM		9:00	8:15	8:30		9:00	8:30	9:00
	PM 7:30	5:30	4:15	5:10	4:20	4:00			




Resp.	22	22	22	22	22	22	22	22
F.M.	Passed	Passed	Passed	Passed	Passed	Passed	Passed	Passed
Urino	Passed	Passed	Passed	Passed	Passed	Passed	Passed	Passed
Wt.	110/70	110/60	104/68	110/70	110/70	104/62	110/68	120/80

SIGNATORIES

CANDIDATE NAME

NAME: MISS FAITH SAKOE

SIGNATURE: 

DATE: 6/07/2023

THE MIDWIFE IN- CHARGE (AGGIE'S MATERNITY HOME)

NAME: MS. AGNES MMUAH

SIGNATURE: 

DATE: 14/07/2023

SUPERVISOR


NAME: MS. MONICA BOAKYE

SIGNATURE: 

DATE: 6/07/2023

THE PRINCIPAL

MONICA NKRUMAH

SIGNATURE: 

DATE: 14/07/2023

AGGIE'S MATERNITY HOME
FAMILY AND COMMUNITY SAFETY
WOMEN'S HEALTH SERVICES