HOLY FAMILY NURSING AND MIDWIFERY TRAINING COLLEGE, BEREKUM.

A CLIENT/ FAMILY CENTERED MATERNITY CARE STUDY ON

MADAM YUSSIF ZULFAWO

BY

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SUBMITTED TO THE NURSING AND MIDWIFERY COUNCIL OF GHANA IN PARTIAL FULFILMENT TOWARDS THE AWARD OF LICENSE TO PRACTICE AS A PROFESSIONAL REGISTERED MIDWIFE

AUGUST 2022

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PREFACE

The client/family centered maternity care study is a systematic approach used in giving holistic obstetrical care to a pregnant woman and her family from the period of antenatal, labour and puerperium. With the new changes in customer needs and patient charter, it helps the student midwife to acquire the right kind of approaches to care for the pregnant woman. Some of these approaches are, explaining procedure to the client to gain the client's consent, providing privacy and getting the family involved in the care. The maternity care study helps the student midwife to acquire knowledge which can be used to solve any problem associated with pregnancy, labour and puerperium. The competence of the student midwife is also tested in the practical aspect through the maternity care study which the student uses to identify both short-term and long-term problems, set objectives for these problems and give intervention that will help her solve them. The main reason for carrying out this care study is to reduce maternal and infant mortality rate and to promote the health of the baby and mother, including the family. It is in this view that the World Health Organization (WHO) develops the partograph in managing the first stage of labor. Using this tool assists the midwife to identify any complication of labor for prompt intervention. The student midwife during this care study gets the chance to use the partograph to enable her to become competent in using it.

Finally, the client/family centered maternity care is an obligation for every final year student midwife as a requirement by the nursing and midwifery council of Ghana in partial fulfillment towards the award of registered midwifery certificate.

ACKNOWLEDGEMENTS

My supreme gratitude goes to our Lord God for his mercy, grace, blessings and gift of life granted me to write this script. My special thanks go to the Principal of Holy Family Nursing and Midwifery training college Berekum, Ms. Monica Nkrumah and also to my Supervisor Mrs. Celestine Ahiawornu, Teaching and Non-teaching Staff of (HFNMTC) especially the Midwifery tutors, I say a very big thank you for your guidance. May God richly bless you. To Madam Yussif and her husband Mr. Seidu and the entire family, I express my endless appreciation. Without them, this study would have never been successful. I thank them for the acceptance, cooperation, love and commitment they showed towards this piece of work. I am very indebted to them. May God bless them abundantly. Also, many thanks goes to the Midwife in- charge of Alice Maternity Home/Clinic and her Staff for their guidance and support during my clinical. Furthermore, a warm appreciation goes to my parents and siblings for their support and encouragement and to my Priest Reverend Father Asamoah Yeboah for his prayers and advice making my completion a success. To all my friends and relatives, thank you a lot and God bless you.

Finally, my sincere thanks goes to the authors and publisher whose books I extracted valuable information to enhance the writing of this script. To all examiners who are going to mark this script and to everyone who helped in one way or the other, I am very thankful

INTRODUCTION

Family centered maternity care study is a learning experience which orientates the student midwife to properly care for the expectant mother throughout her pregnancy, labour and puerperium using the nursing process as systematic approach to nurse the expectant mother involving the family based on a good understanding of the client as a unique individual with specific problems and needs. It is also a learning tool for the student midwife in which she exhibits the knowledge and skills she has acquired during her training.

The care study started on 25th October, 2021 and was carried out on Madam Zulfawo Yussif a 31-year-old pregnant woman, gravida 4 Para 3. She was 37 weeks when she was met at Alice maternity home/clinic during one of her usual antenatal visit and introduction was made and since she was within the criteria, she was picked as client. Client was anxious in the beginning but was relaxed and welcoming after our short interaction.

This care study is in four chapters;

Chapter one includes client's profile, habits of daily living, physical and psycho-social home environment, family, medical, surgical and menstrual histories, past and present obstetric histories are also included.

Chapter two describes the first contact with the client, the first antenatal home visit, her subsequent visit to the clinic and subsequent antenatal home visits and nursing care plan concludes this chapter.

Chapter three contains the admission and management of the first to fourth stage of labour including immediate and subsequent care of the baby and nursing care plan.

Chapter four deals with management of puerperium with emphasis on care of mother and baby, from the day of delivery to the first seven days after delivery and also the second postnatal visit

to the clinic. The problems identified during this period and the nursing care plan terminates this chapter.

It also includes termination of care, summary and conclusion, bibliography, appendices thus, antenatal records, present obstetric history records, laboratory investigations, partograph, post-delivery observation form, mother and baby chart, pharmacology of drugs used for mother and baby and finally signatories.

LITERATURE REVIEW

PREGNANCY

According to Tiran (2008) Pregnancy is the period when the fertilized ovum embeds in the maternal uterus until is born. Is the state from conception to the delivery of the baby; normal duration is 280 days (40 weeks or 9 months and 7 days), counted from the first day of last normal menstrual period to delivery, or 265 days from conception to delivery.

Marshall & Raynor (2014), the uterus plays a remarkable role in pregnancy by stretching and expanding to accommodate the growing fetus. During pregnancy there are changes in woman's emotional state due to hormonal factors, examples of these hormones are progesterone, oestrogen and human gonadotrophin hormone. Some common disorders of pregnancy include nausea and vomiting, breast engorgement, back pain, leg cramp, headache, fatigue and constipation.

Fraser & Cooper (2009), pregnancy is a time of enormous physiological and psychological changes facilitating, adaptation and preparation for birth and transition of parenting. Most women react to the news of being pregnant in a manner relevant to her individual situation.

King et.al (2014), pregnancy is a time of profound anatomic and physiologic change in a woman`s body. In addition to the reproduction organs all maternal physiologic system makes adaptations needed support the developing fetus and at the same time, maintain maternal homeostasis. Pregnancy last approximately two hundred and sixty, six days (266 days) or thirty, eight weeks (38 weeks) from ovulation.

Signs of pregnancy

Possible (presumptive) signs**:** Early breast changes (unreliable in multigravida), amenorrhoea, morning sickness**,** bladder irritability**,** quickening.

Probable signs**:** Presence of human chorionic gonadotrophin (HCG) in urine and blood**,** softened isthmus (Hegar's sign)**,** bluish discolouration of vagina (Chadwick's sign)**,** Pulsation of fornices (Coriander's sign)**,** uterine growth**,** changes in skin pigmentation**,** braxton hicks contractions**,** ballottement of fetus

Positive signs**:** Visualization of gestational sac by transvaginal and transabdominal ultrasound.**,** visualization of heart pulse by transvaginal and transabdominal ultrasound.**,** fetal heart sounds by Doppler and fetal stethoscope**,** fetal movement both palpable and visible.**,** visualization of fetus by X ray.

Konar (2013), during pregnancy, there is progressive anatomical physiological and biochemical change not only confined to genital organs but also to all systems of the body. This is principally a phenomenon of maternal adaption to the increasing demand of the growing fetus. Unless understood, this physiological adaptation to normal pregnancy can be misinterpreted as pathological. There is enormous growth of the fetus during pregnancy. The uterus which in non-pregnant state weighs about 60g with a cavity of 5-10ml and measure about 7.5cm in length, at term, weighs 900-1000gm and measure 35 in length. The capacity is increased by 500-1000 times and changes occur in all part of the uterus. There is increase in growth and enlargement of the body of the uterus. Not only the individual muscle fibers increase in length and breadth but there is limited addition of new muscle fibers. These occur under the influence of the hormones; oestrogen and progestrone limited to the first half pregnancy pronounced up to twelve weeks (12). Three (3) distinct layers of muscle fibers are

evidenced; outer longitudinal, inner-circular and intermediate. Normal anteverted position is exaggerated up to eight (8 weeks). Thus, the enlarged uterus may lie on the bladder rendering it incapable of filling, clinically evident by frequent micturition. Afterwards, becomes erect; the long axis of the uterus conforms more or less to the axis of the inlet.

Konar (2013) states that, there is marked congestion with hypertrophy of the muscle and elastic tissues of the wall. In late pregnancy, the bladder mucosa becomes oedematous due to venous and lymphatic obstruction especially in primigravida following early engagement. Increased frequency of micturition is noticed at 6-8 weeks of pregnancy which subsides after 12 weeks. It may be due to resetting of osmoregulation causing increased water intake and polyuria. In late pregnancy, frequency of micturition once more reappears due to pressure on the bladder as the presenting part descends down the pelvis. Stress incontinence may be observed in late pregnancy due to urethral sphincter weakness. The gums become congested and spongy and may bleed to touch. Muscle tone and motility of the entire gastrointestinal tract are diminished due to high progesterone level. Cardiac sphincter is relaxed and regurgitation of acid gastric content into oesophagus may produce chemical esophagitis and heart burn. There is diminished gastric secretion and delay emptying time of stomach. Risk of peptic ulcer disease is reduced. A tonicity of the gut leads to constipation while diminished peristalsis facilitates more absorption of food materials. Vulva becomes edematous and hyperemic, superficial varicosities may appear especially in multipara. Labia minora are pigmented and hypertrophied. Vagina walls become hypertrophied, edematous and more vascular. Increased blood supply of the Venus plexus surrounding the walls gives the bluish colouration to the mucosa (*jacquemier's sign*). The length of the anterior vaginal wall is increased. The initial softening phase of the cervix is dependent on progesterone, begins at conception and continues until approximately 32 weeks.

Secretion: The secretion becomes copious, thin and curdy white, due to marked exfoliated cells and bacteria. The pH becomes acidic (3.5-6) due to more conversion of glycogen into lactic acid by the *lactobacillus acidophilus* consequent on high oestrogen level. The acidic pH prevents multiplication of pathogenic organisms.

Breast: The changes in the breasts are best evident in primigravida. Increased size of the breasts becomes evident even in early weeks. In late pregnancy, colostrum may leak from the breasts, progesterone causes the nipple to become more prominent.

Cutaneous changes

The distribution of pigmentary changes is selective

- Face (chloasma gravidarum or pregnancy mask): it is an extreme form of pigmentation around the cheek, forehead and around the eyes. It may be patchy or diffuse; disappears spontaneously after delivery.

- Abdomen

- Linea nigra**:** it is brownish black pigmented area in the midline stretching from the xiphisternum to the symphysis pubis. The pigmentary changes are probably due to melanocyte stimulating hormone from the anterior pituitary.
- Striae gravidarum**:** these are slightly depressed linear marks with varying length and breadth found in pregnancy. They are prominently found in the abdominal wall below the umbilicus, sometimes, over the thighs and breasts. Apart from the mechanical stretching of the skin, increase in aldosterone production during pregnancy is the responsible factor.

Marshall & Raynor (2014) however, made emphasis on the aims of antenatal care as to monitor the progress of pregnancy to optimize maternal and fetal health. To achieve this the midwife critically evaluates the physical, psychological and sociological effects of pregnancy on the woman and her family.

The Ghana Health Service (2008), states that antenatal care is the health care and education given during pregnancy and are important since they help prevent complication and promote health care. The number of times a client needs to be seen during pregnancy may vary. For the uncomplicated pregnancy it is recommended that at least four ANC visits should be made according to the following schedule. The objectives of antenatal include:

- To detect and treat high risk conditions arising during pregnancy, whether medical, surgical or obstetric.
- To ensure safe delivery and postpartum health.
- To promote quality care, antenatal care services must be organized in such a manner as to provide comprehensive and individualized care. As much as possible all care activities e.g. history taking, physical examination and treatment, should be provided by the same care provider to the pregnant woman. (Focus Antenatal Care).
- To help prepare the mother to breast feed successfully, experience normal puerperium and take good care of the child physically, psychologically and socially.

Number of Visits: the number of times a client needs to be seen during pregnancy may vary. For the uncomplicated pregnancy it is recommended that at least four ANC visits should be made according to the following schedule:

First visit is from onset of pregnancy up to 16weeks gestation

Second visit is from between the 24^{th} to 28^{th} week of pregnancy

Third visit is from 32nd week of pregnancy

Fourth visit is at 36th week.

The following laboratory and other investigations are done during first visit

- Urine for: Proteins, sugar, midstream specimen of urine for bacteriuria, ova and pyuria (pus cells), pregnancy test to confirm pregnancy (first trimester)
- Stool for: Ova, parasites e.g. worms
- Blood for: Haemoglobin level, sickling, group and rhesus factor, VDRL, HIV (must be accompanied by counselling) then CD4 count if HIV is positive., Hepatitis.

LABOUR

Fraser & Cooper (2009), labour is the process by which the fetus, placenta and membranes are expelled through the birth canal. Normal labour occurs between thirty-seven to forty-two weeks of gestation.

King et.al (2014) states that, labour is the process by which childbirth occurs, requiring uterine contractions of sufficient frequency, duration, and intensity to cause demonstrable effacement and dilatation of cervix. The onset of labour is classically defined as the occurrence of regular painful contraction that promotes dilation of the cervix. Contractions that occur at regular intervals with increasing frequency, duration, and intensity are the hallmark of labour. The onset of spontaneous labour cannot be reliably predicted, although many pregnant women experience premonitory signs or symptoms of impending labour. Common signs and symptoms suggestive of physiologic progress towards labour include descent of the fetus, cervical changes, increase in uncoordinated uterine contractions, rupture membranes, bloody show or

increased mucus discharge from the vagina, maternal perception of increased energy, gastrointestinal distress. The physiologic adaptations during labour are required to support the unique demands imposed on both the woman giving birth and her fetus. Traditionally, the processes involved in labour and birth have been conceptualized as those that affect the power (uterus), the passenger (fetus), and the passage (pelvis).

Marshall & Raynor (2014) described labour as the process by which the fetus, placenta and membranes are expelled through the birth canal. However, normal labour according to World Health Organization (WHO,1999) is defined as, having low risk throughout spontaneous in onset with the fetus presenting by vertex, culminating in the mother and infant being in good condition following birth. Labour for each woman has its own ebbs and flows. Walsh (2010a) describes this as labour rhythms. Labour tends to be described and recognized universally as having distinct stages;

The first stage of labour; is usually recognized by the onset of regular uterine contractions, accompanying effacement and at least 4cm dilatation of the cervix and finally culminates in full dilatation of the cervix. It normally lasts up to 15hours in multiparous woman and may last up to 18 or 24 hours in primigravid woman. First stage of labour is subdivided into 3 phases;

Latent phase of labour may last for 6- 8 hours in primigravida when the cervix dilates from 0 to 4cm and the cervical canal shortens from 3cm long to less than 0.5 cm long.

Active phase which is also dilatation of the cervix from 4cm and in the presence of rhythmic contractions, is completed to 10cm or full dilatation.

The transitional phase is when the cervix is around 8cm dilated until it is fully dilated (10cm).

Marshall & Raynor (2014) further states that in order to provide woman-centered care during labour, the midwife should:

Assess the needs and the expectations of each individual woman regarding labour and birth. Plan care with each woman in other to meet her specific needs and expectations. Put the care plan into practice and evaluate the care given to measure its effectiveness.

Konar (2013), assessment of progress of labour and partograph recording are also done. Partographs are tools that allow labour progress to be graphically recorded and visually assessed. It aids in the early detection of abnormal labour progress and are credited by some for decreasing rates of prolonged labour, oxytocin use, caesarean sections and intrapartum morbidity/mortality as compared to usual care.

Use of the partograph is initiated during presumed active labour. It contains detail about the fetal condition, maternal condition and progress of labour. It also helps the midwife to render quality health care which include monitoring of the fetal heart rate and wellbeing, mothers blood pressure, temperature, pulse, urine output and content to know mother's wellbeing, cervical dilatation and descent of the presenting part to help provide conducive environment for labour.

The second stage of labour begins with full dilatation of the cervix and complete effacement and ends with the complete expulsion of the fetus. It may last for about an hour in first pregnancy.

The third stage of labour starts from the delivery of the baby till the delivery of the placenta and its membranes. It usually last between 5 and 15minutes but any period up to 1 hour may be considered normal.

The fourth stage of labour is a period of observation of both the mother and the baby which is carried out immediately after the complete expulsion of the placenta and membranes up to the first six hours. The baby is properly managed through physical examination monitoring of the

heart rate, respiratory rate, colour or appearance, the reflex activity and muscles tone. It also entails cord dressing and ensuring that baby's condition is stable. The mother is made to rest comfortably and observed for further complications.

PUERPERIUM

Fraser & Cooper (2009), puerperium is the period of six weeks after child birth which begins as soon as the placenta is expelled. During this period, the uterus, other reproductive organs and structures which have been affected by the pregnancy return to their non-pregnant state.

Marshall & Raynor (2014), it starts immediately after birth of the placenta and membranes and continues for six weeks. The uterus and other organs and structures which were affected by the pregnancy return to their non-pregnant state. They further stated that, the provision of midwifery care and support to newly birthed mothers needs to be woman –focused and family oriented. Good communication to explain what is considered to be normal physical, emotional/ psychological, occurrences during the postnatal period will reassure a mother that she is going through a normal physiological process. Care rendered during postnatal includes; giving education on nutrition, family planning and hygiene, head to toe examination of both the mother and the baby, palpating the uterus for signs of involution and inspecting pad for bleeding and lochia.

Konar (2013) states that, lochia is the vaginal discharge for the first fortnight during puerperium. The discharge 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: 5-9 days, the colour is yellowish or pink or pale brownish.

• Lochia alba: 10-15 days, pale white

The average amount of discharge for the first 5-6 days is estimated to be 250ml. Normal duration may extend up to 3 weeks.

Marshall & Raynor (2014), It is essential that midwives offer support and advice on common breast and breastfeeding problems such as engorgement, cracked nipples, mastitis. Engorgement on the postnatal day 3 and 4 is a common problem for most mothers, they are advice to feed on demand, perform breast massage and to take analgesia if necessary. And further states that, afterpains are caused by involution, contractions and usually last for two to three days after child birth. And are mostly resolved with analgesia. Postnatal exercises are encouraged to speed up the healing process and strengthen the pelvis floor and abdominal muscles. Postnatal visits are encouraged to monitor the wellbeing of both the mother and the baby. The National Childbirth Trust (NCT) makes it clear that it is the quality of postnatal care provided to women and their families in the first days and weeks after birth can have a huge impact and affects mothers' and families' experiences of the transition to parenthood.

WHY CLIENT WAS CHOSEN

Madam Zulfawo Yussif G4P3 was first met at the Antenatal clinic on 3rd November, 2021 at Alice maternity home/clinic, Techiman. During interaction with her that morning, when she was being served with her routine drugs, she made some comment which indicated that Madam Yussif had little knowledge on the importance of the routine drugs during pregnancy and do not take her drugs daily. She was given education on the importance of the routine drugs during pregnancy and the need to take them. She was also asked of her gestational age and was told she was in her 37^{th} week. Since client gestation and other information met the requirements of the Nursing and Midwifery Council (NMC) of Ghana needed for the study. An introduction as a student midwife from Holy Family Nursing and Midwifery Training College, Berekum on practical was made and was informed that she would be taken as a client for the study and be monitored for the last days of her pregnancy, labour and puerperium. She was anxious in the beginning but became relaxed after the introduction. Phone numbers were exchange and directions to her house was given for home visit. She was thanked and bid goodbye

CHAPTER ONE

ASSESSMENT OF CLIENT AND FAMILY

1.0 INTRODUCTION

This chapter entails information about client's personal, social, hobbies and lifestyle,

family, medical, surgical, menstrual, present and past obstetric histories.

1.1 PERSONAL AND SOCIAL HISTORY

Madam Zulfawo Yussif G4P3 is a 31-year-old woman who hails from Bawku in the Upper East region of Ghana. She stays at Kenten, house number A163/3 with her husband and three children. Madam Yussif is a Seamstress. She is a Muslim. She is dark in complexion, 170cm tall and weighs 79kg. Client speaks Twi and Mossi with formal education up to Junior high school. Client is married to Mr. Seidu Sulemani who is a Driver and hails from Wa in the Upper West Region of Ghana. Client's next of kin is her husband, Mr. Seidu Sulemani.

1.2. HABITS OF DAILY LIVING / HOBBIES

According to the client, she wakes up around 6:00am to do her household chores. And prepares her children for school and herself for work around 7:00 am to 7 :30am and closes mostly at 5:30pm. She often empties her bowel at least once a day and any time she feels the urge and also urinates often. She takes porridge with bread, boiled or fried yam and stew, "fufu" with groundnut soup, "banku" with okro soup, Tuo zafi ''Green'' soup and many more as meals for breakfast, lunch, and supper respectively. Her favorite meal is "Tuo zafi" ''Green'' soup. She usually takes mashed "kenkey" with bread as snack. She baths at least twice a day. She usually watches television, chat with her neighbors and rest sometimes during her leisure time. Finally, she goes to bed between 8:00pm to 9:00pm.

1.3. FAMILY HISTORY

Her father, Mr. Yussif Adams is a farmer who resides at Bawku in the Upper East region of Ghana. Madam Yussif is the second born of the three children of her parents. She said her family has no known medical history like hypertension, sickle cell disease, heart disease, epilepsy, mental illness etc. in the family. Client also said multiple pregnancies run in the family. Death occurs naturally in their family.

1.4. MEDICAL HISTORY

Madam Yussif has never been admitted at the hospital but has received outpatient department treatment for ailments such as headache, stomach upsets and malaria.

Client said there is no existing condition like hypertension, sickle cell, heart disease, diabetes, asthma, epilepsy, respiratory disease and mental illness. And she has no allergy to any food or drug. Client said she has never drunk alcohol nor smoke before.

1.5 SURGICAL HISTORY

Madam Yussif said she has never undergone any surgical procedure ever since she was born and has also never sustained any injury either through road traffic accident or domestic accident that affected her pelvis, limbs or spine. Upon examination, she had no scar indicating surgical procedure. And have never been transfused before.

1.6 MENSTRUAL HISTORY

Client's had her menarche at the age of 16 and the menstrual cycle is 28 days lasting usually for 5 days. She bleeds moderately without any dysmenorrhea. Client gave her last menstrual period date to be on the 28/01/2021.

1.7 PAST OBSTETRIC HISTORY PREGNANCY

Madam Yussif, gravida 4 para 3 all alive. Her firstborn is a female who is 12 years old, her second born is also a female who is 9 years old and her last born is a male who is 3 years old now. All her pregnancy was at term that is 38 to 40 weeks of gestation before labour was due.

Client said she has had no abortion either induced or spontaneous. During pregnancy, client experienced some minor disorders such as waist and back pains, nausea and loss of appetite. She received her first and second tetanus diphtheria injections and full dose of sulfadoxine pyrimethamine in her past pregnancy.

LABOUR

Madam Yussif had a spontaneous vaginal delivery to her firstborn at the Holy Family Hospital Techiman who cried immediately after delivery and had no complication. Her birth weight was 3.3kg. She also had spontaneous vaginal delivery to her second and third born at Alice Maternity home/clinic at Techiman and they both cried immediately after delivery and had no complication. She also added that she did not labour for more than 18 hours and has no episiotomy or perineal tear. After delivery, placenta and membranes were completely expelled shortly after an injection and blood loss was minimal.

PUERPERIUM

Client claimed puerperium was without any complications such as puerperal sepsis, post-partum hemorrhage or mastitis. She practiced exclusive breastfeeding for 6months and continued with complementary feeds such, weanimix, cereals and other foods taken by the family and usually wean her babies by the age of one year 10 months. Client said her babies received care and immunizations during postnatal visits to the postnatal clinic and child welfare clinic. Client received support from the husband, mother in-law and sister in-law during puerperium. Client practiced artificial method of family planning by using the implant jadelle.

1.8 PRESENT OBSTETRICAL HISTORY

Madam Yussif G4P3 first reported to Alice Maternity Home/Clinic on 28/04/2021 with early cyesis and complained of lower abdominal pains and general body weakness. Client had her

last menstrual period on 17/02/2021. The expected date of delivery was calculated to be 24 /11/2021.

Vital signs checked and recorded as follows.

Temperature	-	36.4degree Celsius
Pulse	-	80 beats per minute
Respiration	-	22 cycles per minute
Blood pressure	-	106/60 millimeters per mercury
Height	-	170 centimeters
Weight	-	79 kilograms

Urine test for protein, acetone and sugar tested negative. Other laboratory investigations were done and recorded as follows;

Hemoglobin level	13.8g/dl
Blood group	O
Rhesus factor	Positive
HIV status	Negative
Hepatitis B	Negative
G6PD	No defect
Sickling	Negative

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

Tablet Folic Acid - - 5 milligrams daily for 30days

Tablet ferrous sulphate - -200 milligrams daily for 30days

Tablet Multivitamin - - milligrams for 30 days

Client said that she was given a mosquito net and also education was given to her on

prevention of malaria, rest and sleep, nutrition, and personal hygiene. Client has been fully immunized against tetanus diphtheria which was confirmed in her antenatal book. She had taken four (4) doses of sulfadoxine pyrimethamine and was a regular attendant at AN

CHAPTER TWO

ANTENATAL CARE

2.0 INTRODUCTION

This chapter provides information about client's visit to the antenatal, care rendered to client and subsequent visits made by the student midwife to client's home. Client's problems were stated and care plan was drawn to provide holistic care.

2.1 FIRST CONTACT WITH CLIENT

The first contact with Madam Yussif was on 3rd November, 2021 at Alice Maternity Home/Clinic Techiman. She came to the Antenatal unit as one of her usual visits. She was given education on the need to take her routine drugs because she was not taking it daily as she was asked to. After which she was asked of her gestational age and was told she was in her 37^{th} week. Introduction was made as a student midwife from the Holy Family Nursing and Midwifery Training College, Berekum who has been assigned to the Maternity home/clinic to find a client who fit the criteria to be used for the client and family centered maternity care study and would like her to be my client. She gladly accepted it. Her antenatal book was taken and she had had seven appointment records already. Self-introduction was made and rapport was established. All details of information and procedures involved in the study were explained to her and she gladly agreed and promised to give all the information needed and the maximum cooperation. The following was her vital signs checked that morning and the care provided at the antenatal unit. The records of which were as follows:

Temperature - 36.5 degrees Celsius

Pulse - 85 beats per minutes

Respiration - 22 cycles per minute

Blood pressure - 100/60 millimeters of mercury

Weight - 87 kilograms.

Her midstream urine and blood sample were taken to the lab for further investigations

Haemoglobin level	12.3 grams per decilitre
Urine for protein and sugar	Negative

The procedure for the head to toe examination was explained to her and she was asked to empty her bladder. As the equipment's for the examination was already set in the palpation room. Privacy was provided and client was assisted to undress herself for the head to toe examination. She first sat on the bed and laid left laterally before assuming a supine position. Permission was first sort from the client before the procedure was carried out. Hand washing was done with soap under running water and was dried.

GENERAL PHYSICAL EXAMINATION

A tray comprising of the following items;

A sterile gallipot with sterile cotton wool swabs with a lid

A receiver for used cotton wool swabs

A tape measure

A fetal stethoscope

A watch with a second hand

A pen and client's folder.

HEAD TO TOE EXAMINATION

Head and neck

Hair; was examined for cleanliness, lice, dandruff, ringworm, alopecia, scalp infection and no abnormality was detected. Client was congratulated for keeping the hair clean and encouraged to keep it up. The face; was inspected for edema, rashes and chloasma and nothing abnormal was detected. Her eyes were also inspected for pallor of the conjunctiva, yellowish or jaundice of the sclera but no abnormality was detected. The ears were also inspected for discharges and alignment with the eyes and nothing abnormal was detected. The mouth was inspected for dryness, cracks and infections of the lips. The gums and tongue for pallor, sores, and lesions and the teeth for decay but no abnormalities were detected. She was encouraged to brush her teeth two times daily and rinse her mouth after each meal. The neck was palpated for enlarged thyroid gland, distended neck veins and enlarged lymph nodes and nothing abnormal was detected.

Breast

Both breasts were exposed to check for size, shape and condition of the skin. One breast was covered and was asked to put the hand 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 of the breast, nipples were squeezed gently for fluid (colostrum) for odor or blood and cleaned with cotton wool swab. On examination, both breasts were almost equal in size with areolar and no lymph nodes and lumps detected. Client was encouraged on the need to perform self-breast examination regularly as it helps in early detection of any abnormality. Client was encouraged to wear well- fitting braziers to support the breast and enhance comfort. Chest Was observed for breathing pattern.

Extremities

The upper and lower extremities were checked for tingling sensations, stiffness, edema, and varicosities. Palms and soles were checked for pallor. Nails were examined for cleanliness, capillary refill and cyanosis. And no abnormality was detected no extra digits.

Abdominal examination

Client was asked to empty her bladder if she has the urge, then abdominal examination was started by robbing hands together in order to help prevent premature induction of contraction.

On inspection

The shape of the abdomen was ovoid with no scars or rashes. Linea nigra and striae gravidarum were present. Fetal *movement was obviously noticed.*

Measurement of the abdomen

Upon measuring the Symphysio-fundal height, the xiphisternum and upper boarder of the symphysis pubis were located. The zero mark of the measuring tape was placed on the fundus and extended along the uterus and then extended to the symphysis pubis. The Symphysio-fundal height was 36 centimeters and gestational age was 37 weeks.

On Fundal palpation

Facing the head end of client, palms were rubbed for warmth and fundal palpation was done with both palms curved inwards at the fundus of the uterus. Through the process, it was detected that the buttocks of the foetus were occupying the fundus.

Lateral palpation

On lateral palpation still facing the woman, the palms were place on either side, with one hand stabilizing one side of the maternal uterus, the other hand in a rotary movement to locate the fetal back. This was repeated at the other side and the fetal limbs were felt at the left side. The position of the fetus therefore was occipito-anterior.

Pelvic palpation

On pelvic palpation, the lower pole of the abdomen is just palpated. Client was asked to bend her knees slightly in other to relax her abdominal muscles and take a deep breath through her mouth. The sides of the uterus just below the umbilical level are grasped without causing any discomfort between the palms. The fingers are held together downwards and inwards, a hard mass with a round outline was felt which indicates the fetal head.

Descent

The anterior shoulder was located during palpation, upon locating the symphysis pubis with the ulna boarder just above the symphysis and anterior shoulder. Five fingers occupied the space indicating descent of $5/5^{th}$.

Auscultation

The fetoscope was warmed by rubbing it on the palms. The fetoscope was placed at the area where the back was located to listen to the fetal heart rate which was been compared with the maternal pulse to prevent wrong readings. Fetal heart was 140 beats per minutes. Client was asked to lie on her left side and stand up and was given a seat to sit down.

Vulva examination

Permission was sought to inspect her vulva. Client's vulva was inspected, before the examination the light was turned on and directed towards the genital area for clear view. Hands were washed and dried then gloves were worn. The labia, clitoris and the perineum were checked, they had no abnormalities such as edema, rashes, warts or blisters and there was no female genital mutilation and no abnormal discharges were seen. The gloves were removed after the examination. Education was given on birth preparedness and complication readiness, diet, prevention of malaria and personal hygiene. She was encouraged to report to the clinic when she detects any abnormality. Findings were communicated to client and recorded. She was informed of her next visit to the clinic. The intention of visiting her house was made known to her and direction to her house was shown as phone numbers were exchanged and appointment was also booked to visit her in her house. A date which was scheduled for the home visit was on 6th November, 2021.

Her routine medications were given to her as follows;

Tab folic acid 5mg daily for 7 days

Tab ferrous sulphate 200mg daily for 7 days

Tablet multivitamin 200mg daily for 7 days was given.

She was encouraged to take the drugs as prescribed. Client was further asked if there is any problem and she complained of experiencing pains in her lower abdomen, fatigue and heart burns. She was reassured and was told that the pain at the lower abdomen was as a result of the foetal head descending into the pelvis. She should also reduce the intake of spicy foods and have enough rest. Client was reminded

again, of the next visit to the clinic which was 10st November, 2021.She was thanked for cooperation and was escorted.

2.2 SUBSEQUENT VISIT TO ANTENATAL CLINIC

On 10th November 2021, Madam Yussif came to the clinic as scheduled around 9am. She was welcomed and offered a seat. Vital signs were checked and recorded as follows;

Temperature - 36.4 degree Celsius

Blood pressure - 100/60 millimeter per mercury

Pulse - 84 beats per minutes

Respiration - 22 cycles per minutes

Weight - 87 kilograms

Client's midstream urine and blood sample was taken to the lab for further investigations. Results are as follows;

Blood for hemoglobin level - 12.5g/dl

Urine for sugar and protein - Negative.

Physical examination from head to toe was done and nothing abnormal was detected. Abdominal examination was done, and the abdomen looked globular. Fetal movements were noticed.

On palpation, the fundal height was 36cm with 38weeks gestation. The lie was longitudinal, presentation was cephalic and a descent of 5/5th above the pelvic brim.

On auscultation, the fetal heart rate was 133bpm with regular rhythm and good volume. Client was thanked and helped off the examination bed and then assisted to dress up and a seat was

given to her. All findings were communicated and documented in her maternal health record book. Client complained of constipation and was encouraged to take in enough fluid, foods rich in fiber and fruits to aid in bowel movement. She was given education to take in foods rich in iron like green leafy vegetables, palm oil plantain to help increase the hemoglobin level. She was asked about her previous complains and she stated that she is following the advice given. Client's routine drugs were given. These were as follows;

Tablet folic acid 5mg daily for 7 days

Tablet ferrous sulphate 200mg daily for 7 days

Tablet multivitamin 200mg daily for 7 days

Next appointment day was communicated to her as 17th November, 2021 to report before the scheduled date if she encounters any challenge or experience the signs of labour taught. Madam Yussif was escorted

2.3. FIRST ANTENATAL HOME VISIT

The first visit to Madam Yussif's house was on 6th November 2021, which was on Thursday at 11:40 am as scheduled. The main aim of the visit was to observe the environment, source of water, light, ventilation, number of people she shares her room with, where she disposed her refuse and her interpersonal relationship with her family members and neighbors. And also, how she was doing. Client's house is about 12 minutes' drive from the clinic but the road is rough and untarred. Madam Yussif came to meet me at the roadside and took me to her house. She welcomed me and offered me a seat. The house is located close to Zen filling station Techiman- Kenten and is near the road side.

PHYSICAL ENVIRONMENT

Client lives with husband, children and other tenants in the house.

The house was built with blocks and plastered with cement, roofed with aluminium sheet and painted in two colors. The top was painted with peach and below was colour green. It has eight rooms with bathroom and toilet located outside the house. Their source of water is the pipe borne water which is located near the house. Client cooks in front of her room since she has no kitchen. There is a large space in front of the house used for domestic purposes. According to Madam Yussif, the dust bin is emptied every morning after sweeping the environment. Permission was asked to go to her room and was granted. The room was well kept with sofa chairs and table arranged neatly in the room, client was congratulated and asked to keep it up. The room had two small windows which makes ventilation poor, she was advised to open the windows for fresh air and always arrange the room neatly to ensure good air circulation in the room. In the room, they had a wooden bed with an insecticide treated net hanging loosely over it, Madam Yussif, was encouraged to sleep in it with the family every night. Their clothes were nicely folded in her wardrobe and their source of light was a florescent light. The backyard was well cleared and tidy. Client was advised on the use of antiseptic solution in and on the toilet seat before using, since she was at risk of urinary tract infection, and also to wash the hands with soap under running water after visiting the toilet and touching objects. Madam Yussif, was asked about the preparations towards delivery and layette was inspected, everything on the delivery list was intact except cot sheet which was not enough and was advised to get additional cot sheet to add up. The rest of the items were neatly arranged in a traveling bag. She said she had a blood donor and her husband was a taxi driver so there was no problem for transportation in case emergency arises. Education on the signs of true labour which were, painful regular and rhythmic uterine contractions, blood stained mucoid discharge thus show from the vagina,

rupture of membranes was given. Client was encouraged to visit the clinic immediately any of these signs are experienced and take her drugs as prescribed. Client was further asked if there is any problem and she complained of experiencing pains in her lower abdomen, fatigue and heart burns. She was reassured that the lower abdominal pains was due to the advance stage of pregnancy, encouraged to ensure enough rest during the day and educated to reduce the intake of spicy foods. A day was scheduled for the next visit, and that was on 13th November, 2021. She was thanked and bid good bye.

PSYCHOSOCIAL ENVIRONMENT

Madam Yussif, her husband, her children and family have a warm relationship with each other. She has a warm and friendly relationship with her neighbours and other relatives who stay around her area. Client said she do not have a lot of friends but usually visits the few friends she has at her leisure and convenient time and they also visits her sometimes. She is really cheerful, free and does not find it difficult making new friends. She also added that she has respect for everyone who comes her way being it a child, age mate or the elderly. She indeed loves everyone unconditionally client said. She also added she attends every social gathering in her community when given invitation. Client was congratulated and was asked to keep it up.

2.4 SECOND ANTENATAL HOME VISIT

On 13th November 2021, the second home visit was made. The main aim of the visit was to know how client and family are doing and to remind client on birth preparedness and complication readiness. On arrival, the client gave a smiling welcome and a seat was offered. Client was asked how she was faring and a quick introduction was made to the family since they were all around. Inspection was made on the required items for delivery and everything was intact. Education was given to them on the importance of family bonding especially between children and the unborn baby to prevent sibling rivalry, the need to practice exclusive

breast feeding after birth was also made. Client complained of increased frequency of micturition and explanation was given as a normal physiology during the later part of pregnancy. It was further explained that the fetal head exerts pressure on the bladder which causes increased urination.

Client said her husband and sister in law would be the helpers to the clinic if labour commences. Education was given on the signs of true labour and was encouraged to report as soon as those signs are noticed. She was also encouraged to take her routine drugs daily. Madam Yussif and her husband were thanked. Permission was sought to leave and client was told to call anytime she sees any signs of labour or if any problem occurs.

2.6. NURSING CARE PLAN DURING ANTENATAL CARE

PROBLEMS IDENTIFIED

Client complained of;

Lower abdominal pains

Fatigue

Heart burns

Constipation

Increased frequency in micturition.

SHORT TERM OBJECTIVES

Client will be able to cope with lower abdominal pains within 24 hours and throughout her period of pregnancy

Client energy will be restored within 24 hours.

Client will be relieved of heartburns within 48 hours.

Client will restore her normal bowel movement within 48 hours.

Client will be able to cope with increased frequency of micturition within 24 hours

LONG TERM OBJECTIVE

Client will stay healthy throughout her pregnancy period without any complication.

NURSING CARE PLAN DURING ANTENATAL CARE

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVE	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUA-TION	SIGN
03/11/2021 11:40am	Lower abdominal pains related to pressure exerted by the presenting part.	Client will be able to cope with lower abdominal pains within 24 hours and throughout pregnancy as evidenced by; 1. Client verbalizing she is able to cope with pains. 2. Midwife visualizing that that client is able to cope with the pain.	1. Explain to client the cause of lower abdominal pain. 2. Educate client to wear low heel shoes and sandals. 3. Educate client to assume sitting position when performing activities.	1. Cause of the lower abdominal pain was explained to her. 2. Client was educated to wear low heel shoes and sandals. 3. Client was educated to assume sitting position when performing activities	04/11/2021 7:30pm	Goal was fully met as evidenced by client verbalizing that the pain has reduced.	SAH

			4. Encourage client to have enough rest during the day and night. 5. Encourage client to adopt a comfortable position when sitting or lying down	4. Client was encouraged to have enough rest during the day and night. 5. Client was encouraged to adopt a comfortable position when sitting or lying down.			

NURSING CARE PLAN DURING ANTENATAL CARE CONTINUES

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVE	NURSING ORDERS	NURSING INTERVENTIONS	DATE/ TIME	EVALUA-TION	SIGN
03/11/2021 11:40am	Fatigue related to advanced stage of pregnancy	Client energy will be restored within 24 hours as evidenced by; 1. Client verbalizing her endurance to routine activities.	1. Educate client to ensure enough rest 2. Educate client's family members to assist in the household chores. 3. Encourage client to rest and sleep in between activities to conserve energy. 4. Encourage client to plan her daily activities and prioritized them individually to reduced workload.	1. Client was educated to ensure enough rest 2. Client was educated to allow family members assist in the household chores. 3. Client was encouraged to rest and sleep to conserve energy. 4. Client was encouraged to plan and prioritize her daily activities to reduce workload.	04/11/2021 11:30am	Goal was fully met as evidenced by client verbalizing her endurance to routine activities.	SAH

		2. Midwife visualizing client's ability to rest in between activities.	5. Encourage intake of foods rich in protein, iron minerals and carbohydrates to boost energy level.	5. Client was encouraged to take in foods rich in protein, iron, minerals and carbohydrate.			

NURSING CARE PLAN DURING ANTENATAL

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVE	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
03/11/2021 11:40am	Gastrointestinal reflux related to physiological process of late pregnancy.	Client will be relieved of heartburns within 48 hours as evidenced by; 1. Client verbalizing that she has been relieved of heartburns. 2. Midwife visualizing that; client is	1. Educate client to avoid bending over immediately after eating. 2. Educate client to sit when doing household chores. 3. Educate client to avoid spicy and oily foods. 4. Encourage client to eat small amount of meals at frequent intervals.	1.Client was educated to avoid bending over immediately after eating 2. Client was educated to sit when doing household chores. 3. Client was educated to avoid spicy and oily foods. 4. Client was encouraged to eat small amount of meals at frequent interval and avoid over eating.	05/11/2021 12pm	Goal was fully met as evidenced by client verbalizing that the heartburns have been reduced.	SAH

		adhering to management measures.	5. Educate client to eat early and rest for some time before bedtime.	5. Client was educated to avoid going to bed immediately after eating.			

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVE	NURSING ORDERS	NURSING INTERVEN-TIONS	DATE/ TIME	EVALUATION	SIGN
10/11/2021 11:40am	Altered bowel movement (constipation) related to deficient peristaltic movement in the gastro intestinal tract secondary to hormonal influence (progesterone)	Client's normal bowel movement will be restored within 48 hours as evidenced by; 1. Client verbalizing that she is able to pass stools once daily.	1. Encourage client to take at least 3 litres of water daily. 2. Educate client to take in roughages and fiber diet. 3. Encourage client to do exercise such as walking or sweeping. 4. Encourage client to empty her bowel anytime she feels the urge to.	1. Client was encouraged to take at least 3 litres of water daily. 2. Client was educated to take in roughages. 3. Client was encouraged to do exercise such as walking or sweeping. 4. Client was encouraged to empty her bowel anytime she feels the urge to.	12/11/2021 12:00pm	Goal fully met as client was able to pass stool once daily	SAH

		2. Client's sister in law verbalizing client passing stool once a day.	5. Educate client to take in lukewarm water early in the morning before meals.	5. Client was educated to take in lukewarm water in the morning before meals.			

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVE	NURSING ORDERS	NURSING INTERVEN-TIONS	DATE/ TIME	EVALUATION	SIGN
13/11/2021 11:40am	Frequency of micturition related to descent of the presenting part.	Within 24 hours, client will understand the physiology behind frequency of micturition and cope with it throughout pregnancy. As evidenced by client	1. Reassure client 2. Explain the physiology of frequency of micturition to her. 3. Encourage client on the need to keep vulva clean and wear cotton under wears. 4. Educate client to limit fluid intake before bedtime.	1. Client was reassured 2. The physiology of frequency of micturition was explained to the client. 3. Client was encouraged on the need to keep vulva clean and wearing of cotton under wears. 4. Client was educated to limit fluid intake to avoid sleep disturbance.	14/11/2021 11:45am	Goal fully met as client verbalized that she has now understood why she is urinating frequently and will	SAH

		verbalizing her ability to cope. 2. Client's sister in law verbalizing client's ability to cope with frequent micturition.	5. Encourage her to have a pail close to her bedside when sleeping.	5. Client was encouraged to use a pail at night rather than walking a distance to urinate		try to cope with it.	

CHAPTER THREE

LABOUR

3.0 INTRODUCTION

This chapter talks about the care rendered to the client during labour which includes; management of first and second stage, immediate care of baby at birth, active management of third stage, delivery and examination of placenta and membranes, examination of baby, management of fourth stage and summary of labor.

3.1. ADMISSION AND MANAGEMENT OF FIRST STAGE OF LABOUR

On Tuesday,16th November 2021 around 2:10pm, Madam Yussif came to the clinic with husband and sister in law. They were welcomed and offered a seat. Client complained of having lower abdominal pains and hardening of the abdomen which was uterine contractions which started around 7:00am in the morning. She said the pains were becoming very strong and that she couldn't bear them anymore.

On assessment client was seen to be in pain but was coping with it as seen in her facial expression and was anxious. She was then taken to the first stage room and offered a bed, she was asked if she had eaten anything and the answer was yes and she was further asked of the food eaten and according to client she ate rice and stew in the morning around 9am. Client's antenatal book was taken and glanced through for previous history and gestational age which was 38 weeks plus 6 days. Client was given a bedpan and was asked to urinate in whenever she had the urge to. A bed was prepared and she was assisted to change her clothing. Baby's layette was checked again (because it was first checked during home visit) and everything was intact. She was asked to empty her bladder for which she did to help with the decent of the foetal head. Urine was straw in color and measured 150 mls. Midstream urine sample was taken to test for protein and sugar and it all recorded negative. Prior to the procedure of examination,

client was given an explanation on the procedures to be performed and also consent was sought from her before performing any procedure.

The following are the results of her vital signs taken during admission;

Temperature - 36.2 degree Celsius

Pulse - 87 beats per minute

Respiration - 24 cycles per minute

Blood Pressure - 130/70 millimeters per mercury

She was then assisted into a supine position and provided with privacy as well. After hand washing, head to toe examination was done under the supervision of the in-charge and no abnormalities were detected. Her face was a bit tensed because of the painful contractions.

ABDOMINAL EXAMINATION

On abdominal inspection

The abdomen was ovoid with the presence of striae gravidarum and linea nigra.

Measurement of the abdomen

The Symphysio fundal height was 36cm and gestational age of 38 weeks+6 days.

On abdominal palpation

On fundal palpation, the softness broadness showed the fetal buttocks, laterally the right side of the abdomen was smooth and curved which indicated the back of the fetus whilst the left side of the abdomen felt rough indicating the limbs of the fetus. The lie was longitudinal, pelvic examination revealed a hard mass which indicated that the presentation was cephalic. The descent was $3/5^{th}$.

On auscultation; the fetal heart beat was 148 beats per minute and uterine contractions of 2 in 10 minutes lasting for 42 seconds.

Vaginal examination

Consent was sought from Madam Yussif at 2:24pm to perform vaginal examination to determine the dilatation of the cervix. Procedure was explained to client to allay anxiety and she agreed. A tray was set containing a sterile glove, a gallipot with sterile cotton wool swabs and another gallipot containing savlon, a sanitary pad and a receiver. Client was helped to assume a lithotomy position and was draped. Hands were washed thoroughly with soap under running water, hands were dried and sterile gloves were worn. The vulva was inspected and nothing abnormal was detected. The vulva was then swabbed with five sterile cotton wool swabs soaked in savlon solution.

The vulva was swabbed from labia majora to minora, and then the vestibule using a different swab each time. She was then sensitized (touched) on the inner thigh to notify her that vaginal examination was about to be performed. On vaginal examination, the vagina was warm and moist. The cervix was soft, thin and the presenting part well applied to it. The cervical dilatation was 5 centimeters. The membranes were intact and moulding of +. The sacral promontory was not reached and the ischial spines were blunt. She was cleaned and a pad was applied to the perineum. Hands were thoroughly washed and dried. The findings were communicated and explained to client by showing her the dilatation board and recorded it on the partograph.

PREPARATION FOR BIRTH

In preparing for birth a skilled and an unskilled helper were identified. Client's sister in law served as an unskilled helper, she was told she would be called in case she was needed, the midwife in – charge served as the skilled helper to assist in caring for both mother and baby.

The emergency plan which included transportation in case of any referral was made ready. Telephone numbers of the receiving facility was on the wall of the labour ward. The area for delivery was prepared closing the windows to provide privacy. The mother's hands and chest were cleaned to prepare for skin to skin care when labour was imminent. The lamp was tested to check if it was working, an emergency lamp was also ready, and the environment for delivery was also cleaned. The ambubag and mask were tested and they were in good shape for use. Client was informed that her time of delivery was getting near and she should be ready. Client was then told to lie on her left side to enhance placental blood flow to the fetus, she was also told to urinate whenever she had the urge to empty her bladder since it would help in the decent of the fetal head. Client was encouraged to do deep breathing exercise when pain commenced and she was not to bear down. She was reassured and was told that the discomfort was due to the engagement of the fetal head. Client was given sacral massage to restore her comfort. Client was sweating so she was encouraged to take in enough fluid and IV ringers' lactate 500mls was given to prevent dehydration. Fetal heart, contraction, and pulse were checked and recorded every 30 minutes. Vaginal examination, decent of fetal head and blood pressure were monitored four hourlies. Temperature was also

recorded two hourlies. At 2:30pm, Uterine contractions was 2 in 10 minutes lasting 42 seconds, fetal heart rate 141bpm, maternal pulse 84bpm and temperature of 36. 2^{o} c.

At 4:30pm, Uterine contractions was 3 in 10minutes lasting for 42 seconds, fetal heart rate was 140bpm and maternal pulse was 82bpm, whiles temperature was recorded as 36.7^{o} c. She also complained of hunger. Her sister in law bought her some porridge and she ate all. Later client was seen touching her perineum with ungloved hands. She was then advised to avoid such practice as she is introducing infections into her body. At 6:30pm; Uterine contractions was 4 in 10minutes lasting 50 seconds, fetal heart rate was 146bpm and maternal pulse was 82bpm,

whiles temperature was recorded as 36.3^{o}c. The next vaginal examination was also done which indicated that the cervical os had dilated for 9cm and to rule out cord prolapse as there was spontaneous rupturing of membranes that time. Descent was 1/5th fetal skull moulding was ++, blood pressure was 120/80mmHg. She was assisted to lie on her left and breathe through her mouth since she was complaining of severe pains. Fetal heart was confirmed by the midwife on duty heart rate was 146bpm. She complained of bearing down around 7:08pm. Vaginal examination was done to confirm full dilatation of the cervix. Then client was encouraged to breathe through her mouth. It was explained to Madam Yussif that the cervix was fully dilated and was confirmed by vaginal examination of 10cm and moulding of ++, descent 0/5th and her baby would soon be delivered. Delivery trolley already set was pushed to client's bedside to conduct delivery.

The top shelf contained the following items

Sterile delivery packs containing;

Two artery forceps

Four clean towels

Two gallipots with cotton wool swab and gauze respectively

One cord scissors

Episiotomy set

Sterile gloves

Lower shelf containing

Perineal pads

Receiver for placenta

Measuring jug

Syringe and needle

Receiver for used swabs

Identification band

2 urethral catheters of different sizes

Urine bag

Fetoscope

Antiseptic lotion

Oxytocin

Bed pan

Mackintosh

Three clean cot sheets

Cord clamp

A drug tray containing injection Oxytocin, Lidocaine, water for injection, injection vitamin K, and Chloramphenicol eye drop.

3.2. MANAGEMENT OF SECOND STAGE OF LABOUR

The second stage of labour starts from full dilatation of the cervix (10 centimeters), to the delivery of the fetus. Madam Yussif was assisted to assume the lithotomy position which she chose with her legs well supported on the bed. Catheter was passed to empty her bladder and a clear amber urine of about 100mls was drained. Protein and sugar were tested which recorded

negative respectively. Protective clothes were worn and hands were washed with soap and water then dried with a clean towel. Sterile gloves were put on and delivery pack was opened. The perineum, pubis and upper thighs were cleaned with savlon solution. Clean towel was used to drape the abdomen and another was placed under the buttocks. Fetal heart rate was also checked to assess the wellbeing of the fetus and recorded as 138beats per minutes. Vaginal examination was done again to confirm full dilation and then client was asked to bear down with contractions and rest in between. A clean perineal pad was applied to the perineum to support it. As soon as the head advanced, fingers were placed on the occiput to maintain flexion to allow the smallest diameter to distend to prevent damage to the pelvic floor tissues and the vagina as well as to prevent rapid expulsion of the head. After crowning, she was told to stop bearing down as the head was delivered slowly by extension as the sinciput, face and chin swept the perineum. The baby's eyes were cleaned with moist sterile gauze from the inner canthus out, to prevent infection to the eyes. The mouth was suctioned first to prevent liquor aspiration followed by the nostril with the bulb syringe. The neck was felt for cord around to prevent neonatal asphyxia and there was none. Then waited for restitution of the head to occur to indicate the shoulders are in anterior posterior diameter with the pelvic outlet followed by external rotation of the head. The anterior shoulder was delivered by downward traction and posterior shoulder by upward traction. The rest of the body was delivered by lateral flexion unto the mother's abdomen at 7:25pm and she was congratulated. The abdomen was then palpated to exclude undiagnosed twins but there was none. 10 units of oxytocin injection was given intramuscularly on the lateral side of the woman's thigh.

IMMEDIATE CARE OF THE NEW BORN

The baby was cleaned thoroughly and was then placed skin to skin on the abdomen to promote bonding. The baby and mother were covered with clean cloth to prevent hypothermia and

promote warmth. The baby's cord was clamped with artery forceps at 2cm and 3cm away from umbilicus and cut in between the two forceps after pulsations had ceased 3 minutes after the birth of the baby, the cord was covered with a piece of gauze to prevent splashing of blood. Baby was shown to the mother to identify the sex which was a female child. An identification band was placed on the baby's wrist with the sex, mother's name and time of delivery and she was placed on the mother's abdomen and covered with a warmth cot sheet. Baby's Apgar score assessed at first one minute of birth was 8/10 and then five minutes after birth was 9/10.

3.3. MANAGEMENT OF THE THIRD STAGE OF LABOUR

After delivery of the fetus, the uterus was palpated to rule out any undiagnosed second twin after which 10 units of oxytocin was given intramuscularly on the thigh. The bladder was emptied by passing a straight catheter and urine was estimated to be 100mls.The soiled delivery pad was changed to make her comfortable.

A sterile receiver was placed at her perineal region to receive the placenta and membranes. The non-dominant hand was placed on the fundus to feel for contraction of the uterus. The cord was re-clamped nearer to the perineum with one artery forceps. The cord and artery forceps were held with the dominant hand. As soon as the uterus contracted, the non-dominant hand was removed and placed just above the symphysis pubis with the palm facing the abdomen of the mother to provide counter traction to prevent uterine inversion during removal of the placenta. At the same time, the dominant hand that held the clamped cord was pulled gently in a downwards traction. With steady controlled cord traction, the process was repeated until the placenta was visible at the vulva. The placenta was held with the two hands, and was gently turned until the membranes were twisted. The placenta was then pulled slowly. The time of delivery was noticed as 7:32pm. The placenta was examined briefly for completeness and abnormality. The uterus was rubbed to expel clots to initiate contractions. The cervix, vaginal

walls and perineum was cleared and inspected for lacerations and tears but none was found. She was taught how to massage her uterus and monitor blood loss. She was tidied up and a clean perineal pad was placed at the vulva and she was accompanied to the 4th stage room and made comfortable in bed. She was once again congratulated.

EXAMINATION OF THE PLACENTA

A thorough inspection of the placenta and membranes was done in order to ensure no part of it have been retained during its delivery. The placenta was held by the cord allowing the membranes to hang loosely downwards. The cord was of normal size and shiny and was centrally inserted with one big vein and two arteries surrounded by Wharton's jelly. The fetal surface was shinny and smooth with its color being 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. Through inspection, the color was dark red and the cotyledons were intact. There were no infarcts or extra lobes on the maternal surface and neither was it edematous. It was then disposed off appropriately.

The working surface was wiped with 0.5% chlorine solution and decontaminated the delivery instruments in 0.5% chlorine solution for 10 minutes, washed with soap, rinsed, allowed to air dry and packed into the autoclave for sterilization. Findings were recorded on the labor ward sheet, delivery book and summary of delivery in the antenatal booklet. The partograph was also completed.

3.4. MANAGEMENT OF THE FOURTH STAGE OF LABOUR

Fourth stage of labour is a period of first six hours following delivery of the placenta and membranes. It also includes the care and close monitoring of the mother and baby. Uterus was felt for contractions and her vital signs together with bleeding were monitored every 15 minutes for 2 hours, 30 minutes for 1 hour, 1 hourly till the end of the 6 hours. The baby's condition

was checked alongside with monitoring of the mother. There was no bleeding from the cord and no other abnormality was detected. Madam Yussif's first post-delivery vital signs were checked at 7:55pm and was recorded as;

Temperature	-	36.6 degree Celsius
Pulse	-	85 beats per minute
Respiration	-	23 cycle per minute
Blood pressure	-	120/70 mmHg
Lochia	-	Red
Symphysio - fundal height	-	17cm

She was encouraged to empty the bladder frequently to prevent postpartum complications such as postpartum hemorrhage, massage her uterus and monitor blood loss. Client passed urine measuring 85 mls. She was educated on personal hygiene and exclusive breastfeeding. Vital signs were checked and recorded on the partograph.

Mother and baby were made comfortable in a bed after the third stage. Hands were washed with soap under running water to prevent infection. The eye of the baby was cleaned and chloramphenicol eye drop was administered to protect the eye against infection such as ophthalmia neonatorum. The cord was also dressed using 6 cotton wool swabs soaked with methylated spirit.

Mother was educated to wash hands before and after breast feeding baby.

EXAMINATION OF THE BABY

Head to toe examination

Head to toe examination of the newborn was done in the presence of the mother. The procedure was explained to the mother and consent was sought. Hands were washed and gloves were worn. The baby was placed on a clean warm surface and the part being examined was exposed at a time.

Head and neck;

The head was examined for shape and size, fontanels, overriding of bones at sutures, any edematous swelling and lacerations. The circumference was then measured by encircling the head with a tape measure from the occipital protuberance to the supra orbital ridges. The eyes were clear with no redness. The ear was examined and the cartilage of the two ears was well developed. The nose was inspected for size, shape, presence of polyps and the septum to detect if there was any deviation. The mouth was checked for cleft lip and palate by using the little finger to feel the palate, the gums for presence of false teeth and the tongue for tongue tie. Suckling and rooting reflexes were also checked. The neck was examined for congenital goiter and rigidity, swelling or any growth but no abnormality was detected.

Chest;

With the examination of the chest, inspection was done to check shape, movement of the chest wall, grunting respiration and sternal retraction. The breast was palpated for masses, the position of the nipple and extra nipple were checked but everything was normal. The apex heart beat was also checked and recorded.

Upper Extremities

The upper extremities were inspected for extra digits, webbing, missing digits, hands and arms for symmetry, movement, paralysis, number of palmer creases, shape and color of nail beds and also grasping and moro reflexes were checked.

Abdomen;

The abdomen was inspected for shape, size, and distension and palpated for enlarged spleen and liver, the cord for bleeding and number of vessels. The bowel was auscultated for bowel sounds, palpated for tone and distention. The bladder was palpated for masses and tenderness.

External Genitalia;

The external genitalia were examined for patency. The anus was also checked for patency as baby passed meconium and urine.

Lower extremities;

The lower limbs were also examined and no abnormality was detected.

Posterior trunk;

The baby was turned on his back with the head turned to one side and the spine was checked for presence of any swelling, dimples, hairy patches, spinal bifida and meningocele.

Skin;

The skin was examined for color, rashes, birthmark and peeling. In all there was no abnormality found. The length, head circumference, weight and temperature of the baby were taken and recorded. Finally, injection vitamin K 1.0mg was given on the right thigh of the baby to prevent

hemorrhagic disease of the new born. Vital signs were also checked and the findings were communicated to the mother and documented as follows:

Head circumference - 32 centimeters

Length - 49 centimeters

Weight - 3.0 kilogram

Temperature - 36.5 degree Celsius

Respiration - 43 cycles per minute

Pulse - 125 beats per minutes

SUMMARY OF LABOUR

Date and time for delivery	16th November, 2021 at 7:25pm
Time of expulsion of placenta and its membranes	7:42pm
Blood loss	120millilitres
Mode of delivery	Spontaneous vaginal delivery
Drugs (Oxytocin)	10units

DURATION OF LABOUR

1st Stage	5 hours
2nd Stage	17 minutes
3rd Stage	7 minutes

Total time	5 hours, 24minutes

Condition of Mother After Delivery

Temperature	36.6 ^{o}c
Pulse	87bpm
Respiration	22cpm
Blood pressure	120/70mmHg
Uterus	Well contracted
Symphysio fundal height	17cm
Perineum	Intact
Lochia	Red

SUMMARY OF BABY AFTER BIRTH

Sex	Female
Birth weight	3.0 kilograms
Pulse	125 beats per minute
Respiration	45 cycle per minute
Temperature	36.4 degree Celsius
Length of the baby	49 centimeters
Head circumference	32 centimeters
Meconium	passed
Urine	Passed

Baby’s condition was satisfactory.

Apgar Score

Apgar	First Minute	Fifth Minute
Appearance	2	2
Pulse	2	2
Grimace	1	1
Activity	1	2
Respiration	2	2
Total	8/10	9/10

3.5. NURSING CARE PLAN FOR LABOUR

This includes problems identified during labor, nursing diagnosis, short term objectives, long term objectives and care plan for labor.

PROBLEMS IDENTIFIED

Client complained of lower abdominal pains

Client was anxious

Client complained of painful uterine contractions

Client was sweating excessively

Client was seen touching her perineum with ungloved hands

SHORT TERM OBJECTIVES

Client will cope with lower abdominal pains within 6 hours and throughout labour,

Client will be less anxious within 2 hours and throughout labour.

Client will be able to cope with uterine contractions within 2 hours and till delivery.

Client will be relieved of excessive sweating within an hour.

Client will be free from infection within 72 hours and throughout labour.

LONG TERM OBJECTIVE

Client will go through labour and deliver safely without any complications to her and the baby.

NURSING CARE PLAN DURING LABOUR

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVE	NURSING ORDERS	NURSING INTERVENTIONS	DATE/ TIME	EVALUA-TION	SIGN
16/11/21 5:00pm	Lower abdominal pains related to painful uterine contractions in labour.	Client will cope with lower abdominal pains within 6 hours and throughout labour as evidenced by; 1. Client verbalizing that she is coping with the pain.	1. Explain the cause of the pain to her. 2. Encourage deep breathing exercise when there are contractions. 3. Give sacral massage to client. 4. Provide diversional therapy.	1. Cause of pain was explained to her. 2. She was encouraged to perform deep breathing exercise. 3. Sacral massage was given frequently to client. 4.Client was engaged in a conversation.	16/11/21 11:30pm	Goal was met as client verbalized that she is coping and midwife observed client adopted coping mechanism.	SAH

		2. Midwife visualizing client adopting good coping mechanisms.	5. Allow client to assume a comfortable position and walk about if she wants to, for relief.	5. Client was allowed to assume a comfortable position and walk around if she wanted to, for relief.			

NURSING CARE PLAN DURING LABOUR

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVE	NURSING ORDERS	NURSING INTERVENTION	DATE /TIME	EVALUATION	SIGN
16/11/21 5:00pm	Anxiety related to unknown outcome of labour	Client will be less anxious within 2 hours and throughout labour, as evidenced by; 1. Client being able to relax and cooperate during procedures.	1. Explain all procedures involved to client. 2. Sit by client and engage her in conversation to bring out her questions and answer appropriately. 3. Involve relatives to give emotional support to the woman.	1. All procedures involved were explained to client. 2. I sat by client and engaged her in conversation to bring out her questions and answered appropriately. 3. Client's relatives were involved to give emotional support to the woman.	16/11/21 7:00pm	Goal fully met as client was no more anxious and cooperated during labour procedures.	SAH

		2. Midwife visualizing that client is able to relax.	4. Encourage her to voice out all her needs and fears. 5. Tell client about progress of labour and congratulate her.	4. Client was encouraged to voice out all her needs and fears. 5. Client was informed about progress of labor and was congratulated.			

NURSING CARE PLAN DURING LABOUR

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVE	NURSING ORDER	NURSING INTERVENTIONS	DATE/ TIME	EVALUA-TION	SIGN
16/11/21 5:00pm	Painful uterine contractions related to physiological involvement of labour	Client will be able to cope with painful uterine contractions within 2 hours and till delivery as evidenced by 1. Client verbalizing she is coping 2. Midwife visualizing client abiding the education given.	1. Reassure client that the pain is temporal. 2. Educate her on the physiology of the pain. 3. Teach client how to perform deep breathing exercise. 4. Encourage client to ambulate. 5. Educate her to assume a comfortable position but harmless.	1. Client was told that the pains will help her baby to be delivered. 2. Patient was educated on the physiology on the pain 3. Client performed deep breathing exercise during uterine contractions. 4. Client walked around the ward. 5. She was educated to assume a comfortable but harmless position.	16/11/21 7:00pm	Goal fully met as client reported she was coping and midwife observing the client performed deep breathing exercise during contractions.	SAH

NURSING CARE PLAN DURING LABOR

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVE	NURSING ORDER	NURSING INTERVENTIONS	DATE/ TIME	EVALUA-TION	SIGN
16/11/21 5:00pm	Excessive sweating related to painful uterine contraction	Client will be relieved of excessive sweating within an hour time as evidenced by; 1. The midwife observing that the excessive sweating has reduced. 2. By the client verbalizing reduction of sweating	1. Open nearby windows for air to circulate. 2. Give sips of cold water to client. 3. Mop her face and body with a clean damp towel 4. Change bed linen when wet to make her comfortable. 5. Switch on nearby fans to encourage ventilation.	1. Nearby windows were opened for air to circulate. 2. Client was given a water to sip. 3. Client's face and body was mopped with a clean damp towel. 4. Client's bed linen was changed when wet to make her feel comfortable. 5. Nearby fans were switched on.	16/11/21 6:00:pm	Goal fully met as midwife observed the excessive sweating has reduced.	SAH

NURSING CARE PLAN DURING LABOUR

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVE	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
16/11/21 5:00pm	Potential for infection related to client's poor hygiene practices.	Client will be free from infection within 72 hours and throughout labour as evidenced by; 1. Client showing no signs and	1. Educate client on the importance of practicing good personal hygiene. 2. Educate client on how to dispose of used pads. 3. Place sanitary pads at easy reach for client.	1. Client was educated on the importance of practicing good personal hygiene. 2. Client was educated on how to dispose of used pads. 3. Sanitary pads were placed at easy reach for client.	19/11/21 5:00pm	Goal fully met as evidenced by client not showing signs of infections	SAH

		symptoms of infection. 2. Midwife visualizing client has no signs of infection such as fever.	4. Encourage client to change soiled pads always. 5. Encourage client to wash the hands before and after changing soiled pads	4. Client was encouraged to change soiled pads always 5. Client was encouraged to wash her hands before and after changing soiled pads.			

CHAPTER FOUR

PUERPERIUM

4.0 INTRODUCTION

This chapter comprises of the day of delivery, postnatal home visits, first and second postnatal visit to the clinic.

4.1 MANAGEMENT DURING PUERPERIUM

Madam Yussif and her baby were sent to the lying-in ward after the third stage. They were made comfortable in bed. Their conditions were monitored closely and she was encouraged to have good sleep. At 8:15pm, mother was assessed for bleeding and blood loss was 50mls, her lochia was red and the flow was normal. The uterus was firm and well contracted with Symphysio-fundal height being 17cm. Her vital signs were checked and recorded as follows;

Temperature -36.8 degree Celsius Pulse

- 82 beats per minute

Respiration - 22 cycles per minute

Blood pressure - 120/80mmHg

Lochia - rubra

Vital signs were checked every 15 minutes for 2 hours, 30 minutes for 1 hour and hourly for the last 3 hours. On examination, no abnormality was detected. She was encouraged to empty her bladder frequently to prevent postpartum hemorrhage and also change her perineal pad when soaked to prevent infection. She was asked to massage the uterus by rubbing the palm on the fundus to help in the involution of the uterus and arrest hemorrhage. At 8:35pm, client complained of lower abdominal pain and she was served with 1g of tablet paracetamol to help relieve pain. She was educated to breastfeed exclusively on demand and wash hands before

breastfeeding baby. She breastfed her baby after which her husband and sister in law came to congratulate her. Client was left to rest.

SUBSEQUENT CARE OF THE BABY

The baby was allowed to be with the mother for some hours. After that period the mother was informed about the need for thorough head to toe examination to exclude any abnormality and birth injuries to the baby. A set up tray containing the following (sterile gallipots with cotton wool, swabs, cord ligature, cord scissors, receiver, warm towel, tape measure and gloves, plastic apron, good light source and normal saline) and weighing scale were sent to the examination table for the procedure. This was done in the presence of the mother. The nearby windows were closed to make the room warm to prevent the baby from hypothermia. My hands were washed and dried before. The baby was placed on a covered flat surface, and exposed only the part of the body to be examined. The moro, suckling and rooting reflexes were present. Her general appearance and cry were normal, colour was pink, no skin rashes, lesion, peeling or birthmarks were noticed. There was vernix caseosa and lanugo present on the baby.

HEAD TO TOE EXAMINATION

Head and neck;

The head was examined, and the size and shape were normal, no caput succedaneum or lacerations were noticed. The sutures were not wide and fontanelles were not bulging or sunking and pulsation was also good. The eyes were examined and they were normally situated. There was no redness, discharge, hemorrhage or jaundice. The ears were normally situated with the pinna well formed with no discharge. The nose was also situated in the center of the face and septum well formed. The nostrils were inspected and there was no discharge. There was no cleft palate or harelip notice on the mouth, no false teeth and tongue tie were seen in the

mouth. The neck was examined and found to be flexible. No congenital goiter, swelling and growth were detected.

Chest;

The chest was examined for shape and no abnormality was detected. Breast was palpated for consistency engorgement and masses but none was noticed. The nipples were at their normal position and no extra nipple and fluid were seen.

Upper extremities;

The upper extremities were examined and hands were of the same length. There was no extra or missing digits, clubbing or webbed fingers. The nail bed and the grasping reflex were present.

Anterior trunk;

The abdomen was inspected and there was no distention. No liver and spleen were palpable. The cord was not bleeding and it has three vessels in it.

External genitalia and lower extremities;

The external genitalia were examined and there was no abnormality detected the lower extremities were examined, legs and feet were of the same length. There were no missing digits webbed or clubbed feet and forefoot abduction.

Posterior trunk;

The back was also checked for any swelling, dimples or hairy patches and missing vertebra but no abnormality was detected. The hip was checked the Barlow's test for developmental hip dislocation was done and nothing abnormal was detected. The findings of the examinations

were communicated to the mother and no abnormalities were detected. Vital signs were checked and recorded as;

Temperature - 36.5 degree Celsius

Respiration - 44 count per minutes

Weight - 3.0kilogram

Length - 49 centimeters

Head circumference - 32 centimeters

BABY'S FIRST BATH

Baby was given her first bath after six hours of delivery. Procedure was explained to client. Trolley was set and pushed to client's bedside containing

Top Shelf contained

Methylated spirit in sterile galipot

Sterile cotton wool swabs and gauze in a galipot

Sterile water in a galipot

Bottom shelf

Baby's towel and baby's diapers

Baby's dress

Surgical gloves

Cot sheet to wrap the baby

Baby's sponge

Soap in a soap dish

Disposable gloves

Jug of hot water

Jug of cold water

A bowl for mixing water

Kidney dish for used gauze and swab

A receptacle for used water

Mackintosh apron

The procedure was explained to the mother on how to bath the baby and all items to be used were assembled. Plastic apron was worn. Hands were washed with soap and dried and gloves worn. Cold and hot water were mixed and temperature tested with elbow. Baby was placed on a protected flat surface and undressed after which she was wrapped with a cot sheet. Baby was not over exposed to prevent hypothermia. Client was asked to be present and observed so that when they go home, she will repeat the same process till cord falls off. Baby was placed on a clean cot sheet and started with the cleaning of the eyes, this was done with two cotton wool wet in sterile water, the inner cantus was cleaned to the outer cantus and the face was cleaned with clean dumped towel. The head was also bathed, supported with one hand and thumb and index finger of the same hands were also used to plug the ears to prevent water from entering. The head was washed with soapy sponge, rinsed and dried. Baby was then exposed; the arms and front trunk were washed. Baby was turned with hand supporting one arm and chest and the baby resting in the elbow and the back of the body was bathed. Baby was immersed in the bath of warm water with the head above the water and rinsed. Baby was dried

with a clean towel paying attention to the skin folds. Hands were washed and gloved with surgical gloves using an aseptic technique. The ligature was observed for looseness and relegated. The stem of the cord was held with one swab soaked in methylated spirit. The skin was swabbed 5cm away from the base of the cord. The base of the cord was cleaned with a fresh cotton wool swab. The stem of the cord was swabbed from the base upwardly in strokes to the tip. The cord was exposed and baby sent to mother. Findings were communicated to the mother. Shea butter was smeared on the baby's skin, hair combed and diaper was put on. Baby was well dressed and wrapped in a clean cot sheet again and handed over to the mother to breast feed. Client was advised not to cover the cord with diapers and also to change wet diapers frequently to prevent infection. She was advised to top and tail the baby till the cord falls off before proper bathing.

4.2 FIRST DAY POSTNATAL AND DISCHARGE

On 17th November, 2021 which marked the first day of post delivery, client and her baby looked healthy with no abnormality detected after head to toe examination was done.

Their vital signs were checked and recorded as;

MOTHER

Temperature	36.4degree Celsius
Pulse	84 beats per minutes
Respiration	23 cycles per minutes
Blood Pressure	110/70mmHg
Fundal Height	16cm
Breast	Lactating

BABY

Temperature	36.4^{o}c
Apex heart beat	135 beats per minutes
Respiration	42 cycles per minutes
Weight	3.0 Kg

Permission was sought from client to perform a quick assessment on her and was granted. On palpation, the uterus was well contracted. The perineal pad was inspected with lochia being red (rubra) and in small amount and not offensive. She was encouraged to change her pad frequently to prevent ascending infections to the uterus. She was encouraged to breastfeed baby exclusively and on demand. Permission was sought to examine the baby. Hands were washed with soap and dried with clean dry towel. On general examination there was no abnormality detected. The cord was checked for bleeding and discharge but there was none. The baby passed meconium and urine which was normal. The baby was dressed and put to breast. Client was educated on the effect of hot compress application on baby's head in other to close fontanels and was discouraged from doing so. She was educated on provision of warmth and prevention of infection. The mother and the baby were reassessed with no abnormality detected. She was encouraged to wrap baby well to maintain his temperature, and to breastfeed baby exclusively for six months on demand especially in the night, mother was encouraged to feed baby every 2 to 4 hours or 8 to 12 times per day, and also on how to recognize and manage some common breast problem such as cracked nipple, breast engorgement, and mastitis. She was also encouraged not to apply anything on the cord aside the methylated spirit that will be given to her. Client was encouraged to have enough rest and perform post-natal exercise.

Madam Yussif and family were informed about her discharge. Some routine drugs were given to her and the dosage and time for taking the drug were explained to her. Client was informed of continuity of care for seven days where she would be visited at home. She was assisted in packing her things and was encouraged to register the baby at the birth and death registry. Client was encouraged to send baby for immunization at the reproductive and child health clinic. Client was discharged home at 11:00am with the following drugs;

Tablet folic acid	5mg once daily for 7days.
Tablet paracetamol	1g twice daily for 3days.
Capsule Amoxicillin	500mg tds x 7days
Tablet ferrous sulphate	200 mg once daily for7 days.

4.4. FIRST DAY POSTNATAL HOME VISIT (2ND DAY OF DELIVERY)

On 17th November, 2021, on the evening after the discharge, Madam Yussif and her family were visited at 5:30pm. The purpose of the visit was made known as to support her and the baby during postnatal period to prevent complications to them. She had already taken her bath and was well dressed. Head to toe examination was done on her after the procedure had been explained to her and no abnormality was detected. The lochia was rubra (red) and was moderate with no offensive smell. Her vital signs were checked and recorded as;

Temperature	36.1
Pulse	80bpm
Respiration	20cpm
Blood pressure	110/80mmHg
Lochia	Rubra

Uterus	contracted
Breast	lactating

Permission was sought from the mother to top and tail the baby with warm water. Afterwards, the cord was dressed with methylated spirit and cotton wool swabs and left it opened while mother was sitting close watching the procedure. The procedure was explained to her and the baby was physically examined from head to toe but no abnormalities were detected. There were no swellings or bruises on her head or body. Her skin colour was pink all over. The breathing pattern was normal. After the procedure, mother told me that the baby passed meconium stool and urine. She was then encouraged to change diapers frequently. The baby's vital signs were checked as;

Temperature	36.6 degree Celsius
Apex heart rate	130 beat per minute
Respiration	45 cycles per minute
Cord	clean and not bleeding
Colour	pink
Suckling	good

She complained of lower abdominal pain during breastfeeding, she was encouraged to continue breastfeeding and was reassured that the pain will subside as it is normal after delivery

4.5. SECOND DAY POSTNATAL (3RD DAY OF DELIVERY)

Client and her family were visited again on the 18th November, 2021, third day post-delivery in the house. In the morning and evening to assess their general condition and progress of their health. Permission was sought from the mother to performed general examination on her and baby after the procedure was explained to her. Madam Yussif was given education on personal

hygiene, balanced diet and to continue with the exclusive breast feeding. Client was thanked and permission was sought to leave and it was granted.

She was reminded that she will be visited the next day. Permission was sought to leave.

MOTHER

VITAL SIGNS	MORNING	EVENING
Temperature	36.4ºC	36.3ºc
Pulse	82bpm	80bpm
Respiration	20cpm	20cpm
Blood pressure	110/60mmHg	120/70mmHg
Lochia	Rubra	Rubra
Fundal height	15cm	15cm
Uterus	contracted	Contracted
Breast condition	lactating	Lactating

BABY

VITAL SIGNS	MORNING	EVENING
Temperature	36.3	36.4
Apex heart rate	140bpm	138bpm
Respiration	49cpm	44cpm
Weight	2.9kg	_
Cord	Shrinking	Shrinking
Suckling	Good	Good

Stool colour	Dark green	Dark green
Colour	Pink	Pink

VITAL SIGNS	MORNING	EVENING
Temperature	36.8 degree Celsius	36.7degree Celsius
Apex heart rate	132 beats per minute	135 beats per minute
Respiration	46 cycles per minute	43 cycles per minute
Cord	Shrinking	Shrinking
Suckling	Good	Good
Stool colour	dark green	dark green
Colour	Pink	Pink
Weight	2.8 kilograms	-

4.6. THIRD POSTNATAL HOME VISIT (4th day of delivery)

On 19th November 2021, in the morning and evening a visit was paid to Madam Yussif and family, they were all in good health. She was examined from head to toe. She complained of cracked nipples and she educated to continue breast feeding and also apply freshly expressed breast milk onto the nipples after breast feeding the baby. Both baby and mother's vital signs were checked and recorded morning and evening respectively below.

VITAL SIGNS	MORNING	EVENING
Temperature	36.6degree Celsius	36.8degree Celsius

Pulse	81 beats per minute	85 beats per minute
Respiration	20 cycles per minute	20 cycles per minute
Blood pressure	110/70 mmHg	110/70 mmHg
Fundal height	14cm	-
Lochia	Rubra	Rubra
Uterus	Contracted	Contracted
Breast condition	Lactating	Lactating

4.7 FOURTH POSTNATAL HOME VISIT (5th day of delivery)

Client and family were visited on 20th November, 2021 at 7:00am. The aim of the visit was to know how they were doing. The main motive of the visit was made clear to them. Permission was asked to conduct a head to toe examination and it was granted.

Head to toe examination was done and there was no abnormality detected on the client, perineal pad was inspected for lochia and the flow was moderate, pink in color (serosa) and not offensive. Findings recorded as follows;

Temperature	36.5 degree Celsius
Pulse	80 beats per minute
Respiration	22 cycles per minute
Blood pressure	110/80 millimeters of mercury
Lochia	Serosa
Uterus	Contracted
Fundal height	13 centimeters
Breast condition	Lactating

Baby was topped and tailed by the client under supervision. Baby's cord was dressed with methylated spirit and it looked dried and about to slough off, and baby was dressed nicely and wrapped in white cloth and made comfortable in bed.

Baby was assessed and the observations was recorded as follows;

Temperature	36.8 degree Celsius
Apex heart rate	132 beats per minute
Respiration	42 cycles per minute
Cord	shrinking
Suckling	good
Stool colour	Yellowish brown
Colour	pink
Weight	2.8 kilograms

Client was encouraged on good and enough breastfeeding during the day and to ensure the atmosphere is calm at night this will enable the baby to sleep at night and can also rest. Client was also advised to sleep in the afternoon when the baby too is asleep.

4.8. FIFTH POST NATAL HOME VISIT (6TH Day of delivery)

At 7:30 am on 21st November, 2021, client was visited once again. On arrival, Madam Yussif was brushing her teeth. The rest of the family members were asked how they were doing and they responded they were fine by God's grace. Her sister in law had already started with the baby bath so she was supervised in the process and the stump of the cord was dressed with methylated spirit and kept in a cot sheet.

On observation, it was noticed that there were heat rashes on baby's back. Client confirmed that she has been over packing baby at night because the ceiling fan is always on at night. Permission was asked to perform head to toe examination and was granted. Permission was sought for the examination to be carried out and nothing abnormal was detected. Her perineal pad was inspected and lochia was serosa with moderate flow and odorless. The perineum and vulva were clean and the Symphysio fundal height was taken. Vital signs checked and was recorded as follows:

Mother's vital signs

Temperature	36.4 degree Celsius
Pulse	85 beats per minute
Respiration	19 cycles per minute
Blood pressure	100/80 millimeters of mercury
Lochia	Serosa
Uterus	contracted
Fundal height	12 centimeters
Breast condition	Lactating

Baby's vital signs

Temperature	36.6 degree Celsius
Apex heart rate	120 beats per minute

Respiration	44 cycles per minute
Cord	off and clean
Suckling	Good
Stool colour	Yellowish brown
Colour	Pink
Weight	2.9 kilograms

Findings were communicated to her. she was then asked if she had any complains or concern but there was none. She breastfed baby till she slept. She was educated on proper and regular hand washing before changing of pad when soiled to prevent infection. She was encouraged to wash underwear and dry them in the sun and not in the room. She was advised to change baby's diapers regularly when wet and was educated on vulva toileting.

4.9 SIXTH POSTNATAL HOME VISIT (7th day of delivery)

Client was visited at 8:00am on 22nd November, 2021. On arrival, client and husband were eating, so seat was offered. Afterwards the aim of my visit was made clear. Her husband was excused and we entered her room. Permission was asked to perform head to toe examination and no abnormality was detected. Fundus was measured and perineal pad was checked and the flow was slight and no offensive smell. Client said that she had normal bowel and bladder function. She was encouraged to continue with the postnatal exercise to hasten the involution of the reproductive organs. She was also encouraged to continue to sleep under a treated mosquito net with the baby to prevent malaria. According to her, she was helped with house chores by the family and as a result she never was tired during the day and therefore had enough time to rest. Her husband was encouraged that, though exclusive breast feeding was a natural method of family planning, it would only last for a short period and so they had to visit a family

planning unit at six weeks to start with a modern and preferred method. Baby was soundly sleeping, a quick head to toe examination was made and no abnormality was detected. Client's assessment and vital signs done were recorded as follows;

Temperature	36.4 degree Celsius
Pulse	84 beats per minute
Respiration	20 cycles per minute
Blood pressure	110/60 millimeters of mercury
Lochia	serosa
Uterus	contracted
Fundal height	11 centimeters
Breast condition	lactating

Baby's assessment done and was recorded as follows;

Temperature	36.6 degree Celsius
Apex heart rate	136 beats per minute
Respiration	41 cycles per minute
Cord	off with clean stump
Suckling	Good
Stool colour	Yellowish
Colour	Pink
Weight	3.0 kilograms

4.10 SEVENTHDAY POSTNATAL HOME VISIT (8th day of delivery)

On 23rd November,2021 at 9:30am was the last visit to Madam Yussif's house. Client was doing well with baby and the entire family. All procedures to be carried out were explained. Hands were washed and examination from head to toe was done but no abnormality was detected. Her symphysio fundal height was measured as 10cm. Lochia was inspected and it was pink in colour (serosa) with no odour. The breast was soft and was lactating very well. Vital signs were checked and recorded and observations as,

Temperature	36.8 degree Celsius
Pulse	80 beat per minute
Respiration	20 cycles per minute
Blood pressure	110/70 millimeter of mercury
Breast	Well Lactating

The baby was examined and client supervised to bath and dress the stump of the cord which was done perfectly.

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

Temperature	36.7degree Celsius
Apex heart beat	138 beat per minute
Respiration	42cycle per minute
Stool	Yellow
Weight	3.1kg

The baby was dressed and handed over to the mother for breastfeeding. Emphasis was made on her perineal care and the intake of nutritious diets as well as avoiding the use of hot application on the fontanels. Client was encouraged to continue exclusive breastfeeding for 6

months. It was further explained that, exclusive breastfeeding could serve as a family planning method. She was also educated on the positions she can assume during breastfeeding, keeping her back straight when breastfeeding the baby in a sitting position to prevent back pain. Mother was reminded of the postnatal visit to the clinic and its importance. Client was told to report to the hospital when there was any problem as soon as possible and also made her aware that, the day was the last visit to her house, Madam Yussif together with the entire family was thanked for their cooperation. Client and her family also expressed their heartfelt gratitude after which goodbye was said.

4.11 FIRST POSTNATAL VISIT TO THE CLINIC

On the eighth day, 24th November, 2021 at 9:25am Madam Yussif and baby accompanied by her sister in law arrived at the clinic for postnatal care. Client was neatly dressed and looked cheerful. They were welcomed and given a seat.

Health educations on nutrition, immunization against preventable childhood diseases and family planning as well as care of the baby were given. Client was asked about her condition and that of the baby and she said they were doing well.

Client said her baby was able to feed well and passes urine and stools regularly. Permission was sought from client to examine the baby generally. Permission was granted and the procedure was explained to her.

The baby was taken, undressed and then wrapped with a clean cot sheet and placed on a flat surface for the examination in the presence of the mother. Baby's weight was 3.2kg. There were skin rashes detected on the baby however there were no discharges from the eyes, nose and ears. No discoloration of the mucus membranes, palms, eyes, conjunctiva and feet were observed during inspection. Baby's abdomen was not distended and the umbilical stump was almost healed.

The baby's vital signs was checked and recorded as follows;

Temperature	36.4^0 C
Apex beat	143 beats per minutes
Respiration	50 cycles per minutes
Weight	3.2 kilograms
Head circumference	32 centimeters
Baby length	49 centimeters

The baby was neatly wrapped before she was given back to the client sister in law. The findings were communicated to the mother.

Madam Yussif was advised not to over dress the baby so as to prevent the rashes on the baby's skin from becoming worse. Client was examined and her vital signs was recorded as follows;

Temperature	36.6 ^{0}C
Pulse	82 beats per minutes
Respiration	19 cycles per minutes
Blood pressure	110/70 mmHg

Blood sample was taken to test for hemoglobin level and the result was 11.9g/dl. Permission was sought from client to examine her from head to toe. The procedure was explained and she was asked to empty her bladder and a sample of midstream urine was taken and tested for glucose and protein and all tested negative. Hands were washed and dried and examination was commenced.

On inspection, it was observed that the conjunctiva of the eyes was not pale, the nose was not discharging. Client's breasts were soft with no cracks or sore on the nipples. There was also no abdominal tenderness and the symphysio-fundal height measured 9cm and she was encouraged to do abdominal exercise. The flow of lochia was less and was serosa. After, findings were communicated to her and advised not to absent herself from post-natal clinic. Client was encouraged to report to the facility in case any emergency arises of any health issues.

SECOND POSTNATAL VISIT TO THE CLINIC (6 WEEKS)

According to the midwife in charge, Madam Yussif reported to the clinic at 9:00 am on the 27th December, 2021. She came along with her baby and they both looked nice and active. Every procedure to be carried out was explained to her. She was asked to empty her bladder and midstream urine was taken and tested for sugar and protein and the results were negative. Her haemoglobin level was 12.2g/dl. Her vital signs were taken which recorded as

Temperature- 36.3 degree Celsius

Pulse- 78 bpm

Respiration- 20cpm

Blood pressure- 100/60mmHg.

The baby was also examined from head to toe and everything was normal and her vital signs were checked and recorded as;

Temperature -36.6 degree Celsius

Apex beat- 134bpm

Respiration- 48cpm

Weight- 3,8kg.

Madam Yussif and her baby were sent to the Child Welfare Clinic for immunization as well as family planning unit after which they were handed over to the public health nurse for continuity of care.

TERMINATION OF CARE

Madam Yussif was informed that the study at the facility has ended and for that matter she has been handed over to the midwife in charge to continue her postnatal care and she will be called if the need arises for any information, and she gladly said she will be available anytime needed. Both mother and baby were healthy without any complications. She and her entire family were thanked for making time for the study, kindness and cooperation and wished them the best of luck

4.12 NURSING CARE PLAN DURING THE PUERPERIUM

This includes problems identified during puerperium, short term objectives, long term objectives and care plan for puerperium.

PROBLEMS IDENTIFIED

Client complained of lower abdominal pains.

Client complained of backache.

Client complained of sleepless night.

Skin rashes observed on the baby during physical examination.

Cracked nipples were observed on mother during physical examination

SHORT TERM OBJECTIVES

Client will be to cope with the lower abdominal pain within 72 hours.

Client backache will subside within 24 hours.

Client will be able to sleep 2 hours during the day and 3 hours at night within 24 hours.

Client's baby will have normal skin integrity within 5 days.

Client cracked nipples resolve within 48 hours and throughout puerperium.

LONG TERM OBJECTIVE

Client and baby will go through puerperium without any complications.

NURSING CARE PLAN DURING PUERPERIUM

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVE	NURSING ORDERS	NURSING INTERVENTIONS	DATE/ TIME	EVALUATION	SIGN
16/11/21 8am	After pain related to involution of the uterus.	Client will be able to cope with lower abdominal pain within 72 hours as evidenced by; 1. client verbalizing that the pain has reduced. 2. midwife visualizing client in a relaxed	1. Explain to client the physiology of after pain during the puerperium. 2. Encourage client to urinate frequently to enable the uterus to contract. 3. Tell client to apply warm compress to the abdomen to relieved pain.	1. Physiology of after pain during puerperium was explained to client. 2. Client was encouraged to urinate frequently to enable the uterus to contract. 3. Client was told to apply warm compress to the abdomen to relieve pain.	19/11/21 8am	Goal was fully met as client verbalized that she was relieved of after pain.	SAH

		mood of expression.	4. Serve prescribed analgesics (Tablet paracetamol, 1g.) 5. Encourage client to continue breastfeeding.	4. Prescribed analgesic was served (Tablet paracetamol, 1g). 5.Client was to encouraged to continue breastfeeding.			

NURSING CARE PLAN DURING PUEPERIUM

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVE	NURSING ORDERS	NURSNG INTERVENTION	DATE/ TIME	EVALUATION	SIGN
18/01/21 6am	Backache related to poor posture during breastfeeding	Client will be able to cope with backache within 24 hours as evidenced by; 1. client verbalizing that backache has been relieved. 2. midwife visualizing client adopting	1. Explain to client the physiology behind the pains. 2. Educate client to sit on a chair with a back rest and raise her legs on a small table whiles breastfeeding baby. 3. Demonstrate to client the correct position and attachment of baby to breast. 4. Educate client to have enough rest and sleep.	1. Physiology behind the pains was explained to client. 2. Client was educated to sit on a chair with a back rest and raise her legs on a small table whiles breastfeeding. 3. Client was taught the correct position and attachment of baby to breast. 4. Client was educated to have enough rest and sleep.	19/1/21 6:00am	Goal was fully met as client verbalized that backache had been relieved.	SAH

		good posture during breastfeeding.	5. Serve prescribed analgesics (tablet paracetamol 1g).	5. Prescribed analgesic was served (tablet paracetamol 1g).			

NURSING CARE PLAN DURING PUERPERIUM

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVE	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
18/11/21 7 :36 am	Insomnia related to night breastfeeding.	Madam Yussif will be able to sleep 2 hours during the daytime and 3 hours at night within 24 hours as evidence by; 1.Client verbalizing	1. Explain the importance of night breastfeeding to client. 2. Encourage her to breastfeed the baby on demand. 3. Encourage her to sleep when the baby is asleep. 4. Encourage her support person to help her in the household chores.	1. The importance of night breastfeeding was explained to her. 2. Client was encouraged on the essence of breastfeeding the baby on demand. 3.She was encouraged to sleep when baby was asleep. 4. Her relatives were encouraged to help her in her household chores like washing to enable her to sleep during the day.	19/11/21 9am	Goal met as Madam Yussif said that she slept 6 hours during the night and 2 hours during the day.	SAH

		having enough sleep. 2. Client's sister in law verbalizing observing client had enough sleep.	5. Encourage the client to rest enough during the day.	5. Client was encouraged to rest enough during the day,			

NURSING CARE PLAN DURING PUERPERIUM

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVE	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
21/11/21 7 :30 am	Skin rashes related to excessive sweating of baby at night.	Baby will have normal skin integrity within 5 days as evidenced by; 1. Mother verbalizing that skin rashes have subsided.	1. Educate client not to overdress the baby at night. 2. Educate client not to scratch the rashes to prevent infection. 3. Educate client to change baby's diapers regularly 4. Educate client to apply barrier cream (e.g. Vaseline and nkuto) to the area	1. Client was educated not to overdress the baby at night. 2. Client was educated not to scratch the rashes to prevent infection. 3. Client was educated to change baby's diapers regularly. 4. Client was educated to apply barrier cream (e.g. Vaseline and nkuto) to the area.	26/11/21 9am	Goal was fully met as skin rashes subsided; baby had normal skin integrity.	SAH

		2. Midwife visualizing diminished skin rashes on examination.	5. Educate client to bath baby with mild soap and water always.	5. Client was educated to bath baby with mild soap and water always			

NURSING CARE PLAN DURING PUERPERIUM

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVE	NURSING ORDERS	NURSING INTERVETION	DATE/ TIME	EVALUATION	SIGN
19/11/21 7:00am	Cracked nipples related to poor attachment of baby to breast.	Client will be able to cope with cracked nipples within 48 hours as evidenced by 1. Client verbalizing that pain from the	1. Explain the causes of painful nipples to client. 2. Teach client on proper positioning and fixing of baby to breast. 3. Encourage client to use warm soaked towel to bath the breast and teach client how to do it to prevent stasis of milk and enhance flow of breast milk.	1. Causes of painful nipples was explained to client. 2. Client was taught proper position and fixing baby to breast. 3. Client was encouraged to use warm soaked towel to bath the breast and taught how to do it to prevent stasis of milk and enhance flow of milk.	21/11/21 8:00am	Goal was fully met as client verbalized that she is coping with the cracked nipples.	SAH

		cracked has subsided. 2. Client sister in law verbalizing that client is coping with breastfeeding.	4. Encourage her to apply freshly expressed breast milk to the nipples after each feed. 5. Teach client to express breast milk into a clean bowl and feed baby with spoon if she is experiencing pains.	4. Client was encouraged to apply freshly expressed breast milk to the nipples after each feed. 5. Client was taught how to express breast milk into a clean bowl and feed baby with spoon if she was experiencing pains.			

SUMMARY AND CONCLUSION

This client and family centered maternity care study was carried on Madam Yussif, a 31-year-old gravida 4 Para 3 all alive and her entire family through pregnancy, labour and puerperium safely without any complications.

Madam Yussif was met as a regular attendant at the clinic who was in her 37th week at the time she was met. Arrangements were made for her to be used as client and she accepted willingly. Various histories were taken and she was visited to render midwifery care to her entire family in her house. Client was assisted throughout her late pregnancy, labour and puerperium safely without any complication. During the care, she encountered some minor disorders and was managed appropriately through the use of the nursing process. She was also educated on importance of exclusive breastfeeding, personal hygiene; danger signs in pregnancy, nutrition, postnatal exercise among others were all discussed until she delivered.

Client had a spontaneous vaginal delivery of a live female child on 16th November, 2021 with weight of 3.0kg at 7: 25pm. Placenta and membranes were delivered by the active management of the third stage. Client went through normal puerperium without any complications as of the time she was discharged home on the 17th November, 2021. Postnatal care was well rendered to her and the baby and all problems during the period were addressed promptly. Visits were made to her house to give daily routine care. She was visited till the 7th day after delivery and she later reported to the clinic for the first week and was handed over to the midwife - in charge and the child welfare clinic for continuity of care.

In conclusion, client family centered maternity care study equipped me with the skills to deal with challenges of pregnant, labouring and puerperal women. It also established between the midwife and client as well as her family good interpersonal relationship.

Again, care study encourages learning by doing, the development of analytical and decision-making skills as well as reporting skills. Being base on the nursing process, the students become familiar with the use of nursing process as a basic for practice thereby encouraging evidence-based nursing care, as it provides a systematic way of collecting data, analyzing information and reporting the results of nursing care. It gives an in-depth description and explanation of how a patient's response to a specified disease condition is diagnosed and given intervention.

The study also broadened student knowledge on issues concerning pregnancy, labour and puerperium. With this experience gained, standard care will be rendered to all clients that will come irrespective of their social status and the environment in other to reduce maternal and infant morbidity and mortality.

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APPENDIX I

ANTENATAL CHART

DATE	WEIGHT	BLOOD PRESSURE	URINE TEST	GESTATIONAL AGE	SYMPHYSIO FUDAL HEIGHT	PRESENTATION	DESCENT	FETAL HEART RATE	TREATMENT	COMPLAINS	NAME/ SIGN.
28/04/21	79	106/60mmHg	negative/ negative	EP	NP	-	-	-	Routine Drugs	Nausea	LG
26/05/21	80.4	100/60mmHg	negative/ negative	EP	NP	-	-	-	Routine Drugs	Low abdominal pains	JBH
23/06/21	82	110/60mmHg	negative / negative	18weeks	17	-	$5/5^{th}$	FM+	Routine Drugs	Nausea and abdominal pains	AKU

21/07 /21	84	110/70m mHg	negative / negative	22weeks	20	Cephalic	5/5th	142	Routine Drugs	No complains	AKU

DATE	WEIGHT	BLOOD PRESSURE	URINE TEST	GESTATIONAL AGE	SYMPHYSIO FUNDAL HEIGHT	PRESENTATION	DESCENT	FOETAL HEART RATE	TREATMENTS	COMPLAINS	NAME/SIGN
18/08/21	85kg	95/67mmHg	negative	26 weeks	25 cm	cephalic	5/5th	142bpm	Routine drugs	No complains	AKU
15/09/21	85.2kg	96/54mmHg	negative	30 weeks	29cm	cephalic	5/5th	138bpm	Routine drugs	No complains	AKU
29/09/2021	87kg	90/60mmHg	negative	32 weeks	30cm	cephalic	5/5th	140bpm	Routine drugs	Lower abdominal pains	AKU
13/10/1021	87kg	100/60mmHg	negative	34 weeks	32cm	cephalic	5/5th	148bpm	Routine drugs	No complains	AKU
27/10/2021	88kg	100/60mmHg	negative	36 weeks	35cm	cephalic	5/5th	143bpm	Routine drugs	No complains	AKU

DATE	WEIGHT	BLOOD PRESSURE	URINE TEST	GESTATIONAL AGE	SYMPHYSIO FUNDAL HEIGHT	PRESENTATION	DESCENT	FOETAL HEART RATE	TREATMENTS	COMPLAINS	NAME/ SIGN
03/11/2021	88.6kg	90/70mmHg	Negative	37 weeks	36cm	cephalic	$5/5^{th}$	138bpm	Routine drugs	No complains	SAH
10/11/2021	87kg	90/60mmHg	Negative	38 weeks	36cm	cephalic	$5/5^{th}$	140bpm	Routine drugs	Constipation	SAH

APPENDIX II

COMPLETE DIAGNOSTIC INVESTIGATIONS

DATE	SPECIMEN	IVESTIGATION	NORMAL VALUES	FINDINGS	REMARKS
1 28/04/2021	Blood	Haemoglobin level	11.4g/dl-16g/dl	13.7g⁄dl	Normal
		Sickling status	Negative	Negative	Normal
		Grouping and Rhesus factor	A, B, AB, and O	O	Normal
		HIV status	Positive and negative	Positive	Normal
		VDRL	None reactive	Negative	Normal
		Hepatitis status	None reactive	Non-defect	Normal
		G6PD status	Negative	Negative	Normal
		Sugar	None reactive	Non-defect	Normal
	Urine	Protein	Negative	Negative	Normal
			Negative	Negative	Normal
2 26/05/2021	Urine	Sugar	Negative	Negative	Normal
		Protein	Negative	Negative	Normal

23/06/2021	1.Urine Blood	Sugar Protein Haemoglobin level	Negative Negative 11.4g/dl-16g/dl	Negative Negative 13.2g/dl	Normal Normal Normal

1 21/07/2021	1.Urine Protein	Sugar Protein	Negative Negative	Negative Negative	Normal Normal
1 18/08/2021	1.Urine 2. Blood	Sugar Protein Haemoglobin level	Negative Negative 11.4g/dl-16g/dl	Negative Negative 13.0g/dl	Normal Normal Normal
DATE	SPECIMEN	IVESTIGATION	NORMAL VALUES	FINDINGS	REMARKS
15/09/2021	1.Urine 2. Blood	Sugar Protein Haemoglobin level	Negative Negative 11.4g/dl-16g/dl	Negative Negative 12.8g/dl	Normal Normal Normal
29/09/2021	1.Urine	Sugar Protein	Negative Negative	Negative Negative	Normal Normal
13/10/2021	1.Urine	Sugar	Negative	Negative	Normal

		Protein	Negative	Negative	Normal
27/10/2021	1.Urine	Sugar Protein	Negative Negative	Negative Negative	Normal Normal

APPENDIX III

PHARMACOLOGY OF DRUGS USED (MOTHER)

NAME OF DRUGS	CLASSIFICATION	DOSAGE	ROUTE OF ADMINISTRA-TION	ACTION & USE	ACTUAL EFFECTS	SIDE EFFECT OF DRUGS	SIDE EFFECT EXPERIENCED
Tablet folic acid	Haematinics	5 milligrams once daily	Orally	Proper formation and functioning of red blood cell and also prevent neural tube defect.	Haemoglobin level increase	Nausea and vomiting	None
Tablet Multivitamin	Vitamin preparation	200 milligrams twice daily	Orally	Increased appetite. Helps in the metabolic	Increase appetite.	Gastro intestinal disturbances	None

				process in the body.			
Tablet Ferrous Sulphate	Iron supplement	200 milligrams 2 twice	Orally	Help in formation of hemoglobin and red blood	Hemoglobin level increased	Gastrointestinal disturbance	Dark stool

APPENDIX III

PHARMACOLOGY OF DRUGS USED (MOTHER)

NAME OF DRUGS	CLASSIFICATION	DOSAGE	ROUTE OF ADMINISTRATION	ACTION & USE	ACTUAL EFFECTS	SIDE EFFECT OF DRUGS	SIDE EFFECT EXPERIENCED
Tablet folic acid	Haematinics	5 milligrams once daily	Orally	Proper formation and functioning of red blood cell and also prevent neural tube defect.	Haemoglobin level increase	Nausea and vomiting	None
Tablet Multivitamin	Vitamin preparation	200 milligrams twice daily	Orally	Increased appetite. Helps in the	Increase appetite.	Gastro intestinal disturbances	None

				metabolic process in the body.			
Tablet ferrous sulphate	Iron supplement	200 milligrams 2 twice	Orally	Help in formation of hemoglobin and red blood	Haemoglobin level increased	Gastrointestinal disturbance	Dark stool

PHARMACOLOGY OF DRUGS USED CONTINUED (MOTHER)

NAME OF DRUGS	CLASSIFICATION	DOSAGE	ROUTE OF ADMINISTRATION	ACTION & USE	ACTUAL EFFECTS	SIDE EFFECT OF DRUGS	SIDE EFFECT EXPERIENCED
Tablet Sulphadoxine Pyrimethamine	Anti-malaria and prophylaxis	3 doses stat from 16 weeks or after quickening and the remaining doses within 4 weeks interval until she delivers.	Orally	Treatment and prevention of malaria	Malaria prevention	Itching, nausea, dizziness, headache	None

PHARMACOLOGY OF DRUGS USED CONTINUED (MOTHER)

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

Tablet paracetamol	Analgesia and antipyretic	100 milligram 3 times daily for 3 days	Orally	Helps to reduce high body temperature and reduce pain	Pain was reduced	Liver damage	None
Capsule Amoxicillin	Antibiotic	500 milligram 3 times daily start	Orally	Action against susceptible bacteria during the stage of active multiplication.	Client was free from infection	Diarrhoea	None

APPENDIX IV

PHARMACOLOGY OF DRUGS USED (BABY)

NAME OF DRUGS	CLASSIFICATION	DOSAGE	ROUTE OF ADMINISTRATION	ACTION & USE	ACTUAL EFFECTS	SIDE EFFECT OF DRUGS	SIDE EFFECT EXPERIENCED
Vitamin K	Group K vitamins (coagulant)	1.0mg	Intramuscular	Production of prothrombin which aids in clotting	No bleeding	None	None
Chloramphenicol eye drop	Antibiotics	2 drops	Instillation	To prevent infection	Infection of the eye was prevented	None	None
Oral polio vaccine	Antigen vaccine	2 drops	Orally	Production of antibodies	Baby was under observation	There may be diarrhea	None

Injection Bacillus Calmette Guerin	Antigen vaccine	0.5 Milligrams	Intradermal	Production of antibodies for prevention of tuberculosis	Baby was under observation	Blister formation	None

WHO Modified Partograph

Registration No.: 14230/21 Name(Last, First) Zulfawo Yussif Age: 31yrs
Date: 16/11/21 Parity/Gravida 3/4 LMP 17/02/21 EDD 24/11/21 Gestation(wks) 38+6
ROM: 6:30pm/16/11 Labour Duration (Hrs) 5hrs, 24mins Facility/Clinic Name Alice Maternity Home

FETAL HEART RATE

LIQUOR MOULDING

CERVIX (CM)

Plot X

DESCENT Plot C

HOURS

TIME

Alert

Action

16/11/2021 SVD @ 7:25pm
OF LFC.
A/S - 8/10, 9/10
B/wt - 3.0 kg
3rd Stage - complete
Peri - intact
EBL - 120mls. DL - 5hrs, 24mins under my care.
Delivered by: Serwaah Akua Henrietta.
Assisted by the Midwife in charge.

CONTRACTIONS PER 10 MINS

Oxytocin U/L Drops / minute

DRUGS & IV FLUIDS

IV R/L 500mls

BLOOD PRESSURE & PULSE

TEMPERATURE

URINE Amount Protein

LABOR NOTES

Client G4P3 reported to the ward at 2:10pm with complains of labour. At 7:25pm, client had a spontaneous vaginal delivery to a live female child with Apgar score - 8/10, 9/10. Birth weight of 3.0kg, Head circumference 32cm, full length of 49cm. Active management of third stage of labour done with oxytocin 10units given IM on the thigh. Placenta and it's membranes delivered successfully using control cord traction. Blood loss - 120mls. Perineum intact. Fundus was 17cm. Both mother and baby cleaned and made comfortable in bed.

Please circle or write responses.

DELIVERY

DATE: 16/11/21 TIME: 7:25pm METHOD: (Spontaneous) / Vacuum Extraction / C/S / Other

PERINEUM: (Intact) / Episiotomy / Laceration

ANESTHESIA: (None) / Local / General

THIRD STAGE

Active Management: (Yes) / No · Medication: Time 7:25pm Type/Dose Oxytocin 10 units.

PLACENTA: TIME: 7:32pm (Complete) / Incomplete

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

BABY

Weight: 3.0 kg

Sex: Male / (Female)

Baby Position: (Vertex) / Breech / Other

APGAR

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

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

FOURTH STAGE MONITORING

Frequency	Time	B/P.	Pulse	Fundus	Bleeding	Bladder
Every 15 minutes first 2 hours	7:55pm	120/70	85 bpm	17 cm	moderate	85mls
	8:10pm	120/70	87 bpm	17 cm	moderate	
	8:25pm	120/80	82 bpm	17 cm	moderate	—
	8:40pm	120/75	88 bpm	17 cm	moderate	
	8:55pm	110/60	73 bpm	17 cm	moderate	110mls
	9:10pm	120/60	76 bpm	17 cm	moderate	
	9:25pm	110/70	74 bpm	17 cm	moderate	—
	9:40pm	110/60	72 bpm	17 cm	moderate	
Every 30 minutes For 1 hour	10:10pm	110/60	75 bpm	17 cm	moderate	100mls.
	10:40pm	110/60	71 bpm	17 cm	moderate	

Birth Attendant Serwaa Afua Henrietta (student Midwife) Date 16/11/2021

Supervised by: Abdul-Karim Ubaida.

MATERNITY CHART

NAME: Yussif Zulfawo

AGE: 31 yrs WARD: Lying-in

IP NO.: 14230/21 BED NO.: 3

Date	16/11/21	17/11/21	18/11/21	19/11/21	20/11/21	21/11/21	22/11/21	23/11/21
Days in Hospital	DD	1	2	3	4	5	6	7
Days P. O.								
Hour Am		9:10	7:36	7:00	7:00	7:00	7:30	8:00
Hour Pm	7:55	5:30	5:00	5:00				
Temperature C / F								
Pulse	22	24	20	21	22	19	20	20
Resp.	37	37	37	37	37	37	37	37
B.M.	—	—	—	—	—	—	—	—
Urine	Passed	Passed	Passed	Passed	Passed	Passed	Passed	Passed
B. P. Am		110/70	110/60	110/70	110/80	100/80	110/60	110/70
B. P. Pm	120/70	110/80	120/70	110/70				

Key
- Symphysio fundal height
- Temperature

Scale = 1cm : 1unit

NEW BORN EXAMINATION FORM

Name: Baby Abena Yussif Date of Assessment: 17/11/2021 Time: 9:10am
Date of Birth: 16/11/21 Time of Birth: 1:25pm Sex: ☐ M ☑ F Age at time of Assessment (days/hrs) 8hrs
Astational Age 38 wks + 6 days Mode of Delivery: ☑ Vaginal Assisted Vaginal C-Section
APGAR: 1min 8/10 5min 9/10 Birth Weight: ☐ 3.0kg ☐ Length: 49 cm Head Circumference: 32 cm
Temperature at time of Assessment: 36.4 °C Urine passed: Yes No Meconium passed: Yes No
Name of Assessor (Midwife/Doctor): _____

1. Respiration
Rate 42cpm
☐ Rate < 30 b/m *
☐ Rate < 60 b/m *
☑ 30-60 b/m
☐ Retractions *
☐ Grunting *
☐ Stridor *

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

3. Tone
☑ Normal
☐ Floppy *
☐ Increased *

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

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

6. Cry
☑ Normal
☐ Shrill *
☐ Absent *

7. Suck
☑ Good
☐ Weak
☐ Absent

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

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

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

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

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

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

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

16. Clavicle
☑ Normal
☐ Swelling/Fracture

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

18. Heart rate
Rate: 135bpm
☑ Normal (100-160)
☐ <100 *
☐ >160*

19. Femoral pulse
☑ Present
☐ Not palpable*

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

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

22. Limbs
☑ Normal
☐ Abnormal _____

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

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

24. Anus
☑ Patent
☐ Imperforate*

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

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

***May indicate severe disease that requires urgent referral**
Diagnoses (if known) Spontaneous Vaginal delivery

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

NEW BORN EXAMINATION FORM

Name: Baby Abena Yussif Date of Assessment: 16-11-2022 Time: 8:30pm
Date of Birth: 16-11-2022 Time of Birth: 7:25pm Sex: ☐ M ☑ F Age at time of Assessment (days/hrs) 1hr
Astational Age 38 wks + 6 days Mode of Delivery: ☑ Vaginal Assisted Vaginal C-Section
APGAR: 1min 8/10 5min 9/10 Birth Weight: ☐ 3.0 kg ☐ Length: 49 cm Head Circumference: 32 cm
Temperature at time of Assessment: 36.4 °C Urine passed: Yes No Meconium passed: Yes No
Name of Assessor (Midwife/Doctor): Serwaa Atua Henrietta

1. Respiration
Rate 45cpm
☐ Rate < 30 b/m *
☐ Rate < 60 b/m *
☑ 30-60 b/m
☐ Retractions *
☐ Grunting *
☐ Stridor *

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

3. Tone
☑ Normal
☐ Floppy *
☐ Increased *

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

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

6. Cry
☑ Normal
☐ Shrill *
☐ Absent *

7. Suck
☑ Good
☐ Weak
☐ Absent

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

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

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

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

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

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

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

16. Clavicle
☑ Normal
☐ Swelling/Fracture

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

18. Heart rate
Rate: 125bpm
☑ Normal (100-160)
☐ <100 *
☐ >160*

19. Femoral pulse
☑ Present
☐ Not palpable*

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

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

22. Limbs
☑ Normal
☐ Abnormal _____

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

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

24. Anus
☑ Patent
☐ Imperforate*

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

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

*May indicate severe disease that requires urgent referral
Diagnoses (if known) Spontaneous vaginal delivery

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

TEMPERATURE CHART

NAME: Baby Abena Yussif

AGE: New WARD: Lying-in

IP NO.: 21113/21 BED NO.: 3

Date	16/11/21	17/11/21	18/11/21	19/11/21	20/11/21	21/11/21	22/11/21	23/11/21
Days in Hospital	DD	1	2	3	4	5	6	7
Days P. O.								
Hour Am		9:10	7:36	7:00	7:00	7:30	8:00	9:30
Hour Pm	7:55	5:30	5:00	5:00				

Temperature

C	F
41.1°	106°
40.5°	3.2 105°
40.0°	3.1 104°
38.5 39.4°	3.0 103°
38.0 38.9°	2.9 102°
37.5 38.3°	2.8 101°
37.0 37.7°	2.7 100°
36.5 37.2°	2.6 99°
36.0 36.6°	2.5 98°
35.1°	97°
35.5°	96°
35°	95°

Key
- Baby's weight
- Baby's temperature

Scale - 1cm : 1 unit

Pulse	125	135 130	140 138	132 135	132	120	136	138
Resp.	45	42 48	48 44	46 43	42	44	41	42
B.M.	Passed	Passed	Passed	Passed	Passed	Passed	Passed	Passed
Urine	Passed	Passed	Passed	Passed	Passed	Passed	Passed	Passed
B. P.								

NEW BORN CHART

Name: Baby Abena Yussif ..... No: 21113/21 ..... Birth Weight: 3.0kg .....

Sex: female ..... Mother's No: 14230/21 ..... Length: 49 cm .....

Nature of Delivery: Spontaneous vaginal delivery ..... Diagnosis: Term Baby .....

Date of Birth: 16-11-2021 ..... Time: 7:25 pm ..... Date of Discharge: 17-11-2021 .....

Date	16/11/21		17/11/21		18/11/21		19/11/21		20/11/21		21/11/21		22/11/21		23/11/21		24/11/21					
No. of Days	DOD		D1		D2		D3		D4		D5		D6		D7		D8					
Weight	3.0 kg		3.0kg		2.9 kg		2.8 kg		2.8 kg		2.9kg		3.0kg		3.1 kg		3.2kg					
	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM
Temperature		36.5°C	36.4°C	36.6°C	36.3°C	36.4°C	36.8°C	36.7°C	36.8°C		36.6°C		36.6°C		36.7°C		36.4°C					
Stools		Passed	Passed	Passed	Passed	Passed	Passed	Passed	Passed		Passed		Passed		Passed		Passed					
Urine		Passed	Passed	Passed	Passed	Passed	Passed	Passed	Passed		Passed		Passed		Passed		Passed					
Remarks	Head Neck Limbs Genitalia		MAD																			

SIGNATORIES

THE STUDENT MIDWIFE

NAME: HENRIETTA AKUA SERWAA

SIGNATURE: .....

DATE: 03-10-2022

THE MIDWIFE IN CHARGE

NAME: MS. ABDUL -KARIM UBAIDA

SIGNATURE: ..... (For)

DATE: 07/10/2022

THE SUPERVISOR

NAME: MRS AHIAWORNU CELESTINE

SIGNATURE: ..... (For)

DATE: 07/09/2022

THE PRINCIPAL

NAME: MONICA NKRUMAH

SIGNATURE: ..... (for)

DATE: 30th September, 2022

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