HOLY FAMILY NURSING AND MIDWIFERY TRAINING COLLEGE, BEREKUM

A CLIENT/ FAMILY CENTERED MATERNITY CARE STUDY ON

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BY

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A CLIENT/FAMILY CENTERED MATERNITY CARE STUDY SUBMITTED TO THE NURSING AND MIDWIFERY COUNCIL OF GHANA IN PARTIAL FULFILMET TOWARDS THE AWARD OF LICENCE TO PRACTICE AS A PROFESSIONAL MIDWIFE (DIPLOMA).

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PREFACE

Birth is a dynamic and transforming experience, both on an individual and the societal level, and has the power to profoundly affect the lives of those involved. It is a physiological process characterized by non-intervention, a supportive environment and empowerment of the woman.

The client and family **centered** maternity care study is a study of the care rendered to a pregnant woman and her family. The study starts during pregnancy, continues through labour and ends after a successful puerperium. The study gives the student midwife the opportunity to ensure proper management of pregnancy, labour and 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.

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A very big thanks to the almighty God for his grace and mercies upon my life. I am very thankful to him for giving me the wisdom, courage strength and understanding in carrying out this care study successfully.

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I would also like to make known my sincere gratitude to my client Miss Stella Bewaa 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.

Another thanks go to the midwife in-charge of Arms Hospital and her humble staff for supporting and teaching me everything I needed to know about this study and this profession as a whole.

Not only that but also, I would also like to acknowledge my mum Ms. Rose Ameyaw for their upbringing and teaching me to be upright at all times.And to Mr.Owusu David,words cannot explain how much I appreciate all that you have been doing for me. All that I say is a very big thank you and may God richly bless and replenish all that you have lost while bringing me up.

I am also thankful to the authors whose books and literature were used in this study, I am very grateful to them.

INTRODUCTION

Family centered maternity care study which involves rendering holistic obstetric care to a particular client and her family from the first day we met during antenatal period through to labour and puerperium. The care study was conducted on Miss Stella Bewaa, 31-year-old woman who is gravida 3 para 2 alive at the time of the study. She comes from Nandom in the Upper West Region. The interaction with her started on 15th November,2021 during her 7th visit to the facility and she was 37 weeks pregnant,upon arrival the clinic client was worried and reported immediately of pedal oedema. Education was given on the physiology of pedal oedema.She had a spontaneous vaginal delivery to a baby girl on 6th December, 2021. Care was rendered to her during pregnancy, thus her antenatal visits through to labour and puerperium. Interactions with her ended eight days after delivery. The client was healthy throughout the beginning to the end of my interactions with her.

The study is divided into four (4) sections based on chapters as follows:

Chapter one (1) consists of client's social history, medical, surgical, past obstetrical, present obstetrical, family, menstrual and habits of daily living.

Chapter two (2) consists of care rendered in the antenatal period. The chapter ends with a care plan which outlines care given based on the nursing process.

Chapter three (3) is narrative of the care given during the first, second and third stages of labour. It ends with a care plan.

Chapter four (4) explains the care provided during puerperium. It consists of daily visits to the client and family. The chapter also explains client's visit to the facility for postnatal care. It also ends with a care plan.

This script also contains literature review, summary and conclusion to the whole study. It contains signatories which makes the work authentic.

LITERATURE REVIEW

PREGNANCY

Fraser & Cooper (2009) 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, 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. 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 contractility and elasticity. The vagina also increases vascularity which results in the violet colour. There is increased volume of vaginal secretions due to high level of oestrogen resulting in thick, white discharge known as leucorrhoea. Larger amount of glycogen is deposited in the vaginal epithelium due to high oestrogen availability. The glycogen is metabolized to lactic acid by the lactobacillus acidophilus, (Doderlein's bacillus), and this leads to increase vaginal acidity.

Weller (2014) defines pregnancy as being with child, the condition from conception to the expulsion of the fetus. During this period, a lot of physiological and psychological changes take place in the woman. This affects the entire system as a result of hormonal influence, some women suffer minor disorders like vomiting, heart burns, constipation, waist pains, nausea, ptyalism (excessive salivation), food craving and others which most of these changes go away after delivery. Also, if these are not treated early, they can lead to severe complications which could be life threatening, therefore, it is important for the pregnant woman to attend antenatal clinics as soon as she realizes she is pregnant, for supervision, observations, investigations, and examinations for

early detection and treatment of any deviation from normal. During this period, the expectant mother needs special education, encouragement and care, in order to cope with these minor disorders. These educations are given at the antenatal clinics by the attending midwife. Antenatal care is a special care to promote a healthy mother and foetus. 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 foetal 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.

Oduro-Kwarteng (2012) defines pregnancy as having a developing embryo of fetus in the uterus as a result of the union of an ovum and spermatozoa. The normal duration of pregnancy is 280days (40wks or 9months and 7 days) counted from the first day of the last menstrual period.

According to Perry (2006), pregnancy is the period of physical and physiological preparation for child birth and parenthood. The expectant mother ideally should begin prenatal visit soon after the first missed menstrual period for early detection of complications and to ensure good health of the expectant mother and foetus. Normal pregnancy last for about fourty (40) weeks or two hundred and eighty (280) days and healthcare providers refer to early, middle and late pregnancy as trimesters. The first trimester last from week one (1) to thirteen (13) weeks and the second from fourteen (14) to twenty-six (26) weeks whereas the third trimester from twenty-seven (27) weeks to fourty (40) weeks. Any pregnancy that advances from thirty-eight (38) to forty (40) weeks is considered to be at term.

Marie (2013) defines pregnancy as when the woman's egg and a man's sperm cell unit to form zygote. The duration of pregnancy has traditionally been calculated by the clinicians in terms of

10 lunar months or 9 months and 7 days or 280 days or 40 weeks, calculated from the first day of the last menstrual period. This is called menstrual or gestational age. It is divided into 3 trimesters. First trimester (first 12 weeks), second trimester (13 to 28 weeks) and last trimester (29 to 40 weeks), Third trimester - 27th week to 42nd of week gestation. Ideally this should be more flexible depending on the need, and the convenience of the patient.

LABOUR

Perry (2006) explained five factors that affect the process of labour and birth. These are the Passenger which is the fetus and placenta, Passageway which is the birth canal, Powers which is the contractions, Position of the mother and Psychological responds. T stages of labour as follows; the first stage of labour begins with the onset of regular uterine contractions, effacement, dilatation of the cervix and progress in descent of the presenting part. The first stage of labour has been divided into three phases namely; the latent phase where there is more progress in effacement of the cervix and a little increase in descent. Active phase and transitional phase where there are more rapid dilation of the cervix and increase rate of the descent of the presenting part. The second stage of labour; this stage begins with full cervical dilation (10 centimeters) and complete effacement and ends with the baby's birth and the second stage takes an average of 20 minutes for multiparous women and 50 minutes for nulliparous women. The third stage of labour which lasts from the birth of the fetus until the placenta is delivered. The placenta normally separates with the third or fourth strong contractions after the infant has been born. The duration of the third stage may be as short as 3-5minute although up to 1 hour is considered within the normal limits. Lastly, the fourth stage of labour last for 6 hours after delivery of the placenta. It is the period of immediate recovery when homeostasis is re-established. It is an important period of observation for complication such as bleeding.

According to Oduro-Kwarteng (2015), normal labour occurs when the;

Foetus is born at term and alive

Presented by vertex

Process complete spontaneously by natural unaided effort of mother

Time does not exceed 12 hours when the woman enters active phase of labour

Baby is born without complications.

Marie 2013) (defines labour as a series of events that takes place in the genital organs in effort to expel the viable products of conception out of the womb through the vagina into the outer world. Labour is called normal if it fulfills the following criteria; Spontaneous in onset. With vertex presentation. Without undue prolongation. Natural termination with minimal aids. Without having any complication affecting the health of the mother and/ or the baby. The features of true labour signs are: Painful uterine contraction at regular intervals. ''Show''. Progressive effacement and dilatation of the cervix. Formation of the'' bag of waters''. The events of labour are divided into four stages; first, second, third and fourth stage. First stage starts from the onset of true labour pain and ends with full dilatation of the cervix. Its average duration is 6 hours in multipara. Second stage starts from full dilatation of the cervix and ends with expulsion of the foetus from the birth canal. Third stage begins after the expulsion of foetus and ends with the expulsion of the placenta and membranes (afterbirth). Average duration is about 15 minutes in both multi and primigravidae. Fourth stage is the stage of observation after the expulsion of the afterbirth. Four factors are significant in the process of labour; that is the pelvis, passenger, powers and psyche.These are known as the four P's.

Fraser & Cooper (2009) described labour as the process by which the foetus, placenta and membranes are expelled through the birth canal. It also explained that the first stage of labour can be divided into 3 stages namely:The latent phase which is prior to active phase of first stage of labour and may last for 6-8 hours in primigravida when the cervix dilates from 1cm to 3-4cm and the cervical canal shortens from 3cm long to less than 0.5 cm long.The active phase which is the

time the cervix undergoes more rapid dilatation. This begins when the cervix is 3-4cm dilated and in the presence of rhythmic contractions, is completed when the cervix is fully dilated (10cm). The transitional phase which is the stage of labour when the cervix is from around 9cm dilated until it is fully dilated (or until the expulsive contractions of second stage are felt by the woman). There is often a brief lullitensity of uterine activity at this time.

Henderson and Macdonald (2009) To provide woman-centered care during labour, the midwife should: asses the needs and expectations of each individual woman regarding labour and birth.Plan care with each woman in labour, tailored to meet her specific needs and expectations.Put the care plan into practice.Evaluate the care given to measure its effectiveness. Labour is divided into four (4) stages, these are: first stage which deals with the onset of painful rhythmic uterine contractions and dilatation of the cervix. Second stage which deals with full dilation of the cervix and expulsion of the fetus. Third stage is the delivery of the placenta, membranes and the control of haemorrhage.The fourth stage is when the mother and baby are being monitored for the first six hours.

Myles (2014) labour purely in the physical sense may be described as the process by which the foetus, placenta and membranes are expelled through the birth canal. Labour has four stages. stage one comprises of the latent phase and last 6 to 8 hours in primigravida when the cervix dilates from 1cm to 4cm. The active phase within the first stage is when the cervix usually undergoes more rapid dilatation. This begins when the cervix is 4cm dilated and in the presence of rhythmic contractions, progressively dilated to 10cm or full dilatation. Second stage of labour is the explusion of the feotus. It begins when the cervix is fully dilated and the woman has the urge to expel the baby. There is stretching of the clitoris, gasping of the anus and bulging of the perineum. Labour completes when the baby is born. In multigravida women, it last 15to 30 minutes. The

stage begins after the explusion of the foetus and ends with the explusion of the placenta and membranes. The fourth stage is a period of carful observation of the mother made to assess excessive bleeding and the firmness of the contracting uterus immediately after the third stage of labour and it six hours after delivery of the placenta.

Tiran (2008), Labour is the parturition or child birth which normally occurs spontaneously between thirty- seven and forty- two weeks gestation with a vertex presentation of a single foetus without maternal and fetal trauma. The foetus should present with the vertex and once started, the contraction should increase in strength and frequency without interruption or artificial stimulating until baby, placenta and membranes have completely expelled by the maternal effort through the vagina. Partograph is the graphical recording of labour progress obtained by assessment of visual patterns of cervical dilation and descent of the presenting part in conjunction with records of maternal and foetal well-begin.

Marshall & Raynor (2014) labour, purely in the physical sense, may be described as the process by which the fetus, placenta and membranes are expelled through the birth canal; however, labour is much more than a purely physical event. What happens during labour can affect the relationship between the mother and baby and can influence the likelihood and or experience of future pregnancies. Human pregnancy is considered to last approximately 40 weeks, with labour usually occurring between 17 and 42 weeks gestation. Complex physiological and psychological changes occur during the last few weeks of pregnancy and also during the onset of labour that prepare the woman for the process of labour and birth. Traditionally, three stages of labour are described, the first, second and third stage, but this is a rather pedantic view, as labour is obviously a continuous process. It has also been acknowledged that there are more than three stages of labour, namely, the

latent, active and transitional phases, and these not only encompass specific physical changes but should also account for the emotional effect observed in women during this time.

Fraser & Cooper (2009), "Labour is the process by which viable foetus, placenta and membranes are expelled through the birth canal" they described its onset as spontaneous and the presenting part being the vertex which is of normal presentation. Labour being in three stages; First stage is the onset of regular rhythmic uterine contraction and finally culminates in complete effacement of the cervix. The latent phase is prior to active first stage of labour and may last 6-8 hours in the first time mother when the cervix dilates from 1cm to 4cm dilations. Active first stage is the time when the cervix undergoes more rapid dilatation. This begins when the cervix is 3cm to 4cm dilatation in the presence of rhythmic contraction and is complete when the cervix is fully dilated (10cm). The partograph is used during this stage to monitor the progress of labour, maternal condition and foetal condition to detect any deviation from normal for prompt action. The second stage is the expulsion of the foetus. It begins when the cervix is fully dilated. In psychological labour, the woman usually feels the urge to expel the foetus and complete when the baby is born. The first stage of labour is the period from the onset of regular uterine contractions to full dilation of the cervical OS. It lasts 12-14 hours in primigravida and 6-12 hours in multigravida. The first stage of labour comprises of; Painful uterine contractions; Progressive dilation of the cervix, Formation of the fore waters, Rupture of the membranes. The second stage of labour starts from the full dilation of the cervical OS to the complete expulsion of the baby. It lasts about one hour in a primigravida and 5-30minutes in a multigravida. Strong uterine contractions, descent of the head through the pelvis, and the birth of the child are the features of the second stage of labour. The third stage of labour entails complete expulsion of the placenta and membranes, usually within 5-15 minutes of the birth of the infant. The other feature of the 3rd stage, apart from the detachment and expulsion

of the placenta, is the control of bleeding. The third stage is the separation and expulsion of placenta and membranes. It starts from birth of the baby until the placenta and membranes have been expelled. During this stage, controlled cord traction and oxytocin drug is used to expel the placenta and control haemorrhage.

National Safe Motherhood Service Protocol (2008), normal labour begins when there are regular painful contractions lasting at least 20 seconds [timed by a trained observer], occurring at frequency of at least two contractions in every 10 minutes. There are four stages of labour described as follows; First stage; this start from the onset labour till the cervix is fully dilated and is accompanied with painful rhythmic regular uterine contractions. It last for 6 to 10 hours in multigravida and 12 to 14 hours in primigravid. Partograph is used to managed the first stage of labour [during the active stage]. Second stage, starts from full dilatation of the cervix [10cm] to the explusion of the baby through the birth canal. It usually lasts up to 30 minutes in multiparous woman and 60 minutes in primigravida respectively. Third stage starts after delivery of the baby and ends with the delivery of the placenta and its membranes from the birth canal as well as control bleeding after explusion.

(Konar,2011), labour is called normal if it fulfills the following criteria, [1] Spontaneous in onset and at term. [2] With vertex presentation. [3] Without undue prolongation. [4] Natural termination with minimal aids. [5] Without having any complications affecting the health of the mother and or the baby. Event of labour are divided into; First stage, starts from the onset of true labour pain and ends with full dilatation of the cervix. Its average duration is 12 hours in primigravidae and 6 hours in multiparae. Second stage starts from fully dilatation of the cervix and ends with expulsion

PUERPERIUM

Perry (2006) defined postpartum period as the interval between the birth of the newborn and the return of the maternal reproductive organs to their normal non pregnant state. He said that the term puerperium refers to the six weeks' period elapsing between the termination of labour and the return of the reproductive organs to their normal condition. This includes both the progressive changes in the breast for lactation and involution of the internal reproductive organ. He also enumerates that, there are 3 types of lochia namely:lochia rubra: it is seen in the first 3 days and consists of blood, decidua and trophoblastic debris and may contain some small clots. It is bright red in colour. Lochia serosa: it is seen during the next 4-9 days. It consists of old blood serum, leucocytes and tissue debris. It is pinkish in colour. Lochia alba: it is seen after 10 days and consists of leucocytes, decidua, epithelial cells and cervical mucus. It is white in colour and continues for 10-14 days.

Fraser & Cooper (2009) puerperium begins immediately after delivery of the placenta and membranes and continues for six (6) weeks. The expectation is that by 6th week after birth, all the systems affected by the pregnancy in the woman's body would have recovered and returned to their non-pregnant state except the breast because of lactation. Myles also striked the difference between exercise and healthy activity verses rest, relaxation and sleep. Exploring each person's level of activity will encourage advice in relation to appropriate exercise and by association, nutritional intake and rest or relaxation and sleep. Undertaking regular pelvic floor exercise is of benefit to the woman's long-term health.

According to Marie (2013) puerperium is the period following childbirth during which the body tissues, especially the pelvic organs revert back approximately to the pre-pregnant state both anatomically and physiologically. The period is divided into; Immediate –within 24 hours. Early-

up to 7 days, Remote –up to 6 weeks. Immediately following delivery, the uterus becomes firmer and retracted with alternating hardening and softening. At the end of 6 weeks, its measurement is almost similar to that of the non-pregnant state and it weighs 60 gram. The vaginal discharge for the first fortnight during puerperium is the lochia. The lochia originates from the uterine body, cervix and vagina. Depending upon the variation of the colour of the discharge it is named as: Lochia rubra (red) 1 -4 days. Lochia serosa (yellowish or pink or pale brownish) 5-9 days. Lochia alba (pale white) 10 -15 days. The average amount of discharge, for the first 5-6 days is estimated to be 250 ml.

Oduro-Kwarteng (2015) defines puerperium as a period that starts immediately after delivery of the placenta up to 6-8 weeks. This period is characterised by a lot of physiological changes some of which may include the following

A) Lactation is well established
B) The reproductive organs return to their non- pregnant state
C) Other physiological changes which occur during pregnancy are reverseThe foundations of the relationship between the infant and it's parents are laid.
D) The mother recovers from physical and emotional stresses of pregnancy and delivery and assumes responsibilities for the care and nature of the infant.

Ojo and Briggs (1997) puerperium is a period of six (6) weeks after delivery where all organs and structures which went through some changes during pregnancy return to their pregravid state. This process is known as involution. The genital tract is greatly distended, bruised and perhaps lacerated. The abdominal muscles are flaccid and within a period of six weeks postpartum is called puerperium. Lactation is established during the said period. The first ten day of puerperium is term

as the lying -in period where close observation of both mother and baby are considered. This process of readjustment is called involution. Lochia is the term use to describe the discharge from the uterus during the puerperium. The woman is educated on what goes on throughout the puerperal period how to cope with the changes. The puerperal woman needs a lot of rest and sleep, regular exercise, intake of adequate fluid and nutritious diet rich in, carbohydrate and vitamins. The mother is educated on how to care for the baby to prevent infections. Among the education include cord dressing, change of napkins frequently and exclusive breastfeeding. Emphases on family planning within six weeks after childbirth.

WHY CLIENT WAS CHOSEN

Madam Stella was seen at Arms Hospital as a client on one of her usual antenatal visits to the clinic. On the first contact,on arrival to the client was worried and reported immediatelly of Pedal Oedema,an opportunity was ceased to education her on the physiology of Pedal Oedema. 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,a multiparous woman with no complication in her previous pregnancy, labour, and puerperium and also in her 37th gestational weeks.

CHAPTER ONE

CLIENT PARTICULARS

1.0 INTRODUCTION

Assessment of client and family is the collection of information from patient which involves the client past and present obstetric, medical, surgical, menstrual, personal and family histories.

1.1 PERSONAL AND SOCIAL HISTORY

Madam Dewaa Stella is 27years old. She is Gravida 3 Para 2(G3P2) and comes from Nandom in the Upper West Region of Ghana. She stays at Techiman specifically Asueti with her two children. She is 155cm tall, 71kg in weight and fair in complexion. She speaks Dagare and Twi. She is a member of Catholic Church at Asueti. Her educational level is Senior High School. She is a hair dresser. Her partner Mr. Kuntiri Godfred comes from Upper West region (Nandom) and stays at Techiman, Asueti to be precise. He is a trader and a member of the Catholic church. Mr. Kuntiri is Madam Stella's next of kin. Madam Stella neither smoke nor drink alcohol.

1.2 FAMILY HISTORY

Madam Stella comes from a family of five with three siblings, two females and one male including the mother and father. She is the last born of her parents. According to the client both parents (Mr and Mrs. Bewaa) are still alive and are natives of Nandom.

According to her there is no chronic or hereditary disease such Diabetes Mellitus, Hypertension, heart and sickle cell disease. There is no history of congenital abnormalities in the family but a history of multiple pregnancies. They die a natural death.

1.3 MEDICAL HISTORY

Client stated, she has never been hospitalized as far as she can remember and also has no history of conditions such as diabetes mellitus, hypertension, sickle cell, heart disease, respiratory disease, epilepsy or mental illness. She has no known records of drugs or food allergies. She said she has neither donated nor received blood transfusion in her life.

1.4 SURGICAL HISTORY

Madam Stella said she has never undergone any surgical procedure and has also never sustained any injury either through road traffic accident or domestic accident that affected her pelvis. Upon examination, she had no scar indicating surgical procedure.

1.5 MENSTRUAL HISTORY

Madam Stella had her menarche at age of sixteen (16) and stated that she bleeds moderately with no dysmenorrhea for six (6) days. She uses sanitary pad and changes it when soaked. Her Last Menstrual period was march 2021 but cannot remember the actual date and her expected date of delivery was calculated to be in December, 2021 and scan gave 6th December, 2021.

1.6 CLIENTS LIFESTYLE AND HOBBIES

Madam Stella is a regular woman who goes about her days in a similar trend each day. She wakes up around 5:30 am and says her morning prayers, goes through her daily domestic chores such as sweeping her room, compound and sees to other household chores if any. Client then takes her bath and grooms herself for work. Her bowel movement is once daily and also bath twice daily. Her favorite food is Tuo Zaafi and ayoyo stew which she normally takes at supper as well as banku and okra stew. Client's breakfast is usually porridge made from millet dough with beans cake (koose). She goes to bed around 9pm after the family had finish daily activities.

1.7 PAST OBSTETRIC HISTORY

Pregnancy

Madam Stella has three pregnancies with two birth (G3P2). Her first pregnancy in 2011, second in 2015 band the third one in 2021. Client said she has never had complications in pregnancy such as anaemia, pregnancy induced hypertension (PIH), pre-eclampsia, diabetes in pregnancy, and vaginal bleeding but she experienced some minor disorders of pregnancy such as vomiting, frequency of micturition, backache and waist pains. Madam Stella attended antenatal care (ANC) regularly at Arms hospital. Client had received the four doses of tetanus diphtheria injection in the previous pregnancies and she took all the doses of sulphadoximepyrimethamine. Client was asked about her family planning method and she said she was using depo provera and her children are all in good health.

Labour

According to Madam Stella, she said all her babies were delivered per vaginum, perineum intact and they cried immediately after delivery but could not remember the duration of labour. Placenta and membranes were completely delivered with minimum blood loss. According to Madam Stella, she was discharged 24 hours after delivery at the ward.

Puerperium

Madam Stella said her puerperium was without any complication like puerperal infection or breast engorgement. The children had all their immunization against the childhood disease and client practiced exclusive breastfeeding for six (6) months and initiated complementary feeding like porridge and water. However, babies were breastfed up to one and half year before weaning them completely. According to Madam Stella, she used Depo-Provera as her family planning method.

Her children did not suffer any kind of sickness while growing up and were monitored at the child welfare clinic.

1.8 PRESENT OBSTETRICAL HISTORY

Madam Stella's first visit to the hospital was on 19th April, 2021 which she was 7weeks gestation. Client could not remember the date of her last menstrual period but could only remember the month which she said it was March 2021, therefore expected date of delivery was calculated as December 2021.The following vital signs and other assessment was checked and recorded as follows;

Temperature - 36.5degrees Celsius

Pulse - 91 beat per minute

Respiration - 18 cycles per minutes

Blood pressure - 120/76 millimeters of mercury

Weight - 71 kilograms

Height - 155centimeters

Other laboratory investigations were done and recorded as follows;

Hemoglobin - 12.5gram per deciliter

Sickling Test - Negative

Blood group - A

Rhesus factor - Positive

Hepatitis B - Negative

G6PD - No defect

PMTCT - 120

stool - No abnormality detected

Urine - negative

Client's physical and abdominal examination was done and no abnormalities were detected. She was also given the following routine drugs.

Tablet Folic Acid - - - - - - - - - - - - 5 milligrams daily for 30

Tablet ferrous sulphate - - - - - - - - -200 milligrams daily for 30days

Tablet multivitamin- - - - - - ---------200milligrams daily for 30days

She has taken four (4) doses of sulphadoxinepyrimethamine and was a regular attendant at ANC.

CHAPTER TWO

ANTENATAL CARE

2.0 INTRODUCTION

This chapter entails first contact with client, first antenatal home visit, subsequent home visits and visits by the client to the clinic and nursing care plan drawn to solve problems encountered by the client. Antenatal services are important to prevent and promote health care.

2.1 FIRST CONTACT WITH THE CLIENT

Madam Stella was first met on 15th November, 2021 at Arms Hospital around 03:00pm. During antenatal care, it was realized that client was seen with Pedal Oedema. Looking at this, client was approach and educated on the dangers and effects of pedal oedema to the mother and baby's health.Madam Stella was also educated to elevate lower limbs.Opportunity was taken to ask client her Gestational age and was confirmed in her antenatal book as 37weeks. Self -introduction was made as student midwife from Holy Family Nursing and Midwifery Training College, Berekum, who has been stationed there for seven weeks to write care study and would like to take her as a client. She was then introduced to the Midwife in-charge for her approval. Client vital signs and other assessment were checked and recorded as follow;

Temperature	36.3degree celcuis
Pulse	80 bpm
Respiration	20 cpm
Blood pressure	120/80 millimetres of mercury
Weight	72 kilograms

HB 12.5g/dl

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

Madam Stella was encouraged to empty her bladder if she had the urge, after the procedure of physical examination from head to toe has been explained to her and her consent sought. Client was assisted unto a couch for the examination. Privacy was provided; hands were washed with soap under running water and dried.

HEAD-TO-TOE EXAMINATION

REQUIREMENT

1. Sterile cotton wool swab in a sterile gallipot with a lid
2. Receiver for used cotton wool swabs
3. Fetoscope
4. Tape measure
5. A watch with a second hand
6. A pen and a client's folder

Head and neck

Standing at the right-hand side of the client, the hair was examined and it was neatly braided. Lice and dandruff were absent on the scalp. There was no edema and rashes on the face. The sclera was checked for jaundice and the conjunctiva for pallor but none was detected. The nose and the ears were examined for pain and discharge but none was present. The ears were in alignment with the eyes with no discharges. The lips were examined for dryness, pallor, sore and cracks but none was detected. Client was engaged in conversation and there was absence of halitosis, the gum was inspected for bleeding, sores, lesions which were absent and the tongue was neither pale nor coated. The neck was inspected and palpated for enlarged lymph nodes, thyroid glands and distended veins and enlarged thyroid gland but none was detected.

Breast examination

The breast was exposed and inspected for size, shape, signs of pregnancy, dimpling and nipple retraction, and condition of the skin and no abnormality were detected. One breast was covered and she was asked to put the hand of the part to be examined under her head. The breast was palpated systematically in a circular manner using the inner aspect of the fingers and client was taught self-examination and no abnormality detected. Nipples were squeezed gently with cotton wool for fluid (colostrum) and were examined for odour or blood and colour. The same was done for the other breast and no abnormality was noted. Breastfeeding history was asked and her desire to breastfeed was positive as her child was breastfed. Client was encouraged to wear a well-fitting brazier to support the breast and enhance comfort.

Extremities

Client's upper extremities were inspected for equality, edema of the finger and pallor of the palms and no abnormality was detected. The lower extremities were also inspected for edema, equality, size, tenderness in the calf muscle and varicose veins but none was detected and no extra digits.

Back

The back was examined for spinal or vertebrae abnormalities such as scoliosis, kyphosis and costo-vertebral angle for tenderness but none was detected.

Abdominal Examination

The hands were rubbed together in order to help prevent pre-mature induction of contraction.

Permission was asked to expose her abdomen for inspection after assisting her to lie on her back. The abdomen was examined to detect any deviation from normal. Items used for the examination were shown to her to allay fear.

Abdominal Inspection

The shape of the abdomen was ovoid. The abdomen was inspected for scars, striae gravidarum and linea nigra and all of these, except scars were present. There was no evidence of foetal movement.

Measuring of symphysio- fundal height

After locating the fundus, the zero end of the tape measure was placed on the fundus and extended along the midline to the upper border of the symphysis pubis. Her symphysio-fundal height was 37cm and her gestational week was 37.

Abdominal Palpation

On abdominal palpation, hands were rubbed to generate warmth. The palms were placed on either side of fundus for fundal palpation. The fingers were curved around the fundus to determine what lies in the upper pole. The abdomen was palpated for tenderness, masses, enlarged spleen and liver, suprapubic tenderness but none was present. She was asked if there is pain and she replied negatively.

Fundal Palpation

On fundal palpation, eye contact was maintained as both hands were placed on either side of the fundus. The fingers were held closed together and gentle pressure was applied using palmer surface of the fingers, a soft mass was felt indicating the buttocks.

Lateral Palpation

On lateral palpation, hands were placed on each side of the uterus, midway between the symphysis pubis and the fundus, the uterus was stabilized with one hand and examined with the other and palpated the entire area from the abdominal midline to the lateral side and from the symphysis pubis to the fundus in a rotatory manner. A smooth curve was felt which indicated the back at the right side of the abdomen, the process was then repeated on the left side of the abdomen and an irregular mass and movement were felt which indicated the limbs. This helps to locate where to place the fethoscope to listen to the foetal heart sound. The position was therefore right occipitoanterior.

Pelvic Palpation

Position was changed to face the feet of client. She was asked to bend the knees slightly and breathe in slowly. Palms were placed on either side of the uterus with palms just below the level of the

umbilicus and the fingers directed inwards towards the symphysis pubis with thumbs almost meeting. The head was palpated as hard mass occupying the lower pole. The presentation was cephalic.

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

On Auscultation; A fetoscope was rubbed in the palms to make it warm and was placed at the area where the back was located to listen to the fetal heartbeat. Whiles listening to the heart beat, one hand was placed at the maternal radial pulse to ensure that it is not the maternal pulse being listened to. As soon as the maternal pulse was heard, client hand was left. The fetal heart rate was checked for one minute noting the volume and rhythm and was recorded as 144 beat per minute.

From the above abdominal examination, lie was longitudinal, Descent was $5/5^{th}$ and presentation was cephalic.

Vulva examination

Permission was sought to inspect the genital area and she agreed. Hands were washed with soap and water and dried with a clean towel. Examination gloves were worn. The vulva was inspected for edema, scar, clitoridectomy (FGM), rashes, ulcer of the vulva, discharges such as genital warts and varicocele but none was present. The mons pubis was well shaved. Client was encouraged to continue practicing good vulva hygiene. Client was asked to assume lateral position and sit up before getting out of bed. Hand washing was done and dried with clean towel.

All findings were recorded in client's antenatal book and communicated to her. Client was educated on good nutrition and exercise. She was asked not to lift heavy objects and avoid prolong standing. She was advised to have enough rest and sleep. Client took the fifth dose of sulphadoxinepyrimethamine and was given routine drugs but was asked to take the Folic Acid a day after because sulphadoxinepyrimethamine counteracts the actions of Folic Acid. The routine drugs given to client were;

Tablet ferrous sulphate 1daily for 2 weeks

Tablet Folic Acid 1 daily for 2 weeks

Tablet multivitamin 1daily for 30 days

Client was asked to report to the clinic if any abnormality was observed. Education was given on birth preparedness and complication readiness. Appointment for home visit was scheduled for on 18th December, 2021. Direction to her house was taken and contacts were exchanged. Permission was sought from the Midwife-in-charge to accompany client to her house and it was granted.

2.2 FIRST ANTENATAL HOME VISIT

Madam Stella was visited on 18th November, 2021 at around 4:00pm. The purpose of the visit was to know the environment in which she lives, check on the health status of client and her family, inspect the items for labour and delivery and to educate her on birth preparedness and complication readiness plan.

On arrival, warm welcome and a seat was offered. A quick assessment was made on the environment before sitting down. Water was served and gratitude was expressed. Madam Stella was asked about her health and that of the family and responded that her family is doing well, as

well as herself but she complained of finding it difficult to sleep at night. Client was educated to take a warm bath and warm drink before going to bed to induce sleep and to void before going to bed.

Client lives in a two rooms house with her children and other neighbours. The house is built with mud and roofed with pine grass. There is one big traditional kitchen in the house which everyone has access to. Client stated that she goes to throw her rubbish at the back of her house and was educated on need to throw the rubbish at the refuse dump as it can cause cholera, malaria and among others and to allow her second child who is a female to help her in cleaning the back of the house.

The compound was very neat, all weeds cleared and their bathroom and toilet are located outside the house which was also clean. Madam Stella fetches water from a pipe which is located along the of street of her house. It was noticed that, client was not using insecticide treated net and when asked she gave a reason that she does not like it. She was however encouraged to sleep under it to prevent her and the unborn child from getting malaria. She was educated to hang it in the shade early in the morning for three days to prevent the irritation and also unfold it in the morning and refold it in the evening.

The position of the windows was good with a net for proper ventilation. Client was asked to assemble her layette. Client was educated on birth preparedness and complication readiness plan such us finding a blood donor, adding money to the layette, a taxi driver and among others. She was encouraged to take her routine drugs as prescribed. A day was scheduled for the next home visit which was on 20th Novermber,2021. Madam Stella was thanked for the nice reception and permission was sought to leave.

2.3 SECOND ANTENATAL HOME VISIT

The second home visit was made on 20th Novermber,2021. The purpose of the visit was to know how client was coping and her preparation towards her delivery. Madam Stella was in the house cleaning her kitchen stools with her daughter. On reaching there, she gave a smiling welcome and offered a seat and water to drink. The aim of the visit was to see how client was coping with her term pregnancy and preparation so far. She was asked her about preparation towards delivery and this opportunity was used to inspect her items. On observation, she had fixed the insecticide treated net and sleeping in it. She was congratulated on sleeping in the insecticide net and asked how she and the family were faring and the response was good but she complained of waist pains. The physiology was explained to her as a result of the fetal head descending into the pelvis and she was reassured that it will resolve after delivery. She was educated on the danger signs of pregnancy which were severe headache, blurred vision, virginal bleeding, and severe vomiting, and advised that she should report immediately to the facility if she experiences any of them. She was educated on the true signs of labour which includes the appearance of show and painful rhythmic regular uterine contractions. Client was told to also report to the facility as soon as she notices these signs. She was thanked for her cooperation and was reminded of her next antenatal care visit and permission was sought to leave and next meeting was schedule on 22nd Novermder,2021.

2.4 SECOND VISIT TO THE CLINIC

On 22nd Novermber, Madam Stella visited the clinic at 9:00 am. She was offered a chair and welcomed. An enquiry was made about her waist pain which she said it has resolved. She was asked about the signs of true labour to know if she recall the education on the previous visit which she said she was coping and frequent urination at night had reduced, and also, she repeated the education on the rhythmic painful uterine contractions and the appearance of show and was

congratulated. Client was examined from head to toe and no abnormality was detected. Vital signs and other assessment are as follows:

Temperature	36.1 degree celsius
Pulse	78 beats per minute
Respiration	22 cycles per minute
Blood pressure	120/67 millimeters of mercury
Weight	74kilograms
SFH	38centimeters
Descent	$5/5^{th}$
Fetal heart rate	134 beats per minute

Urine was tested for protein and glucose and was negative. She was educated to have enough sleep and to eat foods rich in energy and vitamins. She was accompanied to the road side and bid farewell.

2.5 SUBSEQUENT VISIT TO THE CLINIC

Madam Stella visited the hospital on 29th Novermber,2021. She was welcomed and given a chair to sit. An enquiry was made about her health and that of the family and she said they are all doing well.

Madam Stella health was enquired and she complained of constipation and less food intake.She was encouraged to take in more fluid and fruits to aid her move her bowels and also have enough

rest. Concerning the loss of appetite, she was encouraged to clean her mouth twice daily and to take food in bit but frequently. Client was examined from head to toe and no abnormality was detected. Vital signs and other assessment were checked and recorded as follows;

Temperature 36.3 degree Celsius

Pulse 83 beats per minute

Respiration 18 cycles per minute

Blood pressure 126/70 millimeters of mercury

Weight 76kilograms

SFH. 39centimeters

Descent $5/5^{th}$

Fetal heart rate 134 beats per minute

Urine was tested for protein and glucose and was negative.

Client was educated to take in food rich in vitamins, minerals and proteins. She was also educated to take in enough fruits that contains roughages and was encouraged to take in more fluid. She was educated on perineal hygiene and encouraged to take in her routine drugs. She was accompanied to the road side and was bid farewell. Further home visit was made.

2.6 ANTENATAL CARE PLAN

Nursing care plan seeks to identify problems and assisting to solve the ones involving the client and family.

Problems identified during antenatal care

1. client complained of insomnia
2. client was seen with pedal oedema.
3. client complained of constipation
4. client complained of less food intake
5. client complained of waist pains

Short tem objectives

1.Client will be able to sleep at least 4 hours within 24 hours.

2. Client swelling feets will be reduced within 48hours and cope throughout pregnancy.

3 Client will regain bowel movement (once a day) within 48 hours.

4. Madam Stella will be able to eat at least half of the meal served.

5. Client waist pain will be reduced within 48 hours and cope throughout pregnancy.

Long term objectives

Madam Stella will go through pregnancy,labour and puerperium successfully without any complications.

ANTENATAL CARE PLAN

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES	NURSING ORDERS	NURSING INTERVENTIONS	DATE/ TIM	EVALUATION	SIGN
18/11/21 10:00am	Insomnia related to frequency of micturition	1.Client will able to sleep at least 4 hours within 24 hours and coped throughout pregnancy as evidenced by client action.	1. Reassure client. 2. Advice client to keep bedpan at bedside. 3. Educate client on the physiology of frequency of micturition. 4. Encourage client to take warm bath prior to bed time. 5.Served prescribed medication.	1. Client was reassured that she will have enough sleep. 2. Client was advised to keep bedpan at bedside when sleeping. 3. Client was educated on the physiology on frequency of micturition. 4. Client was encouraged to take warm bath. 5. Client was served with prescribed sleeping medication.	19/11/21 10:00am	Client was able to sleep for 5hours within 24hours as evidenced by client verbalizing.	A.B.F.

DATE/ TIME	NURSING DIAGNOSIS	OBJECTIVE/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
18/11/21 3:00pm	Pedal oedema related to increased venous pressure in the lower limbs[feets].	Client swelling feets will be reduced within 48hours and cope throughout pregnancy as evidenced by client action.	1. Reassure client 2.Explain the physiogy of pedal oedema to the client. 3.Encourage client to elevate oedematus extremities(feets). 4.Encourage client to limit prolong standing.	1. client was reassured that she will be relieved from swell feet. 2. The physiology was explained to client as the increased venous pressure causing lower extremities to be oedematus. 3. Client was encouraged to elevate the lower limbs. 4. Client was encouraged to limit prolong standing.	20/11/21 3:00pm	Client swelling feet was reduced within 48hours as indicated.	A.F.B

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES	NURSING ORDERS	NURSING INTERVENTIONS	DATE/ TIME	EVALUATION	SIGN
21/11/21 4:30pm	Constipation related to activity of progesterone causing decreased peristalsis and relaxation of the smooth muscle of the large bowel during late pregnancy	Client will regain bowel movement (once a day) within 48 hours as evidenced by client verbalizing.	1. Reassure client. 2. Explain the physiology of constipation to the client. 3. Encourage client to take 1500mls of fluids. 4. Encourage client to take in fresh fruit and vegetables. 5. Advice client on exercise.	1. Client was reassured. 2. The Physiology of constipation was explained to client as relaxation of the large intestine by progesterone. 3. Client took in about 1500mls of fluid a day. 4. Client agreed to take in fresh fruit and vegetables after eating like orange, lettuce and among others. 5. Client walked around as a form of exercise.	23/11/21 4:30pm	Client regained bowel movement(once a day)within 48hours as indicated.	A.F.B

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES	NURSING ORDERS	NURSING INTERVENTIONS	DATE/ TIM	EVALUATION	SIGN
21/11/21 4:00pm	Inadequate food intake related to loss of appetite	Madam Stella will be able to eat at least half of the meal served within 24 hours as evidenced by client action.	1. Reassure client. 2. Serve client favorite meal. 3. Encourage to take in easily digestible foods. 4.Encourage client to take her routine drugs.	1. Client was reassured. 2. Client was served with favorite meal. 3. Client was encouraged to eat easily digestible foods 4. Client was encouraged to take her routine drugs.	22/11/21 4:00pm	Goal fully met as client verbalized that she ate half of her food served within 24hours as indicated	A.F.B

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES	NURSING ORDERS	NURSING INTERVENTIONS	DATE/ TIME	EVALUATION	SIGN
22/11/21 3:00pm	Waist pain related to the effects of pregnancy hormones on the musculoskeletal system.	Client waist pain will be reduced within 48 hours and cope throughout pregnancy as Evidenced by client action.	1.Reassure client. 2. Explain physiology behind waist pain to the client. 3. Encourage client to wear low heel shoes. .4.Teach client the body mechanics. 5. Serve prescribed analgesic such as paracetamol.	1.client was reassured to cope with the waist pains 2. The physiology behind waist pain was explained to client. 3. Client agreed to wear low heel shoes. 4.client should squat when picking items from the floor. 5. Paracetamol 1g was served.	24/11/21 3:00pm	Waist pain reduced as indicated.	A.F.B

CHAPTER THREE

LABOUR

3.0 INTRODUCTION

This chapter talks about first to fourth stage of labour, immediate care of the baby at birth, examination of the newborn, the various problems identified and care plan drawn.

3.1 ADMISSION AND MANAGEMENT OF FIRST STAGE OF LABOUR

On the 6th December, 2021, Madam Stella arrived at the labour ward at 10:30am accompanied by her sister with a history of lower abdominal pain and having seen a bloody mucoid discharge. Rapport was established and they were offered a seat. Before examination, the antenatal care record book was collected and read through quickly. Client's appearance indicated that she was having labour pains. Client disclosed that she had not taken anything for breakfast and so her sister was asked to get her porridge and koose to eat. According to Madam Stella, labour pains started about two hours, thirty minutes ago when she called on phone and was told to arrive at the facility immediately. Client was taken to the delivery room, and was offered a well laid bed and reassured of a successful birth outcome while her sister was offered a seat outside and was reassured that her sister is in the hands of competent student midwife as well as the staff midwife as the supervisor.

Procedures to be done were explained to her and consent was gained. Client’s vital signs were checked and recorded as follows;

Temperature	36.4 degree Celsius
Pulse	87 beats per minute

Respiration	21 cycles per minute
Blood pressure	125/80 millimeters of mercury.

Client was served with a bed pan to empty her bladder and midstream urine specimen was taken and tested negative for protein and glucose. The amount of urine emptied was 200 mls clear umber urine. Client was helped unto the couch; hands were washed and dried with clean towel. Client was examined from head to toe and no abnormalities were found.

On abdominal examination.

Inspection; the shape was ovoid with normal size and there was linea nigra and striaegravidarum present on the abdomen but no previous surgical scar observed.

Measuring of the symphysio-fundal height

The symphysio-fundal height was 38 centimeters while the gestation was 40 weeks.

On fundal palpation; the fetal buttock was felt occupying the upper pole of the uterus.

On lateral palpation; the fetal limbs were palpated at the right side and the fetal back was felt at the left side of the mother's abdomen.

On pelvic palpation; the lie was longitudinal and the presentation was cephalic.

Descent The anterior shoulder was located using two fingers. Four fingers were admitted in-between the anterior shoulder and the upper boarder of the symphysis pubis indicating a descent of 4/5th above the pelvic brim.

On auscultation;

the fetal heart rate was 135 beat per minute with regular rhythm and good volume. Contractions were 2 in 10minutes lasting 25 seconds respectively.

Vaginal examination;

Requirement

1. Two sterile gallipots, with each containing cotton and savlon
2. Receiver for collecting used swap
3. Sterile gloves
4. Perineal pad

Permission was sought to continue with vaginal examination. Client was asked to lie in a lithotomy position and flex her knees. Hands were washed with soap and water and dried with clean towel, a pair of sterile glove was worn. On inspection, there was no scar, rashes, warts, varicose vein or sores. Five (5) cotton swabs were used for the examination. The dominant hand was use to pick the cotton wool swab and dipped into savlon lotion. Swab was dropped from the dominant hand into the non-dominant hand per stroke. Labia majora was wiped from anterior to posterior and the used swab was discarded into the receiver. Labia minora was also wiped from anterior to posterior and used swab was also disposed into the receiver. The vestibule was parted using the non-dominant, a swab in the dominant hand was used to wiped the vestibule from anterior to posterior and disposed into the receiver. Client permission was sought and the middle finger of the dominant hand was inserted into the vagina by firmly pressing downwards. The index finger was also inserted and this cause relaxation of vagina walls and muscles. The vagina felt warm and moist,

cervix was soft and thin, effaced and cervical dilatation was 4cm at 11:00am with the presenting part well applied to the cervix with intact membranes and no moulding, ischial spines were blunt and promontory was not reached at 12cm and there was an evidence of show. The midwife in-charge also confirmed the findings. She was cleaned and a pad was applied to the perineum. The gloved hands were immersed in 0.5% chlorine solution and was removed by inverting them inside out and disposed off into a plastic container. Hands were washed with soap and water and dried with a clean towel. She was helped to lie on her left side to get out of bed. Dilatation board was used to explain how far she had gone with labour. She was advised on deep breathing exercises as she complained of lower abdominal pains. She was also encouraged to ambulate and to empty her bladder when she feels the edge to improve decent and contraction.

Findings were communicated to her and encouraged to ask questions. She was reassured of the competency of the health team. All findings were documented and recorded on partograph.

3.2 PREPARATION FOR BIRTH

The midwife in-charge who would supervise labour and delivery and also assist in the care of the baby was identified as the skilled helper whereas the unskilled helper happened to be the client's sister, who accompanied her to the clinic and would be needed in case of any help.

Emergency plan was reviewed, which includes communicating with the physician assistant to be alert and attend to any emergency when called upon. Client's sister was asked to inform taxi driver to be alert in case of emergency. The delivery area was cleaned and a good source of light was ensured and emergency portable light was present and functioning. The resuscitation table was checked, cleaned and all equipment and instrument were assembled and tested for their function. Windows and doors would be closed if labour was near to provide privacy and provide warmth.

Madam Stella's hands and abdomen would be washed prior to second stage. The delivery pack and emergency drugs like magnesium sulphate, oxytocin and among others were made available. There was monitoring of maternal pulse, respiration, contractions and fetal heart rate at every 30 minutes. The temperature, blood pressure, decent and vaginal examination were done 4 hourly and results were plotted on the partograph.

3.3 MANAGEMENT OF FIRST STAGE OF LABOUR

Contractions were becoming frequent and strong. Client was encouraged to breathe through her mouth and not to push when she has not been asked to prevent edematous cervix. Client was assigned to a comfortable position (lithotomy). Hand hygiene was performed, sterile gloves were worn and vaginal examination was conducted. At 3:00pm vaginal examination was done, the cervix was 8cm dilated as membranes spontaneously ruptured while removing hand with clear amniotic fluid and moulding (+). Abdominal examination revealed, fetal heart rate of 130bpm with descent of two fifth. Contractions were 3 in 10 lasting 45 seconds. Findings were communicated to her and was asked to ambulate but when tired, she should lie on her left side to prevent the uterus from compressing on the inferior vena cava that can alter blood circulation to the fetus. Client complained of painful uterine contraction and was encouraged to relax and was reassured that, contractions aid in dilatation of the cervix and that in no time she will be due. Client was anxious and complains of feeling fatigued. Education was given on the need to rest in between contractions. Madam Stella's sister was informed about the progress of labour. Client was served with water and her sacral massage was rubbed gently from time to time. Client complained of frequency of micturition and was encouraged to empty her bladder whenever she had the urge, to

help in the descent of the fetal head. She also complained of feeling nauseated and salivating she was served with water.

Madam Stella was asked to ambulate and education was given to her to breathe through her mouth whenever she feels the edge to push. Findings were recorded on the partograph. Vital signs and other assessment were as follows;

Temperature	36.4 degree Celsius
Pulse	77 beat per minute
Respiration	19 cycles per minute
Blood pressure	120/84 millimeters of mercury
Fetal heart rate	130 beat per minute
Contractions	3 in 10 lasting 47 seconds
Descent	$2/5^{th}$
Urine	150 millimeters
Protein	Negative
Glucose	Negative

At 5:00pm Vaginal examination was done to exclude cord prolapse, cervical os was 10centimeters(10cm) dilated with moulding of two pluses which indicates apposition of the

parietal bones and clear liquor, contractions were stronger, that was 4 in10 lasting 48 seconds, fetal heart was 140 beat per minute. She was asked not to ambulate since membranes have ruptured and to lie on her left side. She was asked to cooperate and was reassured. Findings were recorded on the partograph. Her vital signs and other assessment were as follows;

Temperature	36.3 degree Celsius
Pulse	80 beat per minute
Respiration	20 cycles per minute
Blood pressure	125/70 millimeters of mercury
Fetal heart rate	140 beat per minute
Contraction	4 in 10 lasting 49 seconds
Descent	$0/5^{th}$
Urine	100mls
Protein	Negative
Glucose	Negative

SETTING OF TROLLEY

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

THE TOP SHELF

- 2 sterile artery forceps
- Sterile cord scissors
- 4 Sterile drapes
- Sterile gallipot with cotton wool swabs

- Sterile episiotomy set (artery forceps, dissecting forceps, episiotomy scissors, suturing forceps)
- Cord clamp (removed from cover)

LOWER SHELF

- Perineal pad
- Cot sheets
- Cheatle forceps in its container
- Drum containing sterile gauze
- Bulb syringe in a bowl of water
- Identification band
- Measuring jug
- Receiver
- Antiseptic solution
- Examination gloves
- Bottle containing antiseptic solution
- Mackintosh
- Injection tray containing oxytocin, vitamin k, syringe and needle
- lidocaine
- fetoscope

3.4 MANAGEMENT OF THE SECOND STAGE OF LABOUR

Full dilatation was confirmed by the midwife in charge at 5:00pm and client was asked to assume any comfortable position she wished and she opted for the lithotomy position after demonstrating the various types as explained during first stage of labour. Windows were closed and curtains were well drawn for privacy. Madam Stella was then assisted to assume the position. Protective clothing such as apron, cap, face mask, goggles and boots were worn. Hand washing was done and sterile gloves with cotton were used to clean the vulva which was soaked in savlon. A pad was put to the perineum to prevent faecal matter from contaminating the delivery field and she was asked to push with contractions. She was supported emotionally and physically throughout delivery. As the head advanced, flexion was maintained with two fingers placed on the head to allow the smallest diameter of the fetal head to distend the vulva. Client was encouraged to rest if there were no contractions and was reminded that the baby will be delivered onto her abdomen.

When the head crowned, she was asked to give only small pushes with contractions. By extension of the fetal head which is one of the movements used by the fetus as it passes through the birth canal, the sinciput, face and mentum swept the perineum and the head was born. The baby's face and eyes were gently wiped inside out with sterile gauze. The neck was felt for cord around neck but there was none detected. Restitution was followed by external rotation of the head, which indicated internal rotation of the shoulders that the shoulders were in anterior posterior diameter of the outlet. The palms were placed on each side of the baby's head and she was asked to push gently. The anterior shoulder was delivered by downwards traction and posterior shoulder by upwards traction. With lateral flexion the baby was delivered onto mother's abdomen as the midwife in charge noted the time as 5:10pm. The baby cried soon after delivery. Liquor was wiped

off the baby; the wet sheet was changed and replaced by a dry one to prevent heat loss. The baby was placed on mother's abdomen for skin to skin contact. First minute APGAR score was 8/10. Madam Stella was thanked for her effort.

3.5 IMMEDIATE CARE OF THE BABY

Immediately after the delivery of the baby, the eyes were cleaned with sterile gauze from inside out, mouth and nose were suctioned to clear the airway and to prevent aspiration of secretions. The baby was dried thoroughly with warm sheet and wet sheet removed and replaced with warm dry sheet. The cord was clamped two finger breadth away from the baby's abdomen and the second clamped was placed three finger breadth away from the first clamp. The cord was cut with sterile scissors covered with sterile gauze to avoid splashing of blood. Mother identified the sex of the baby when shown to her. The baby was placed on mother's abdomen to ensure skin to skin and bonding. Monitoring of breathing pattern was also continued. First and fifth minute APGAR score were 8/10 and 9/10 respectively. Identification band with mother's name, sex, date, and time of delivery was placed on baby's wrist. Breastfeeding was initiated.

3.6 MANAGEMENT OF THE THIRD STAGE OF LABOUR

The procedure was explained to Madam Stella. Abdomen was palpated to exclude undiagnosed twin and there was none. 10 units of oxytocin was injected intramuscularly in the right thigh by the midwife in charge, one minute after the delivery of the baby to aid contraction of the uterus and separation of the placenta. A receiver was placed in-between her thigh to receive the placenta and its membranes. Controlled cord traction was used in the delivery of the placenta.

The cord was re-clamped closer to her perineum. The non -dominant hand was placed on the fundus and as soon as there was contraction, one hand was placed above client's pubic bone and the other hand held the clamped cord. The cord was re-clamped and waited for strong uterine contractions. The non-dominant hand was turned with the palm facing the client abdomen and counter pressure was applied to avoid inversion of the uterus and with controlled cord traction, when the uterus contracted, the cord was downwardly and steadily pulled to deliver the placenta. This procedure was repeated until placenta became visible at the vulva. The dominant and non-dominant hands were used to receive the placenta and gently twisted till membranes were teased out at 5:20pm. A quick examination was done and placenta placed in a receiver for examination later at the sluice room. The uterus was massaged until it was well contracted and client was taught how to massage her uterus to expel blood clots. Expelled blood clots were added to the blood loss. Gauze was wrapped on two fingers of both hands to examine the vagina for laceration or tears. The cervix was also examined in clockwise manner to rule out any cervical tears. There were no tears and lacerations on examination. She was cleaned and sterile pad was applied. Madam Stella was made comfortable in bed with baby still on the abdomen and covered with dry cloth. Blood loss was estimated as 150 millimeters.

3.7 EXAMINATION OF THE PLACENTA AND MEMBRANES

Under a good source of light, a thorough inspection of the placenta and membranes is done in order to ensure that no part of it being retained during delivery. The placenta was dipped inside a 0.5% chlorine solution. The cord was of normal size and the cut edge of the umbilical cord had two arteries and one vein surrounded by Wharton's jelly. The cord insertion was central. The placenta was held by the cord with the membranes hanging. The membranes were checked for

completeness by spreading out hand inside the membranes and it was intact. The placenta was put on a flat surface and was examined, the amnion was peeled from the chorion up to the umbilical cord to permit full visualization of the chorion. The fetal surface was shiny and bluish grey. The branches of the cord vessels were seen radiating on its surface. The placenta was placed in the palm with the maternal surface facing upward. The lobes were intact with no infarcts or extra lobes nor edematous.

It was then decontaminated and disposed appropriately. The working surface was wiped off with 0.5% chlorine solution. All findings were recorded on the labour ward sheet, delivery book and summary of delivery in the antenatal booklet. The partograph was then completed.

3.8 MANAGEMENT OF FOURTH STAGE OF LABOUR

Client and her baby were transferred to the lying-in ward after putting the baby skin to skin for an hour. Monitoring of Madam Stella and the baby continued strictly for the first 6 hours after expulsion of the placenta and membranes and arresting of haemorrhage. Vital signs were checked every 15 minutes for 2 hours, 30 minutes for 1 hour and one hourly for the remaining three hours and recorded behind the partograph.

Post- delivery vital signs were checked and recorded as follows

MOTHER

Temperature 36.4 degree Celsius

Pulse 72 bpm

Respiration 18 cpm

Blood Pressure 125/80mmHg

Madam Stella was encouraged to micturate frequently and change perineal pad when soaked. Lochia was red (rubra) in colour with small flow, fundal height was 16cm. She was educated on how to massage her uterus to aid in contraction. Mother was advised to show pad for colour of lochia, amount of blood loss and odour before discarding it. Client was seen to be fatigued and was encouraged to have some rest. Her sister was allowed into the lying-in to see the baby and ask client what she wanted to eat. She was very happy on seeing the baby. Client and support person were educated on the need for rest and sleep and also education and demonstration on proper positioning when breastfeeding was done. Mother and baby were in good condition. She was served with rice with soup. Mother was encouraged to breastfeed the baby on demand and also exclusively since the source of nutrient for the baby is the breast milk.

BABY

PREVENTION OF DISEASE IN THE NEWBORN

After the birth of the head, the eyes were cleaned from the inner canthus to outer canthus. Care was given to the eye to prevent eye infection where chlorphenicol eye drop was instilled on each of the eye. Vitamin K injection was given to prevent bleeding.

Cord was also dressed with methylated spirit to prevent any infection and to keep the cord dry at all times. Infection prevention techniques such as washing of hands before and after touching the baby were also ensured to prevent any cross infection. Mother was also educated on the need to use only methylated spirit given to her to dress the cord and to avoid application of herbs, other creams and cow dungs on the cord to prevent infection of the cord.

3.9 EXAMINATION OF THE NEWBORN

The procedure to be carried out on the baby was explained to the mother. Hands were washed, dried with a clean towel and an examination gloves was worn. The baby was put on a flat surface for examination in the presence of the mother. Baby was then exposed systematically as it was examined from head to toe. Its colour was pink on observation.

Head and neck;

The head was examined for shape and size, widened sutures, bulging/depressed fontanelles, edematous swelling, caput succedaneum, microcephaly, anencephaly and hydrocephaly but none was detected. The middle and the index finger was used to ran through the head to feel for widened sutures and was absent. A tape measure was used to encircle its head starting from the occipital protuberance to the supra orbital ridges to measure the head circumference and it was 35 centimeters. The ears were examined for size, shape, patency, softness of the cartilage, the eyes were in alignment with the ears. The eyes were examined for the presence of eye ball and redness of the eyes, jaundice on the sclera and any abnormal discharges. The nose was examined for shape, discharges, size, patency, and deviated septum. The mouth was examined for false teeth, tongue tie, cleft lip and palate by using the little finger to feel for palate for any sub mucous cleft and no abnormality was detected. Rooting, suckling and swallowing reflexes were present, the neck for congenital goiter, but no abnormality was detected.

Chest and Abdomen;

On the chest, respiratory movement was normal (34 cycles per minute), nipples were in alignment and breast had no mass. The abdomen was examined for shape and size, enlarge spleen and liver,

bleeding from the umbilical cord and abnormalities such as omphalocele and gastroschisis and among others were absent. All findings were normal.

Upper Extremities;

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

Lower Extremities;

The lower extremities were inspected for equality, clubbed feet, extra/loss digits, talipes. Congenital hip dislocation was also checked using ortholani's test and it was absent.

Back;

The baby was turned on her side, the thumb was used to run through the back to exclude abnormalities like, missing vertebrae and inspected for spinal bifida, meningocele but none was found. The skin of the back was also examined for its color and any hairy patches. No hairy patches were seen.

Genitalia and Anus;

The labia majora was fully developed and larger in size; urethra and anus were patent as it passed urine and meconium respectively.

Gloves were removed and disposed aseptically before washing and drying hands with a clean towel. The length of the baby, weight and head circumference was checked and gloves were removed and disposed off according to infection prevention guidelines. Hands were washed and dried, weight and height checked recorded as 2.9kg and 50 centimeters respectively and head circumference was 35 centimeters when measured. Vital signs were checked and findings were communicated to the mother as follows;

Apex heart beat	134 beat per minute
Temperature	36.5 degrees Celsius
Respiration	34 cycles per minute

The baby was classified as normal after the examination and routine plan

3.10 SUMMARY OF LABOUR AND DELIVERY

CONDITION OF BABY AT BIRTH

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

The following findings were obtained and recorded as;

Temperature	36.5 degree Celsius
Apex heart rate	134 beat per minute
Respiration	34 cycles per minute
Baby's weight	2.9 kilograms
Head circumference	35centimeters
Length	50centimeters
General condition of baby	Satisfactory
Meconium	Passed
Urine	Passed
Sex	Female

SUMMARY OF LABOUR

Date and time of delivery	- 6th December, 2021at 5:10pm
Type of delivery	- Spontaneous Vaginal Delivery

Time of expulsion of placenta and membranes. - 5:20pm

Drug given - Injection Oxytocin (10 units)

DURATION OF LABOUR

1ST stage	6hours,10 minutes
2nd stage	10 minutes
3rd stage	10 minutes
Total time	6hours, 30 minutes

CONDITION OF MOTHER AT BIRTH

General condition of the mother was stable as evidence by the following findings.

Condition of mother	Stable
Perineum	Intact
Fundal Height	16cm
Temperature	36.4 degree Celsius
Pulse	72 cycles per minute
Respiration	18 cycles per minute
Blood Pressure	125/80 millimeters of mercury

CONDITION OF THE PLACENTA

Lobes - Intact

Membranes - Intact

Fetal Surface - Greyish blue in colour

Maternal Surface - Dark red in colour

State of Placenta - Complete and healthy

Blood Loss - 150mls

Cord vessels - Two arteries and one vein

3.11 LABOUR CARE PLAN

PROBLEMS IDENTIFIED DURING LABOUR

lower abdominal pain.

anxiety.

frequency of micturition.

Fatigue

nausea and salivation.

SHORT TERM OBJECTIVES

1. Client will be able to cope with her lower abdominal pains throughout labour.

2. Client anxiety will resolve by the end of labour.

3.. Client will be able to cope with frequency of micturition throughout labour

4. client will be relieved of fatigue 2 hours after labour.

5. Client nausea and salivating will be reduced within 3hours and cope through labour.

LONG TERM OBJECTIVES

Madam Stella will go through all the stages of labour and puerperim successfully without any complications.

DATE/ TIME	NURSING DIAGNOSIS	OBJECTIVES/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTIONS	DATE / TIME	EVALUATION	SIGN
6/12/21 10:00am	Lower abdominal pains related to uterine contractions.	Madam Stella will cope with the lower abdominal pains throughout lalour as evidenced by client action.	1. Reassure client 2. Explain the process of labour to client. 3. Encourage client to practise the deep breathing exercise. 4.Encourage client to empty her bladder frequently. 5. Engage client in a conversation as a form of divisional therapy. 6. Encourage ambulation	1. Client was reassured to cope with the lower abdominal pains. 2. The process of first and second stage of labour was explained to the client. 3. Client was encouraged to practise the deep breathing exercise. 4. Client was encouraged to empty her bladder frequently. 5. Client was assisted to watch television. 6. Client was encouraged to walk around her bed.	6/12/21 5:00pm		A.F.B

DATE/ TIME	NURSING DIAGNOSIS	OUTCOMECRITERIA/ OBJECTIVE	NURSING ORDERS	NURSING INTERVENTIONS	DATE/ TIME	EVALUATION	SIGN
6/12/21 11:00am	Nausea and salivation related to physiological processes during ladour.	Client nausea and salivation will reduced and cope throughout labour as evidenced by client action.	1. Reassure client. 2. Encourage client to take 150mls fluids. 3. Educate client on nausea and salivation. 4. Remove nauseated items from the side of client.	1. Client was reassured. 2. Client was encouraged to take 150mls of fluids 3. Client and partner were educated on nausea and its management. They asked questions which were answered respectively. 4. All nauseated items were removed from client's side.	6/12/21 2:00pm	Client nausea and salivation was reduced and coped throughout labour as indicated.	A.F.B

DATE/TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES	NURSING ORDERS	NURSING INTERVENTIONS	DATE/ TIME	EVALUATION	SIGN
6/12/21 10:30am	Maternal exhaustion related to physiology of labour.	Client will be relieved of fatigue 2 hour after labour after labour as evidenced by client verbalizing it.	1. Reassure client. 2.Encourage client to rest between contractions. 3.Encourge client on relaxation techniques. 4.Encourage client to stop screaming and conserve energy. 5.Give client nutritious diet.	1. Client was reassured. 2.Client was encouraged torest in between contractions. 3.Client was taught deep breathing exercise. 4.Client stopped screaming to conserve energy. 5.Client was served with nutritious diet.	6/12/21 4:00pm	Goal fully met as midwife observed client go through labour successfully.	A.F.B

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES	NURSING ORDERS	NURSING INTERVENTIONS	DATE/ TIME	EVALUATION	SIGN
6/12/21 11:00am	Frequency of micturition related to pressure of the presenting part on the bladder.	Client frequent micturition reduced 72hours after labour as evidenced by client action	1. Reassure client condition is temporal and it will resolve after delivery. 2. Explain the physiology of frequency of micturition to client. 3. Encourage client to urinate whenever she has the urge. 4.Encourage client to ambulate to enhance descent of presenting part 5. Educate client on the importance of micturition.	1. Client was reassured that condition was temporal and it will resolve after delivery. 2. The physiology of frequency of micturition was explained to client as descent of fetal presenting part reducing the bladder capacity was explained to client. 3. Client was encouraged to urinate whenever she has the urge. 4. Client was educated to ambulate to aid descent of the presenting part. 5. Client was educated on the importance of frequency of micturition.	9/12/21 14:00pm	Client frequent micturition	A.F.B

DATE/ TIME	NURSING DIAGNOSIS	OBJECTIVES/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
6/12/21 10:30am	Anxiety related to unknown outcome of labour.	Client anxiety will resolve by the end of labour as evidenced by 1. Client cooperating with the progress of labour. 2.. Midwife observing that client has relax in bed	1. Reassure client that her anxiety will resolve. 2. Explain every procedure to be carried to her to allay fear. 3. Educate her on possible outcome of labour. 4. Encourage the deep breathing exercise. 5. Introduce client to other staff.	1. Client was reassured that her anxiety will resolve. 2. Every procedure to be carried out was explained to client. 3. Client was educated on possible outcome of labour. 4. Client was encouraged to do the deep breathing exercise. 5. Client was introduced to other staff. .	6/12/21 5:30pm	Goal fully met as client's anxiety was resolved as client verbalizing.	A.F.B

CHAPTER FOUR

PUERPERIUM

4.0 INTRODUCTION

This chapter describes the management of both mother and baby from day of delivery up to six weeks postpartum and care plan drawn for the various problems identified.

4.1 DAY OF DELIVERY

On 6th December, 2021 Madam Stella was cleaned and transferred to the lying-in ward at 4:50pm after skin to skin. She was served with rice and soup. She was educated on the need to empty her bladder to prevent post-partum hemorrhage. Symphysiofundal height was 16 centimeters. Her first vital signs were checked and recorded as follows:

VITAL SIGNS

Temperature	36.4 degree Celsius
Pulse	72 beat per minute
Respiration	18 cycles per minute
Blood pressure	125/80 millimeters of mercury

Lochia was bright red (rubra) and flow was small. Perineum was intact and mother was educated to massage her uterus and report any bleeding per vaginum. She was educated to feed baby on demand 1-2 hourly or 8 to 12 times daily to ensure adequate feed and to serve as a method of family planning and also increase bonding. She was told to change perineal pad frequently and

wash hands before breastfeeding the baby and also after changing pad. Head to toe examination was done and no abnormalities were detected. She was nicely asked to take her bath.

4.2 SUBSEQUENT CARE OF THE BABY

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

BABY BATH

REQUIREMENTS

TOP SHELF

2 gallipots one with cotton and the other one with sterile water.

Cord dressing tray

BOTTOM SHELF

Soap

Sponge

Cream/ powder

Basin

Towels: 1 big towel and 3 small ones

Cot sheets 2

Gloves

A clean baby dress, cap and socks (if available)

Mackintosh

2 jugs containing hot and cold water each

Two receptacles for used water and dirty linen

A receiver for used swab

Methylated spirit for cord dressing

Baby was bathed 17 hours after delivery(at10:00am), procedure was explained to mother. All items to be used for the procedure were assembled, as above.

PROCEDURE

The procedure to be carried out was explained to the mother and it was done in her presence.

A plastic apron was put on and hands were washed with soap and water and dried with clean towel. Examination gloves were worn and the baby was put on a safe flat surface and was undressed. Baby was then wrapped with a cot sheet and examined thoroughly. The head was exposed for it to be bathed. The eyes were cleaned (wiped) with clean cotton wool swabs soaked in clean water and the face cleaned with damp face towel and dried. The nape of the baby's neck was supported with one hand. The head was supported and the baby's ears plugged with two fingers. The head was then washed with soapy sponge. Baby was then lifted off flat surface, still supporting at the nape of the neck and the body resting in the elbow and brought, to the edge of the basin and soap rinsed off baby's hair and dried. Baby was then put on protected flat surface and exposed. The arms and front of trunk were washed paying attention to the skin folds. Then baby was turned with one arm supporting the chest and with the other hand holding the distal arm of the baby. The back was washed down to the feet, paying attention to the skin folds. Baby was supported firmly and immersed in a bath of warm water which temperature was tested with the elbow and confirmed by

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

CORD DRESSING

A tray was set aside containing (sterilised gallipot, cotton wool swab and methylated spirit). Procedure for dressing the cord was explained to the mother and procedure performed still in her presence. Hands were washed with soap and water and dried with a clean towel. Sterile gloves worn and cord exposed. The cord would be cleaned with six cotton wool swabs dipped in methylated spirit. The cord was inspected for bleeding, pulsation and the tip of the cord held with a swab. The skin around the base of the cord was cleaned 5cm away from the base with sterile cotton wool with methylated spirit and then discarded .The whole cord was clean with sterile cotton wool and methylated spirit from the base upwards once at each side of the cord (front and back) and the tip clean with separate sterile cotton wool swab soaked with methylated spirit and cord left exposed. Hands were immersed in 0.5% chlorine solution, gloves removed and disposed. Hands were washed and dried with towel. Baby was then dressed and given to the mother to breastfeed. Client was advised to use only the sterile cotton wool swab and methylated spirit given to her to dress the cord and always keep the cord exposed after dressing, she was advised how to apply dipper below the umbilicus.

Mother was encouraged to maintain baby's temperature to prevent the baby becoming too cold or too hot by dressing baby with clothing before wrapping her. Mother was encouraged to breastfeed

baby exclusively and on demand or 8 to 12 times a day. She was also educated on breastfeeding problems and how she would manage the problem like breast engorgement, sore nipple and cracked nipple and to report if problem persist. Mother was advised to use only prescribed drug for cord care. Client was advised to wash hands before and after handling the baby. All findings were communicated to the mother and recorded afterwards.

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

Temperature	36.5
Apex heart rate	134 beat per minute
Respiration	34 cycles per minute
Weight	2.9kilogram

4.3 FIRST DAY POST DELIVERY AND DISCHARGE

The first day post-delivery was on 7th December, 2021 at 7:30am,She woke up looking strong and healthy. She brushed her teeth and was assisted to take her bath. She was served with porridge and bread by her sister. Head to toe examination was done and no abnormalities were detected on both mother and baby. Baby was bathed and cord dressed in the presence of the mother. She was taught how to dress the cord with six cotton wool swabs soaked in methylated spirit. She complained of after pain and was encourage to empty her bladder whenever she has the urge. Symphysio fundal height was 14 centimeters. First day post-partum check done on client and recorded as follows:

Temperature	36.6 degrees Celsius
Pulse	80 beat per minute

Respiration 19 cycles per minute

Blood pressure 125/70 millimeters of mercury

Lochia was bright red with small flow and also not offensive. The baby passed meconium and urine. No abnormalities detected on head to toe examination. Weight was 2.8kilograms.

Baby's vital signs and assessment were;

Temperature 36.2 degree Celsius

Apex heart beat 136 beat per minute

Respiration 44 cycles per minutes

The baby was reexamined head to toe and confirmed by the midwife in charge to exclude any abnormality of the baby before discharge. Baby was dressed nicely in a warm and clean baby sheet and handed over to her mother for breastfeeding. A demonstration on how to position the baby during breastfeeding was done in the presence of the sister and was educated to blow air after feeding. Baby was intradermally injected with Bacilli Calmette Guerin (BCG) and oral polio '0' vaccine by Community Health Nurses. She was educated on the effects of BCG and not to apply anything at the site of injection. She was educated to report on danger signs of the baby such as fever, difficulty in breastfeeding and breathing problems. She was assisted to pack her belongings because she would be discharged home. Education was given to her on how to take the prescribed medications. She was served the following drugs per hospitals protocol:

Caps Iron (111) polymaltose 100mg once daily x 30days

Tablet folic acid 5mg once daily x 30days

Tablet metronidazole 400mg three times daily x 7 days

Capsule amoxicillin 500milligram three times daily x 7days

Tablet paracetamol 1 gram three times daily x 5days

She was told she would be visited at home to provide care for her and baby. She was also reminded to come for one-week postnatal care on 14th December, 2021. She was reminded to do exclusive breastfeeding, recognizing and management of common breastfeeding problems like breasts engorgement. She was educated on proper hand washing (washing hand with soap under running water) before and after each feed which is a way of helping to prevent infections. The mother was educated to complete immunization schedule. She was taught to eat well balanced meal, fruits to enhance in the prevention of constipation and also promote growth and development in the baby. She was told to change her perineal pad every 4 hours or when soiled, proper disposal of it and hand washing after removing the pad. Client had registered with the National Health Insured scheme so her bills were taken care off. Her sister was advised to give support to the mother in the care of the baby and the other children. All documents were signed and recorded. At 10:00 am, client was discharged and was reminded that she would be visited at home the next seven days continuously to ascertain the progress of the mother, baby and the entire family. She thanked all the staff and also bid farewell to the other clients at the ward. She was accompanied to the junction for them to board a taxi home.

4.4 FIRST POST NATAL HOME VISIT

On 7th December 2021, at 4:00pm, Madam Stella was visited in her house and was asked how she and her baby were doing after exchanging greetings. Madam Stella said her condition was getting

better and her previous complaints had improved and she also said that the baby was feeding and sleeping well. The family was much pleased to be visited. Explanation was given to Madam Stella that she and the baby were going to be examined from head to toe to detect any abnormality for early treatment. The client's conjunctiva was examined and there was no pallor, the breasts were firm, soft and were lactating well, the uterus was well contracted and the symphysio fundal height measured 14cm. The perineum was clean when inspected the lochia was red with moderate flow and without odour.

Baby was examined from head to toe and no abnormality was found. She was not jaundiced and pale. Baby's weight was checked and recorded as 2.8 kilograms. Baby's vital signs were taken and recorded as follows;

OBSERVATION ON BABY (7th December, 2021)

OBSERVATION	**EVENING**	
Temperature	36.6	
Apex heart beat	136 bpm	
Respiration	43cpm	
OBSERVATION	**MORNING**	**EVENING**
Skin Colour	Pink	Pink
Cord bleeding	No	No
Cord	Drying	Drying
Suckling	Yes	Yes

Weight	2.8 kg	
Stool Colour	Meconium	Meconium

Madam Stella was encouraged to breastfeed the baby on demand and at least 8 to 12 times a day. Permission was sought to top and tail the baby and it was granted. Baby was toped and tailed. As the baby was being toped and tailed, the procedure was also demonstrated to Madam Stella and her mother paying attention to the skin folds. The cord was also dressed with cotton wool soaked in methylated spirit; it was clean and quite dry. The baby had passed meconium and urine when the diaper was removed and it was inspected for meconium and urine. Madam Stella complained of after pains and it was explained to her that the pain was due to the involution of the uterus was asked to continue taking paracetamol given to her as prescribed. A promise was made to visit them again the following day and client said good bye and the family were bid fare well.

Assessment made was:

OBSERVATION ON MOTHER (7th December, 2021)

OBSERVATION	EVENING
Temperature	36.6
Pulse	80 bpm

Respiration	19 cpm
Blood pressure	125/70mmHg
Lochia	Rubra
Fundal height	14
Condition of the uterus	Contracted
Breast	Lactating

Baby was given to mother to be breastfeed. All findings were communicated to her and recorded. She was told of the visit the next day. Permission was sought to leave.

4.5 SECOND POSTNATAL HOME VISIT

On the 8th December 2021, the second visit was made to client's house at 8:00am and 4:00pm. Madam Stella said her pain has resolved. The baby was also doing well. Permission was sought to inspect her perineal pad and the lochia was found to flow scanty, the colour was red (rubra) and not offensive. The head to toe examination was also done and everything was normal. The symphysio fundal height was 13 centimeters.

The baby was toped and tailed paying attention to the skin folds and general examination was carried out and no abnormality was present. The cord was neatly dressed with no abnormality detected and was getting dried. The baby passed stools and urine everyday according to Madam Stella, baby weight was 2.7kilograms. She complained of inadequate sleep and backache. She was educated to feed the baby on demand and adequately prior to bed time. Concerning the backache,

a demonstration on proper position of the baby during breastfeeding was done in the presence of the mother.

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

OBSERVATION ON MOTHER (8th December, 2021)

OBSERVATION	MORNING	EVENING
Temperature	36.5^{0}C	36.8^0 C
Pulse	70 bpm	72bpm
Respiration	18 cpm	19
Blood pressure	128/75mmHg	130/80
Lochia	Rubra	Rubra
Fundal height	13cm	
Condition of the uterus	Contracted	Contracted

OBSERVATION	EVENING
Breast	Lactating

OBSERVATION ON BABY (8th December, 2021)

OBSERVATION	MORNING	EVENING
Temperature	36.4^0C	36.2^0C
Apex heart beat	138 bpm	136 bpm
Respiration	46 cpm	44 cpm
Skin Colour	Pink	Pink
Cord bleeding	No	No
Cord	Shrinking	Shrinking
Suckling	Yes	Yes
Weight	2.7kg	
Stool Colour	Meconium	Meconium

4.6 THIRD POSTNATAL HOME VISIT

On the 9th December, 2021, the third home visit was made to Madam Stella house at 8:00am and 4:30 pm. Greetings were exchanged. Mother and baby were doing well. Permission was sought to inspect client's perineal pad and it was pink, scanty flow without any offensive smell. Her breast was lactating well. Symphysio fundal height was 12 centimeters when measured. Her vital signs were checked and recorded as follows;

OBSERVATION ON BABY (3rd DAY POSTPARTUM)

	3rd day (9th December 2021)	
Observations	**MORNING**	**EVENING**
Temperature	36.2^0C	36.4^0C
Apex heart beat	134 bpm	132 bpm
Respiration	42 cpm	46 cpm
Skin Colour	Pink	Pink
Cord bleeding	No	No
Cord	Shrinking	Shrinking
Suckling	Yes	Yes
Weight	2.7kg	
StoolColour	Dark Yellowish	Dark Yellowish

Baby was toped and tailed paying attention to the skin folds and general examination was carried out and no abnormality was present. The cord was dressed aseptically with no abnormality detected. The baby also passed stools and urine. Weight was 2.6 kilogram.

Madam Stella complained of inability to pass stool, she was educated to take in a lot of fluids and fruits. Permission was sought to leave and Madam Stella said she was very grateful and appreciated the care that was given to them.

OBSERVATION ON MOTHER (3$^{rd\ DAY}$ POSTPARTUM)

	3rd day (9th December 2021)	
Observation	**MORNING**	**EVENING**
Temperature	36.3^{0}C	36.4 ^{0}C
Pulse	80 bpm	82 bpm
Respiration	20 cpm	20 cpm
Blood pressure	125/70mmHg	120/70mHg
Lochia	Rubra	Rubra
Fundal height	12cm	
Condition of the uterus	Contracted	Contracted
Breast	Lactating but engorged	Lactating but engorged

4.7 FOURTH POSTNATAL HOME VISITS

The fourth home visit was made to Madam Stella's house at 8:00am on 10th December 2021. The health status of mother was inquired and she said the pain in her breasts had subsided except the fullness. Lochia was pink (serosa) with scanty flow without odour on inspection. Head to toe examination was done and everything was normal. Symphysio fundal height was measured and it was 10 centimeters.

Baby was top and tailed paying attention to the skin folds and the general examination was carried out, no abnormality was found. The cord was aseptically dressed with methylated spirit and no abnormality was detected and baby was doing well. The baby had already passed stools and urine. Her weight was 2.7kilograms when checked. Baby's stool was bright or mustard yellow. She complained of heaviness in the breast which was as a result of fullness. She was educated to continue breastfeeding the baby on demand and frequently, and to apply warm compress on them to reduce the pain and was asked to breastfeed baby on demand and to make sure one breast is emptied before the other and to wear well-fitting brassier.

She was encouraged to breastfeed the baby on demand and to ensure adequate warmth to baby. During the visit, client under wear was washed and dried in her room and was advised to dry them under the sun to prevent any infection since they thrive in moist area and was also educated to take nutritious meals and to take in fruits in addition since she was prone to getting infections.

OBSERVATION ON MOTHER (10th December 2021)

	MORNING
Temperature	36.7^{0}C
Pulse	82 bpm
Respiration	18cpm
Blood pressure	122/81mmHg

	MORNING

Lochia	Rubra
Fundal height	10 cm
Condition of Uterus	Contracted
Breast	Lactating but slightly engorged

OBSERVATION ON BABY (10th December 2021)

	MORNING
Temperature	36.4^{0}C
Apex heart beat	136 bpm
Respiration	43cpm
Skin colour	Pink
Cord bleeding	No
Condition of cord	Shrinking
Suckling	Yes
Weight	2.8kg
Stool colour	Dark yellow

4.8 FIFTH POSTNATAL HOME VISIT

The fifth postnatal home visit was on 11th December, 2021 at 8:20am. Greetings were exchanged with client and her family after which a seat was offered in client's room. Mother and baby were both in a healthy condition and when it was inquired. She was reassured and was advised to breastfeed baby regularly. Inspection of the lochia was done and the colour was pink (serosa) without any bad odour and flow was scanty. After the head to toe examination, no abnormality was detected. Symphysio fundal height was 9 centimeters when checked.

Baby was top and tailed paying attention to the skin folds, head to toe examination was done and no abnormalities were found on the baby. Her cord showed signs of detachment and was dried. Weight was 2.9 kilograms when checked.

Madam Stella complained of inadequate sleep at night she was advised to sleep when baby was asleep and support person that is mother and sister was asked to assist in the care of the baby during the day. She was reminded of the next visit and she said she was very grateful. Permission was sought to leave.

OBSERVATION ON MOTHER

OBSERVATION	5th day (11th December,2021)
	MORNING
Temperature	36.9^{0}C
Pulse	80 bpm
Respiration	20 cpm
Blood pressure	120⁄70mmHg
Lochia	Serosa

	MORNING
Fundal height	9cm
Condition of the uterus	Contracted
Breast	Lactating

OBSERVATION ON BABY

OBSERVATION	**5th day 11th December 2021**
Temperature	36.2^0C
Apex heart beat	136 bpm
Respiration	44 cpm
Skin Colour	Pink
Cord bleeding	No
Cord condition	Shrinking
Weight	2.9kg
Suckling	Yes
Stool Colour	Yellow

4.9 SIXTH POSTNATAL HOME VISITS

The sixth day postnatal home visit was made on 12th December, 2021 at 8:30am. Greetings were exchanged with client and her family and a seat was offered in client's room. Mother and baby were both in a healthy condition and Madam Stella said the baby's cry had minimized and now sleeps a lot. On head to toe examination, no abnormalities were detected. Her breast was soft and lactating well. Inspection of the lochia was done and the colour was pink (serosa) flow was very scanty without any bad odour. Measurement of symphysio fundal height was 7 centimeters when checked. She moved her bowel as well as that of the baby.

Baby was given a warm bath paying attention to the skin folds since the cord was off the previous evening and head to toe examination was done with no abnormality found on the baby. The stump was then dressed and the area was cleaned with methylated spirit. Weight was 3.0kilograms.

Client complained of backache. Madam Stella was educated on proper positioning when breastfeeding and how to put baby to breastfeed. She said she appreciated that a lot, and she was thanked for her co-operation. Client was reminded that the next day was going to be the last visit to her house and permission was sought to leave.

MOTHER

OBSERVATION ON MOTHER	**6^{th}day(12th December,2021)**
	MORNING
Temperature	36.2^0C
Pulse	75 bpm

Respiration	19 cpm
Blood pressure	120/80mmHg
Lochia	Serosa
Fundal height	7
Condition of the uterus	Contracted
Breast	Lactating

OBSERVATION ON BABY

OBSERVATION	**6th day (12th December,2021)**
Temperature	36.3^{0}C
Apex heart beat	137 bpm
Respiration	45cpm
Skin Colour	Pink
Cord bleeding	No
Cord condition	off
Weight	3.0kg
Suckling	Yes
Stool Colour	Yellow

4.10 SEVENTH POST NATAL HOME VISITS

The last visit for the week was on 13th December, 2021 at 8:00am. The condition of mother and baby was very good. Head to toe examination was done after explaining the procedure to her.

Permission was sought and perineal pad was inspected. Lochia was creamy white (Alba) but very little and not offensive. Nothing abnormal was detected. Symphysio fundal height was 5 centimeters when checked.

Baby was bathed by the client and cord stump dressed and it went on well, under supervision. Head to toe examination was done and no abnormality was found. Weight was 3.1kilograms.

All the findings were explained to the client and she was educated on the importance of visiting the clinic for the first weeks postnatal and the importance of immunizing the baby fully. She was thanked for her support and co-operation and farewell was done

MOTHER (7th day postnatal)

	13th December 2021
	MORNING
Temperature	36.3^{0}C
Pulse	74 bpm
Respiration	20cpm
Blood pressure	120/70mmHg
Lochia	Serosa

	13th December 2021
	MORNING
Fundal height	5cm

Condition of uterus	Contracted
Breast	Lactating

BABY

	(13th December 2021)
Temperature	36.5^{0}C
Apex heart beat	133bpm
Respiration	43cpm
Skin colour	Pink
Cord bleeding	No
Cord stamp	Healing
Weight	3.1kg
Suckling	Yes
Stool colour	Dark Yellow

4.11 FIRST POSTNATAL VISIT TO THE CLINIC

Madam Stella came to the postnatal clinic on 14th December 2021 at 9:40am with her mother who accompanied her; they were welcomed immediately and offered seats. Client said her family was doing well when asked. Every procedure to be done was explained to her to gain her consent her weight was 80 kilograms when checked. Vital signs were checked recorded as follows:

Temperature	35.6 degrees Celsius
Pulse	79 beat per minute
Respiration	20 cycles per minute
Blood pressure	120/80 millimeters of mercury

She was asked to take specimen of urine as she went to empty bladder. Her urine was tested and it was negative for both protein and sugar. Hemoglobin level was 11.6 grams per deciliter. Privacy was provided and she was helped onto the examination bed and head to toe examination was performed. Client's hair looked very nice, the eyes and nose were inspected and no abnormality was found. The conjunctiva was neither pale nor jaundiced. Breasts were examined but there was no abnormal mass, soreness of the nipples, engorgement present. The upper and lower extremities were inspected and no abnormality was present. On abdominal examination, the spleen was not enlarged, there was no tenderness after palpating the liver and symphysio fundal height was also 8 centimeters when measured. The vulva was examined for any perineal infection, and lochia flow was Alba. No abnormality was found in all. Findings were communicated to Madam Stella and she was commended for her cooperation and she was also thanked as well.

Baby was also examined from head to toe. The conjunctiva was not pale, neither was there jaundice of the sclera nor eye discharges. The ears and nose were inspected as well as the lips and mouth, but no abnormality was found. The umbilical stump was neatly healed. Baby's weight was 3.1kg when checked. Vital signs were checked and recorded as follows:

Temperature	36.2 degree Celsius
Apex heart beat	135 beat per minute

Respiration 44 cycles per minutes

After the examinations, findings were communicated to Madam Stella that nothing abnormal was detected on the baby. Client was educated on family planning, to help her and the partner space their birth and give birth to the number of children they could cater for. She agreed and said that since the partner was present at that time, she chose lactational amenorrhea method as a natural method which is temporal. Madam Stella was also reminded on the need to completely attend baby clinic to complete the child's immunization schedules and also attend six weeks post-natal clinic for examination.

4.12 TERMINATION OF CARE

Explanation was given to Madam Stella on the need to be handed over to the midwife in-charge for continuity of care on 14th December, 2021, at 11:30 am. Explanation was made to her that our programme had ended on the 14th December, 2021 but client was reassured of midwife in-charge's competency. Client was accompanied to her house and a seat was offered. Client and her mother together with her partner were thanked for their cooperation, information provided throughout the study, they were reminded to register the baby at birth and death registry. And also, to complete baby's immunization schedule and permission was sought to leave.

4.13 SECOND POST NATAL VISIT TO THE CLINIC

According to the midwife in charge, on the 24th January, 2022. Madam Stella came to the clinic for six weeks visit. They were warmly welcome and they all looked very healthy. General examination was conducted on the client from head to toe as well as vital signs after her permission was sought. Her vital signs were checked and recorded as follows:

Temperature 36.4ºC

Pulse 78bpm

Respiration 20cpm

Blood Pressure 130/70mmHg

Madam Stella was given a urine sample container to provide some urine to be sent to the laboratory for urine analysis to be performed. She was educated on the need and procedure to provide midstream urine for the examination. A sample of blood was also taken from Madam Stella 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 Stella 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 subinvolution, tenderness, enlargement of liver and spleen was detected and uterus was not palpable. Certain condition such as edema was looked out for at the lower extremities, such as edema was looked out for. It was detected that she showed no abnormality.

Speculum examination revealed no bruises on the cervix but showed slit-like appearance. She had not resumed her menses when asked.

Her baby was also examined from head to toe to look out for abnormalities. On the head, the anterior fontanelle was palpated for pulsation and it was normal. The posterior fontanelle had closed. There were no discharges from the eyes and nose. The skin was nice with no rashes. The chest, upper and lower extremities were normal. The lower extremities were normal. The findings on the baby were as follows:

Temperature 36.2℃

Respiration	34cpm
Apex heart beat	134bpm
Weight	3.5kg

Madam Stella and her baby were handed over to the child welfare clinic for continuity of care and for the six weeks' immunization against diphtheria, pertussis, tetanus, haemophilus influenza and hepatitis B. According to the midwife in charge she was educated on family planning methods and she choose combined oral contraceptive. She was encouraged to ask questions but she had none and no complaints either. She was reminded on exclusive breastfeeding, rest and sleep, exercise and nutritious diet, which would help in lactation. She was finally referred to the public health nurse for continuity of care but report to the facility anytime she encounters any health-related problem. She was thanked for her co-operation and understanding.

4.14 CARE PLAN DURING PUERPERIUM

PROBLEMS IDENTIFIED DURING PUERPERIUM

1. After pain.

2. Inadequate sleep.

3. Backache.

4. inability to pass stool.

5. Breast engorgement.

SHORT TERM OBJECTIVES

1. Client's after pain will be resolved within 72hours

2. Client will sleep 1 hour at day time and 3hours at night within 24 hours

3.Mother's backache will be resolved within 48hours

4. Client's breast engorgement will be reduced within 48 hours

5.Client will regain bowel movement within 48hours.

LONG TERM OBJECTIVE

Madam Stella and baby will go through puerperium successfully without any complication.

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVE/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
9/01/21 7:20 am	Backache related to poor body posture during breast feeding	Client will be relieved of backache within 48hours as evidenced by client verbalizing.	1. Reassure client. 2. Demonstrate to client on how to position herself when breast feeding her baby. 3. Explain the physiology backache to client. 4. Encourage client to support her back with pillows when sitting. 5. Serve prescribed analgesics (paracetamol)	1. Client was reassured 2. A demonstration was done on how to position herself when breastfeeding such as selecting a firm chair and sitting upright when breast feeding. 3. Education on backache was given to client. 4. Client was encouraged to support her back with pillows when sitting. 5. Paracetamol was served as prescribed.	12/01/21 07:20 am	Client backache was reduced within 48hours as indicated.	A.F.B

PUERPERIUM CARE PLAN CONTINUED

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVE/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
03/01/21 07:30 am	After pain related to involution of the uterus	Client after pain will resolved after 72 hours as evidenced by .client action	1.Reassure client 2.Educate client on physiology of after pain 3. Encourage client to empty her bladder whenever she has the urge. 4.Encourage client to adopt a comfortable position . 5. Serve analgesics as prescribed. E.g. paracetamol	1. Madam Stella was reassured. 2. It was explained to the client that her pain was due to the involution of the uterus that is the uterus returning back to it non pregnant state. 3. Client was encouraged to empty her bladder whenever she has the urge. 4.She was encouraged to adopt a comfortable position when breast feeding. 5. Client was served with tab paracetamol1g tds x3 days	05/01/21 07:30 am	Goal met as client verbalized that her pains has reduced as indicated.	A.F.B

PUERPERIUM CARE PLAN CONTINUED

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVE/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
05/01/21 7:30am	Insomnia related to night breast feeding.	Client will sleep 1 hour at day time and 3hours at night within 24 hours as evidenced by client verbalizing.	1. Reassure client 2. Encourage client to feed baby on demand 3. Encourage client to feed baby adequately before going to bed. 4. Educate client relative to help in taking care of the baby. 5. Encourage client to sleep when baby is asleep.	1. Client was reassured that baby demand is important so she will be assisted. 2. Client fed baby on demand. 3. Client was encouraged to feed baby adequately before going to bed to make sure baby is well fed to sleep well. 4. Client relative helped her in taking care of the baby. 5. Client was encouraged to sleep when baby is asleep.	06/01/21 7:30am	Goal met ad client said that she slept for 3 hous during the night and 1 hour during the day.	A.F.B

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
06/01/21 8:00 am	Constipation related to pains caused by trauma during delivery.	Madam Stella will regain bowel movement within 48hours once a day as evidence by client verbalizing.	1.Reassure client. 2.Explain the cause of constipation during puerperium to the client 3.Educate client on the need to take in fruit and 150mls fluids. 4. Encourage client to take in food containing fiber. 5.Encourage client to perform mild exercise.	1.Client was reassured. 2.The cause of constipation during puerperium was explained to client such as inadequate fluid intake. 3. Client was educated to take in more fruit and a lot of fluid. 4.Client was encouraged to take in foods containing fiber such as orange and oat. 5.Client has been encouraged to do mild exercise to promote free bowel movement.	08/01/21 8:00am	Goal fully achieved as client verbalized that she is able to move her bowel at least once a day.	A.F.B

PUEPERIUM CARE PLAN CONTINUED

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVE/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
07/01/21 7:00am	Breast engorgement related to unable to empty breast.	Client engorged breast will be relieved within 48 hours as evidence by breast.	1. Reassure client. 2. Demonstrate to client on correct attachment of the baby to the breast. 3.Encourage client on gentle manual expression excess milk. 4.Encourage her to continue breast feeding the baby. 5. Encourage client to apply warm and cold compress alternatively.	1. Client was reassured 2. A demonstration was done how to properly fix baby to breast and stored. 3. Client was encouraged on gentle manual expression of breast milk 4. Client was encouraged to continue breast feeding the baby on demand and frequently. 5.Client was encouraged to apply warm and cold compress on both breasts.	09/01/21 7:00am	Goal met as client engorged breast has subside within 48 hours as indicated.	A.F.B

SUMMARY AND CONCLUSION

The care study is an important and managerial tool which gives opportunity to student midwives to put into practice theoretical knowledge and to be able to deal with obstetric problems as midwifery professional.

The Client/Family Centered Maternity Care Study was conducted on Madam Bewaa Stella a 27-year-old gravida 3 para2 and her entire family through pregnancy, labour and puerperium and she went through these processes safely without any complications.

Madam Stella became a regular attendant to the Hospital. She was managed through pregnancy, labour and puerperium safely through which all minor disorders experienced were managed using the nursing care plan. She had a spontaneous vaginal delivery to a live female baby on 6th December, 2021 and discharged the next day. Client and family were visited for the first seven days after delivery.

Madam Stella visited the child welfare clinic on her first week and six weeks postnatal and the baby was in a healthy condition and they were handed over to the Midwife-In-Charge of ANC for continuity of care.

Client and her family were much grateful at the end of the study.

The care rendered to Madam Stella has helped in equipping me with skills necessary to meet the needs of pregnant, labouring and puerperal women. It has also established between us a good interpersonal relationship.

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APPENDIX I

ANTENATAL CHART

Date	Weight (kg)	Blood pressure (mmHg)	Urine Protein Sugar	Gestational age	Fundal height (cm)	Presentation	Descent	Foetal heart rate	Complains	Treatment	Name and signature
19/04/2021	59	120/80	Negative	7	-	-	-	-	No complain	Tablet (Multivite, folic acid, ferrous sulphate,	M.A
17/05/21	60	100/70	Negative	11	-	-	-	-	No complain	Tablet (Multivite, folic acid, ferrous sulphate.	M. A
14/06/21	61	120/70	Negative	15	14	-	-	-	No complain	Tablet (Multivite, folic acid, ferrous sulphate,	M. A
Date	**Weight (kg)**	**Blood pressure (mmHg)**	**Urine Protein Sugar**	**Gestational age**	**Fundal height (cm)**	**Presentation**	**Descent**	**Foetal heart rate**	**Complains**	**Treatment**	**Name and signature**
12/07/21	64	120/80	Negative	19	17	-	-	140 beat per minute	Waist pains	Tablet (Multivite, folic acid, ferrous sulphate, sulphadoxinepyr emethamine	M.A

09/08/21	66	120/80	Negative	23	20	Cephalic		142 beat per minute	No complain	Tablet (Multivite, folic acid, ferrous sulphate, Paracetamol	M.A
06/09/21	68	120/70	Negative	27	25	Cephalic	$5/5^{th}$	146 beat per minute	No complain	Tablet (Multivite, folic acid, ferrous sulphate) Sulphadoxine Pyrimethamine	M.A
04/10/21	69	120/80	Negative	31	29	Cephalic	5/5	134 beat per minute	No complain	Tablet (Multivite,folic acid ferrous sulphate.	M.A
Date	**Weight (kg)**	**Blood pressure (mmHg)**	**Urine Protein Sugar**	**Gestational age**	**Fundal height (cm)**	**Presentation**	**Descent**	**Fetal heart rate**	**Complains**	**Treatment**	**Name and signature**
19/10/2021	70	120/80	Negative	33	31	Cephalic	$5/5^{th}$	135 beat per minute	Constipation	Tablet (Multivite,folic acid ferrous sulphate. Sulphadoxine Pyrimethamine	M.A
1/11/2021	71	120/80	Negative	35	33	Cephalic	$5/5^{th}$	140	No complain	- Tablet (Multivite,folic acid ferrous sulphate.	M.A

08/11/2021	72	117/66	Negative	36	35	Cephalic	5/5	134	No complain	Tablet (Multivite,folic acid ferrous sulphate. Sulphadoxine Pyrimethamine	M.A
15/11/2021	73	125/88	Negative	37	36	Cephalic	5/5	144	Oedema at the feets	- Tablet (Multivite,folic acid ferrous sulphate	A.F.B
22/11/2021	74	118/80	Negative	38	37	Cephalic	5/5	135	No complain	- Tablet (Multivite,folic acid ferrous sulphate	A.F,B
29/11/2021	75	126/70	Negative	39	38	Cephalic	5/5	144	L.A.P	- Tablet (Multivite,folic acid ferrous sulphate	A.F.B
06/12/2021	77	120/80	Negative	40	38	Cephalic	4/5	149	L.A.P	-	A.F.B

Table 1: Antenatal Chart

ITN Given – 19/04/2021

INTERMITTENT PREVENTIVE TREATMENT (IPT)FOR Malaria	1ST dose SP* 3 tabs (Directly Observed Therapy) 12/07/2021	Gestation age In weeks 19weeks	2nd dose (1 month after 1st dose (Directly Observed Therapy) 09/08/2021	Gestation age In weeks 23weeks	3rd dose (1 month after2nd dose(Directly Observed Therapy)06/09/21	Gestational age in weeks 27weeks
	4th dose 3 tabs (Direct observed therapy)04/10/21	Gestation age in weeks 31weeks	5th dose 3 tabs (Direct Observed Therapy)01/11/21	Gestation age in weeks 35weeks		

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

APPENDIX II

COMPLETE DIAGNOSTIC INVESTIGATION

DATE	SPECIMEN	INVESTIGATION	NORMAL VALUE	FINDING	REMARKS
19/04/2021	Urine Blood	Sugar protein Haemoglobin level Sickling Grouping Rhesus factor HIV/AIDS Hepatitis VDRL G6PD	Negative Negative 11.4g/dl- 16g/dl Negative A,B,AB,O Positive/nega tive Negative Negative Negative Normal	Negative Negative 14.1g/dl Negative A Positive Negative Negative Non-reactive Normal	Normal Normal Normal Normal Normal Normal Normal Normal Normal Normal
17/05/2021	Urine	Sugar protein	Negative Negative	Negative Negative	Normal Normal
14/06/2021	Urine	Sugar Protein	Negative Negative	Negative Negative	Normal Normal
12/07/202	Urine	Sugar protein	Negative Negative	Negative Negative	Normal Normal
09/08/2021	Urine	Sugar protein	Negative Negative	Negative Negative	Normal Normal
06/09/2021	Urine	Sugar protein	Negative Negative	Negative Negative	Normal Normal
04/10/2021	Urine	Sugar Protein Haemoglobin	Negative Negative 11.4g/dl- 16g/dl	Negative Negative 11.7g/dl	Normal Normal
08/11/2021	Urine	Sugar Protein	Negative Negative	Negative Negative	Normal Normal
DATE	**SPECIMEN**	**INVESTIGATION**	**NORMAL VALUE**	**FINDING**	**REMARKS**
15/11/2021	Urine	Sugar Protein	Negative Negative	Negative Negative	Normal Normal

22/11/2021	Urine	Sugar Protrein	Negative Negative	Negative Negative	Negative Negative
29/11/2021	Urine	Sugar Protein	Negative Negative	Negative Negative	Negative Negative
06/12/2021	Urine	Sugar Protein	Negative Negative	Negative Negative	Negative Negative

APPENDIX III

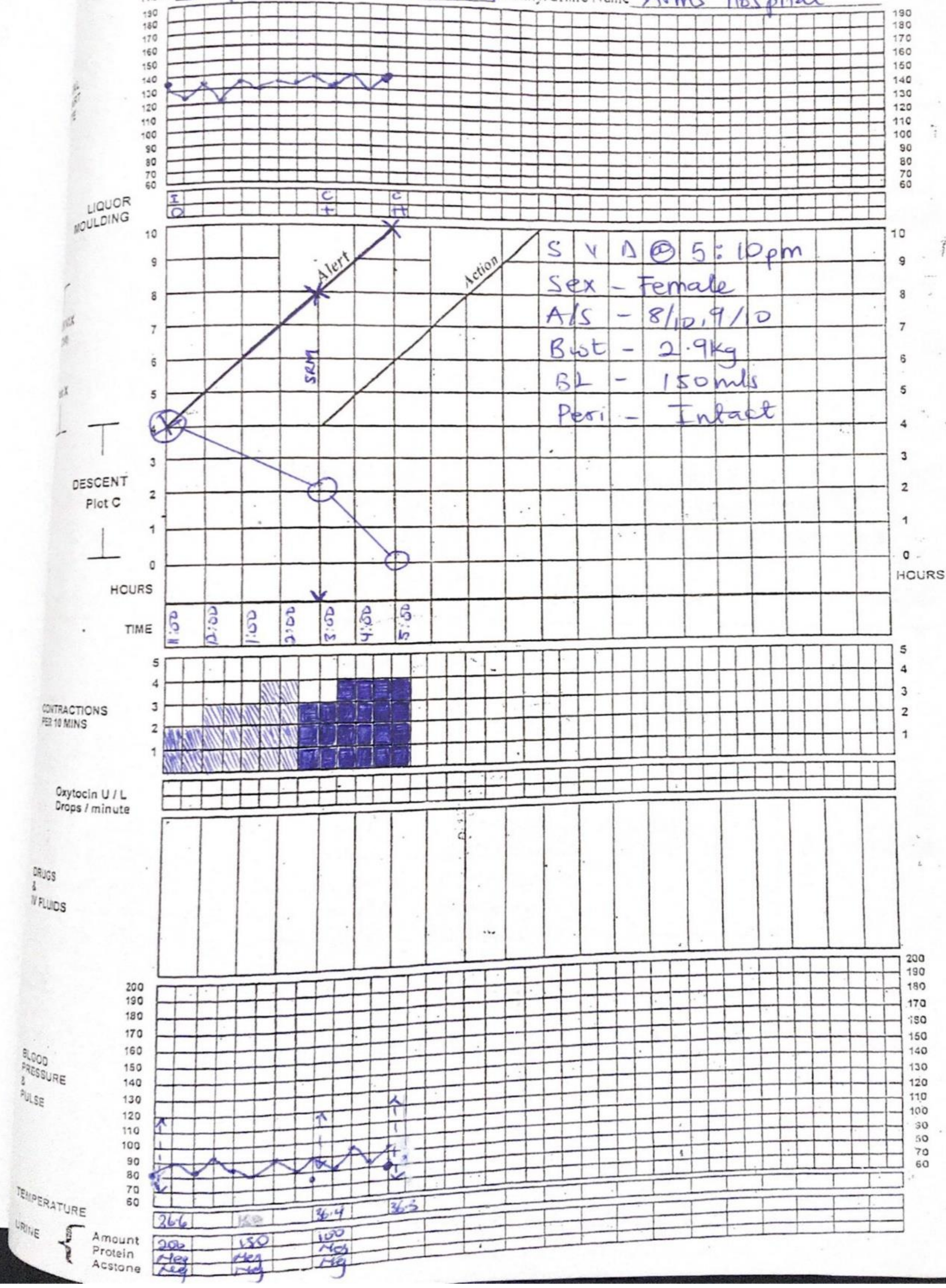
NAME OF DRUG	CLASSIFICATION	ROUTE	DOSAGE	ACTION AND USE	ACTUAL EFFECT	SIDE EFFECT	SIDE EFFECT EXPERIENCED
Tablet folic acid	Vitamin preparation	Oral	5mg daily for 30days	Proper formation and functioning of red blood cell.	Maturation of red blood cells	Nausea and vomiting	None
Tablet Multivitamin	Vitamin preparation	Oral	200mg daily for 30days	Increased appetite. Helps in the formation of red blood cell.	Increased appetite	Gastrointestinal irritation	None
Tablet ferrous sulphate	Iron preparation	Oral	200mg daily for 30days	Help in formation of haemoglobin and red blood cell.	Formation of red blood cells	Abdominal discomfort, diarrhea dark stool	None

Tablet Sulphadoxine pyrimethamine	Anti-malaria and prophylaxis	Orally	3 tablet start from 16weeks intervals/quickening and the rest are taken in 4 weeks til delivery.	Treatment and prevention of malaria.	Prevent malaria in pregnancy	Itching, vomiting, nausea	None
Oxytocin	Oxytocic drug	Intramuscular	10units	Stimulate uterine contractions.	Increase contractions	Hypotension and hyper stimulation	None
Vitamin A	Group A vitamin supplement	Oral	200000unit once daily	Growth development, immaturity and proper sight.	Growth development, prevent infection and blindness	Vomiting	None
Tablet paracetamol	Analgesic	Oral	500mg	Help to relieve pain.	Relieve pain	Liver damage with prolong use	None

PHARMACOLOGY OF DRUG

NAME OF DRUG	CLASSIFICATION	DOSAGE	ROUTE	ACTION AND USE	ACTUAL EFFECT	SIDE EFFECT	SIDE EFFECT EXPERIENCED
Vitamin K	Group K vitamins	1milliliter	Intramuscular	Production of prothrombin which is and clotting	Production of prothrombin that aids in clotting.	Hypersensitive reaction	None
Chloramphenicol eye drop	Antibiotics	2 drops	Instillation	Prevention of eye infection.	To prevent eye infection.	None	None
Oral Poliomyelitis	Antigen vaccine	2 drops	Orally	Production of antibodies.	Baby is under observation.	Diarrhea, fever	None
Injection Bacillus Calmette Guerin	Antigen vaccine	0.05 ml	Intradermal	Production of antibodies and prevention of tuberculosis.	Baby is under observation.	Blister formation and slight fever	Blister was formed

NAME OF DRUG	CLASSIFI-CATION	DOSAGE	ROUTE	ACTION/ USES	ACTUAL EFFECT	SIDE EFFECT	SIDE EFFECT EXPERIENCED
Pneumo Coccal	Antigen	0.5 milligram	Intramuscularly	Vaccinates neonates against pneumonia	Pneumonia prevention	Redness at the side of injection and fever	None observed
5 in 1 vaccine (Pentavalent)	Antigen	0.5 milligram	Intramuscularly	Vaccinates neonates against diphtheria, pertussis (whooping cough), tetanus, hepatitis B, haemophilus influenza type B	Prevention of childhood preventable diseases	Low grade fever	None observed
Rota virus	Antigen	1.5 milligrams (2 drops)	Orally	Prevention of gastroenteritis	Gastroenteritis prevention	None	None observed


WHO Modified Partograph
Registration No.:
Name(Last, First) Stella Bewaa
Age: 27years
Date: 06/12/21 Parity/Gravida P2 / G3 LMP 15/03/21 EDD 06/12/21 Gestation(wks) 40weeks
ROM: 3:00pm Labour Duration (Hrs) 6h 30mins Facility/Clinic Name Arms Hospital
LIQUOR
MOULDING
Alert
Action
SVD @ 5:10pm
Sex - Female
A/S - 8/10, 9/10
Bwt - 2.9kg
BL - 150mls
Peri - Intact
SRM
DESCENT
Plot O
HOURS
TIME
CONTRACTIONS PER 10 MINS
Oxytocin U / L
Drops / minute
DRUGS & IV FLUIDS
BLOOD PRESSURE & PULSE
TEMPERATURE
URINE
Amount
Protein
Acetone

LABOR NOTES

Client G3P2 with gestational age of 40weeks had an SVD @ 5:10pm to alive female infant Im oxytocin 10unit was given to mother after which a second twin was not diagnosed on palpation. Skin to Skin contact was ensured. Active third stage of labour was completed successfully through C.C.T @ within 5:25pm. Essential care done to baby is cleaned nicely. client sustained no tear. Baby and mother are in good condition and made comfortable in bed.

Please circle or write responses.

DELIVERY

DATE: 06/12/2022 TIME: 5:10pm METHOD: Spontaneous / Vacuum Extraction / C/S / Other

PERINEUM: (Intact) / Episiotomy / Laceration

ANESTHESIA: (None) / Local / General

THIRD STAGE

Active Management: Yes / No   Medication: Time 5:11pm Type/Dose Oxytocin 10unit

PLACENTA: TIME: 5:   (Complete) / Incomplete

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

BABY

Weight: 2.9kg

Sex: Male / (Female)

Baby Position: (Vertex) / Breech / Other

APGAR

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

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

FOURTH STAGE MONITORING

Frequency	Time	B/P.	Pulse	Fundus	Bleeding	Bladder
Every 15 minutes first 2 hours	7:00pm	120/70	86bpm	16cm	Small	Emptied
	7:15pm	126/70	78bpm	Contracted	Small	—
	7:30pm	110/80	86bpm	✓	✓	—
	7:45pm	110/80	89bpm	✓	✓	—
	8:00pm	110/80	95bpm	✓	✓	Emptied
	8:15pm	120/70	80bpm	✓	✓	—
	8:30pm	120/70	86bpm	✓	✓	—
	8:45pm	110/70	77bpm	✓	✓	—
Every 30 minutes For 1 hour	9:15pm	110/70	70bpm	✓	✓	—
	9:45pm	120/70	86bpm	✓	✓	Emptied

Birth Attendant Ababio Fosuaa Brempomaa & Bernice Bannor Date 06/12/2022

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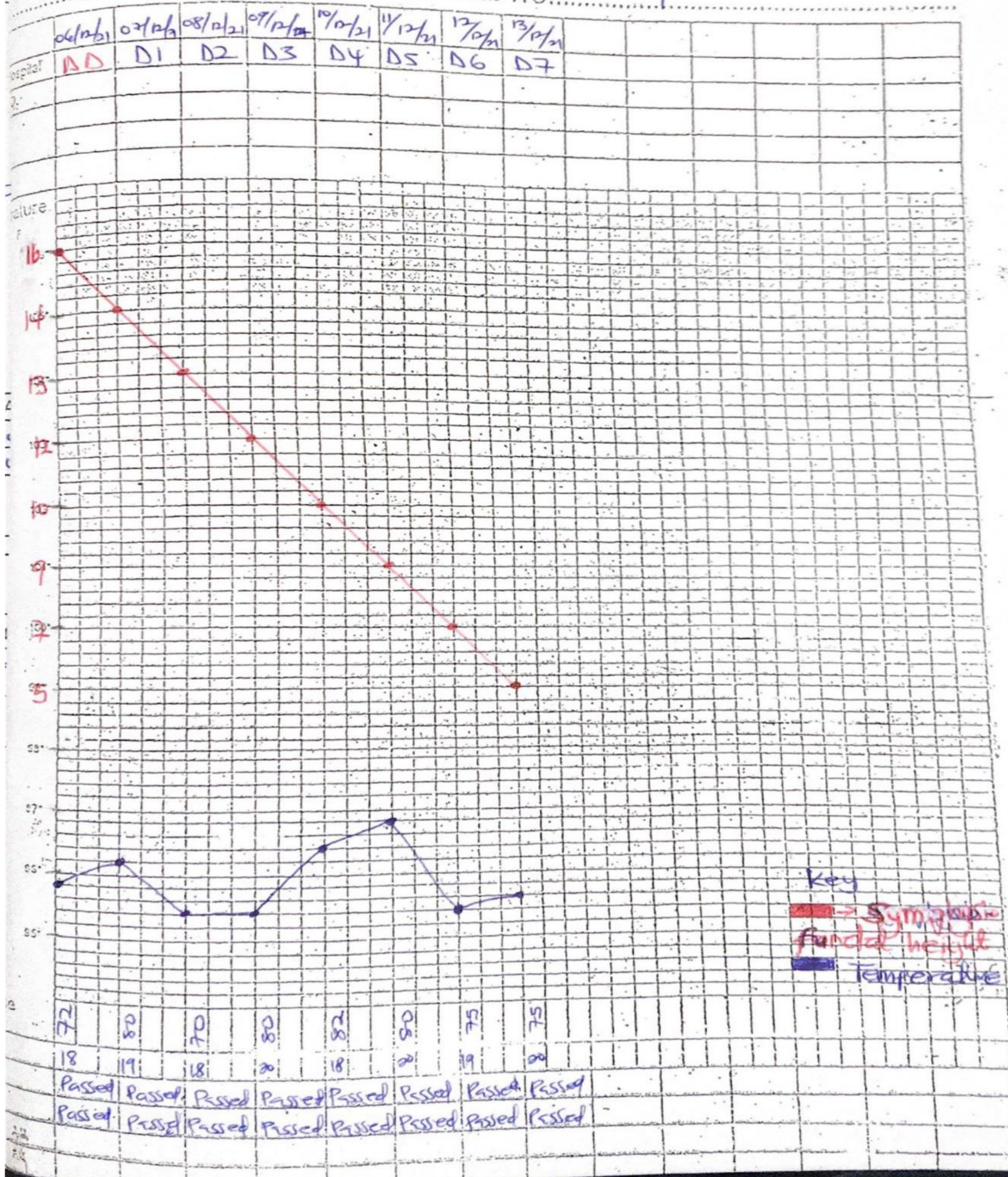
MATERNITY CHART
Stella Bewaa
27yrs
002796/21
WARD: Lying-In
BED NO.: 4
06/12/21 07/12/21 08/12/21 09/12/21 10/12/21 11/12/21 12/12/21 13/12/21
D0 D1 D2 D3 D4 D5 D6 D7
72 80 70 80 82 88 75 75
18 19 18 20 18 20 19 20
Passed Passed Passed Passed Passed Passed Passed Passed
Passed Passed Passed Passed Passed Passed Passed Passed
Key
Symphysis-fundal height
Temperature

NEW BORN EXAMINATION FORM

Name: Baby Adwoa Stella Date of Assessment: 06/12/2021 Time: ______
Date of Birth: 06/12/2021 Time of Birth: 5:10pm Sex: [ ] M [x] F Age at time of Assessment (days/hrs) 1hr
Gestational Age [ ] 40 [ ] Mode of Delivery: [ ] Vaginal Assisted Vaginal C-Section
APGAR: 1min 8/10 5min 9/10 Birth Weight: 2.9 kg [ ] Length: 50 cm Head Circumference: 35 cm
Temperature at time of Assessment: ______ °C Urine passed: Yes No Meconium passed: Yes No
Name of Assessor (Midwife/Doctor): Abagbio Fasuas Brempomaa & Bernice Bannor

1. Respiration
Rate 34cpm
[ ] Rate < 30 b/m *
[ ] Rate < 60 b/m *
[ ] 30-60 b/m
[ ] Retractions *
[ ] Grunting *
[ ] Stridor *

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

3. Tone
[x] Normal
[ ] Floppy *
[ ] Increased *

4. Colour
[x] Pink all over
[ ] Pink body but blue hands/feet
[ ] Blue all over *
[ ] Pale *
[ ] Jaundiced *

5. Cord
[x] Normal
[ ] Red. draining pus
[ ] Bleeding

6. Cry
[x] Normal
[ ] Shrill *
[ ] Absent *

7. Suck
[x] Good
[ ] Weak
[ ] Absent

8. Head swelling
[ ] Caput succedaneum
[ ] Cephalhaematoma
[ ] Subgaleal hemorrhage
[x] No swelling

9. Sutures
[x] Normal
[ ] Overlapping
[ ] Fused
[ ] Widely Separated *

10. Fontanel
[x] Normal
[ ] Sunken *
[ ] Raised *
[ ] Wide (>5cm)*

11. Eyes
[x] Normal
[ ] Subconjunctival bleed
[ ] White pupil or cornea
[ ] Eye discharge
[ ] Other

12. Ears
[x] Normal (size / shape/position)
[ ] Abnormal: ______

13. Mouth
[x] Normal
[ ] Cleft palate
[ ] Cleft Lip
[ ] Other: ______

15. Neck
[x] Normal
[ ] Swelling
[ ] Webbed
[ ] Other: ______

16. Clavicle
[x] Normal
[ ] Swelling/Fracture

17. Chest
[x] Normal (Shape/movement)
[ ] Abnormal ______

18. Heart rate
Rate: 134bpm
[ ] Normal (100-160)
[ ] <100 *
[ ] >160*

19. Femoral pulse
[x] Present
[ ] Not palpable*

20. Abdomen
[x] Normal
[ ] Distended*
[ ] Scarphoid*
[ ] Abdominal defect*
[ ] Maases: ______
[ ] Other ______

21. Back (spine)
[x] Normal
[ ] Abnormal Swelling *
[ ] Hairly patch over spine
[ ] Abnormal dimple
[ ] Abnormal curvature

22. Limbs
[x] Normal
[ ] Abnormal ______

23. Genitalia
Male Genitalia
[ ] Normal
[ ] Undescended testes
[ ] Abnormal meatus
[ ] Hernia
[ ] Other: ______

Female Genitalia
[x] Normal
[ ] Fistula(meconium/urine through abnormal opening in vagina) *
[ ] Large clitoria *
[ ] Other: ______

24. Anus
[x] Patent
[ ] Imperforate*

25. Resuscitation provided
[x] One
[ ] Suction/stimulation
[ ] Bag and mask
[ ] Endotracheal Tube
[ ] Ventilator/CPAP

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

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

LABOR NOTES

Client G3P2 with gestational age of 40weeks had an SVD @ 5:10pm to alive female infant Im oxytocin 10unit was given to mother after which 9 second twin was not diagnosed on palpation. Skin to skin contact was ensured. Active third stage of labour was completed successfully through C.C.T @ within 5:25pm. Essential care done to baby is cleaned nicely. client sustained no tear. Baby and mother are in good condition and made comfortable in bed.

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DELIVERY

DATE: 06/12/2022 TIME: 5:10pm METHOD: Spontaneous / Vacuum Extraction / C/S / Other

PERINEUM: (Intact) / Episiotomy / Laceration

ANESTHESIA: (None) / Local / General

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Active Management: Yes / No · Medication: Time 5:11pm Type/Dose Oxytocin 10unit

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

BABY

Weight: 2.9kg

Sex: Male / (Female)

Baby Position: (Vertex) / Breech / Other

APGAR

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

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

	Frequency	Time	B/P.	Pulse	Fundus	Bleeding	Bladder
FOURTH STAGE MONITORING	Every 15 minutes first 2 hours	7:00pm	120/70	86bpm	16cm	Small	Emptied
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		7:30pm	110/80	86bpm	✓	✓	—
		7:45pm	110/80	89bpm	✓	✓	—
		8:00pm	110/80	95bpm	✓	✓	Emptied
		8:15pm	120/70	80bpm	✓	✓	—
		8:30pm	120/70	86bpm	✓	✓	—
		8:45pm	110/70	77bpm	✓	✓	—
	Every 30 minutes For 1 hour	9:15pm	110/70	70bpm	✓	✓	—
		9:45pm	120/70	86bpm	✓	✓	Emptied

Birth Attendant Ababio Fosuaa Bremponma & Bernice Bannor Date 06/12/2022

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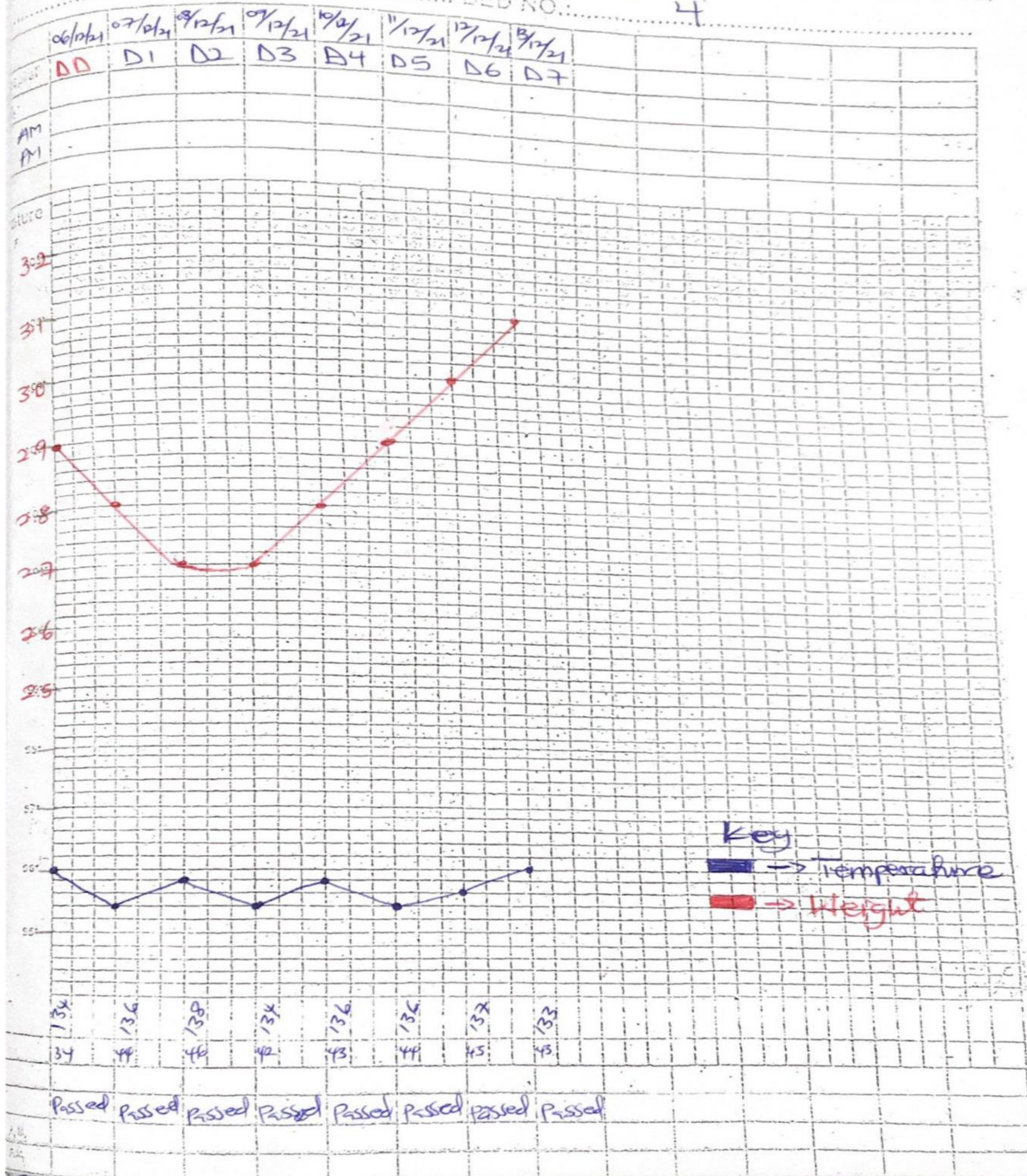

TEMPERATURE CHART
Baby Adwoa Stella
New born
WARD: Lying - In
BED NO.: 4
06/12/21
07/12/21
08/12/21
09/12/21
10/12/21
11/12/21
12/12/21
13/12/21
D0
D1
D2
D3
D4
D5
D6
D7
AM
PM
Key
→ Temperature
→ Weight
134
136
138
134
136
134
134
133
34
44
46
42
43
44
45
43
Passed
Passed
Passed
Passed
Passed
Passed
Passed
Passed

Name: Baby Adwoa Stells No: 002796/21 Birth Weight: 2.9kg

Sex: Female Mother's No: 002796/21 Length: 50cm

Nature of Delivery: Spontaneous Vaginal delivery Diagnosis: Term baby

Date of Birth: 06/12/2021 Time: 5:10pm Date of Discharge: 07/12/2021

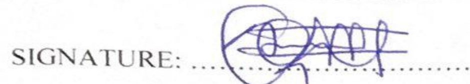
Date	06/12/1																					
No. of Days	D0		D1		D2		D3		D4		D5		D6		D7							
Weight	2.9kg		2.8kg		2.7kg		2.7kg		2.8kg		2.9kg		3.0kg		3.1kg							
Temperature	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM
		36.5°C	36.9°C	36.6°C	36.4°C	36.2°C	36.2°C	36.4°C	36.4°C		36.2°C		36.3°C		36.6°C							
Stools		Passed	Passed	Passed	Passed	Passed	Passed	Passed	Passed		Passed		Passed		Passed							
Urine		Passed	Passed	Passed	Passed	Passed	Passed	Passed	Passed		Passed		Passed		Passed							

Remarks:
Head → NAD
Neck → NAD
Trunk → NAD
Limbs → NAD
Genitalia → NAD

SIGNATORIES

THE STUDENT

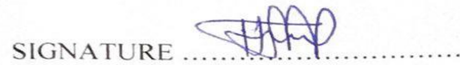
NAME: ABABIO FOSUAA BREMPOMAA

SIGNATURE: 

DATE: 12 – 10 – 2022

THE MIDWIFE IN CHARGE

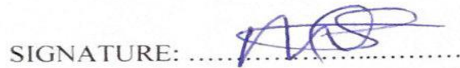
NAME: MS. GRACE YEBOAH

SIGNATURE 

DATE: 13/10/2022

THE SUPERVISOR

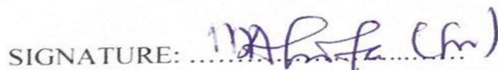
NAME: MARTHA KYEREMAA

SIGNATURE: 

DATE: 13/10/2022

THE PRINCIPAL

NAME: MONICA NKRUMAH

SIGNATURE: 

DATE: 13/10/2022

ACADEMIC CO-ORDINATOR - NURSING
HOLY FAMILY NURSING & MIDWIFERY
TRAINING COLLEGE, BEREKUM